Tribal and Indian Health Program Representatives Meeting

Department of Health Care Services

February 27, 2023

DHCS

Overview

- Welcome and Introductions
- Agenda Review
- Items for Next Meeting

DHCS Coverage Ambassadors

Continuous Coverage Operational Unwinding Plan and Coverage Ambassadors

- **When the COVID-19 PHE ends, 2-3 million Medi-Cal beneficiaries could lose their coverage.**

- **DHCS' Top Goal:** Minimize beneficiary burden and promote continuity of coverage for beneficiaries.

- **DHCS Coverage Ambassador** campaign: Educate, Engage, and Provide Consistency.

Who are DHCS Coverage Ambassadors?

- Trusted messengers who deliver important messages to Medi-Cal beneficiaries.
- DHCS coverage ambassadors are made up of diverse organizations that can reach beneficiaries in culturally and linguistically appropriate ways.
- DHCS Coverage Ambassadors will connect Medi-Cal beneficiaries at the local level with targeted and impactful communication.

Who can sign up to become a DHCS Coverage Ambassador?

- State and Federal Agencies
- Providers
- Managed Care Plans
- Local County Offices
- Health Navigators
- Advocates and Stakeholders
- Community-Based Organizations
- Health Care Facilities
- Clinics
- DHCS Employees

Ambassador Roles

» Stay up to date on the latest information.

» Communicate with Medi-Cal beneficiaries to encourage them to update their contact information and return requested information about their Medi-Cal coverage.

Communication Goals

- **Educate** – Raise awareness of actions beneficiaries need to take and when they need to take them in order to maintain coverage.

- **Engage** – Engage community partners with necessary tools for reaching beneficiaries.

- **Provide Consistency** – Create a consistent voice across community partners.

DHCS Ambassadors Resources

» Join the DHCS Coverage Ambassador mailing list

» Download the Outreach Toolkit on the DHCS Coverage Ambassador webpage

» Contact: Ambassadors@dhcs.ca.gov

Questions?

Contact: Ambassadors@dhcs.ca.gov

DHCS Director's Update

Michelle Baass
DHCS Director

Governor's Proposed Budget

- The Governor's proposed Fiscal Year (FY) 2023-24 budget includes $144 billion in total funds for DHCS.
- Expanding health care access to all Californians is a key focus of the Administration.
  - Expansion of full scope Medi-Cal to adults ages 26 through 49, regardless of immigration status, effective January 1, 2024. The budget includes $844 million total funds ($634.8 million General Fund).
  - With this expansion, full scope Medi-Cal coverage will be available to all otherwise eligible Californians, regardless of immigration status.

Proposed Budget (Continued)

- New major budget issues and proposals include:
  - **Managed Care Organization (MCO) Tax**
  - **Designated State Health Program (DSHP) and Primary Care and Obstetric Rate Increases**
    - Proposal to continue DSHP under the CalAIM waiver effective January 1, 2023 to December 31, 2026.
    - Claim additional $646.4 million in federal funding over four years.
    - As part of the DSHP approval, primary care will receive a 10% increase in fee-for-service (FFS) for all codes under 80% of Medicare.
    - Obstetric care and doulas will receive a 10% increase for both FFS and managed care for all codes under 80% of Medicare (including codes that do not have a Medicare equivalent).

DHCS Budget Proposals (Continued)

- Proposal for a new Section 1115 waiver entitled **California's Behavioral Health Community-Based Continuum (CalBH-CBC) Waiver** to expand access and strengthen the continuum of behavioral health services.
- Proposal to add **Transitional Rent** as part of the CalAIM waiver to authorize an additional Community Support for use by Medi-Cal managed care plans (MCPs).
- Proposal to continue California's progress toward equitable access to comprehensive family planning and related services through the **Reproductive Health Services** Section 1115 waiver.

DHCS Budget Proposals (Continued)

- Proposal to **Strengthen Oversight for Substance Use Disorder Licensing and Certification**, including establishing a new mandatory certification program, and an increase in licensing fees to ensure ongoing support for the program.
- Proposal to utilize Opioid Settlement Funds to expand the Naloxone Distribution Project as part of the **Opioid Response Package**.
- Additional funding for **Community Assistance, Recovery, and Empowerment (CARE) Court** to support county costs.

DHCS Budget Proposals (Continued)

- Given the state's projected General Fund revenue decline, the budget includes several delays in funding for initiatives approved in prior budgets.
  - Delay of **Behavioral Health Bridge Housing Funding** from FY 2023-24 to FY 2024-25.
  - Delay of **Behavioral Health Continuum Infrastructure Program Funding** Round 6 to FY 2024-25 and FY 2025-26.
  - **Delay Buyback of Two-Week Checkwrite Hold** until FY 2024-25.

Resources

- **DHCS Budget Highlights:** https://www.dhcs.ca.gov/Documents/Budget-Highlights/DHCS-FY2023-24-GB-Highlights.pdf
- **Governor's Proposed Budget:** https://ebudget.ca.gov/budget/2023-24/#/BudgetDetail
- **November Medi-Cal Estimate:** https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/default.aspx

Questions and Discussion

CalAIM Justice Involved Initiative

Brian Hansen
Policy Advisor to the Directorate

CMS Approval of CalAIM Justice-Involved Program

National Context for California's 1115 Demonstration Request

Until now, due to a provision of federal Medicaid law known as the "inmate exclusion," inpatient hospital care was the only service that could be covered by Medicaid for individuals considered an "inmate of a public institution."

- In 2018, Congress passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) which requires HHS to provide guidance to states on how to seek 1115 demonstration authority to waive the inmate exclusion in order to improve care transitions to the community for incarcerated individuals.
- Prior to HHS' release of guidance, California, along with 14 other states, submitted 1115 demonstration requests to provide pre-release services to justice-involved populations.
- Through its CalAIM 1115 Demonstration, California received federal approval to provide a targeted set of Medi-Cal services to youth and adults in state prisons, county jails and youth correctional facilities for up to 90 days prior to release.

California is the first state in the nation to get federal approval to provide pre-release services.

Rationale for Providing Pre-Release Services

California has received approval to authorize federal Medicaid matching funds for select Medicaid services for eligible justice-involved individuals in the 90-day period prior to release from incarceration in prisons, county jails and youth correctional facilities.

The intent of the demonstration is to **build a bridge to community-based care for justice-involved Medi-Cal members**, offering them services to stabilize their condition(s) and establishing a re-entry plan for their community-based care prior to release.

This demonstration is **part of California's comprehensive initiative to improve physical and behavioral health care for the justice-involved population** and builds on the State's substantial experience and investments on ensuring continuity of Medi-Cal coverage and access to care for JI populations.

With its 1115 demonstration, California will directly test and evaluate its expectation that **providing targeted pre-release services to Medi-Cal-eligible individuals will avert the unnecessary use** of inpatient hospitals, psychiatric hospitals, nursing homes, emergency departments and other forms of costly and inefficient care that otherwise would be paid for by Medi-Cal.

Justice-Involved Reentry Initiative Goals

The demonstration approval represents a first-of-its-kind section initiative, focused on improving care transitions for incarcerated individuals.

With the implementation of this demonstration, DHCS hopes to achieve the following:

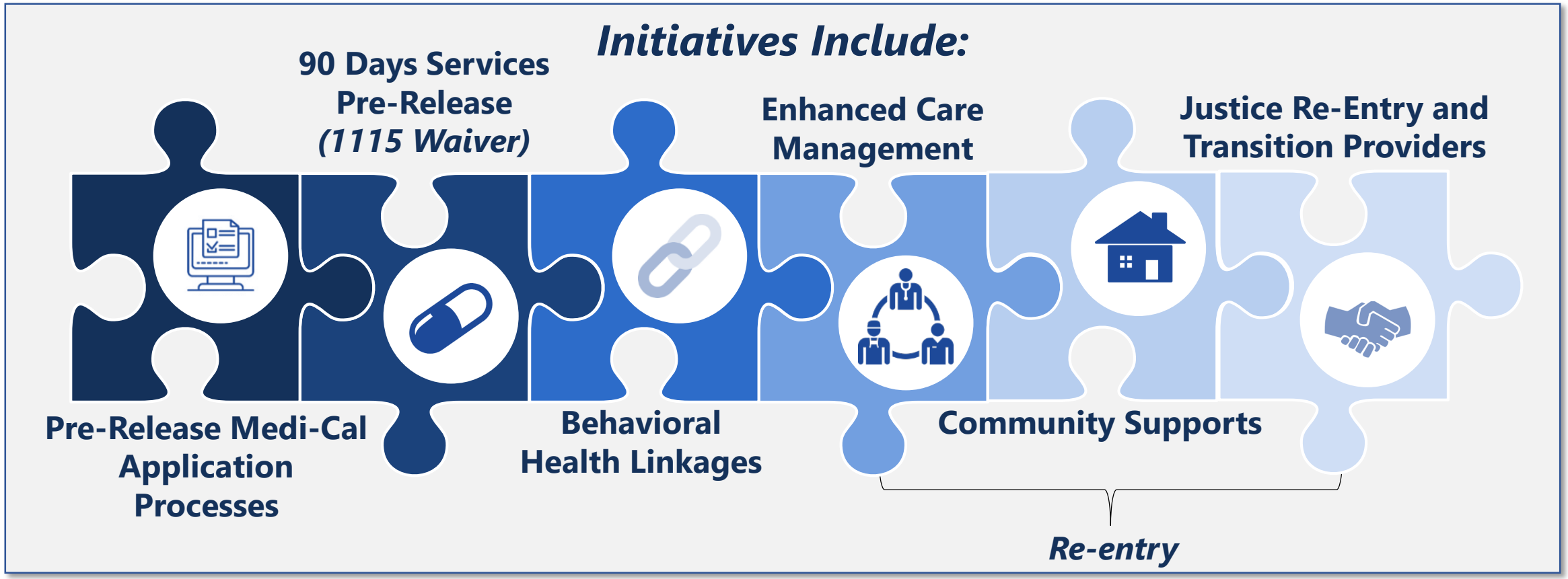
Advance health equity: The issue of poor health, health outcomes, and death for incarcerated people is a health equity issue because Californians of color are disproportionately incarcerated—including for mental health and SUD-related offenses. These individuals have considerable health care needs but are often without care and medications upon release.

Improve health outcomes: By implementing this initiative, California aims to provide a targeted set of services in the pre-release period to establish a supportive community reentry process, help individuals connect to physical and behavioral health services upon release, and ultimately improve physical and behavioral health outcomes.

Serve as a model for the rest of the nation: California is the first state to receive approval for this initiative. We hope our model will serve as a blueprint for the dozen additional states with pending justice-involved 1115 waivers.

The Justice-Involved Reentry Initiative is One Component of the CalAIM Justice-Involved Initiative

CalAIM justice-involved initiatives support justice-involved individuals by providing key services pre-release, enrolling them in Medi-Cal coverage, and connecting them with behavioral health, social services, and other providers that can support their re-entry.



Eligibility Criteria, Covered Services and Capacity Funding

Eligibility Criteria for Pre-Release Services

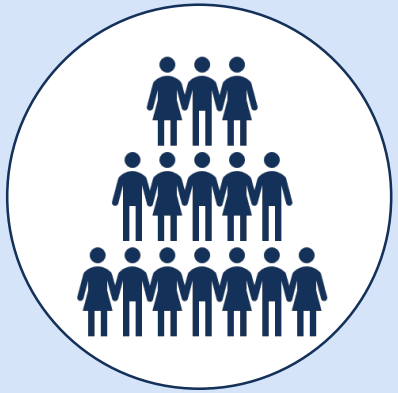
Medi-Cal-eligible individuals who meet the pre-release access screening criteria may receive targeted Medi-Cal pre-release services in the 90-day period prior to release from correctional facilities. DHCS developed detailed definitions for qualifying criteria, based on extensive stakeholder feedback (See Appendix).

Medi-Cal Eligible:

- Adults
- Parents
- Youth under 19
- Pregnant or postpartum
- Aged
- Blind
- Disabled
- Current children and youth in foster care
- Former foster care youth up to age 26

CHIP Eligible:

- Youth under 19
- Pregnant or postpartum



Criteria for Pre-Release Medi-Cal Services

Incarcerated individuals must meet the following criteria to receive in-reach services:

- ✓ Be part of a **Medicaid or CHIP Eligibility Group**, and
- ✓ Meet **one** of the following health care need criteria:
  - Mental Illness
  - Substance Use Disorder (SUD)
  - Chronic Condition/Significant Clinical Condition
  - Intellectual or Developmental Disability (I/DD)
  - Traumatic Brain Injury
  - HIV/AIDS
  - Pregnant or Postpartum

Note: *All incarcerated youth are able to receive pre-release services and do not need to demonstrate a health care need.*

Covered Pre-Release Services

The pre-release services authorized under the Justice-Involved Reentry Initiative include the following services currently covered under DHCS's Medicaid and CHIP State Plans. DHCS worked extensively with stakeholders to develop definitions for each of the covered services *(*See Appendix).

- Reentry case management services;
- Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning;
- Laboratory and radiology services;
- Medications and medication administration;
- Medications for addiction treatment (MAT), for all Food and Drug Administration-approved medications, including coverage for counseling; and
- Services provided by community health workers with lived experience.

In addition to the pre-release services specified above, qualifying members will also receive **covered outpatient prescribed medications and over-the-counter drugs** (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan) and **durable medical equipment (DME)** upon release, consistent with approved state plan coverage authority and policy.

Pre- and Post-Release Care Management to Support Re-Entry

Correctional facilities and community-based care managers will play a key role in re-entry planning and coordination, including notifying implementation partners* of release date, if known, supporting pre-release warm handoffs, facilitating behavioral health linkages, and dispensing medications and/or DME upon reentry.

Enhanced Care Management (ECM)	Behavioral Health Linkages	Warm Handoff Requirement
Individuals who meet the CalAIM pre-release service access criteria will qualify for ECM Justice Involved Population of Focus and **will be automatically eligible for ECM** until a reassessment is conducted by the managed care plan (MCP), which may occur up to six months after release.	To achieve continuity of treatment for individuals who receive behavioral health services while incarcerated, DHCS will require correctional facilities to: » **Facilitate referrals/linkages to post-release behavioral health providers** (e.g., non-specialty mental health, specialty mental health, and SUD). » **Share information with the individual's health plan** (e.g., MCPs, SMHS, DMC-ODS) or program (i.e., DMC).	Prior to release, the pre-release care manager must do the following: » **Share transitional care plan** with the post-release care manager and MCP. » **Schedule and conduct a pre-release care management meeting** (in-person or virtual) with the member and pre- and post-release care managers (if different) to: » Establish a trusted relationship. » Develop and review care plan with member. » Identify outstanding service needs.

*Implementation partners include social services departments, post-release care manager (if different from pre-release care manager, MCPs, and county behavioral health agencies

Providing Access and Transforming Health (PATH) Capacity Building Program

The approved CalAIM 1115 waiver authorizes $410 million for PATH Justice-Involved Capacity Building Program to support collaborative planning and IT investments intended to support implementation of pre-release and reentry planning services in the 90 days prior to release.

Funding from the PATH Justice-Involved Capacity Building Program will provide implementation grants to correctional facilities (or their delegates), county behavioral health agencies, community-based providers, probation officers, sheriff's offices, and other implementation stakeholders.

Funding is intended to support eligible entities as they stand-up processes, protocols, and IT system modifications that are necessary to implement or modify processes to support the provision of pre-release services.

This funding can be used for investments in personnel, capacity, or IT systems that are needed to effectuate pre-release service processes.

DHCS will provide detailed guidance on PATH applications.

Monitoring and Evaluation

Proposed Evaluation Framework

DHCS recognizes that the pre-release services would represent a major new initiative for both California and the Biden Administration. Additionally, Congress and states around the country will be very interested in how the initiative is implemented and its effectiveness.

As such, DHCS is planning a robust evaluation of this intervention which will examine a number of factors, which may include, but are not limited to:

- ☑ The time from incarceration to onset of pre-release services, take up of services, pre-incarceration utilization patterns, and differences in these factors between different types of facilities (state prisons, county jails, youth correctional facilities).
- ☑ Utilization of specific pre-release services, including use of MAT, behavioral health management, prescriptions filled, receipt of durable medical equipment.
- ☑ Actual impacts of pre-release services for engaged enrollees (as compared to enrollees who did not engage in pre-release services) on health outcomes for Medi-Cal members; inpatient and emergency department utilization post-release; and Medi-Cal expenditures.
- ☑ Duration of Medi-Cal eligibility and enrollment for the eligible justice-involved population in the months following release.

Implementation Plan and Readiness Assessment Process

Reentry Demonstration Initiative Implementation Plan

California is required to submit a Reentry Demonstration Initiative Implementation Plan to describe, at a minimum, the state's approach to implementing the initiative, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation.

California will be required to provide detailed information related to the following milestones and actions, no later than 120 days after the Demonstration's approval:

Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated.

Milestone 2: Covering and ensuring access to the expected minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community.

Milestone 3: Promoting continuity of care to ensure access to services both pre- and post-release.

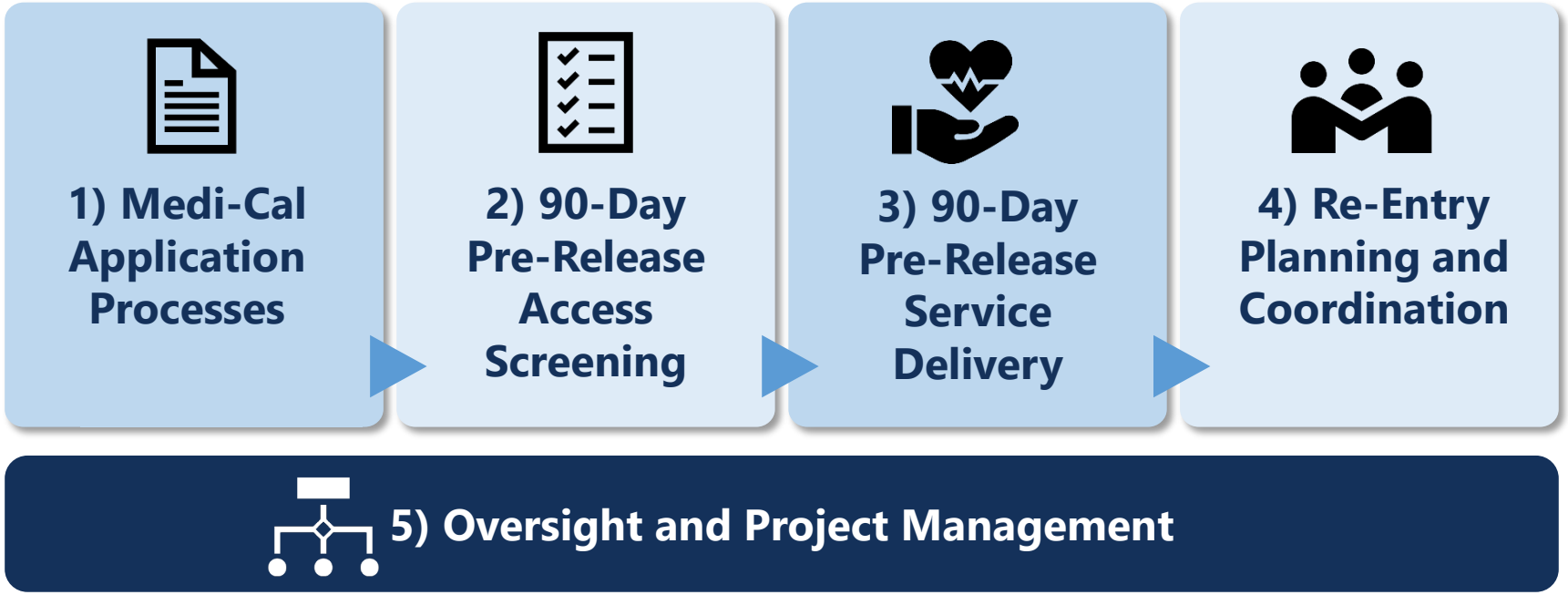
Milestone 4: Connecting to services available post-release to meet the needs of the reentering population.

Milestone 5: Ensuring cross-system collaboration.

Correctional Facility Readiness Assessment Approach

As a condition of the Demonstration, all prisons, jails and youth correctional facilities will be required to demonstrate readiness to participate in the justice-involved initiative prior to going live with pre-release services.

DHCS will launch a readiness assessment process that will focus on five key areas needed to operationalize 90-day pre-release services:



Note: An abbreviated readiness process will also be established for County social service departments to ensure eligibility and enrollment processes facilitate pre-release services.

Summary: Correctional Agency Readiness Assessment

Below is an overview of the readiness elements within each focus area, which will be framed as questions for correctional agencies to describe the general readiness, capabilities, and infrastructure of their facilities.

Focus Areas	Readiness Element	Minimum Requirement for Pass or Conditional Pass?
1: Medi-Cal Application Processes	1a: Screening	Minimum Requirement
	1b: Application Support	Minimum Requirement
	1c: Unsuspension	Minimum Requirement
2: 90 Day Pre-Release Eligibility Screening	2a: Screening	Minimum Requirement
	2b: Eligibility Notification to State Eligibility System	Minimum Requirement
	2c: Release Notification to State Eligibility System	Minimum Requirement
3: 90 Day Pre-Release Service Delivery	3a: Pre-release Care Manager Assignment	Minimum Requirement
	3b: Consultation Scheduling	
	3c: Virtual/In-Person Consultation Support	
	3d: Support for Medications	Minimum Requirement
	3e: Support for Medication Assisted Treatment	Minimum Requirement
	3f: Support for Prescriptions Upon Release	Minimum Requirement
	3g: Support for Durable Medical Equipment Upon Release	
	3h: Medi-Cal Billing	Minimum Requirement
4: Re-Entry Planning and Coordination	4a: Release Date Notification	Minimum Requirement
	4b: Re-Entry Care Management Warm Handoff	Minimum Requirement
	4c: Re-Entry Behavioral Health Warm Handoff	Minimum Requirement
5: Oversight and Project Management	5a: Staffing Structure and Plan	Minimum Requirement
	5b: Governance Structure for Partnerships	
	5c: Reporting and Oversight Processes	Minimum Requirement

- Elements flagged as Minimum Requirement indicates that the correctional agency must have the capability in place in order to go live with pre-release services.
- Elements that are not flagged as Minimum Requirements must still be supported, but DHCS may use discretion when reviewing these elements to determine whether an agency is ready to go live.

Reentry Initiative Reinvestment Plan

Reentry Initiative Reinvestment Plan Overview

As outlined in the STCs, to the extent that the reentry demonstration initiative covers services that are the responsibility of and were previously provided or paid by the carceral facility or carceral authority with custody of qualifying members, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services.

- California will submit a reinvestment plan that **defines the amount of reinvestment required over the term of the demonstration**, based on an assessment of the amount of projected expenditures for which reinvestment is required.

- CMS and DHCS have identified two categories of pre-release services for determining whether and how much reinvestment may be required when net new savings are realized, including:
  - **"New services"** which had not previously been provided by carceral settings prior to the demonstration; and
  - **"Existing services"** which would be newly-Medicaid-matched under the demonstration, but would have been provided by carceral settings prior to the demonstration.

- **FFP projected to be expended for new services covered under the reentry demonstration initiative is not required to be reinvested.**

Allowable Reentry Reinvestments

Allowable reinvestments include, but are not limited to:


New services covered under the reentry demonstration initiative;


Improved access to behavioral and physical community-based health care services and capacity;


Improved access to and/or quality of carceral health care services;


Improved health information technology and data sharing;


Increased community-based provider capacity;


Expanded or enhanced community-based services and supports; and


Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population

Contact Information

CalAIMJusticeAdvisoryGroup@dhcs.ca.gov

Questions and Discussion

Appendix for CalAIM Justice Involved Initiative

Mental Illness and Substance Use Disorder

Qualifying Criteria	Definition
Mental Illness	A person with a "Mental Illness" is a person who is currently receiving mental health services or medications OR meets both of the following criteria: i. The member has one or both of the following: a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities; AND/OR b. A reasonable probability of significant deterioration in an important area of life functioning; AND ii. The member's condition as described in paragraph (i) is due to either of the following: a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems; OR b. A suspected mental disorder that has not yet been diagnosed.
Substance Use Disorder	A person with a "Substance Use Disorder" shall either: i. Meets SUD criteria, according to the criteria of the current editions of the Diagnostic and/or Statistical Manual of Mental Disorders and/or the International Statistical Classification of Diseases and Related Health Problems; OR ii. Has a suspected SUD diagnosis that is currently being assessed through either National Institute of Drug Abuse (NIDA)-modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), American Society of Addiction Medicine (ASAM) criteria, or other state-approved screening tool.

Chronic Condition/Significant Non-Chronic Clinical Condition *(1 of 2)*

Qualifying Criteria	Definition
Chronic Condition / Significant Non-Chronic Clinical Condition	A person with a "Chronic Condition" or a "Significant Non-Chronic Clinical Condition" shall have ongoing and frequent medical needs that require treatment and can include one of the following diagnoses, as indicated by the individual, and may be receiving treatment for the condition, as indicated: • Active cancer; • Active COVID-19 or Long COVID-19; • Active hepatitis A, B, C, D, or E; • Advanced liver disease; • Advanced renal (kidney) disease; • Dementia, including but not limited to Alzheimer's disease; • Autoimmune disease, including but not limited to rheumatoid arthritis, Lupus, inflammatory bowel disease, and/or multiple sclerosis; • Chronic musculoskeletal disorders that impact functionality of activities of daily living, including but not limited to arthritis and muscular dystrophy; • Chronic neurological disorder • Severe chronic pain • Congestive heart failure; • Connective tissue disease • Coronary artery disease; • Currently prescribed opiates or benzodiazepines; • Currently undergoing a course of treatment for any other diagnosis that will require medication management of three or more medications or one or more complex medications that requires monitoring (e.g. anticoagulation) therapy after reentry; • Cystic fibrosis and other metabolic development disorders; • Epilepsy or seizures • Foot, hand, arm, or leg amputee;

Chronic Condition/Significant Non-Chronic Clinical Condition (2 of 2)

Qualifying Criteria	Definition
Chronic Condition / Significant Non-Chronic Clinical Condition	• Hip/Pelvic fracture; • HIV/AIDS; • Hyperlipidemia • Hypertension • Incontinence • Severe migraine or chronic headache • Moderate to severe atrial fibrillation/arrhythmia • Moderate to severe mobility or neurosensory impairment (including, but not limited to spinal cord injury, multiple sclerosis, transverse myelitis, spinal canal stenosis, peripheral neuropathy); • Obesity • Peripheral vascular disease; • Pressure injury or chronic ulcers (vascular, neuropathic, moisture-related); • Previous stroke or transient ischemic attack (TIA); • Receiving gender affirming care; • Active respiratory conditions, such as severe bronchitis, COPD, asthma or emphysema • Severe viral, bacterial, or fungal infections • Sickle cell disease or other hematological disorders; • Significant hearing or visual impairment; • Spina Bifida or other congenital anomalies of the nervous system; • Tuberculosis; or • Type 1 or 2 diabetes.

I/DD, TBI, HIV, Pregnancy

Qualifying Criteria	Definition
Intellectual or Developmental Disability	A person with an "Intellectual or Developmental Disability" is a person who has a disability that begins before the individual reaches age 18 and that is expected to continue indefinitely and present a substantial disability. Qualifying conditions include intellectual disability, cerebral palsy, autism, Down syndrome, and other disabling conditions as defined in Section 4512 of the California Welfare and Institutions Code.
Traumatic Brain Injury	A person with a "Traumatic Brain Injury" means a person with a traumatic brain injury or other condition, where the condition has caused significant cognitive, behavioral, and/or functional impairment.
HIV/AIDS	A person with "HIV/AIDS" means a person who has tested positive for either human immunodeficiency virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) at any point in their life.
Pregnant or Postpartum	A person who is "Pregnant or Postpartum" is a person who is either currently pregnant or within the 12-month period following the end of the pregnancy.

Definitions of Covered Services

Covered Service	Definition
Case Management	Case management will be provided in the period up to 90 days immediately prior to the expected date of release and is intended to facilitate reentry planning into the community in order to: (1) support the coordination of services delivered during the pre-release period and upon reentry; (2) ensure smooth linkages to social services and supports; and (3) and ensure arrangement of appointments and timely access to appropriate care and pre-release services delivered in the community. Services shall include: • Conducting a health risk assessment, as appropriate; • Assessing the needs of the individual in order to inform development, with the member, of a discharge/reentry person-centered care plan, with input from the clinician providing consultation services and correctional facility's reentry planning team; • While the person-centered care plan is created in the pre-release period and is part of the case management pre-release service to assess and address physical and behavioral health needs and HRSN identified, the scope of the plan extends beyond release; • Obtaining informed consent when needed to furnish services and/or to share information with other entities to improve coordination of care; • Providing warm linkages with designated managed care plan care managers (including potentially a care management provider, for which all individuals eligible for pre-release services will be eligible) which includes sharing discharge/reentry care plans with managed care plans upon reentry; • Ensuring that necessary appointments with physical and behavioral health care providers, including, as relevant to care needs, with specialty county behavioral health coordinators and managed care providers are arranged; • Making warm linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups; • Provide a warm hand-off as appropriate to post-release case managers who will provide services under the Medicaid state plan or other waiver or demonstration authority; • Ensuring that, as allowed under federal and state laws and through consent with the member, data are shared with managed care plans, and, as relevant to physical and behavioral health/SMI/SUD providers to enable timely and seamless hand-offs; • Conducting follow-up with community-based providers to ensure engagement was made with individual and community-based providers as soon as possible and no later than 30 days from release; and • Conducting follow up with the individual to ensure engagement with community-based providers, behavioral health services, and other aspects of discharge/reentry planning, as necessary, no later than 30 days from release.

Definitions of Covered Services

Covered Service	Definition
Physical and Behavioral Health Clinical Consultation Services	Physical and behavioral health clinical consultation services include targeted preventive, physical and behavioral health clinical consultation services related to the qualifying conditions. Clinical consultation services are intended to support the creation of a comprehensive, robust and successful reentry plan, including: conducting diagnosis, stabilization and treatment in preparation for release (including recommendations or orders for needed labs, radiology, and/or medications); providing recommendations or orders for needed medications and durable medical equipment (DME) that will be needed upon release; and consulting with the pre-release care manager to help inform the pre-release care plan. Clinical consultation services are also intended to provide opportunities for members to meet and form relationships with the community-based providers who will be caring for them upon release, including behavioral health providers and enable information sharing and collaborative clinical care between pre-release providers and the providers who will be caring for the member after release, including behavioral health warm linkages. Services may include, but are not limited to: • Addressing service gaps that may exist in correctional care facilities; • Diagnosing and stabilizing individuals while incarcerated, preparing them for release; • Providing treatment, as appropriate, in order to ensure control of qualifying conditions prior to release (e.g., to suggest medication changes or to prescribe appropriate DME for post-release); • Supporting reentry into the community; and • Providing behavioral health clinical consultation which includes services covered in the State Plan rehabilitation benefit but is not limited to, clinical assessment, patient education, therapy, counseling, SUD Care Coordination (depending on county of residence), Peer Support services (depending on county of residence), and Specialty Mental Health Services Targeted Case Management covered in the Medi-Cal State Plan

Definitions of Covered Services

Covered Service	Definition
Laboratory and Radiology Services	Laboratory and Radiology services will be provided consistent with the State Plan.
Medications and Medication Administration	Medications and medication administration will be provided consistent with the State Plan.
Medication-Assisted Treatment	• MAT for Opioid Use Disorders (OUD) includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders as authorized by the Social Security Act Section 1905(a)(29) • MAT for Alcohol Use Disorders (AUD) and Non-Opioid Substance Use Disorders includes all FDA-approved drugs and services to treat AUD and other SUDs. • Psychosocial services delivered in conjunction with MAT for OUD as covered in the State Plan 1905(a)(29) MAT benefit, and MAT for AUD and Non-Opioid Substance Use Disorders as covered in the State Plan 1905(a)(13) rehabilitation benefit, including assessment; individual/group counseling; patient education; prescribing, administering, dispensing, ordering, monitoring, and/or managing MAT. Services may be provided by correctional facilities that are not DMC-certified providers as otherwise required under the State Plan for the provision of the MAT benefit.

Definitions of Covered Services

Covered Service	Definition
Community Health Worker Services	Community Health Worker Services will be provided consistent with the Community Health Worker State Plan.
Services Provided Upon Release	Services provided upon release include: • Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with approved Medicaid State Plan). • DME consistent with Medi-Cal State Plan requirements.

CalAIM Behavioral Health Administrative Integration Concept Paper

Paula Wilhelm
Assistant Deputy Director

Objectives

1. Provide background and context for the CalAIM Behavioral Health Administrative Integration Initiative
2. Summarize Behavioral Health Administrative Integration proposal and concept paper
3. Impacts of Behavioral Health Administrative Integration Initiative for Tribal Partners and Q&A

CalAIM Background

» California Advancing and Innovating Medi-Cal (CalAIM) is a long-term commitment to transform and strengthen Medi-Cal. CalAIM includes multiple initiatives designed to reduce complexity across Medi-Cal delivery systems for behavioral health services. CalAIM has three primary goals:

Identify and manage beneficiary risk through whole person care approaches and addressing Social Determinants of Health;

Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and

Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

CalAIM Behavioral Health Administrative Integration

- **Overview:** By 2027, DHCS and counties seek to consolidate specialty mental health services (SMHS) and substance use disorder (SUD) services—covered either by county Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) programs—into a **single county-based behavioral health program**, operated under a single, integrated contract between counties and the state.

- The initiative aligns with other CalAIM behavioral health initiatives designed to streamline and simplify access criteria, reimbursement, and documentation requirements for behavioral health services

Behavioral Health Administrative Integration Framework

Current Administrative Structure	Administrative Integration
• Medi-Cal SMH and SUD services are administered in each county under two distinct contracts. • SMH and SUD have program-specific requirements for clinical documentation, health plan and provider compliance reviews, billing and claiming, licensing and certification, etc.	• Medi-Cal SMH and SUD services are administered in each county under a single, integrated contract by 2027. • SMH and SUD program requirements are aligned and integrated to the greatest extent possible* to increase flexibility and reduce administrative burden for counties, providers, and the state.

*Federal and state law create certain requirements that apply specifically to SMHS and/or SUD services. CalAIM BH Administrative Integration seeks to promote integration primarily within existing financial and legal parameters.

Behavioral Health Administrative Integration Goals

Improve health care outcomes and the experience of care for Medi-Cal beneficiaries (particularly those living with co-occurring mental health and SUD issues).

Reduce the administrative burden for beneficiaries, counties, providers, and the state.

Impacts for Specialty BH Providers

- By 2027, BH Administrative Integration **can**:
  - **Support delivery of integrated BH care by simplifying requirements for providers that contract for both SMH and DMC/DMC-ODS services.**
  - For example:
    - Opportunities to streamline licensing/certification requirements
    - Opportunities for regulatory clean-up to align program specifications

- BH Administrative Integration **will not**:
  - Modify covered benefits for SMHS, DMC, or DMC-ODS
  - Create new requirements for providers or require behavioral health programs/providers to offer additional services (will not require all SMHS providers to offer SUD services or vice versa)
    - New requirements/activities primarily implemented by counties and the state

Impacts for Tribal Partners

- Existing policies for Medi-Cal specialty BH services provided by Indian Health Care Providers will remain in effect.
  - Contracts not required for reimbursement
  - Federal All-Inclusive Rates
  - Managed Care Network Adequacy Mandatory Provider Types
- DHCS Behavioral Health Information Notices:
  - 22-020: SMHS Reimbursement
  - 22-033: Specialty Behavioral Health Network Adequacy
  - 22-053: DMC-ODS Reimbursement
- If contracted with county BH: Opportunities for administrative simplification to improve beneficiary experience.

11 Components of Behavioral Health Administrative Integration

Streamlining the Beneficiary Experience	Integrating County Structures & Processes	Integrating DHCS Oversight Functions
1. County-Operated 24/7 Access Line 2. Screening, Assessment & Treatment Planning 3. Beneficiary Materials, Appeals & Grievances*	4. DHCS-County Contracts 5. Data Sharing & Privacy 6. Cultural Competence Plans 7. Quality Improvement	8. External Quality Reviews* 9. DHCS Compliance Reviews* 10. Network Adequacy* 11. Provider Oversight*

*Component requires adoption of integrated DHCS-County contract.

11 Components of Behavioral Health Administrative Integration

Streamlining the Beneficiary Experience	Integrating County Structures & Processes	Integrating DHCS Oversight Functions
1. County-Operated 24/7 Access Line*	4. DHCS-County Contracts	8. External Quality Reviews
2. Screening, Assessment & Treatment Planning*	**5. Data Sharing & Privacy***	9. DHCS Compliance Reviews
3. Beneficiary Materials, Appeals & Grievances*	**6. Cultural Competence Plans***	10. Network Adequacy
	7. Quality Improvement	**11. Provider Oversight***

***Components that most directly benefit beneficiaries and care providers.**

Streamlining the Beneficiary Experience

Component(s)	Vision for Integration
1. County-Operated 24/7 Access Line	• A single 24-hour access line available in each county to connect beneficiaries to appropriate SMHS or SUD services
2. Screening, Assessment and Treatment Planning	• County protocols ensure appropriate attention to co-occurring behavioral health needs during screening, assessment, and treatment planning activities, consistent with CalAIM initiatives such as No Wrong Door and Behavioral Health Payment Reform • Continued efforts to align and streamline documentation parameters, consistent with the CalAIM Behavioral Health Documentation Redesign initiative
3. Beneficiary Materials, Appeals & Grievances*	• A single beneficiary handbook and provider directory in each county • A single set of beneficiary rights and procedures (e.g., appeals and grievances)

*Component requires adoption of integrated DHCS-County contract.

Integrating County Structures & Processes

Component(s)	Vision for Integration
4. DHCS-County Contracts	• In 2027, counties enter into a single, integrated contract with DHCS that covers the administration of both SMHS and SUD services
5. Data Sharing & Privacy	• Counties implement a DHCS-issued template "universal release" to secure individual authorizations for data sharing, including with respect to SUD-related information regulated by 42 CFR Part 2
6. Cultural Competence Plans (CCPs)	• An integrated CCP using an updated, DHCS-issued CCP template
7. Quality Improvement (QI)	• An integrated QI plan with a comprehensive list of performance measures that address both SMHS and SUD services • A single, integrated QI committee

Integrating DHCS Oversight Functions

Component(s)	Vision for Integration
8. External Quality Reviews (EQRs)*	• A single, annual EQR that addresses both SMHS and SUD *(note: DMC counties are not required to undergo EQR with respect to their SUD activities)*
9. DHCS Compliance Reviews*	• A single, integrated county compliance review for SMHS and SUD
10. Network Adequacy*	• A single set of network certification submission documents • DHCS will certify a single behavioral health provider network and apply standards for both MH and SUD access and capacity
11. Provider Oversight*	• Explore options to streamline and simplify provider licensure and enrollment requirements (to the extent possible) • Providers that offer both SMHS and SUD services utilize integrated credentialing and contracting processes at the county level

*Component requires adoption of integrated DHCS-County contract.

Phased Implementation for Behavioral Health Administrative Integration

Note: The time periods specified above and on the coming slides refer to calendar years. AB 133 currently provides for the statewide adoption of integrated contracts by January 1, 2027. DHCS welcomes feedback on this timeline, particularly if stakeholders anticipate significant implementation challenges with aligning the contract cycle for either Phase 2 or Phase 3 with the calendar year, rather than the State Fiscal Year.

Concept Paper for Behavioral Health Administrative Integration

- The concept paper details the state's framework for meeting the initiative's goals through a phased implementation between now and 2027.
- Concept paper available via DHCS' CalAIM Behavioral Health landing page.

Stakeholder Engagement

Ongoing Stakeholder Engagement

- DHCS will engage counties, tribal partners, and other stakeholders regularly in Initiative activities through the existing Behavioral Health CalAIM Workgroup, as well as topic-specific workgroups

Written Guidance

- DHCS will issue written guidance such as implementation guides, templates, and FAQs, as appropriate.

Webinars and Learning Collaborative

- DHCS will host informational and training webinars to support tribal and public engagement and understanding of DHCS' written guidance.

One-on-One Support for Counties

- DHCS will be available throughout the implementation period to provide TA and support to counties on a one-on-one basis.

Questions and Discussion

Appendix: Additional Detail on Phased Implementation

Phase 1. Voluntary Integration of County Functions Under Existing Contracts (CY 2023 – 2024)

- Counties may continue their efforts to integrate components that do not require any additional policymaking from DHCS, such as processes related to the 24/7 access line, screening, assessment, and treatment planning, as well as county data storage and data sharing.
- DHCS will consider opportunities for guidance to support counties and identify best practices for implementing recent and upcoming CalAIM reforms and will research/analyze potential regulatory reforms to align and streamline requirements for SMH, DMC, and DMC-ODS.
- To prepare for Phase 2, DHCS will develop boilerplate text for the integrated contracts and other materials to support contract integration.

Phase 2. Voluntary Contract Integration (CY 2025 – 2026)

- Interested counties may voluntarily enter into integrated contracts with DHCS that cover both SMHS and SUD services, thereby enabling the integration of DHCS oversight activities
- Volunteer counties may also be required to implement certain integration-related best practices identified in DHCS' Phase 1 guidance.
- During Phase 2, DHCS will finalize regulatory reforms to update and streamline the requirements for Medi-Cal behavioral health programs, in addition to promoting behavioral health integration and other CalAIM goals.

Phase 3. Statewide Behavioral Health Administrative Integration (CY 2027+)

- All counties enter into integrated behavioral health contracts with DHCS and participate in integrated oversight activities.
- DHCS and counties adjust their operations to account for the regulatory reforms finalized in Phase 2.

Medi-Cal for Kids & Teens Outreach & Education Toolkit

René Mollow
Deputy Director

What is EPSDT?

- Federal law enacted in 1967 established the **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** requirement, which requires that comprehensive age-appropriate health care services be provided to all Medi-Cal enrolled children and youth up to age 21.
- Requires preventive screening, diagnostic services, and treatment services.
- Screenings, coverage requirements, and definition of medical necessity for children enrolled in Medi-Cal are more robust than they are for adult care.

Goal of EPSDT

Ensure that children get the

Right Care

at the

Right Time

in the

Right Place

Medi-Cal's Strategy to Support Health & Opportunity for Children & Families

- **Key Initiative:** Outreach and education toolkit on the intent and scope of the EPSDT requirement to enhance understanding and access to care.

- **Initiative Elements Discussed in Strategy:**
  - Core audiences of families, providers, and MCPs
  - Toolkit that describes how EPSDT works and what it covers
  - Coordination of toolkit with a range of child-serving stakeholders (e.g., key state agencies, local government entities, community-based advocates) to deliver targeted messaging related to services available under EPSDT

In 2019, DHCS started to develop member-facing materials focused on children's preventive services in response to a 2019 California State Audit on children's preventive services; work was paused due to COVID-19. This toolkit builds on this prior work and the follow-up 2022 California State Audit.

See Medi-Cal's Strategy to Support Health & Opportunity for Children & Families.

Toolkit Goals

- **Improve member understanding** of how Medi-Cal for children and youth works, what it covers, its role in preventive care screening, diagnosis, and treatment, and medical necessity requirements.

- **Increase coordination with a range of child-serving stakeholders**, including Medi-Cal MCPs, providers, key state agencies, local government entities, and community-based advocates to help disseminate toolkit materials.

- **Develop a standardized EPSDT provider training** for Medi-Cal MCPs to use with their network providers.

Toolkit Components

Member Brochures (child and teen versions)

Your Medi-Cal Rights Letter

Provider Training

Toolkit Consumer Testing Process

From October to November 2022, DHCS conducted consumer testing on the brochures and Medi-Cal for Kids & Teens: Your Medi-Cal Rights letter with parents, caregivers, teens, and young adults enrolled in Medi-Cal who live across the state and speak English and/or Spanish.

Purpose of Consumer Testing

- Gauge participant understanding of EPSDT services available to children and youth up to age 21 enrolled in Medi-Cal.
- Understand any comprehension issues with the member-facing materials and the actions participants would take after reviewing materials.
- Identify language barriers, image concerns, or other issues throughout materials.

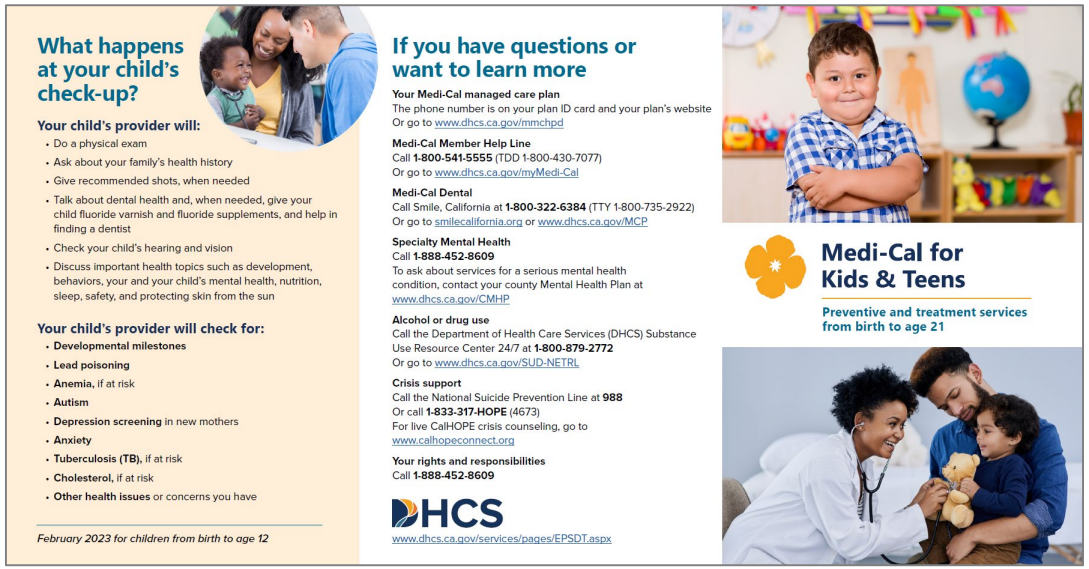
Testing Methodology

1:1 Observation & Feedback	Remote Group Discussion	Post-Session Survey
17 English sessions 5 Spanish sessions	8 English sessions 3 Spanish sessions	50 surveys completed

Medi-Cal for Kids & Teens: Brochures

Included in the brochures

- Overview of covered services, how to access care, and additional resources available, including free transportation to and from an appointment.
- Information about the services provided at check-ups for children and teens/young adults.
- Key contact information, such as the Medi-Cal Member Help Line, 988, and specialty mental health resources.
- In the **child-focused brochure:** Condensed Periodicity Schedule for well-child visits.
- In the **teen/young adult-focused brochure:** Overview of sexual health care and behavioral health care services.



What happens at your child's check-up?

Your child's provider will:

- Do a physical exam
- Ask about your family's health history
- Give recommended shots, when needed
- Talk about dental health and, when needed, give your child fluoride varnish and fluoride supplements, and help in finding a dentist
- Check your child's hearing and vision
- Discuss important health topics such as development, behaviors, your and your child's mental health, nutrition, sleep, safety, and protecting skin from the sun

Your child's provider will check for:

- **Developmental milestones**
- **Lead poisoning**
- **Anemia,** if at risk
- **Autism**
- **Depression screening** in new mothers
- **Anxiety**
- **Tuberculosis (TB),** if at risk
- **Cholesterol,** if at risk
- **Other health issues** or concerns you have

February 2023 for children from birth to age 12

If you have questions or want to learn more

Your Medi-Cal managed care plan
The phone number is on your plan ID card and your plan's website
Or go to www.dhcs.ca.gov/mmchpd

Medi-Cal Member Help Line
Call **1-800-541-5555** (TDD 1-800-430-7077)
Or go to www.dhcs.ca.gov/myMedi-Cal

Medi-Cal Dental
Call Smile, California at **1-800-322-6384** (TTY 1-800-735-2922)
Or go to smilecalifornia.org or www.dhcs.ca.gov/MCP

Specialty Mental Health
Call **1-888-452-8609**
To ask about services for a serious mental health condition, contact your county Mental Health Plan at www.dhcs.ca.gov/CMHP

Alcohol or drug use
Call the Department of Health Care Services (DHCS) Substance Use Resource Center 24/7 at **1-800-879-2772**
Or go to www.dhcs.ca.gov/SUD-NETRL

Crisis support
Call the National Suicide Prevention Line at **988**
Or call **1-833-317-HOPE** (4673)
For live CalHOPE crisis counseling, go to www.calhopeconnect.org

Your rights and responsibilities
Call **1-888-452-8609**

DHCS
www.dhcs.ca.gov/services/pages/EPSDT.aspx

Medi-Cal for Kids & Teens

Preventive and treatment services from birth to age 21

Visit the DHCS Medi-Cal for Kids & Teens Webpage for full copies of the child and teen brochures

Brochures will be translated into DHCS' threshold languages and be available in spring 2023

Medi-Cal for Kids & Teens: Your Medi-Cal Rights Letter

Included in the Letter

- Overview of coverage requirements and "medically necessary" services.
- Overview of the appeals, State Fair Hearing, and/or grievance processes for managed care and FFS.
- Information on what a family can do if Medi-Cal care is denied, delayed, reduced, or stopped, including who to contact, how to file an appeal, how to ask for a State Fair Hearing, and/or how to contact the ombudsman.
- Information on how to file a grievance across Medi-Cal managed care and FFS.
- Key contact information for Medi-Cal delivery systems to help members find the right delivery system to contact about a concern.

Medi-Cal for Kids & Teens

Your Medi-Cal Rights

Please keep!

Important information to help children and youth to age 21 get all the care they need

What services can children and youth get if they are in Medi-Cal?

Under California and federal law, all children and youth to age 21 enrolled in Medi-Cal have the right to regular **check-ups** and other **preventive** and **treatment** services needed to stay or get healthy.

This right is known in federal law as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement. It ensures that every child enrolled in Medi-Cal gets the care they need to grow up as healthy as possible. In California, EPSDT is called **Medi-Cal for Kids & Teens**.

The services are **free**, unless the child or youth was found to have a Share of Cost when they qualified for Medi-Cal.

Visit the DHCS Medi-Cal for Kids & Teens Webpage for full copies of the letter

The letter will be translated into DHCS' threshold languages and be available in spring 2023

Medi-Cal for Kids & Teens Provider Training

Included in the Provider Training

- Starting in January 2024, Medi-Cal MCPs must conduct Medi-Cal for Kids & Teens training for their network providers to ensure they are able to best support families in fully using Medi-Cal for Kids & Teens services.
- Overview of the Medi-Cal for Kids & Teens' comprehensive set of services under federal and state law, including screening, diagnostic, and treatment services.
- Explanation of the medical necessity definition for children and youth in Medi-Cal.
- Information about how providers can support patient access to Medi-Cal for Kids & Teens services.
- Billing codes for required services.
- Overview of mental health and substance use disorder services, California Children's Services, and skilled nursing services.

The Medi-Cal for Kids & Teens training can be accessed at the **DHCS Medi-Cal for Kids & Teens Webpage** prior to January 2024

Distribution Plan for Toolkit Materials

Child & Teen Brochures and Your Medi-Cal Rights Letter

- The brochures and Your Medi-Cal Rights letter will be mailed in summer 2023 (and annually thereafter) to children and youth up to age 21 enrolled in Medi-Cal.
  - Medi-Cal MCPs will be required to mail the member-facing materials annually to households with children and youth up to age 21 and publish on their websites.
  - DHCS will mail the member-facing materials annually to FFS households with children and youth up to age 21 and publish on DHCS' website.
- DHCS will share the member-facing materials with stakeholders, providers, county offices, local health departments, non-licensed child-serving providers, and Local Educational Agencies (LEAs)/schools for broad distribution.

Provider Training

- DHCS will share the provider training with Medi-Cal MCPs and publish on applicable DHCS websites.
- Medi-Cal MCPs will be required to deliver training to network providers at least every two years and publish on their websites.

What's Next?

Tasks	2023				
	Feb	Mar	Apr	May	Jun
Publish toolkit in English on the DHCS website	X				
Share toolkit with stakeholders, state agency partners, MCPs, DHCS listservs, Medi-Cal and Tribal/IHP providers, non-licensed child serving providers, and LEAs/schools	X				
Present toolkit to stakeholder workgroups and a webinar	X	X			
Translate member-facing materials to DHCS' threshold languages, and print and prepare to mail materials	X	X	X	X	
DHCS and MCPs mail member-facing materials to members					X

Questions and Discussion

Behavioral Health Bridge Housing Request for Application

Erika Cristo
Assistant Deputy Director

Need for BHBH

- In 2022, California had an estimated 171,521 individuals experiencing homelessness
  - 60,905 were individuals experiencing chronic homelessness
  - 39,721 were severely mentally ill
  - 36,096 reported chronic substance use
- Bridge housing for individuals experiencing homelessness with behavioral health issues is needed immediately

Need for BHBH

- The BHBH program is identified to meaningfully contribute to the implementation of the California Interagency Council on Homelessness' Action Plan for Preventing and Ending Homelessness in California
- The BHBH program will be implemented in alignment with the Community Assistance, Recovery and Empowerment (CARE) Program, which prioritizes BHBH program resources for CARE Program participants

Need for BHBH

- The BHBH program will be implemented in alignment with the findings of the Tribal Medication Assisted Treatment Statewide Needs Assessment & Recommendations, published by the Keck School of Medicine, University of Southern California

Need for BHBH

- The 2021 Budget Act provided $5.8 billion in infrastructure funding through Homekey, the Behavioral Health Continuum Infrastructure Program (BHCIP), and the Community Care Expansion (CCE) program to create new units and treatment beds for individuals experiencing or at risk of homelessness
- These and other infrastructure projects will take time to construct and become operational
- The BHBH Program primarily provides operational and supportive services funding to address immediate housing needs

BHBH Timeline

Request for County Application Release	February 2023
Request for County Application Due	April 2023
Tribal Stakeholder Engagement	Currently in process
Request for Tribal Application Release (Competitive)	Spring 2023
County Awards Announced	June 2023 (rolling basis)
County Contract Execution/Program Implementation	Summer 2023
Request for Tribal Application Due	Summer 2023
Tribal Awards Announced	Late Summer 2023
Competitive Request for Application (RFA) Release (BHAs and Tribal Entities)	Summer 2023
Competitive RFA Release (BHAs and Tribal Entities)	Fiscal Year 2024-25

BHBH Program Specifications

- The $1.5B BHBH funding allocation is one-time only grant funding administered by DHCS
- Tribal RFA for release in Spring will make available $50M in funding
- Qualifying applicants are county behavioral health agencies, and tribal entities
- Funding must be expended by June 30, 2027
- The emphasis of the BHBH program is on meeting the needs of the currently homeless population with a behavioral health condition

BHBH Program Specifications

- Provide case management and other medical, behavioral or social services and supports, such as those provided by Full Service Partnerships, which provide field capable wrap around services
- Funding cannot supplant specialty mental health and SUD services currently provided– these must continue to be covered by Medi-Cal
- BHBH is intended to pay for housing and housing-related services that are not covered by Medi-Cal, including community supports

BHBH Program Specifications

- BHBH encourages exploring existing facilities that are willing and able to serve this population, but cannot do so without operating funding and enhanced supports, which this effort will support
- Consider what existing facilities need to add in order to meet the needs of this population

Allowable Uses of Funds

- The BHBH program target population is intended for individuals experiencing homelessness with a serious behavioral health condition, with a priority focus for CARE Program participants when applicable
- Applicants will have to demonstrate how funds are being prioritized for the target population and how each setting will be enhanced with behavioral health services to appropriately meet their needs
- Certain elements will be required for funding; others will be added based on each applying entity's priorities and needs

Allowable Uses of Funds

- Considerations for tribal-specific flexibilities are being assessed for inclusion
- The administrative entity DHCS has engaged for BHBH, Advocates for Human Potential, is additionally working with the Native Americans for Restorative Stewardship (NARS) in order to engage multiple tribal stakeholder representatives for RFA input
- The current allowable uses of BHBH funds identified for counties are also being assessed for inclusion in the tribal RFA

Current Allowable Uses of BHBH Funds

- BHBH Implementation
  - Establishing a program lead
  - Implementing methods for gaining input from people with lived experience
  - Working with community initiatives on homelessness and behavioral health efforts and providers
- Outreach and Access
  - Outreach and access
  - Housing navigation and supports to reduce barriers to access bridge housing (pet accommodations, finding, applying, and moving into housing)

Current Allowable Uses of BHBH Funds

- Bridge Housing
  - Housing individuals in shelter, transitional, bridge, or interim housing settings
  - Recovery housing
  - Shared housing
  - Community-based diversion or reentry programs
  - Master leasing
  - Short or mid-term rental assistance
  - Supplemental payments for board and care

Current Allowable Uses of BHBH Funds

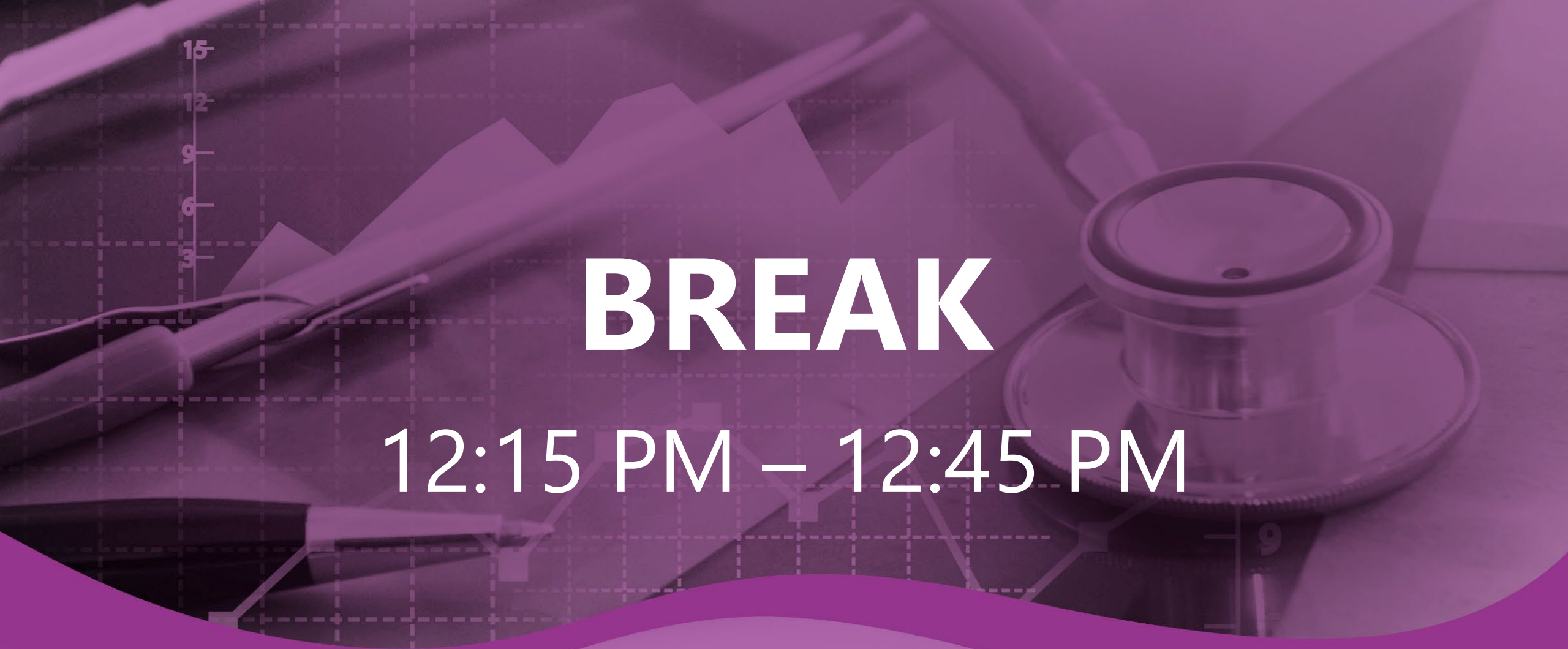
Infrastructure

- Start-up and limited support to enable current facilities to accommodate the needs of individuals with serious behavioral health conditions or to expand bridge housing for individuals with serious behavioral health conditions
  - May include: contributing toward a building purchase, renovations, and other start-up costs
  - All infrastructure must be completed and serving individuals within one year of executed contract

If you have additional questions or have input for the BHBH tribal RFA, please contact us: BHBH@dhcs.ca.gov

Website: https://bridgehousing.buildingcalhhs.com/

Questions and Discussion



BREAK

12:15 PM – 12:45 PM

DHCS

Medi-Cal Eligibility Division Update

Yingjia Huang
Assistant Deputy Director

Consolidated Appropriations Act of 2023

- On December 29, 2022, President Biden signed into law the Consolidated Appropriations Act of 2023 which **delinked the continuous coverage requirement from the public health emergency** and established a March 31, 2023 end date to the continuous coverage requirement.
- When continuous coverage requirements end, states will need to conduct a full redetermination for all beneficiaries who would have otherwise been subject to redetermination
- As a result of the Consolidated Appropriations Act of 2023, CMS released updated guidance in a Centers for Medicaid and CHIP Services (CMCS) Informational Bulletin on January 5, 2023 that maintains the applicability of the unwinding rules from previous CMS guidance

DHCS Medi-Cal COVID-19 PHE and Continuous Coverage Operational Unwinding Plan

- The Medi-Cal COVID-19 PHE and Continuous Coverage Unwinding Plan was originally released in May 2022 and last updated January 13, 2023 to incorporate policy changes as a result of the federal Consolidated Appropriations Act of 2023 and corresponding guidance released from CMS.

- **The plan includes two main components:**
  - **Part 1: Unwinding Medi-Cal Program Flexibilities**
    - Details PHE-related non-eligibility flexibilities obtained during the PHE that DHCS has already made permanent, seeks to make permanent, or will expire at the end of the PHE.

  - **Part 2: Resumption of Normal Medi-Cal Redetermination Operations**
    - Overviews the DHCS guiding principles and implementation approach for redeterminations, retention strategies, federal eligibility flexibilities, outreach, county/system readiness, and data reporting.

Resuming Normal Business Operations

- When the continuous coverage requirement ends, counties will process annual renewals on the beneficiaries next normally scheduled annual renewal date.

- Counties will begin renewal activities on **April 1, 2023** for beneficiaries with a **June 2023** renewal date.
  - The first Medi-Cal discontinuances will occur **July 1, 2023**.
  - A detailed sequencing of annual renewal processing during the Continuous Coverage Unwinding is included in the Medi-Cal COVID-19 PHE and Continuous Coverage Operational Unwinding Plan.

DHCS Outreach Efforts

- **DHCS Coverage Ambassadors (in English and Spanish)**
  - As of January 2023, we have **1700+** DHCS Coverage Ambassadors signed up to help DHCS spread the word on the COVID-19 PHE Unwinding Efforts
  - DHCS developed FAQs for our Coverage Ambassadors to assist with outreach efforts
  - DHCS has also recruited Coverage Ambassadors at the Quarterly Tribal Meetings. Currently, we have approximately 20 Coverage Ambassadors from our Tribal Partners.

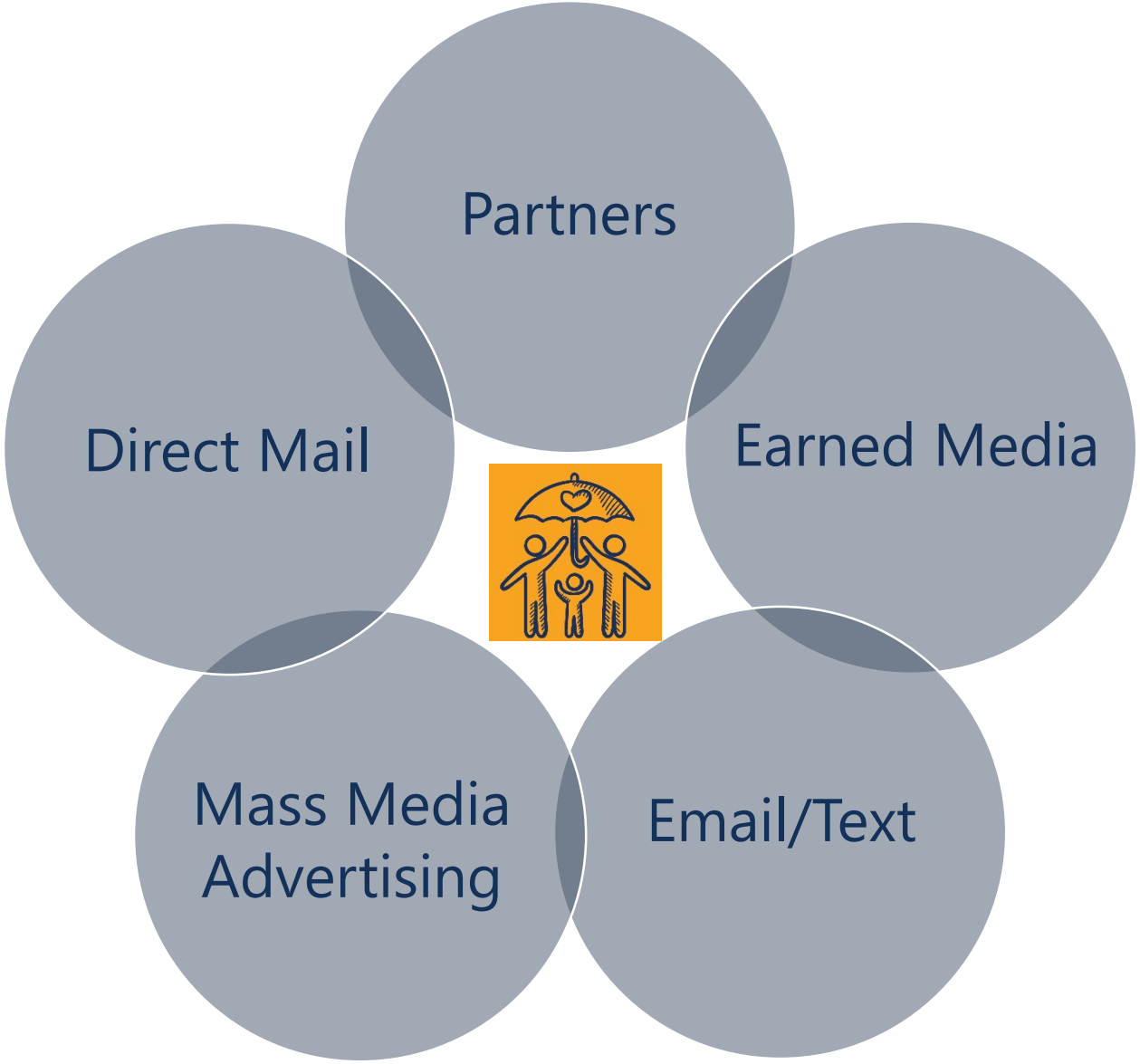
- **DHCS Unwinding Outreach Toolkits**
  - **COVID-19 PHE Toolkit – Phase 1 –** with DHCS approved graphics and messaging to be used by our Coverage Ambassadors.
  - **Phase 2 Toolkit** – Released on February 8, 2023 - includes flyers, one-page fact sheets, social media posts, sample messaging, and infographics, for DHCS Coverage Ambassadors and other partners to use

- **New Landing Page:** www.KeepMediCalCoverage.org for our Medi-Cal beneficiaries and partners

DHCS Outreach Efforts

- **DHCS Outreach Communications Vendor for Media Campaigns (for both COVID-19 PHE and other Eligibility Expansions and Postpartum Extension)**
  - DHCS has awarded a direct contract with **GMMB**, a media vendor, for the DHCS outreach campaigns. The vendor will be responsible for implementing a statewide education and outreach communications campaign targeted to California's 15.5 million Medi-Cal beneficiaries during COVID-19 PHE, throughout the continuous coverage unwinding period, and for all the eligibility expansions (i.e. Asset Elimination, 26-49 Medi-Cal Expansion, Postpartum Extension).
  - One of the goals of continuous coverage unwinding outreach campaign is to maintain eligibility for Medi-Cal beneficiaries by providing outreach materials that inform beneficiaries about the steps necessary to maintain coverage after the COVID-19 public health emergency ends.
  - Campaign includes paid media that will run a mix of different traditional and digital media formats to reach Medi-Cal households in all 19 Medi-Cal threshold languages. The campaign will also include the creation of awareness-focused tactics, such as videos, digital displays, radio, paid search, social media, out-of-home placements, and other language media partnerships.
  - Campaign officially launched in February 8, 2023.

Integrated Communications Strategies



Taking a Phased Approach

- **AWARENESS: February 2023 – May 2024**
  - Statewide California advertising and outreach
  - Targeting households in Medi-Cal income thresholds
  - All Medi-Cal threshold languages across platforms
  - **CORE MESSAGE:** Remind Medi-Cal members to ensure that their local county office has up to date contact information, including mailing address, email address, and phone number.

- **RENEWALS TAKE PLACE: May 2023 – May 2024**
  - Drive timely completion of renewals, responses to renewal packets, and understanding of the process
  - Repeat sequence in 30-day cycles
  - **CORE MESSAGE:** Direct members to complete renewal packet and submit needed documentation, as directed

- **EXPANDED ELIGIBILITY ENROLLMENT: May 2023 – May 2024**
  - Begin work on various expansions and awareness - 26-49 Adult Expansion, asset elimination, 12-month postpartum coverage
  - **CORE MESSAGE:** Reinforce new rules, benefits and services now available to them, and direct members to resources for information and assistance, reinforcing multiple options, including online, in person, telephone, and in-language help where possible.

Bringing Messaging to Life

Social Graphic

Public Transit

Flyer

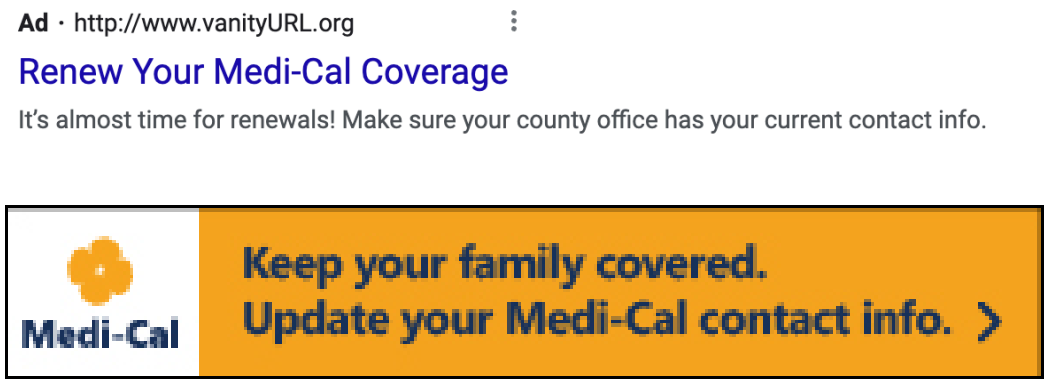
Direct-to-Enrollee Communications

- **Direct mail** to enrollees
- Leverage **email** and **text messages** for 1:1 communications

Advertising

Digital Media

- Digital video
- Digital display ads
- Paid search
- Social media



Out of Home

- Public transit, billboards, retail locations

Advertising

Radio

- Digital Radio
- Broadcast Radio

Spanish media partnership

- Univision to ensure priority placements on Spanish TV channels and radio stations.

Additional Outreach

- **Tribal Communications Toolkit – in development**

- **DHCS Second Outreach Mailer**
  - Is currently in the process of being mailed to all Medi-Cal households in all Medi-Cal threshold languages
  - DHCS will keep track of undeliverable mail

- **Launch of the www.KeepMediCalCoverage.org**

How to strengthen partnerships with Tribal and Indian Health Programs?

- How can DHCS best partner with you to increase awareness of the unwinding work?
- To alert beneficiaries that there is ACTION needed to continue their Medi-Cal?
- DHCS is eager to learn about best practices from you!

Questions and Discussion

Benefits Division Update

Lisa Murawski
DHCS Division Chief

Agenda Topics

- CHW
- Doula
- Dyadic
- Telehealth
- Enrolling CBOs and LHJs as Providers
- Forthcoming Non-Physician Provider Manual updates
- Expansion of Abortion Services in FQHCs

Community Health Workers (CHW) Benefit

CHW Benefit: Billing in THPs

- Effective for dates of service on or after July 1, 2022.
- State plan benefit available in fee-for-service and managed care delivery systems.
- CHW services are separately reimbursable for Tribal FQHC and IHS-MOA Providers.

Billing codes

CPT Code	Description	Length	Number of Patients	Rate
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	30 minutes	1	$26.66
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	30 minutes	2–4	$12.66
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	30 minutes	5–8	$9.46

Doula Benefit

Doula Services as a New Benefit

- Effective January 1, 2023.
- Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.
- State plan benefit available in fee-for-service and managed care delivery systems.

Doula Services Policy

- Doulas offer various types of support throughout the perinatal period (prenatal through one year postpartum).
- Includes the following physical, emotional, and other nonmedical support:
  - Perinatal and labor support and guidance
  - Health navigation
  - Evidence-based education, including development of a birth plan
  - Linkages to community-based resources

Full-Spectrum Doula Care

- Medi-Cal offers full-spectrum doula care:
  - Prenatal and postpartum doula care
  - Presence during labor and delivery (including stillbirth)
  - Doula support for miscarriage and abortion
- Doulas are not licensed and they do not require supervision.
  - Enroll via DHCS Provider Application and Validation for Enrollment (PAVE) Provider Portal
  - Qualify through training or experience pathway

Accessing Doula Services

- Federal “preventive services” requirement
  - Doula services must be recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.
- Medical necessity criteria
  - Pregnant, or was pregnant within the past year, and
  - Would benefit from doula services or requests doula services.

Covered Doula Services

A recommendation for services authorizes the following:

- One initial visit.
- Up to eight additional visits that may be provided in any combination of prenatal and postpartum visits.
- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage.
- Up to two extended three-hour postpartum visits after the end of a pregnancy.

Next Steps

- Doula Implementation Workgroup launching (per SB 65 of 2021)
  - Antoinette Martinez, United Indian Health Services, Inc., workgroup member
  - The first meeting of the new group will be from 12:00 to 2:00 p.m. on Thursday, March 30.
  - More information: DHCS Doula Services
- Needs Assessment
  - Led by a third-party entity, Race For Equity, in partnership with DHCS
  - Assessing technical assistance needs to support doula implementation
  - Eager to hear from tribal partners

Dyadic Services Benefit

Dyadic Services

- Effective January 1, 2023.
- State plan benefit in fee-for-service and managed care delivery systems.
- Dyadic services are preventive behavioral health services for recipients ages 0 to 20 years and/or their caregivers.
  - Dyad = Infant/child and parent/caregiver
- Billed **on the child's Medi-Cal ID**

Dyadic Services

- Dyadic services for recipients ages 0 to 20 years include:
  - Dyadic Behavioral Health (DBH) Well-Child Visits
  - Other supportive services
    - Dyadic Comprehensive Community Support Services, per 15 minutes
    - Dyadic Psychoeducational Services, per 15 minutes
    - Dyadic Family Training and Counseling for Child Development, per 15 minutes

Dyadic Services

- Dyadic caregiver services include the following assessment, screening, counseling, and brief intervention services provided to the caregiver for the benefit of the child:
  - ACE screening
  - Alcohol and drug screening, assessment, brief interventions and referral to treatment (SABIRT)
  - Brief emotional/behavioral assessment
  - Depression screening
  - Health behavioral assessments and interventions
  - Psychiatric diagnostic evaluation
  - Tobacco cessation counseling

Telehealth

Key Telehealth Policies Finalized

- Providers can render Medi-Cal covered services that can be appropriately provided via telehealth modalities (must meet the requirements of the billing code)
- Asynchronous, Audio-only and Video telehealth is covered (providers must designate modality)
- Payment parity between telehealth and in-person services
- DHCS will not impose site limitations for both providers and patients for FQHC/RHCs, Tribal FQHCs and Indian Health Services (Existing federal requirements still apply)
- Telehealth expanded to designated unlicensed practitioners (doulas, CHWs)

Key Telehealth Activities To Date

- Hosted Telehealth Advisory Workgroup
- Published final Telehealth Policy Paper
- Published final Research and Evaluation Plan on Telehealth
- Published Model Telehealth Patient Consent Language for Providers
- Updated Telehealth FAQs on DHCS Telehealth Web page
- Revised the Telehealth Provider Manual
- Submission of SPAs to seek federal approval to continue PHE provisions
- Trailer Bill Language and Legislative Language:
  - SB 184 (Chapter 47, Statutes of 2022)
  - AB 32 (Chapter 515, Statutes of 2022)

Telehealth Activities for 2023

- Publication of updated All-Plan Letter on Telehealth
- Distribute Informational Notice on Telehealth to all Medi-Cal Beneficiaries
- Development and Publication of a Telehealth Data Dashboard and Semiannual Data Report
- New California Health Interview Survey (CHIS) questions on telehealth for 2023 survey
- New telehealth policies beginning in 2024: Patient choice of telehealth modality, preserving access to in-person services

Enrolling CBOs and LHJs as Medi-Cal Providers

Community-based organizations

- Projected implementation in fall 2023
- New provider type in PAVE
- Pathway for CBOs to provide and bill for:
  - Community health worker services
  - Covered justice-involved reentry services
- Standardized CBO requirements

Local Health Jurisdictions

- New provider type in PAVE
- Projected implementation in fall 2023
- Will allow 61 county and city health departments to enroll with DHCS as Medi-Cal providers.

Non-Physician Provider Manual Updates

Recent statute changes

- Business and Professions Codes (BPC) changes
  - Removed physician supervision for Nurse Practitioners (NP), and Certified Nurse Midwives(CNM)
  - Removed requirements that a supervising Physician be available to the Physician Assistant (PA) for consultation, countersignature of patient medical records, and written guidelines for supervision to be established. The new law authorizes the PA to provide services under a practice agreement.

Next steps

- Remove outdated references from provider manual related to supervision and scope of practice
- Expanded list of Medi-Cal covered services (CPT and HCPCS codes) that the practitioners may bill, consistent with their scope of practice
- Update Other Medi-Cal provider manuals as needed (e.g., Home Health Services, Pregnancy: Comprehensive Perinatal Services Program, Abortion Services)

Expansion of Abortion Services to FQHC/RHC/THPs

New Policy To Reimburse FQHC/RHC/THP Abortion Services

- Effective October 1, 2022, FQHC/RHC/THPs may elect to provide abortions and receive fee-for-service (FFS) payment via state general fund
- State only Medi-Cal funds were not previously available to these clinics for abortion services

References

- Medi-Cal NewsFlash: CHW Services are Reimbursable for Tribal FQHC and IHS-MOA Providers
- Medi-Cal NewsFlash: Dyadic Services Added as Medi-Cal Benefits
- Non-Specialty Mental Health Services: Psychiatric and Psychological Services Provider Manual (includes Dyadic)
- Doula Services
- DHCS Telehealth
- Medi-Cal NewsFlash: FQHC, RHC, and Tribal Clinic Providers: Abortion Services

Questions and Discussion

Office of Strategic Partnerships Update

Tisha Montiero
DHCS Branch Chief

Children and Youth Behavioral Health Initiative

DHCS is scaling EBPs/CDEPs across six distinct rounds of grant funding

To be implemented in partnership with MHSOAC (as lead)

RFA Released December 2022

Parent and caregiver support programs

To increase supports and improve parental and caregiver involvement

RFA Released February 2023

Trauma-informed practices and programs

To increase access to services which address BH needs and the impact of adverse childhood events

Anticipated RFA Release March 2023

Early childhood wrap around services

To increase access to home visiting and consultation services that are responsive to community needs

Anticipated RFA Release March/April 2023

Youth-driven programs

To increase peer-to-peer support with programs informed through youth voice

Anticipated RFA Release April/May 2023

Early intervention

To increase early identification and intervention services for children and youth with, or at high risk for BH conditions

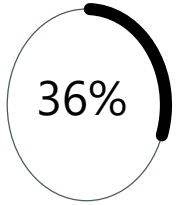
Anticipated RFA Release May/June 2023

Community-defined evidence practices

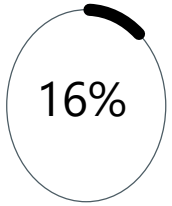
To increase access to culturally relevant and responsive services

Trauma-Informed Practices and Programs: Rationale and Expected Outcomes for Round 2 EBP/CDEP Grants (1/2)

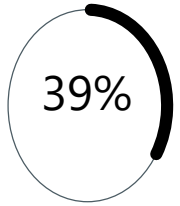
Children with adverse childhood experiences (e.g., abuse, neglect, caregiver substance use, witnessing violence) are at increased risk for behavioral health challenges and chronic conditions[1]



Of children in CA have been exposed to one or more childhood adverse experiences (ACEs)[2]



Of adults in CA have been exposed to at least four ACEs before the age of 18[2]



Increase in emergency department visits for suicidal ideation for youth ages 12-17 nationwide during the pandemic

1. Let's Get Healthy 2. California Department of Public Health

Trauma-Informed Practices and Programs: Rationale and Expected Outcomes for Round 2 EBP/CDEP Grants (2/2)

Given this rationale, the trauma-informed grant round is designed to[1]:

- **Increase early intervention** so children and youth with, or at high risk for BH conditions, can access services before conditions escalate and require higher level care.
- **Support the resilience of children and youth by mitigating the adverse effects of ACEs** (e.g., brain development, emotional and behavioral health).
- **Build knowledge of trauma-informed support and communication** for caregivers and individuals close to children and youth.
- **Increase the capacity of child-serving service systems** (e.g., child welfare, juvenile justice system)**, on trauma-informed practices.**
- **Improve grief support for children and youth with COVID-related trauma** (e.g., death of a parent, loved one).

Trauma-Informed Round 2: EBPs (1/2)

Selected Practices	Description
Attachment and Biobehavioral Catch-up	Three interventions to assist caregiver response to children who have experienced early maltreatment/disruptions in care[2]
Child Parent Psychotherapy	Treatment to improve the caregiver and trauma-exposed child relationship as a vehicle for restoring the child's mental health[3]
Cognitive Behavioral Interventions for Trauma in Schools	School-based, group and individual intervention for students grades 5-12 who have witnessed/experienced traumatic events[4]
Dialectical Behavior Therapy	Cognitive-behavioral treatment to treat chronically suicidal youth diagnosed with borderline personality disorder (BPD)[5]

1. CEBC4W: ABC
2. CEBC4W: CPP
3. CBITS
4. CEBC4W: DBT

Trauma-Informed Round 2: EBPs (2/2)

Selected Practices	Description
Family Centered Treatment	Treatment designed for families faced with disruption of dissolution of their family[2]
Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems	Protocol that organizes practices for children and adolescents with anxiety, depression, conduct problems, and/or traumatic stress and their caregivers[3]
Trauma-Focused Cognitive Behavioral Therapy	Treatment for youth impacted by trauma and their caregivers targeting a broad array of emotional and behavioral difficulties[4]

1. CEBC4W: FCT
2. CEBC4W: MATCH-ADTC
3. TF-CBT

EBP/CDEP Grant Program: Populations of Focus

Populations of focus as identified by the California Reducing Disparities Project:[1]

- African Americans
- Asians and Pacific Islanders
- Latinos
- LGBTQIA+
- Tribal communities

Other populations of focus identified through the stakeholder engagement process:

- Justice-involved
- Low-income
- Persons with physical, intellectual, and/or developmental disabilities
- Refugees, migrant workers, and immigrants
- Rural communities
- Non-English speakers
- Those experiencing housing insecurity and homelessness
- Children in foster care

1 California Reducing Disparities Project

EBP/CDEP Grants: Eligible Grant Recipients

Organizations eligible for grant funding include but are not limited to:

Government Partners

- County or city governments (e.g. county BH departments, public health)
- Statewide and local agencies (e.g. First 5 Associations)
- **Tribal entities**
- Regional centers

Education

- Early learning and care providers (e.g., childcare and preschool settings)
- Local Education Agencies (County Offices of Education, school districts), public K-12 school sites, charter schools
- Institutions of higher education (i.e., California Community Colleges, California State University, University of California)

Healthcare

- Provider clinics (e.g. community mental health, behavioral health, pediatric clinics)
- Hospitals and hospital systems
- Health plans

Community Organizations

- Community-based organizations who provide services to children, youth, and/or families
- Faith-based organizations
- Family resource centers

Source: Based on input from DHCS draft Round 1 RFA

EBP/CDEP Grant Program: Key Dates

February 9: Round Two RFA release and applications open

March 3: Technical Assistance Webinar, March 3, 2023 from 2:00-3:00pm

Register here: https://dhcs.webex.com/weblink/register/r54f255ca4bf7aef747978af3d369693f

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April 10: Round Two applications due by April 10, 2023 by 5:00pm PT

COMING SOON –

- Round Three RFA Release (March 2023) – focused on early childhood wraparound programs
- Award Announcements – Round One Grants (Anticipated by end of April 2023

Questions?

- Please send all questions about the Children and Youth Behavioral Health Initiative, including the EBP/CDEP grant program, to: CYBHI@dhcs.ca.gov

- CYBHI information is also posted on DHCS' website

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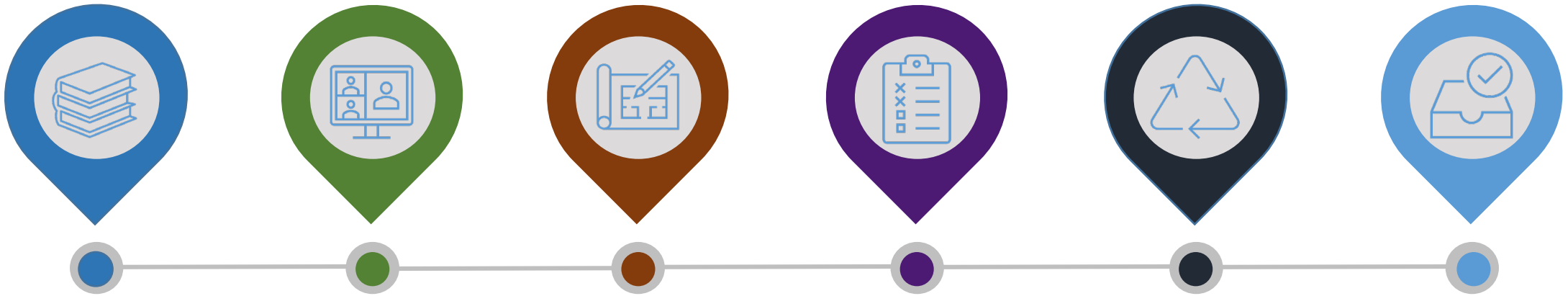
Wellness Coach Profession

Hovick Khosrovian
Senior Policy Advisor

The Wellness Coach role is designed to…

- **increase overall capacity.**
- build a **diverse behavioral health workforce with lived experience** working in a **wide variety of settings.**
- **fill some of the workforce gaps** that exist today.
- ensure the role is both **a desirable occupation** and a **stepping-stone to more advanced BH roles.**
- **engage directly with youth (aged 0 – 25).**
- serve **vulnerable populations where they live, study, and work.**

How the role was developed...



Research

Reviewed 100+ pieces of relevant research

Interview

Conducted 50+ interviews with industry leaders

Design

Developed initial Wellness Coach design options

Test

Tested design options with stakeholder groups

Refine

Refined role design options

Implement

Implement into the workforce (current)

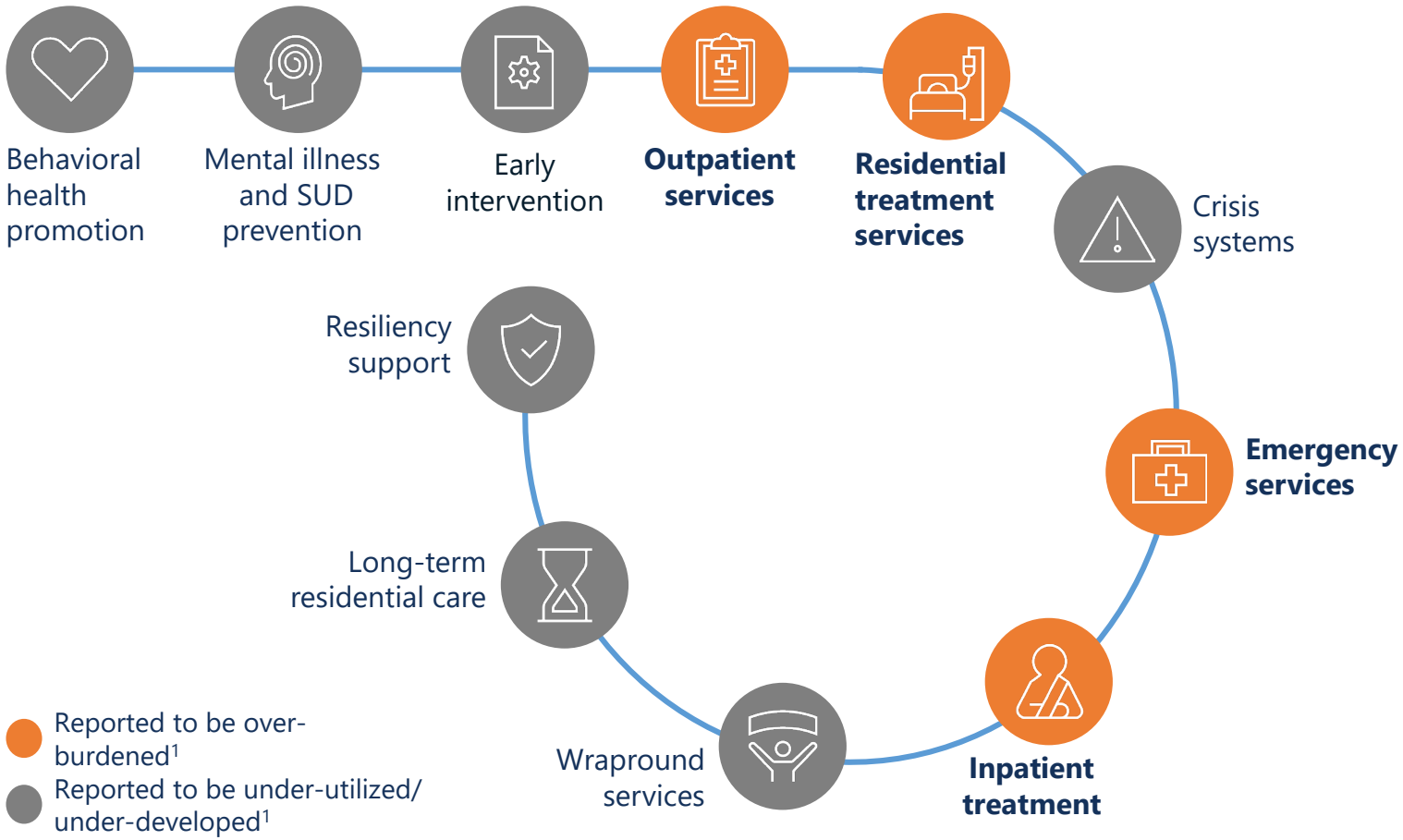
Behavioral Health Career Lattice

Minimum Education Level Required		Illustrative Behavioral Health Lattice with Example Behavioral Health Roles			
Supervised Professional	Certificate	Other non-BH roles	Community health worker	Peer support	SUD counselor
	Associates	Wellness Coach I			
	Bachelors	Wellness Coach II	Social worker		
	Masters	School counselor, psychologist, social worker, or individuals working towards licensure (incl. PPS)			
Independent Practitioner	Licensure	Licensed clinicians, school nurse, educational psychologists (incl. PPS)			
	PhD	Psychologist (incl. PPS)			
	MD	Psychiatrist, primary care providers			

Select Observations

- The Wellness Coach role is designed to be an additional opportunity in the lattice, **bridging the gap between roles** with minimum to no training to Master's-level training.
- The Wellness Coach role **offers employment and training to those that want to advance their careers** to higher levels of the career lattice.

Identifying where Wellness Coaches can best support BH continuum



Considerations for wellness coach role	Consider **employing WC in settings that are promotion/prevention focused** (e.g., schools, community) to reduce likelihood of youth needing services from over-burdened areas further along the continuum of care
Broader considerations for HCAI	**Consider incentivizing providers to work in crisis systems** to alleviate the burden on emergency services and inpatient treatment

1. This framework represents the behavioral health system on a continuum of need (from health to chronic illness). This framework is not intended to represent an individual's care journey

Source: HCAI expert interviews, February 2022

Overview of Wellness Coaches

	Wellness Coach I	Wellness Coach II
Prerequisites to Enter Program	• Near recent or recent high school graduates	• Wellness Coach I certification or Associate's degree in related field
Education Program	• 60 credits of classroom education • 400 hours of field practicum	• 60 credits of classroom education • 400 hours of field practicum
Received Upon Completion	• Associate's degree + Wellness Coach I certification	• Bachelor's degree + Wellness Coach II certification
Services Offered	• Focus on education related to wellness promotion, life skills, and mental health literacy • Provide limited individual and group support with a structured curriculum	• Focus on individual and group support related to wellness education, goal setting, life skills, and coping skills • Perform the same core services as Wellness Coach I with additional expertise

All Wellness Coaches will:

- Serve children and youth aged 0 - 25
- Operate as part of a care team
- Offer 6 core services, including:
  - Wellness promotion and education
  - Screening
  - Care coordination
  - Individual support
  - Group support
  - Crisis referral
- Operate under the direction of and coordination with a PPS credentialed or licensed professional, depending on setting

Services and Competencies

Services

Activities core to the Wellness Coach roles

1. Wellness promotion and education
2. Screening
3. Care coordination and extension
4. Individual support
5. Group support
6. Crisis referral

Additional Competencies

Demonstrated areas of knowledge to be evaluated against during on-the-job training

7. Cultural competency, humility, and mitigating implicit bias
8. Professionalism, ethics, and legal mandates
9. Communication
10. Operating in role and different environments

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Thank You!

Have questions or comments? Email **CYBHI@hcai.ca.gov**

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Appendix B: Additional Information on Wellness Coach

Example Wellness Coach Applicant Pipeline

People who are currently working in healthcare or behavioral health (e.g., community health workers and peer personnel)

People in unrelated entry-level roles that have a desire to work in behavioral health and/or with youth

People currently working in schools, such as paraprofessionals or administrative staff

Near recent or recent high school graduates with an interest in behavioral health

Individuals in colleges, either pursuing a degree or working on campus

Scope of Services for Wellness Coach Roles (1 of 2)

Proposed Core Activity	Description of Potential Wellness Coach I Scope of Services *Under direction of PPS[1] or licensed professional*	Description of Potential Wellness Coach II Scope of Services *Under direction of PPS[1] or licensed professional*

1 **Wellness Promotion and Education**	• Deliver group or classroom programming (e.g., structured curriculum) focused on:
	  • Wellness promotion and education (e.g., building positive relationships, bullying prevention, nutrition and exercise in relation to BH)
	  • Mental health literacy (e.g., symptom recognition, help- seeking strategies, how to provide support)
	  • Life skills (e.g., stress management, time management, problem solving)
		• Deliver group or classroom programming (e.g., structured curriculum) focused on activities listed in Wellness Coach I role and further programming on:
		  • Coping skills (e.g., behavior activation, identifying thinking traps, distraction strategies, emotion regulation)
		• Facilitate surveys, focus groups, and interviews within organizations to identify needs for programming

2 **Screening**	• Support youth completing behavioral health screenings (e.g., answer questions, hand-off screenings to BH professionals) • Administer universal screening programs in school or other community-based organizations per SAMHSA guidelines • Identify and escalate BH needs of youth to BH providers in school or broader organization setting	
3 **Care Coordination and Extension**	• Connect individuals to internal and external BH resources (e.g., local/regional/national organizations, school or broader organization resources, outpatient providers, residential programs, crisis response resources) as well as social services (e.g., food or housing programs) as needed • Facilitate communication with other professionals (e.g., BH providers, school personnel) that are providing support and care to youth, including connecting individuals to licensed providers so all care team members work together and operate at the top of their license or certification • Provide additional support to providers, school, or broader organization personnel, including BH related administrative activities (e.g., billing support) and extension of non-clinical or clinical BH support	

1. Pupil Personnel Services

Scope of Services for Wellness Coach Roles (2 of 2)

Proposed Core Activity	Description of Potential Wellness Coach I Scope of Services *Under direction of PPS[1] or licensed professional*	Description of Potential Wellness Coach II Scope of Services *Under direction of PPS[1] or licensed professional*

4 Individual Support	• Provide brief check-ins (~5-15 min) and scheduled meetings (~30 min) that provide emotional support and/or follow manualized curriculum that enhance wellness; individual support may include:
	  • Wellness education (e.g., basics of BH symptoms, nutrition, and exercise in relation to BH)
	  • Goal setting/planning (e.g., increasing movement, sleep hygiene)
	  • Life skills (e.g., stress management, time management, problem solving)
		• Provide brief check-ins (~5-15 min) and scheduled meetings (~30 min) that provide emotional support and/or follow manualized curriculum that enhance wellness; individual support may include activities listed in Wellness Coach I role and:
		  • Coping skills (e.g., behavior activation, identifying thinking traps, distraction strategies, emotion regulation) for youth

5 Group Support	• Deliver small group programming (e.g., structured curriculum) to enhance wellness and life skills (e.g., social-emotional skills, stress management, time management, organization, problem solving)	• Deliver small group programming (e.g., structured curriculum) to enhance awareness of the most common BH conditions
6 Crisis Referral	• Adhere to a standardized protocol when responding to risk in the school or broader organization setting; identify potential risk and refer to the on-site BH provider, such as a PPS professional • Provide emotional support and engage in warm handoffs with on-site BH providers for youth that are waiting to be seen for crisis services	

1. Pupil Personnel Services

Example Guiding Principles & Activities for Wellness Coaches

Example Guiding Principles	Example Activities Related to Wellness Coach Roles: In scope	Example Activities Related to Wellness Coach Roles: Out of Scope
Prioritize BH-related Support	**Individual and group support** for students with behavioral concerns	Assessing, diagnosing, or providing clinical intervention or treatment
	Understanding how academic advising services are provided to best support youth	Providing academic advising services
	Facilitating promotion/prevention programming, **which can include health education related to BH**	Facilitating system-level programming or creating specialized curricula
Prioritize BH-related Administrative Support	**Documenting** activities related to BH individual and group support	Documenting activities related to student enrollment
	Scheduling BH-related appointments	Developing or administering the master schedule; scheduling academic advising appointments
	Utilizing broad BH screening tools and managing database	Administering academic state or interim assessments
Prioritize BH-related Care Coordination	**Connecting individuals to BH support resources** (e.g., outpatient therapy, support groups) **and social services as needed**	Providing medical referrals (e.g., ENT, PCP)
	Coordinating with other BH providers, including around the provision of BH services, to students with IEPs	Administering and coordinating individual education plans ("IEP")

Multi-Year Timeline

Marketing

Summer 2023
Launch initial marketing campaign to drive awareness and recruit applicants

Certification

Fall 2023
Certification launched for qualified applicants

Training

Early 2024
New Wellness Coach students enter training programs

Grants

Mid/Late 2024
Employer support grant cycle launched

Sustainability

Early 2025
Role reimbursable through Medi-Cal and commercial insurance

Managed Care Update

Bambi Cisneros
Assistant Deputy Director

Objectives for Today's Meeting

Provide updates on Managed Care Plans participating in Medi-Cal in 2024

Transition planning efforts

Managed Care Plans Participating in Medi-Cal in 2024

Managed Care Plans with Direct Contracts effective 2024

- On December 30, DHCS and five commercial health plans announced an agreement to deliver Medi-Cal services to Medi-Cal managed care members in 21 counties across the state starting in January 2024.
- To bring certainty for members, providers and plans, the state used its authority to work directly with the plans.

Managed Care Plans	Counties
Blue Cross of California Partnership Plan ("Anthem")	Alpine, Amador, Calaveras, El Dorado, Fresno, Inyo, Kern, Kings, Madera, Mono, Santa Clara, San Francisco, Sacramento, Tuolumne
Blue Shield of California Promise Health Plan	San Diego
CHG Foundation d.b.a. Community Health Group Partnership Plan	San Diego
Health Net Community Solutions, Inc.	Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tulare, Tuolumne
Molina Healthcare of California, Inc.	Riverside, San Bernardino, Sacramento, San Diego

2024 Managed Care Landscape

New Mix of High-Quality Managed Care Plans Available to Members

Direct Contract with Commercial Managed Care Plans

- Statewide, in counties with a model that includes commercial plans

Model Change in Select Counties

- Conditional approval for 17 counties to change their managed care model
- Subject to federal approval
- Includes a new Single Plan Model and expansion of COHS model

Direct Contract with Kaiser

- Kaiser direct contract in 32 counties
- Subject to federal approval
- Leverages Kaiser's clinical expertise and integrated model to support underserved areas in partnership with FQHCs

Restructured and More Robust Contract Implemented Across All Plans in All Model Types in All Counties

Improved Health Equity, Quality, Access, Accountability and Transparency

More Robust MCP Contract Includes Provisions Strengthening:

- Transparency
- Quality of Care
- Access to Care
- Continuum of Care
- CalAIM Initiatives
- Coordinated / Integrated Care
- Increasing Health Equity and Reducing Health Disparities
- Addressing Social Drivers of Health (SDOH)
- Local Presence and Engagement including designated contract liaisons for Indian health care providers
- Children's Services
- Behavioral Health Services
- Accountability and Commitment to Compliance
- Administrative Efficiency
- Emergency Preparedness and Essential Services
- Value-Based Payment

New MCP contract provisions will apply to all MCPs in all models statewide.

Examples of New 2024 MCP Contract Requirements

- Require public posting of reports
- Clarify dispute resolution requirements with county mental health plans, including clarifying the requirement that the contractor cover services during the dispute period
- Coordinate warm hand-offs to public benefits programs
- Require closed-loop referrals to coordinate and refer the member to available community resources and follow up to ensure those services are rendered
- Require Provider Dispute Resolution reporting at Subcontractor level
- New Community Engagement section added with a MCP requirement for a member and family engagement strategy
- New requirement to have a tribal liaison:

4.3.23 Indian Health Services

Contractor must have an identified Contractor liaison dedicated to working with each Indian Health Service (IHS) Facility in its Service Area and responsible for coordinating referrals and payment for services provided to Indian Members who are qualified to receive services from an IHS Facility, in accordance with the requirements in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center (FQHC), Rural Health Center (RHC), and Indian Health Service (IHS) Facilities*).

Transition Planning Efforts

Transition Planning – Work in Progress

Operational Readiness

- MCP operational readiness review

Communications

- Central webpage that houses information and resources on the 2024 transition, including table with upcoming changes by county and FAQs
- Stakeholder input

Memorandum of Understanding (MOU) development

- DHCS-developed MOU templates for MCPs and partners

APL guidance

- DHCS is developing additional guidance to MCPs to bolster the 2024 Contract requirements

Transition Policy Guide

- Publicly posted document to memorialize transition topics (i.e., member enrollment, data transfer, continuity of care, MCP phase-out requirements, post-transition monitoring, etc.)

Questions and Discussion

Office of Tribal Affairs Update

Andrea Zubiate
Chief

Indian Health Program Request for Application (RFA) Update

- Received a total of 17 applications including
  - 13 Tribal Health Programs
  - 4 Urban Indian Organizations
- OTA is working with applicants to obtain supplemental information to finalize the allocation formula
- OTA is also considering the release of a Round 2 RFA to allow for additional applicants using a set aside of funds
  - DHCS working with the tribal partners to solicit feedback on lack of RFA responses and recommendations for set-aside dollars

Next Tribal and Indian Health Program Representatives Meeting

- DHCS is considering holding the August quarterly meeting in-person or via a hybrid option
- Feedback would be appreciated on preferences for future meetings (e.g, in-person only, hybrid, virtual, combination)
- As a reminder DHCS solicits input on meeting agendas in advance of every meeting. This request is vital in shaping the focus of each quarterly meeting so that it is responsive to the needs of tribal partners

American Indian Policy Panel (AIHPP) Update

- To date DHCS has received 5 of the 8 nominations needed to re-appoint the AIHPP
- Pending receipt of the final 3 nominations, OTA staff will move the appointment packages forward for approvals
- DHCS received 3 at-large membership applications and will move forward the applications for the Director's review. The Director will appoint 2 at-large positions to complete the 10 member AIHPP roster

Questions and Discussion

Items for Next Meeting/Final Comments

Thank You for Participating In Today's Webinar