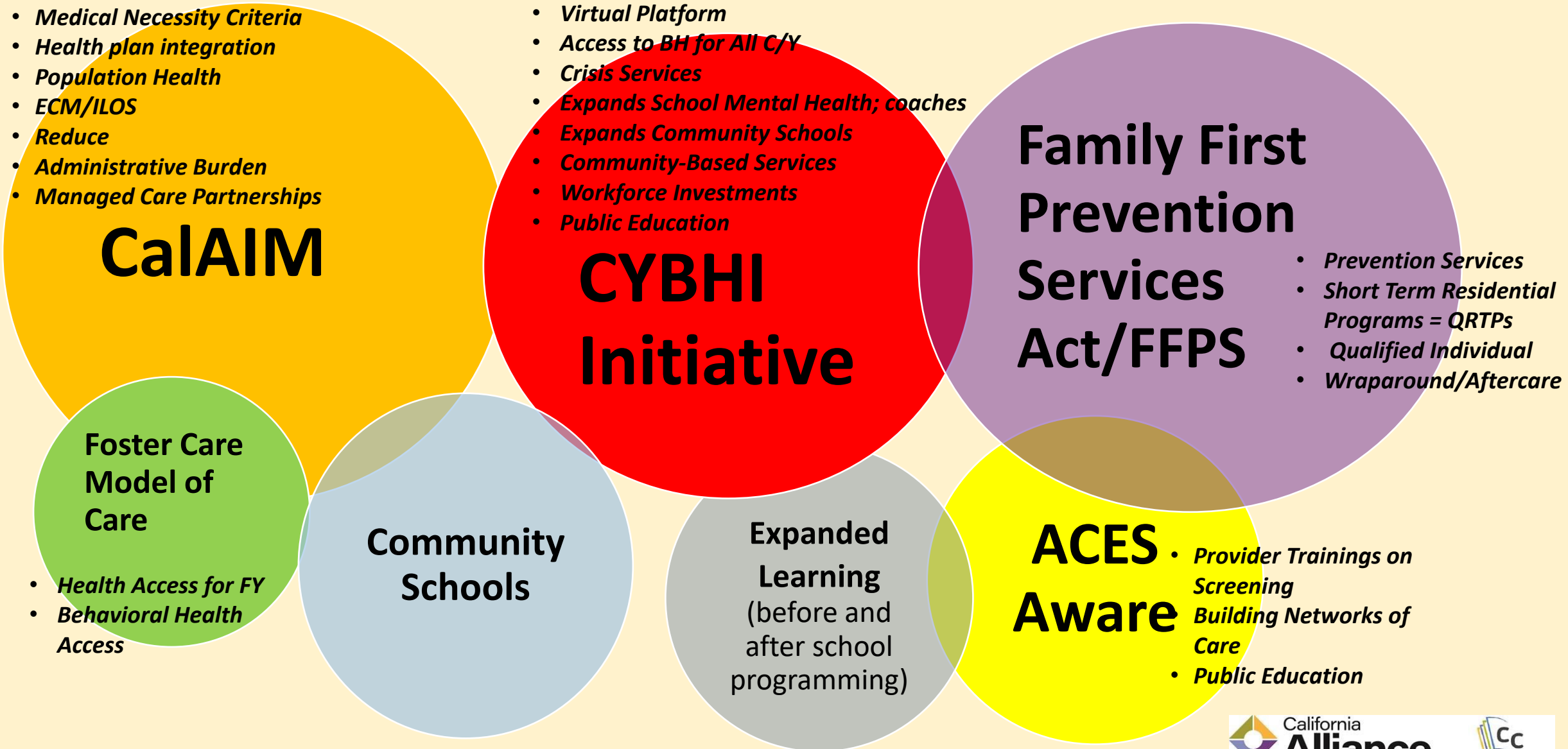
Integrating Behavioral Health Initiatives with Child Welfare Efforts

Presentation to the Child Welfare Council

September 13, 2023

Current Initiatives Impacting Children and Youth



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Catalyst Center

CWC Behavioral Health Recommendations

Strengthening Access to Necessary Behavioral Health Services for Youth and Families

- ***New eligibility determination mechanisms for Specialty Mental Health Services (SMHS) for youth***
- ***Strengthen referrals from the child welfare system to the behavioral health care system***

The Full Continuum of Behavioral Health Services and Supportive Placements Necessary for Child Welfare-Involved Youth and Youth at Risk of Child Welfare Involvement

- ***Prevention and Early Intervention***
- ***Community-Based Supports***
- ***Tiered Therapeutic Options***
- ***Crisis Services***

Behavioral Health System Accountability and Performance Improvement

- ***Identify a clear and simple set of core statewide goals, with corresponding outcomes for youth, parents and families involved in or at risk of becoming involved in the child welfare system***
- ***Develop and enhance the infrastructure necessary to collect, synthesize and monitor outcome data***
- ***Develop and mandate a robust quality improvement process for children's behavioral health statewide***

CWC Behavioral Health Recommendations

Strategies to Support the Successful Implementation of a Universal Array of Behavioral Health Services for Child Welfare-Involved Youth and Youth at Risk of Involvement

Leverage Family First Prevention Services Act (FFPSA) funds

Strengthen interagency collaboration and integration

Invest in enhancing the behavioral health workforce

Enhance internet connectivity for youth and caregivers

Youth and stakeholder input

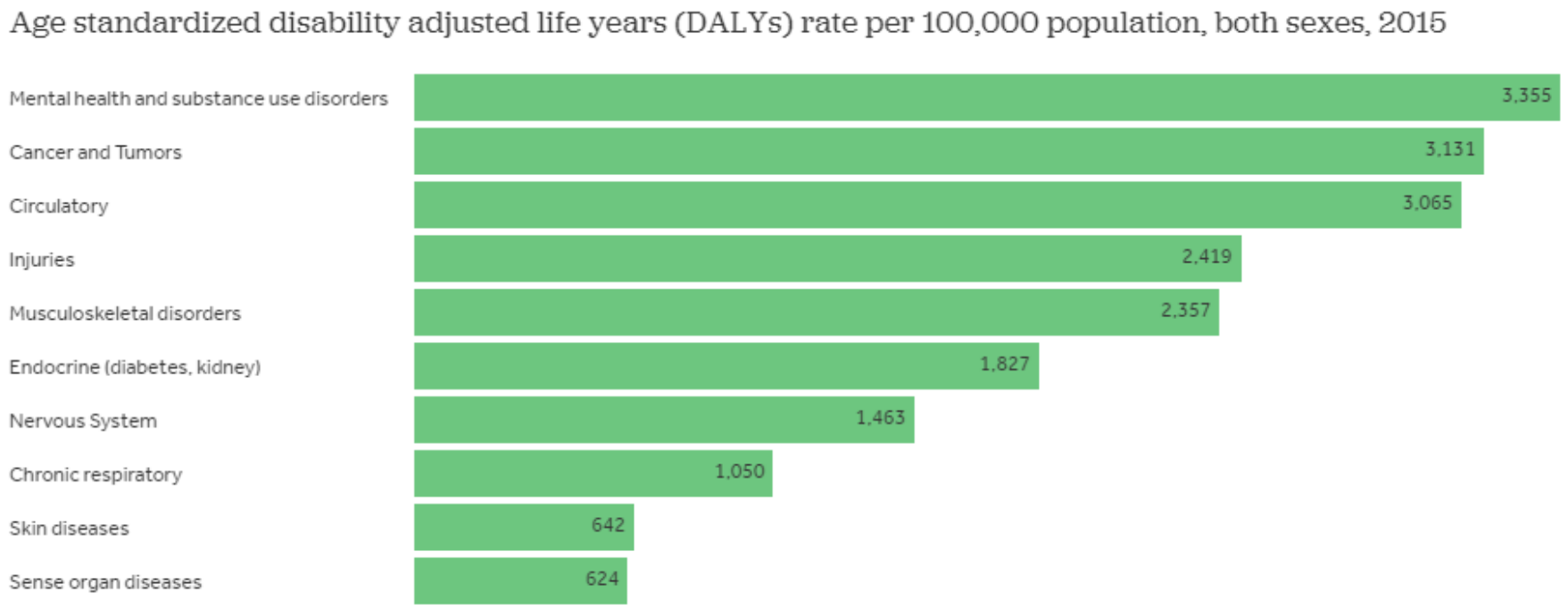
California Children's Trust

NAVIGATING AN UNPRECEDENTED REFORM LANDSCAPE:

CHILD WELFARE COUNCIL

9/8/2023

MENTAL HEALTH AND SUBSTANCE USE DISORDERS ARE THE LEADING CAUSES OF DISEASE BURDEN IN THE US

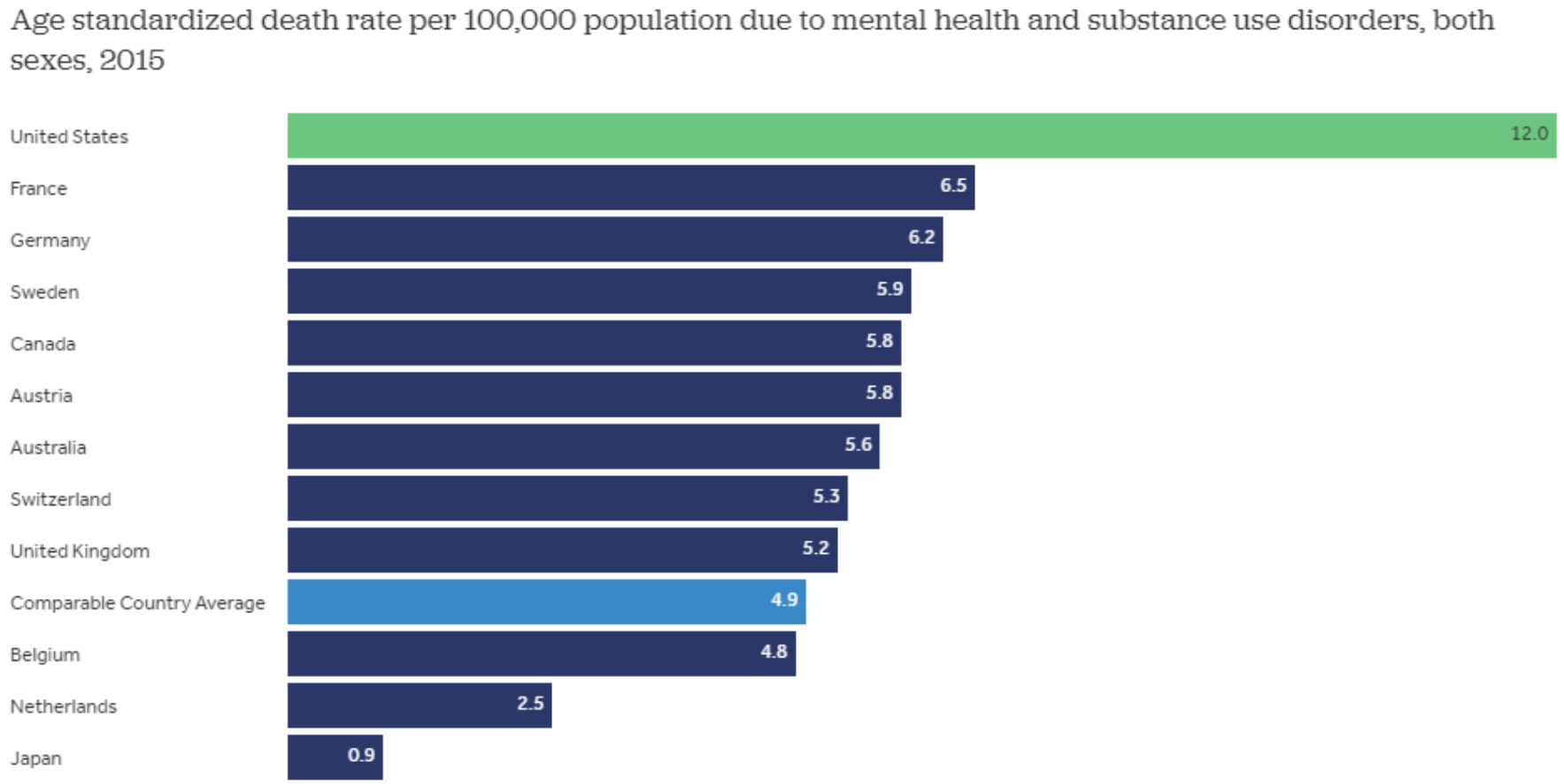


DALY, or the Disability-Adjusted Life-Year, is a metric that combines the burden of mortality and morbidity (non-fatal health problems) into a single number. One DALY can be thought of as one lost year of "healthy" life.

DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences: **DALY = YLL + YLD**

https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/#item-prevalence-mental-illness-among-adults-relatively-stable

AMONG COMPARABLE COUNTRIES, THE U.S. HAS THE HIGHEST RATE OF DEATH FROM MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS



https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/#item-prevalence-mental-illness-among-adults-relatively-stable

THERE IS A CRISIS IN YOUNG PEOPLE'S MENTAL HEALTH

Consider the facts before COVID-19:

Increase in inpatient visits for suicide, suicidal ideation, and self injury
for children ages 1-17 years old, and 151% increase for children ages 10-14

Increase in mental health hospital days
for children between 2006 and 2014

Increase in the rate of self-reported mental health needs
since 2005

California ranks low in the country for providing access to behavioral, social, and development services and screenings

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IMPACT OF COVID: What we feared is coming to pass…

ED VISITS

Beginning in April 2020, the proportion of children's mental health-related ED visits among all pediatric ED visits increased and remained elevated through October

24/31%

Compared with 2019, the proportion of mental health related visits for children aged 5 to 11 and 12 to 17 years increased approximately 24% and 31% respectively

25%

One in for young adults between the ages of 18 and 24 say they've considered suicide because of the pandemic, according to new CDC data that paints a big picture of the nations mental health during the crisis

RADY CHILDREN'S HOSPITAL IN SAN DIEGO:

Between FY2011 and FY2019, annual behavioral health volume has increased

1746%

From 163 visits to 3,009 visits in 8 years

Comparatively, total Emergency Department visits has grown 23% during this same time period

THERE IS REAL OPPORTUNITY TO ADDRESS A CRISIS IN THE LIVES AND EXPERIENCE OF CHILDREN AND FAMILIES:

Public opinion and policymaker agendas are aligned

Political Will: State and Federal administration have established a focus on child and family well-being driven by covid, the youth mental health crisis that preceded it, and decades of evidence from the SDOH movement.

Community Support: Half (52%) of all Californians addressing mental health needs as "extremely important" and list it among the most important issues for the state to address.

Emerging Consensus and Consciousness: Of the impact of adversity, structural racism, and the pandemic on the social and emotional health of children and families.

A Reform Landscape with Unprecedented Level of Investment (10 + Billion) and a shifting payor landscape

TO TAKE ADVANTAGE OF THIS MOMENT PROVIDERS WILL NEED TO:

- Develop new and expanded partnerships with Managed Care Plans (Commercial and MediCal)
- Embrace the critical need to reform our financing and delivery models so that they are team based, healing, and relationship centered.
- Focus on building a health care system for people by people (new provider types and community networks)
- Adopt a paradigm shift that reimagines mental health as a support for healthy development, not a response to pathology.

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DRAMATIC UNDER-INVESTMENT IN CHILDREN

California is in the bottom 1/3 nationally for health spending at $2,500 per child enrollee.

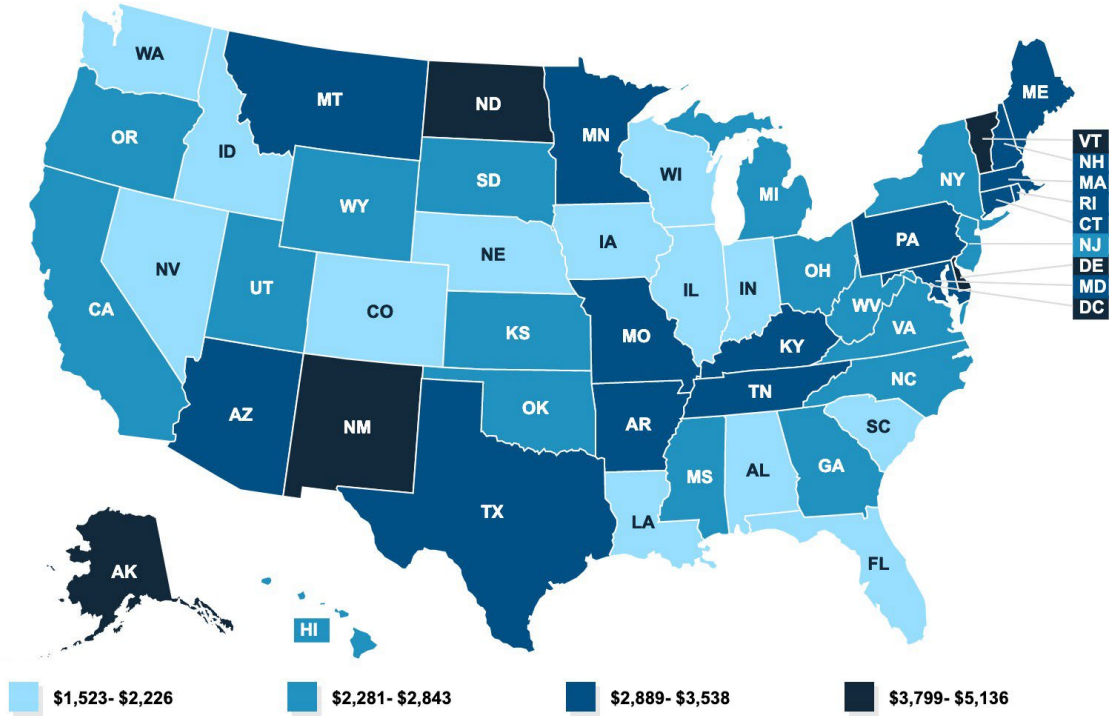
Children represent **42% of enrollees** but only **14% of all expenditures**.

California ranks **44th in the nation of** in access to needed mental health care for children (38th overall).

California operates the largest MediCaid Program in the nation—**April 2019 Audit exposed** significant underperformance under the EPSDT Mandate and Bright Futures Guidelines.

Medicaid Spending per Child

FY 2014



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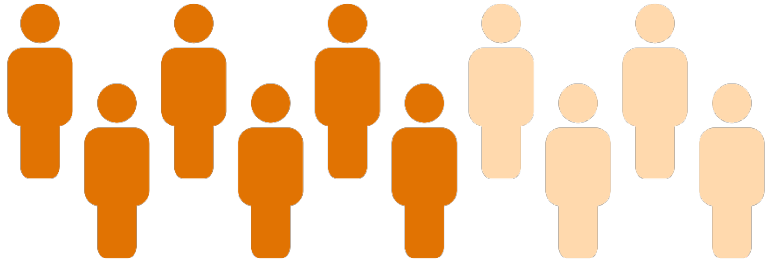
AND ALTHOUGH ELIGIBILITY FOR HEALTH SERVICES HAS INCREASED….



Almost 60% of California's Children are now covered by Medi-Cal and the EPSDT entitlement (a 30% increase over last seven years)

Everyone under 21 living in a family that makes less than 266%FPL qualifies for MediCal (138% for Adults)

Everyone under 25 and over 50 regadless of immigration status are now eligible (26-50's coming in 2023)

Mental Health Access Remains Low:

Less than 6% of all children access any care at all. Less than 3% are in ongoing care.

THE "PRICE" IS HIGHER FOR BLACK AND BROWN CHILDREN

Many receive the wrong services at the wrong time…in restrictive or punitive settings.

81%

81% of children on medicaid are **children of color.**

2X

The **suicide rate for black children**, ages 5-12, is 2x that of their white peers.

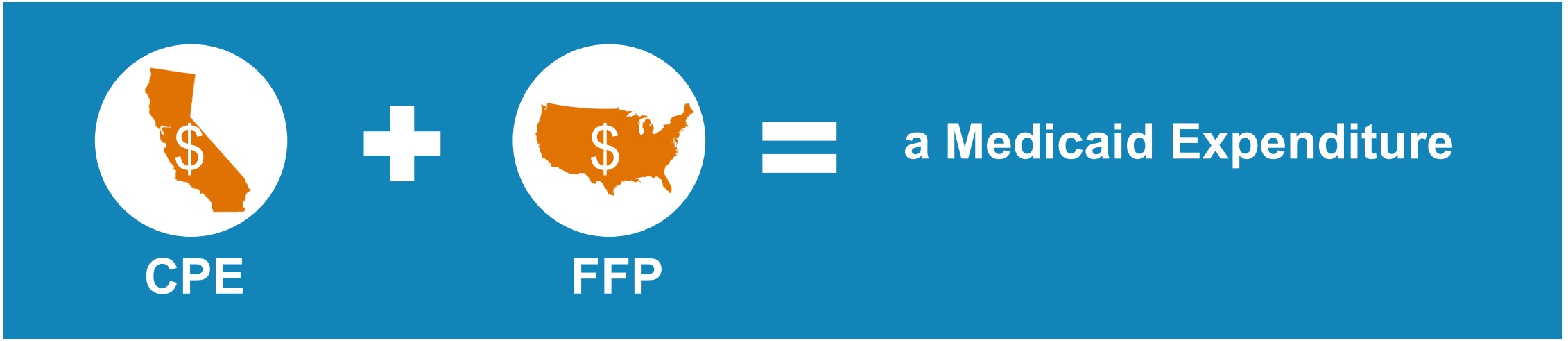
80%

80% **of youth in California's juvenile justice system have unmet behavioral health needs**, and youth of color are dramatically over-represented.

Making Healing Centered Systems…

Requires acknowledgment of how racism and poverty impact the social and emotional health of children and families—and how limited traditional medical model services are to addressing them

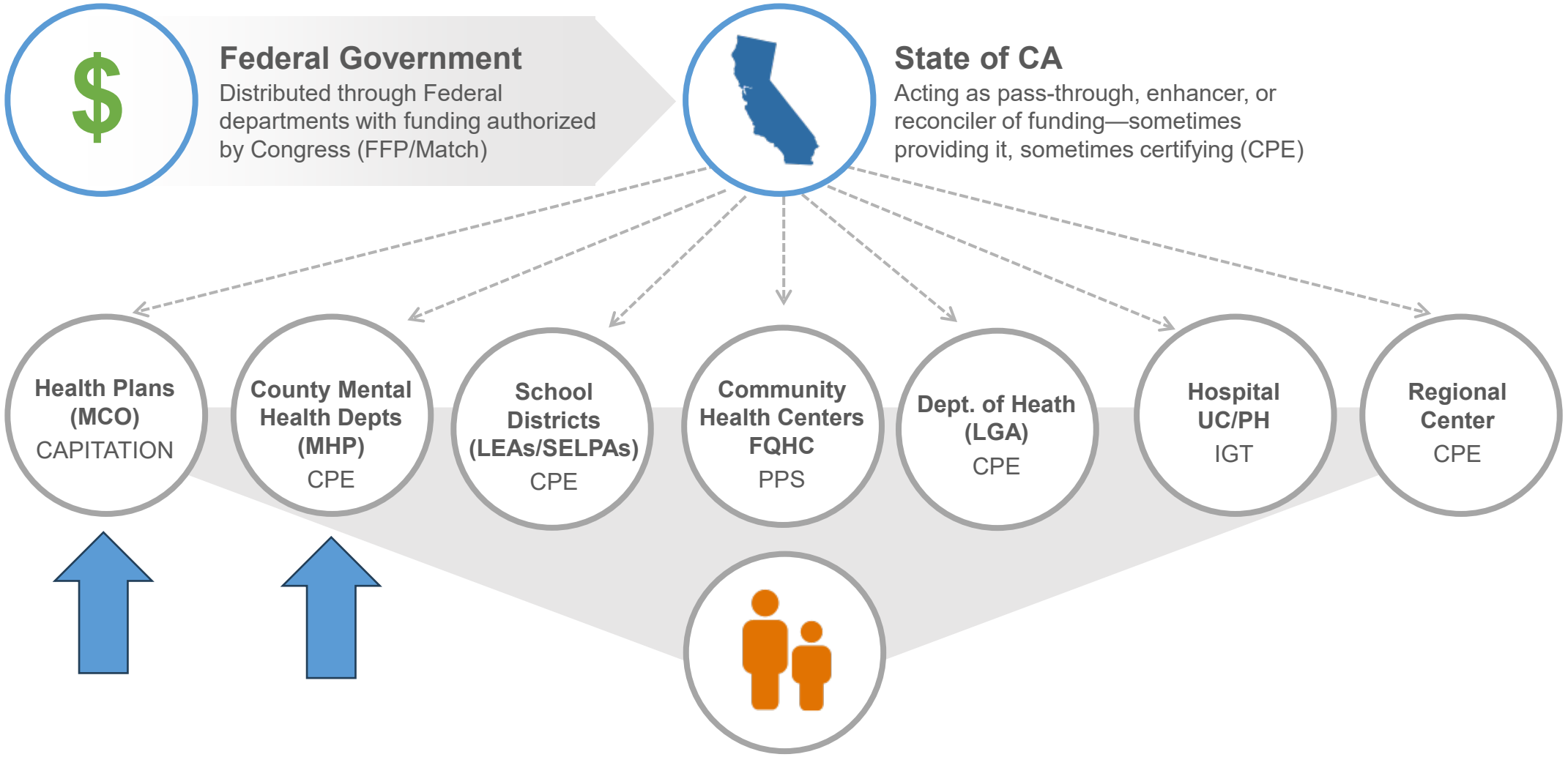
THE FEDERAL MATCH IS GUARANTEED:



Certified Public Expenditure (CPE) = A governmental entity, including a governmental provider (e.g., county hospital, local education agency) incurs an expenditure eligible for FFP under the state's approved Medicaid state plan (DHCS definition).

Federal Financial Participation (FFP) = The federal share of Medicaid dollars when all state and federal requirements are met.

THE MEDICAID MAP: WHO PAYS FOR FEDERALLY ENTITLED SERVICES TO CHILDREN AND FAMILIES

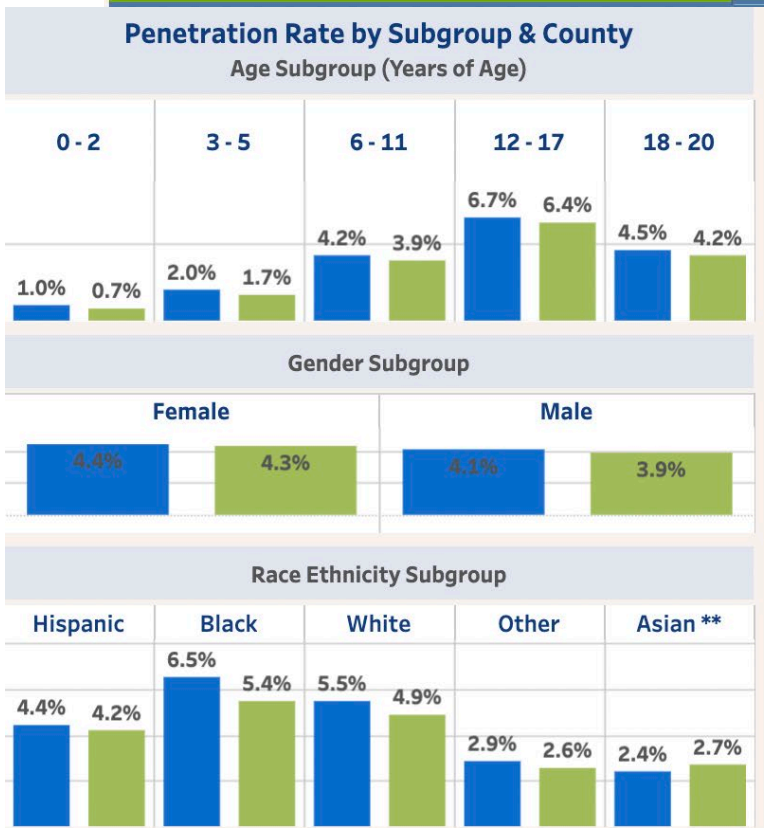


CALIFORNIA CHILDREN & SERVICES DASHBOARD & INTERACTIVE MAP

Access interactive data, https://cachildrenstrust.org/our-work/data-backgrounders/

Specialty Mental Health Plans and Non-Specialty Managed Care Plans for CA Children & Youth Mental Health Medi-Cal Beneficiaries
Access, Penetration, & Engagement, Reporting Year, 2021

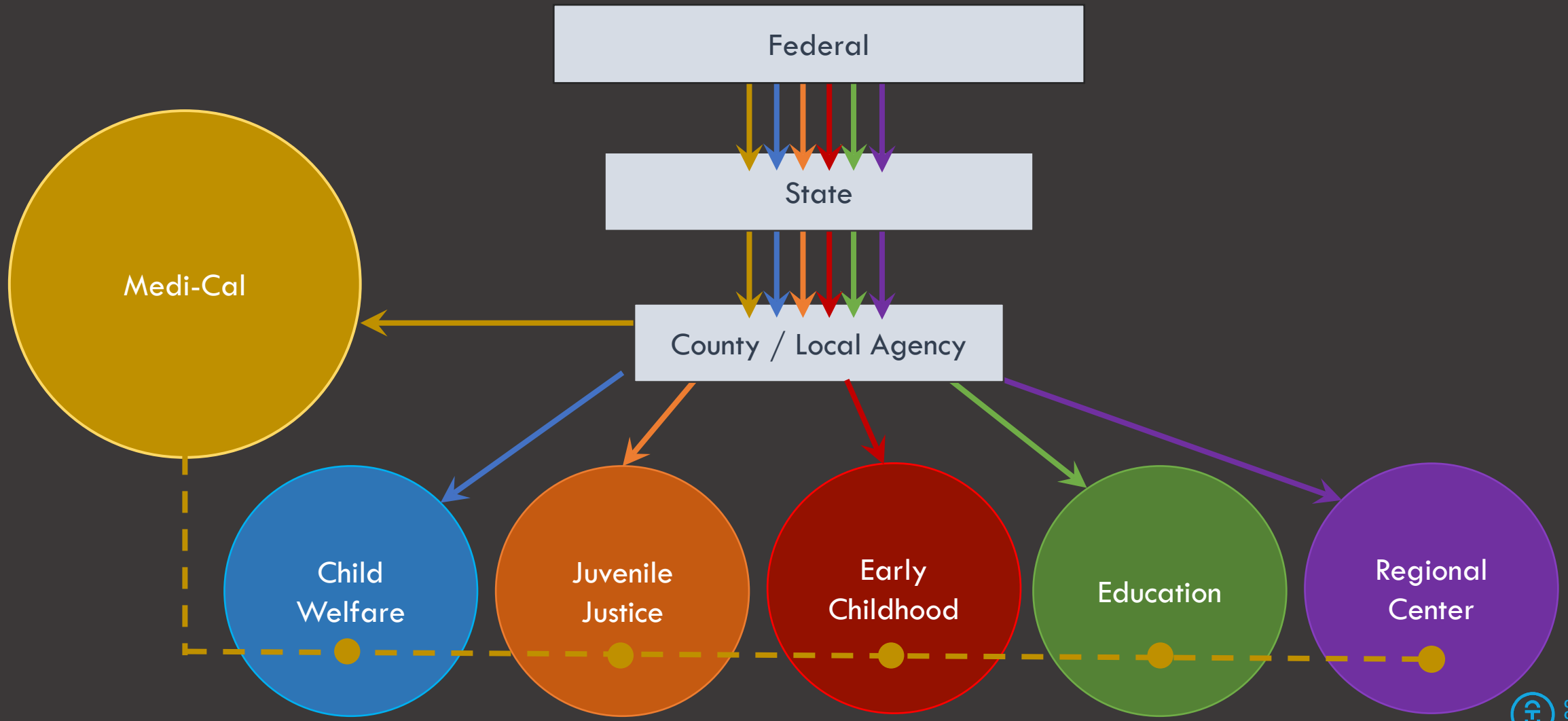
	Total Beneficiaries	Visits 1+	Visits 5+	Penetration Rate	Engagement Rate
Specialty Mental Health Services	5,663,276	241,182	183,043	4.3%	3.2%
Non-Specialty Mental Health Services	5,123,267	206,883	156,816	4.0%	3.1%



Key Facts

- Medi-Cal enrollment is up by 30% due to both state and federal policy.
- Non-Specialty Mental Health Services grew significantly over the same period.
- Children's utilization and acuity have risen sharply across the state.
- Correspondingly, non-federal based revenues have increased.
- However, for children in foster care, penetration and access rates are flat or declining.

MEDICAID AS THE TIE THAT BINDS FRAGMENTED SYSTEMS



California Children's Trust

Medicaid & Child Welfare Impact Areas

Upstream prevention

Provide children, youth, and families in the community with access to services and supports to meet emerging needs.

Intensive evidence-based services

Provide children, youth, and families in the community with access to services and supports to meet emerging needs living in the community.

Tailored services for children in foster care

Proactively address trauma and mental & behavioral health challenges for children and youth in foster care.

SDOH:
A MEDICAID & CHILD WELFARE INTERSECTION

Many of the same factors prevent both maltreatment and poor health outcomes: SDOH

Child welfare seeks upstream prevention strategies & funds—while Medicaid increasingly addresses SDOH.

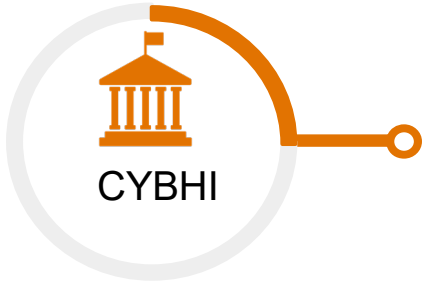
DO WE?

Have the will and skill to build new community and team based models of care that that integrate payors across fragmented safety net systems?

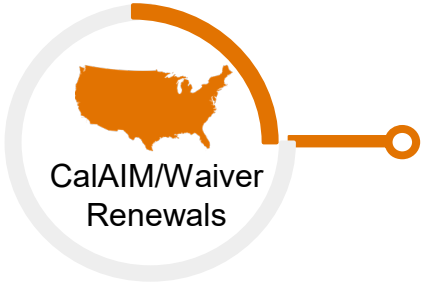
MEDI-CAL AND CALIFORNIA'S UNPRECDENTED REFORM LANDSCAPE

AN UNPRECEDENTED INVESTMENT:

FUNDING OPPORTUNITIES: FOR NEW NETWORKS OF CARE



- Managed Care Plans and Schools/SBHIP ($400 million)
- School Competitive Grants Program ($550 million)
- MHSA SSA funding ($250 million)
- Workforce including BH Coaches ($800 million)
- BH Virtual Platform: ($750 million)
- Expanding Evidence Based Programs ($429 million)
- DYADIC Benefit ($800 Million)
- Universal Feel Schedule: (TBD)



CalAIM: $4.5 billion ($3.1 billion in 22-23 year)

- Population Health Management
- Universal Eligibility for System Involved Children to SMHS
- Enhanced Care Management (ECM)
- Community Supports (CS)
- PATH
  - IPP (incentive payment program)
  - CITED (capacity building for providers)
  - Regional Collaboratives and TA (upcoming)

- Community School Partnership Grant Program ($4 billion+)
- Expanded Learning Opportunity Grant Program ($4 billion)
- Mindfulness ($75 Million); Peer to Peer Demonstration ($10 million)
- Investments in Counselor/Social Worker pipeline
- Educator Effectiveness Grant ($1.5 billion)
- HCSB/Special Ed/Other....($1.5 billion)
- Universal TK ($176 million)
- ESSER 1, II, III ($23.4 billion)

CYBHI: $4.4 Billion Dollar Initiative Centering Schools, Workforce, and Pediatric Primary Care

(One-Time vs Ongoing)

01 **Behavioral Health Service Virtual Platform: DHCS, $749.7 M**

02 **School-Linked Behavioral Health Services: DHCS/DMHC, $950M**

03 Develop and Expand Age-Appropriate, Evidence-Based Behavioral Health Programs: Agency/DHCS, $429M

04 Building Continuum of Care Infrastructure: DHCS, $310M

05 **Plan Offered Behavioral Health Services:** DHCS, $800M

06 **School Behavioral Health Counselor + Behavioral Health Coach Workforce:** OSHPD, $352M

07 **Broad Behavioral Health Workforce Capacity:** OSHPD, $448M

08 **Pediatric, Primary Care And Other Healthcare Providers:** DHCS, $50M

09 **Comprehensive And Culturally And Linguistically Proficient Public Education And Change Campaign:** CDPH + OSG, $100M

10 **Oversight, Coordination, Convening, And Evaluation:** DHCS, $70M

EXPANDING PROVIDER CLASS :

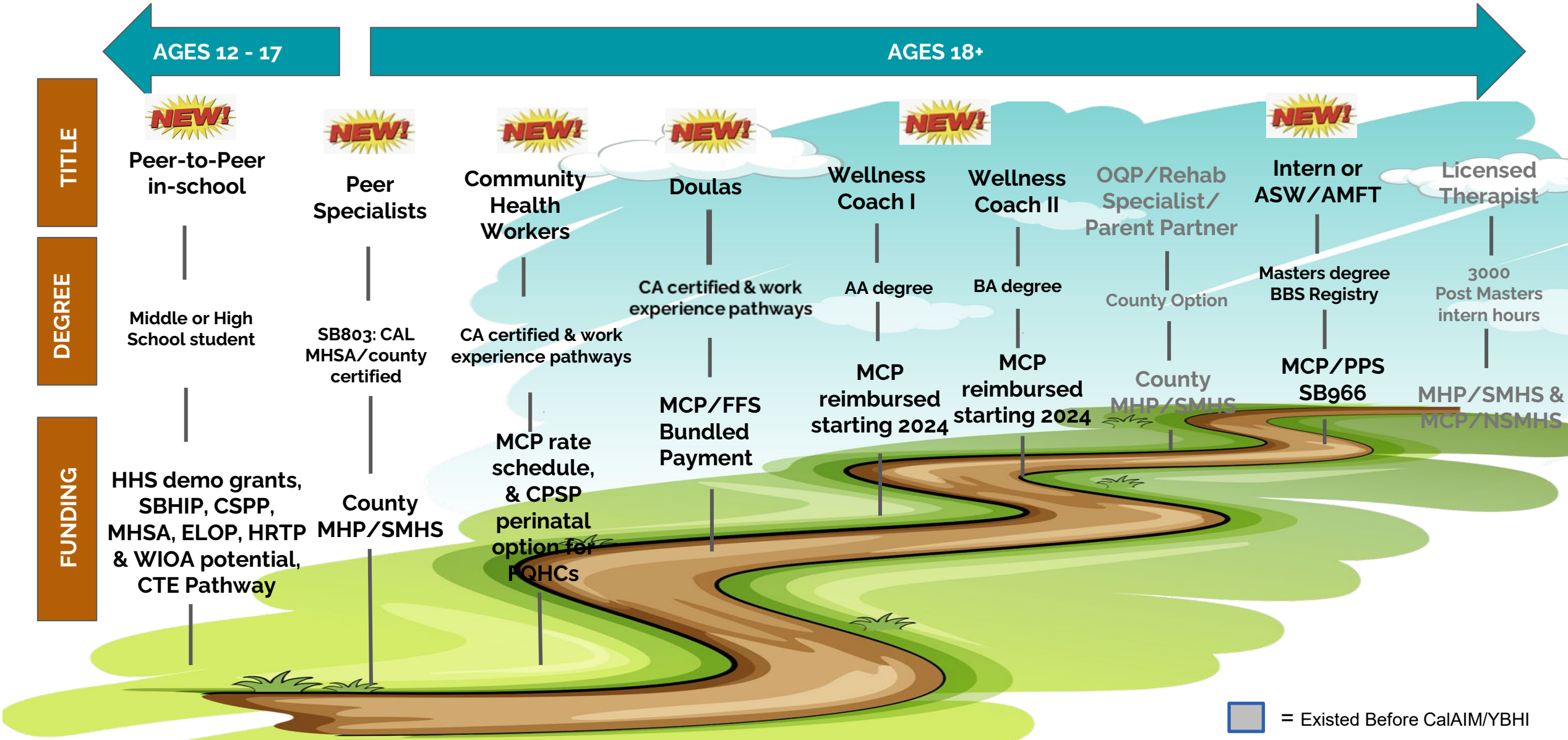
DOULAS, CHWS, PEERS, AND BH COACHES

Provider Expansion Guidelines

Scope	What can the provider do, in what setting, under what supervision and articulation, and what codes will they bill? Are community defined and culturally concordant practices specifically named and included?
Credentialing	Who is responsible for curriculum development, certifying the content and quality of the training, defining the core competencies, and certifying attainment?
Paneling	How does the new class sign-up with the payor? What is the required process and documentation?
Payor	Who pays claims—the Managed Care Organization or Mental Health Plan? Under what authority and what process?
Rates	What is the time, frequency, duration, and reimbursement level of all eligible services? Does it reflect a living wage?

NEW Medi-Cal Reimbursable Career Pathways to Support ACEs Networks of Care

Leveraging and Integrating The Wisdom and Experience of Culturally Concordant Providers

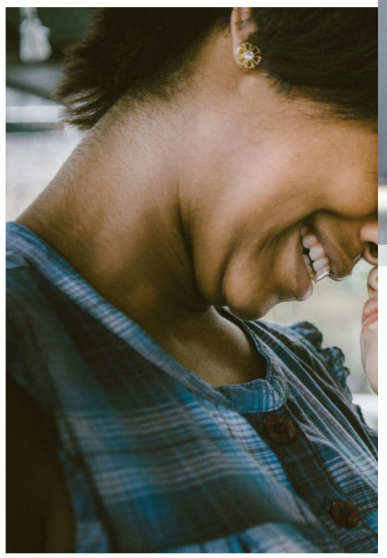


REFORMING MEDICAL NECESSITY AND EXPANDING ACCESS TO INTEGRATED BEHAVIORAL HEALTH

THE REMOVAL OF DIAGNOSIS AS A PRE-REQUISITE FOR CARE AND THE NEW FAMILY THERAPY AND DYADIC BENEFITS:

New California pr
health coverage p
front and center

LAURIE UDESKY (PACES CONNECTION STAFF)



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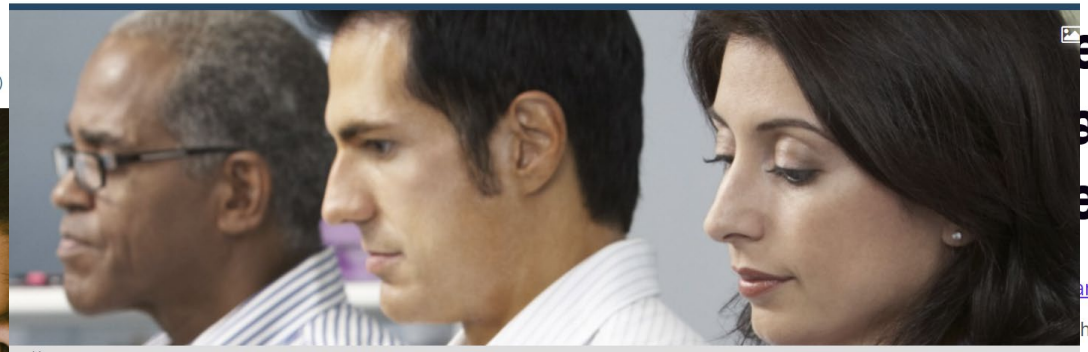

Home

SHARE

California's Medicaid Family Therapy Benefit Reimagines Medical Necessity

Innovations in Youth Mental Health

By Nia West-Bey

HEALTH AND MENTAL HEALTH

Children, Youth & Families
Young Adult Behavioral Health
Youth and Young Adults

Blog Post
May 31, 2022

In 2022, we have seen growing attention on the youth mental health crisis in this country. The U.S. Surgeon General's office issued an unprecedented advisory about the critical state of youth mental health. In response, the Biden Administration released a comprehensive plan and budget proposal. Young people—particularly young people of color and those living in poverty—were

Babies Don't Go to the Doctor By Themselves:

Innovating a Dyadic Behavioral Health Payment Model to Serve the Youngest Primary Care Patients and Their Families

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Proposal Summary

- A statewide demonstration project to align reimbursement with clinical best practices in early childhood mental health
- Essential support for proven dyadic models
- Improving health outcomes for young children and their caregivers
- Pioneering clinical best practices to inform state-level guidance
- Demonstrating partnership with safety-net clinical leadership

eed Parenting Help? Therapy? Food? alifornia Pediatrician Offices May Soon e Able to Help

ariana Dale

hed Nov 16, 2021 1:19 PM

A CALL TO ACTION

1. **Remove diagnosis** as a requirement for treatment (expand Medical Necessity Criteria in context of EPSDT and ACES)
2. **Reform Medicaid** by claiming against exisiting expenditures in child serving systems and expanding the role of MCO's
3. **Center schools and Primary Care** as healing and anti-racist centers of support
4. **Expand Eligible Provider Classes** to address workforce shortages, build culturally concordant workforce, and honor the widsom and intelligence of lived experience
5. **Focus on Benefit Design in Managed Care Organizations to develop scaleable reimbursement for Dyadic Models** in Pediatric Primary Care.
6. **Focus on Care Coordination models** to bring culturally concordant non clinical CBO's into health system networks.
7. **Develop social model, cascading mentorship, and mutual aid** strategies as essential social capital building strategies in Medicaid.

Read and share our policy briefs

cachildrenstrust.org

Join our Coalition

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Sign up for the CCT Newsletter

TAKE AWAYS:

- BIG CHANGES ARE HERE… AND MORE ARE COMING SOON.
- KNOW THE MANY FACES OF MEDICAL AND HOW THEY CAN BE INTEGRATED TO SUSTAIN YOUR WORK—UNDERSTAND THE CENTRICITY OF THE PLANS
- TRACK NEW AND EMERGING BENEFIT DESIGN AND CONSTRUCTION
- MINE THE NEW PROVIDER TYPE OPPORTUNITIES
- THERE IS A LOTS OF ONE-TIME MONEY—SUSTAINABILITY REMAINS MURKY

SUSTAINABILITY DISTILLED:

HEALTH PLANS ARE THE CENTER

BEHAVIORAL HEALTH IS CHANGING

MEDI-CAL WILL PAY FOR THINGS IT DIDN'T PAY FOR BEFORE

MEDI-CAL WILL PAY FOR NEW TYPES OF PROVIDERS

What If?

We aligned all of these efforts around an **unconditional commitment to the success of every child** in out-of-home placement

THAT IS

Built on a vision for universal access to high fidelity Intensive Community Based Mental Health services for all children in child welfare

AND HAS

Consistency across the system with identified models, at defined costs, with common staffing , case rates, performance measure and incentive payments

AND WILL BE

Implemented with fidelity via common contract templates, leveraging new access criteria and new benefits from MCOs, and new opportunities to claim Federal Financial Participation (FFP) under SMHS Payment Reform

HISTORY INFORMS HOPE

CALIFORNIA HAS BEEN ON THIS JOURNEY FOR DECADES…

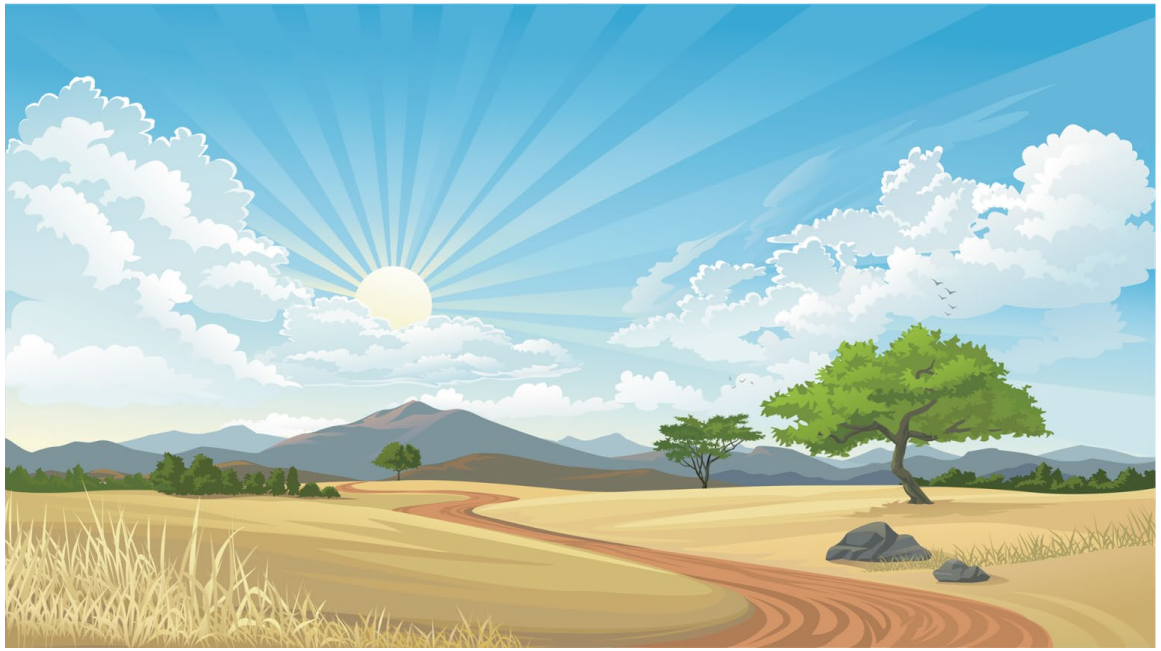
(and there are only 55k kids in care…)

A final destination is in sight

To a Medicaid Mandated Approach: CalAIM created a trauma informed definition of Medical Necessity for all children in CW

To a Paradigm Shift: CCR launched in 2012 and created CFT according to wrap principles

To Litigation: Katie A Settlement in 2011 Established link between MediCal and Wrap

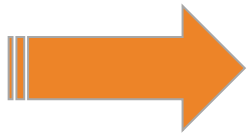


From Legislation: Established in 1997 by SB 163, allowed counties to use state AFDC-FC funding flexibly to support youth in the communities and to create Wraparound Trust Funds. This version of wraparound will be used to meet the aftercare requirements of FFPSA starting in October 2021 (WIC 4086.6)

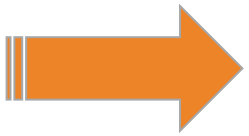
SENECA
FAMILY OF AGENCIES | UNCONDITIONAL CARE

TIER	SUMMARY OF SERVICE	STAFF/ROLES AVAILABLE	AVE HOURS OF DIRECT SERVICE / MONTH	COST/ CHILD/ MONTH
Tier 1	Case Management and Linkages	BA/MHRS Counselor/Coach	12 to 15	$2,500
Tier 2	CM, Linkage and Behavioral Coaching	BA/MHRS Counselor/Coach	20 to 24	$4,000
Tier 3	C/M, Linkage, CFT Facilitation, Behavioral Coaching, flex funds, 24/7 support	MA Facilitator/Clinician, BA/MHRS Counselor	24 to 30	$5,500
Tier 4	C/M, Linkage, CFT Facilitation, Parent Support/Advocacy, Behavioral Coaching, Family Finding and Engagement, 24/7 support	MA Facilitator/Clinician, Parent Partner, BA/MHRS Counselor, Permanency Specialist	30 to 36	$7,000
Tier 5	C/M, Linkage, CFT Facilitation, Parent Support/Advocacy, Behavioral Coaching, Family Finding and Engagement, In-home and in-school stabilization and staffing, Therapy, 24/7 support	MA Facilitator/Clinician, Parent Partner, BA/MHRS Counselor, Permanency Specialist	45 to 50	$10,000
Tier 6	C/M, Linkage, CFT Facilitation, Parent Support/Advocacy, Behavioral Coaching, Family Finding and Engagement, Intensive in-home and in-school stabilization and staffing, Therapy, 24/7 support	MA Facilitator/Clinician, Parent Partner, BA/MHRS Counselor, Permanency Specialist	68 to 75	$15,000

THIS MAPPED TO



THREE LEVELS OF HIGH FIDELITY Support



Tier	Summary of Services	Staff/Roles Available	Average Hours of Direct Service/ Month	Cost per Child per Month
Wrap Tier 1	Case Management, Linkages, Behavioral Coaching	* BA/Mental Health Rehabilitation Specialist (MHRS) Counselor * BA/Coach, Peer Support	12 to 24	$2,500 - $4,000
Wrap Tier 2	**Tier 1 +** CFT Facilitation, Behavioral Coaching, Parent Support/Advocacy, Family Finding and Engagement, flex funds, 24/7 Support	* MA Facilitator/Clinician, Parent partner * BA/MHRS Counselor, Permanency Specialist	24 to 36	$5,500 - $7,000
Wrap Tier 3	**Tier 2 +** Intensive In-Home Stabilization, Therapy	* MA Facilitator/Clinician, Parent partner * BA/MHRS Counselor, Permanency Specialist	45 to 75	$10,000 - $15,000

Unprecedented Opportunity

- Deepened understanding of the impact of trauma and adversity (ACES/Trauma)
- Increased CDSS investment in wraparound concurrent with DHCS enhanced benefit design for CW population
- Millions in complex care funding
- Declining IV-E eligibility rates and need to explore ways to capture FFP
- CalAIM reforms removing barriers to services for system involved youth and redefining MediCal necessity to clarify eligibility
- Need to address system level fragmentation (horizontal and vertical)
- BH CONNECT Design and Development

How Do We Implement?

- Seek consensus.
- Develop consistent, feasible case rate contract templates and roles and responsibilities across CW/MHPs.
- Develop tiered structure of service that is mapped to CANS.
- Set up pilot counties to develop best practices and demonstrate successful implementation.

Children & Youth Components of the BH-CONNECT Demonstration

Child Welfare Council

September 13, 2023

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Opening Remarks

CalAIM Behavioral Health Foundational Policy Changes

Access Criteria for SMHS and DMC/ODS *(January 2022)*	**DMC-ODS Policy Improvements** *(January 2022)*	**Documentation Redesign** *(July 2022)*
No Wrong Door *(July 2022)*	**Standardized Screening and Transition Tools** *(January 2023)*	**Payment Reform** *(July 2023)*

BH-CONNECT Waiver Overview

Why BH-CONNECT?

The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) initiative builds upon unprecedented investments and policy transformations to establish a robust continuum of community-based behavioral health services and improve access, equity, and quality for Medi-Cal members.

- Like the rest of the nation, **California faces a growing mental health crisis**, which has been exacerbated by COVID-19: as of 2019, nearly 1 in 20 adult Californians were living with serious mental illness (SMI), and 1 in 13 California children were living with serious emotional disturbance (SED).
- California has **invested more than $10 billion and is implementing landmark policy reforms** to strengthen the behavioral health care continuum through initiatives that include:
  - ☑ The **California Advancing and Innovating Medi-Cal** (CalAIM) demonstration to transform and strengthen Medi-Cal, including policy changes to move Medi-Cal behavioral health to a more consistent and seamless system by reducing complexity and increasing flexibility.
  - ☑ The **Children and Youth Behavioral Health Initiative** (CYBHI), a historic investment to enhance, expand and redesign the systems that support behavioral health for children and youth.
  - ☑ Investments in infrastructure and new housing settings through the **Behavioral Health Continuum Infrastructure Program** (BHCIP) and the **Behavioral Health Bridge Housing** (BHBH) Program.
  - ☑ Strengthening the behavioral health crisis care continuum, including implementing **mobile crisis services** and the **988 Suicide and Crisis Lifeline**.

Section 1115 Demonstration Opportunity

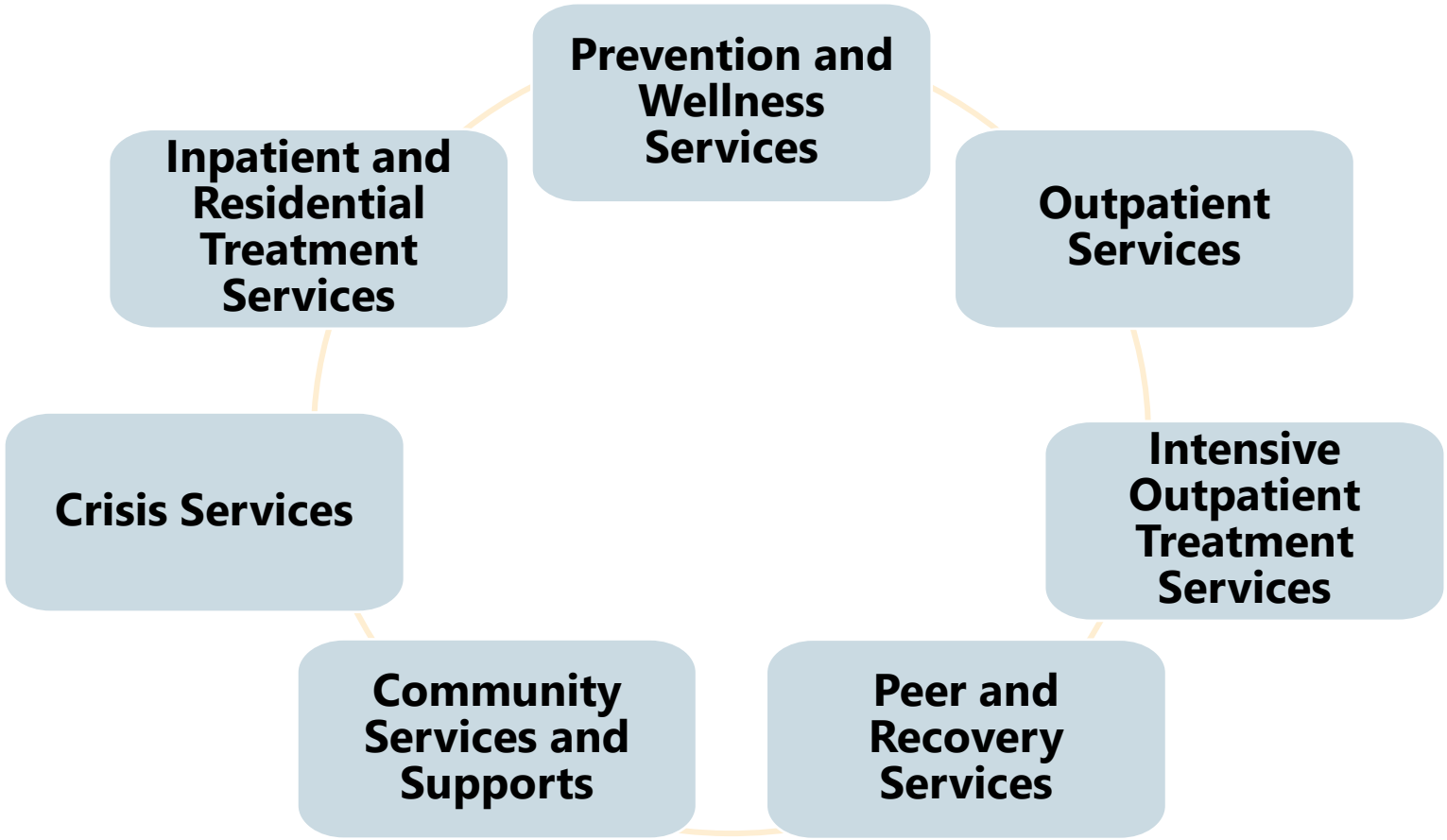
The BH-CONNECT demonstration will strengthen the continuum of community-based behavioral health services, while also taking advantage of CMS' opportunity to receive federal financial participation (FFP) for care provided during short-term stays in Institutions for Mental Diseases (IMDs).

- **CMS' 2018 guidance** permits states to use 1115 demonstrations to receive FFP for short-term care* provided to Medicaid members living with SMI/SED in qualifying IMDs, provided states establish a robust continuum of community-based care and enhance oversight of inpatient and residential settings.
- **California was the first state to obtain a similar waiver allowing IMD expenditure authority for substance use disorder (SUD) care provided in IMDs** in exchange for strengthening SUD services under the Drug Medi-Cal Organized Delivery System (DMC-ODS).
- In October 2021, **CMS created new flexibility to secure FFP for longer stays in Short-Term Residential Therapeutic Programs (STRTPs) classified as IMDs** for youth in the child welfare system for up to two years. States must submit a detailed plan with key milestones and timeframes for transitioning children out of STRTPs that are IMDs.
- In November 2022, DHCS **released an external concept paper outlining the proposed** approach to the BH-CONNECT demonstration (formerly the CalBH-CBC demonstration).
- On August 1, 2023, **DHCS released the proposed BH-CONNECT Section 1115 application.**

**The opportunity is limited to stays that are no longer than 60 days, with a requirement for a statewide average length of stay of 30 days.*

Enhancing the Continuum of Care

BH-CONNECT will complement and further build out the continuum of care for Medi-Cal members living with significant behavioral health needs.



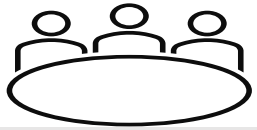
Proposed Approach

BH-CONNECT aims to:

- **Expand the continuum of community-based services and evidence-based practices (EBPs)** available through Medi-Cal.
- **Strengthen family-based and supports** for children and youth living with significant behavioral health needs, including children and youth involved in child welfare.
- Connect members living with significant behavioral health needs to **employment, housing, and social services and supports**.
- **Invest in statewide practice transformations** to better enable county behavioral health plans and providers to support Medi-Cal members living with behavioral health conditions.
- **Strengthen the workforce** needed to deliver community-based behavioral health services and EBPs to members living with significant behavioral health needs.
- Reduce the risk of individuals **entering or re-entering the criminal justice system** due to untreated or under-treated mental illness.
- **Incentivize outcome and performance improvements** for children and youth involved in child welfare that receive care from multiple service systems.
- **Reduce use of institutional care** by those individuals most significantly affected by significant behavioral health needs.

BH-CONNECT Waiver: Stakeholder Voice

DHCS appreciates stakeholder feedback provided to date and continues to seek and consider feedback in the months to come



- Stakeholder feedback on the CalBH-CBC Concept Paper, released in November 2022, is reflected in the revised BH-CONNECT Waiver application, including:
  - Incorporation of additional therapeutic modalities for children and youth;
  - Establishment of Centers of Excellence;
  - Administration of Activity Stipends by counties (rather than by Managed Care Plans).
- Additional components stem from recommendations from the Foster Care Model of Care Workgroup, including:
  - Conducting an Initial Behavioral Health Assessment;
  - Establishing Foster Care Liaisons.

Overview: Elements of the BH-CONNECT Waiver to Support Children & Youth

Approach: Child-Related Demonstration Components

In the design of the BH-CONNECT waiver, DHCS dedicated particular attention to the needs of children and youth, particularly those involved in child welfare.

DHCS will use the BH-CONNECT waiver to make targeted improvements to care for children and youth statewide, including:

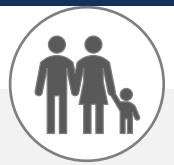
- **Cross-Sector Incentive Program** to reward Managed Care Plans (MCPs), County Mental Health Plans (MHPs), and child welfare systems (CWS) for meeting specified measures related to coordinating care for children and youth in the child welfare system;
- **Activity Stipends** for children/youth involved in child welfare to promote social/emotional well-being, and;

In parallel with the BH-CONNECT waiver, DHCS is making other statewide changes to strengthen services for children and youth that do not require waiver expenditure authority, including:

- **Centers of Excellence** to support the implementation of evidence-based practices for children and youth.
- **Clarification of coverage** of specific evidence-based practices for children and youth (MST, FFT, PCIT, and potentially other therapeutic modalities);
- **Alignment of the Child and Adolescent Needs and Strengths (CANS) tool** to ensure both child welfare and behavioral health providers are using the same CANS tool;
- **Initial Behavioral Health Assessment** jointly administered by the behavioral health and child welfare systems; and
- **Foster Care Liaison Role** requirement within MCPs.

Key Elements of the BH-CONNECT Waiver (1/2)

The waiver proposal includes key elements to strengthen the continuum of care for Medi-Cal beneficiaries living with SMI/SED, with particular attention to the needs of populations disproportionately impacted by behavioral health conditions.



Strengthen Statewide Continuum of Community-Based Services

- ✓ Clarify Coverage of Specific Community-Defined and Evidence-Based Practices
- ✓ Cross-Sector Incentive Pool
- ✓ Activity Stipends
- ✓ Initial Behavioral Health Assessment
- ✓ Foster Care Liaison Role

Support Statewide Practice Transformations

- ✓ Centers of Excellence
- ✓ Statewide Incentive Program
- ✓ Workforce Initiative
- ✓ Statewide Tools to Connect Beneficiaries Living with SMI/SED to Appropriate Care
- ✓ Promotion and Standardization of Quality of Care in Residential and Inpatient Settings

Improve Statewide County Accountability for Medi-Cal Services

- ✓ Transparent Monitoring Approach
- ✓ Establishment of Key Performance Expectations and Accountability Standards in County Mental Health Plan Contract
- ✓ Streamlined Performance Review Process

Key Elements of the BH-CONNECT Waiver (2/2)

The waiver proposal includes key elements to strengthen the continuum of care for Medi-Cal beneficiaries living with SMI/SED, with particular attention to the needs of populations disproportionately impacted by behavioral health conditions.

County Option to Enhance Community-Based Services

- ✓ Assertive Community Treatment
- ✓ Forensic Assertive Community Treatment
- ✓ Supported Employment/Education
- ✓ Coordinated Specialty Care for First Episode Psychosis
- ✓ Community Health Worker Services
- ✓ Transitional Rent Services
- ✓ Clubhouse Services

County Option to Receive FFP for Short-Term Stays in IMDs*

- ✓ FFP for Short Term Stays in IMDs
  - ✓ Includes STRTPs*
- ✓ Requirement to Provide Enhanced Community-Based Services for Beneficiaries Living with SMI/SED
- ✓ Incentive Program for Opt-In Counties
- ✓ Other CMS Requirements

** Waives 60-day length of stay cap for children and youth in STRTPs for a two-year period.*

Focus: Elements of the BH-CONNECT Waiver to Support Children & Youth

Clarification of Coverage Requirements for Specific Community-Defined and Evidence-Based Practices

The BH-CONNECT waiver is designed to expand and strengthen the continuum of community-based care, especially for children, youth and their families.

Proposed Approach:

While a comprehensive set of community-based services for children and youth are currently coverable under Medi-Cal pursuant to the EPDST mandate, specific services are known to help reduce the institutionalization of high-risk children and youth, including those who are involved in the juvenile justice system and those who have been removed from their homes, have experienced homelessness, or confronted other major disruptions. These services include (but are not limited to):

- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- Parent-Child Interaction Therapy (PCIT)
- Potentially Additional Therapeutic Modalities

DHCS intends to issue guidance related to these community-defined and evidence-based practices, including specific service definitions, provider qualifications, implementation requirements, and dedicated billing codes to incentivize provider delivery and monitor utilization and performance.

Centers of Excellence

DHCS intends to establish and fund Centers of Excellence (COEs) to support implementation of the BH-CONNECT Waiver. COEs will support the implementation of evidence-based practices for children and youth, in addition to other key features of the Demonstration.

COEs will focus on:

- **Evidence-based practices for children and youth** (e.g., MST, FFT, PCIT, intensive care coordination, intensive home-based services, high-fidelity wraparound)
- **ACT/FACT** services;
- **CSC for FEP** services;
- **IPS Supported Employment** services;
- **Community-defined practices** (*tentative*)
- Evidence-based practices in **rural areas** (*tentative*; *CBHDA request*)
- **Other evidence-based practices** (e.g., motivational interviewing, motivational enhancement therapy, suicide prevention)

Specific activities conducted by COEs will include:

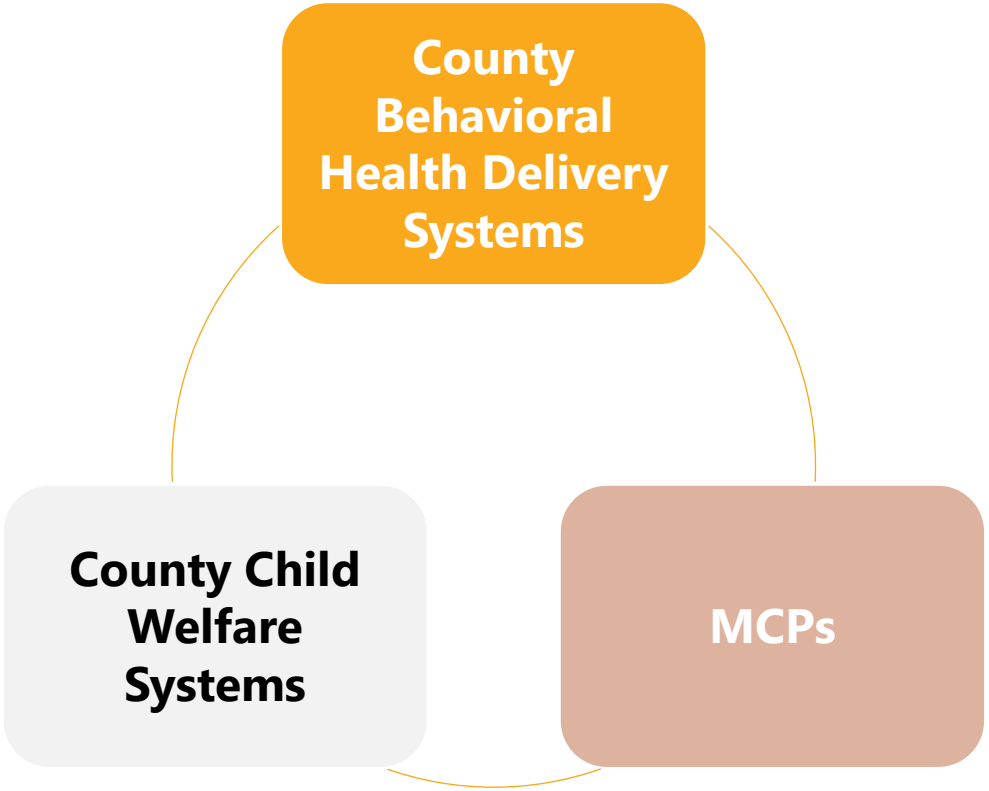
- **Training**
- **Certification/licensing** for specific evidence-based practices (e.g., MST)
- **Technical assistance** and coaching/mentoring
- **Fidelity monitoring**
- **Other supports** to deliver evidence-based practices through a culturally sensitive lens

Statewide Feature: Cross-Sector Incentive Program for Children Involved in Child Welfare

Children involved in child welfare frequently require coordination across multiple systems to meet their needs. DHCS plans to establish a cross-sector incentive program to facilitate innovation and drive outcome improvements through cross-agency collaboration.

The cross-sector incentive program will provide fiscal incentives for three key systems to **work together and share responsibility in improving behavioral health outcomes** among children involved in child welfare.

DHCS has received valuable feedback on potential measures for this incentive program and is working closely with stakeholders on the framework and measure set for the cross-sector incentive program to ensure it is designed in a way to best support children and youth involved in child welfare who are living with behavioral health needs.



Cross-Sector Incentive Program: High-Level Program Measurement Timeline

Initial program metrics may focus on planning, infrastructure development, and establishment of baseline data on systems' quality performance. Throughout the course of the program, metrics may shift to be more outcomes- and performance-based.

High-Level Cross-Sector Incentive Program Measurement Timeline

Program Year 1	Program Year 2	Program Year 3	Program Year 4
Measurement Period 1	Measurement Period 2	Measurement Period 3	Measurement Period 4

Metrics may shift to be more performance-based as the program goes on

EXAMPLE Metric Focus Areas

Process Metrics (Focus Early in Program)	**Outcome Metrics** (Focus Later in Program)
» Alignment of CANS tool across systems/programs » MCPs offering caregiver Respite Services as a Community Support (e.g., standard assessment/referral process, utilization rates, etc.) » Cross-sector coordination (e.g., AB 2083 Children and Youth System of Care implementation, MCPs joining Interagency Leadership Team, etc.)	» Improvement of SUD-related outcomes » Reduction in average time to permanency » Reduction in residential/inpatient length of stay (LOS) and/or placements » Reduction of use of restraints in facilities » Increase in use of community-based care (e.g., HFW, IHBS)

Statewide Feature: Activity Stipends

DHCS is requesting expenditure authority to develop a new support for children ages 3 and older involved in child welfare to increase access to extracurricular activities, which can enhance physical health, mental wellness, healthy attachment, and social connections.

Activity Stipends would support activities not otherwise reimbursable in Medi-Cal, such as:

- Movement activities
- Sports
- Leadership activities
- Excursion and nature activities
- Music and art programs
- Other activities to support healthy relationships with peers and supportive adults

DHCS will work with California Department of Social Services, county child welfare agencies, tribal social services and tribal child welfare programs on distribution of Activity Stipends.

Eligibility Criteria

Members may be eligible for Activity Stipends if they are:

- under age 21 and currently involved in the child welfare system in California;
- under age 21 and previously received care through the child welfare system in California or another state within the past 12 months;
- aged out of the child welfare system up to age 26 in California or another state;
- under age 18 and are eligible for and/or in California's Adoption Assistance Program; or
- under age 18 and currently receiving or have received services from California's Family Maintenance program within the past 12 months.

Aligned Use of the Child and Adolescent Needs and Strengths (CANS) Tool

DHCS intends to align the use of a CANS tool across the child welfare and specialty mental health systems.

Objectives:

Alignment of the CANS across systems is intended to:

- Ensure both child welfare and behavioral health providers are using the same CANS tool with the same modules
- Ensure that the CANS tool is administered in the same way, whether done by a specialty mental health provider or by a child welfare worker, so that outcomes can be tracked over time.
- Produce robust outcome measurements which will allow the State to incentivize outcomes. The BH-CONNECT demonstration specifically proposes to use the CANS as part of the Cross Sector Incentive Pool.

Initial Joint Behavioral Health Assessment

DHCS intends to require an initial child welfare/Specialty Mental Health behavioral health assessment at entry point into child welfare, as proposed by the County Behavioral Health Directors Association and the County Welfare Directors Association.

Proposed Approach:

- DHCS intends to clarify that a specialty mental health provider should accompany the child welfare worker during an initial home visit.
- The home visit would occur within 30 days of a hotline call, after a hearing substantiating an allegation of abuse or neglect and upon the child's entry into the child welfare system.
- The specialty mental health provider would do a comprehensive behavioral health assessment to identify mental health and/or substance use conditions related to the child and/or the family, identify necessary social supports, and then connect the child and family (both the biological family and the resource family, as appropriate) to any needed clinical or community services.
- As part of the BH-CONNECT Demonstration, DHCS proposes to develop standards and requirements for the behavioral health assessment and cross-agency collaboration.

Foster Care Liaison Role

DHCS intends to require the inclusion of a Foster Care Liaison within MCPs to enable effective oversight and delivery of Enhanced Care Management (ECM).

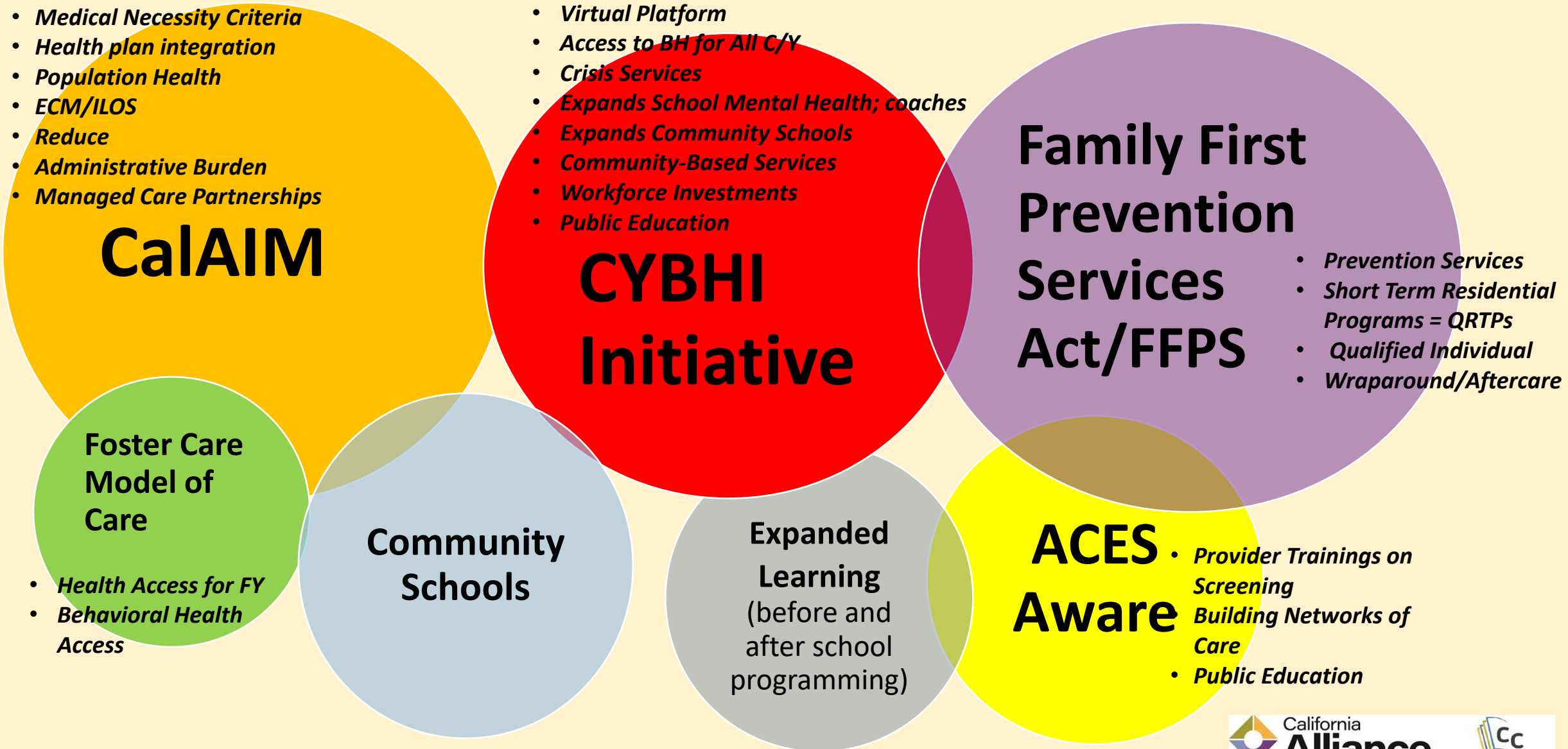
Proposed Approach:

- The Foster Care Liaison will have expertise in child welfare services, county behavioral health services, and other sectors, ensure appropriate ECM staff attend Child Family Team meetings, and ensure managed care services are closely coordinated with other services.
- The Foster Care Liaison will be a management level position at the MCP with responsibility to oversee the ECM providers providing services to child welfare involved children and youth in their case load, provide technical assistance to MCP staff as needed, and serve as point of escalation for care managers if they face operational obstacles when working with county and community partners. In addition, the Foster Care Liaison will be required to designate a primary point of contact responsible for the child's care coordination (which may also be the ECM provider).
- DHCS will develop standards and expectations via contract changes for this role to ensure consistency for all MCPs.

Timeline and Next Steps

- **Public Comment Period.** The BH-CONNECT demonstration application public comment period was August 1, 2023 through August 31, 2023.
- **Response to Public Comment.** DHCS will revise the draft BH-CONNECT demonstration application, integrating stakeholder feedback, in fall 2023.
- **Submission to CMS.** DHCS intends to submit the final BH-CONNECT demonstration application for CMS review in late 2023.
- **Go-Live.** The BH-CONNECT demonstration will be implemented on a phased timeline to ensure ample time for successful implementation.
- **Ongoing Stakeholder Engagement.** DHCS is committed to engaging with stakeholders on an ongoing basis throughout the design and implementation of BH-CONNECT.

Current Initiatives Impacting Children and Youth



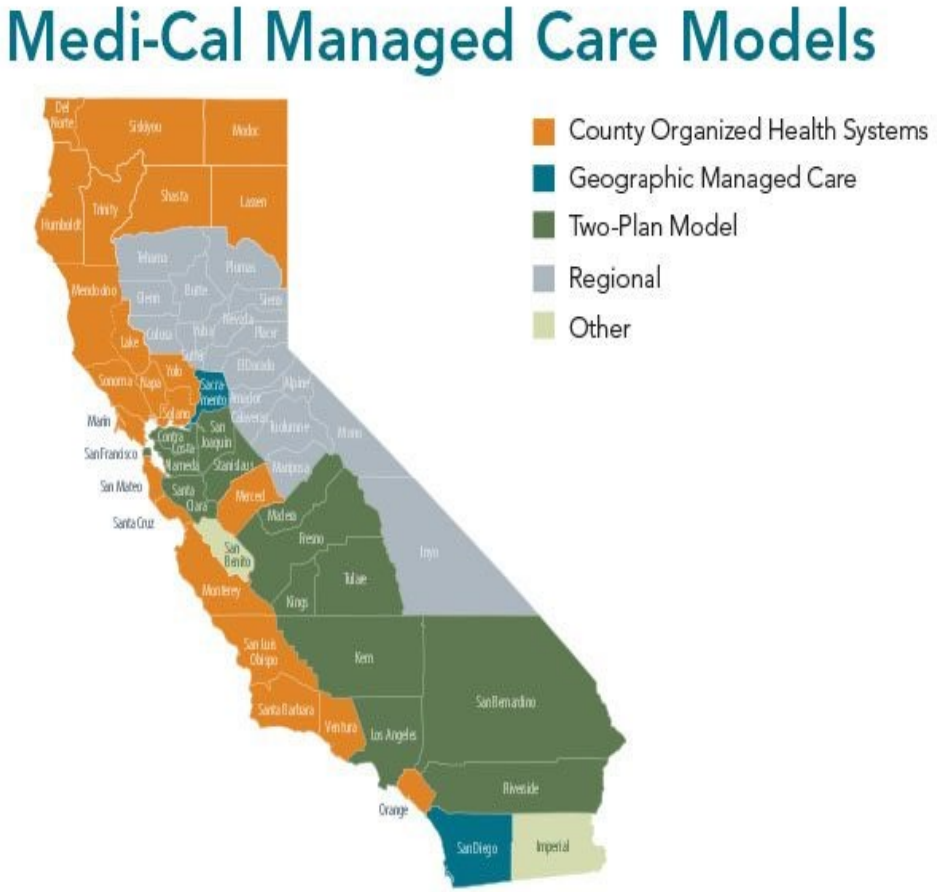
California Alliance
Empowering lives. Enriching futures.

Catalyst Center

CalAIM (Health plans and Social Determinants of Health)

Components of CalAIM:	Enhanced Care Management Community Supports Community Health Workers
Other Medi-Cal Benefit Changes	Family Therapy Benefit through MCPs Dyadic care Doulas

MEDI-CAL MANAGED CARE MODELS BY COUNTY



Source: California Department of Health Care Services.

County Organized Health Systems (Single Payor): 6 plans, 22 counties

Two-Plan: 9 Local Initiatives and 3 commercial plans, 14 counties

Geographic Managed Care: 8 commercial plans, 2 counties

Regional: 2 commercial plans, 18 counties

Imperial: 2 commercial plans, 1 county

San Benito: 1 commercial plan, 1 county

Know the Managed Care Plans (MCPs) in your County:
https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx

CalAIM: Increase Access to Services

Criteria for beneficiary access to Specialty Mental Health Services (BHIN 21-073)

- Condition that places a youth at risk for a mental health disorder as evidenced by
  - High score on trauma screening
  - Involvement in child welfare
  - Involvement in juvenile justice
  - Experiencing homelessness

Youth has at least one of the following:

- Significant impairment
- A reasonable probability of significant deterioration in an important area of life functioning
- A reasonable probability of not progressing developmentally as appropriate
- A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

CalAIM: No Wrong Door

- **Managed Care Plans (MCPs) are required to provide (or arrange for the provision of):**
  - Mental health evaluation and treatment, including individual, group and family psychotherapy.
  - Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
  - Outpatient services for purposes of monitoring drug therapy.
  - Psychiatric consultation.
  - Outpatient laboratory, drugs, supplies and supplements.
- **MCPs must cover emergency room services**
- **MCPS must cover substance use disorder services, including alcohol and drug screening, assessments, brief interventions, and referral to treatment for members ages 11 and older, including pregnant members**

CalAIM: No Wrong Door

- **Mental Health Plans (MHPs) are required to provide (or arrange for the provision of) medically necessary SMHS for beneficiaries in their counties who meet access criteria for SMHS as described in BHIN 21-073.**

- **Services are covered and reimbursable even when:**
  - *Services are provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met;*
  - *The beneficiary has a co-occurring mental health condition and substance use disorder (SUD); or*
  - *NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.*

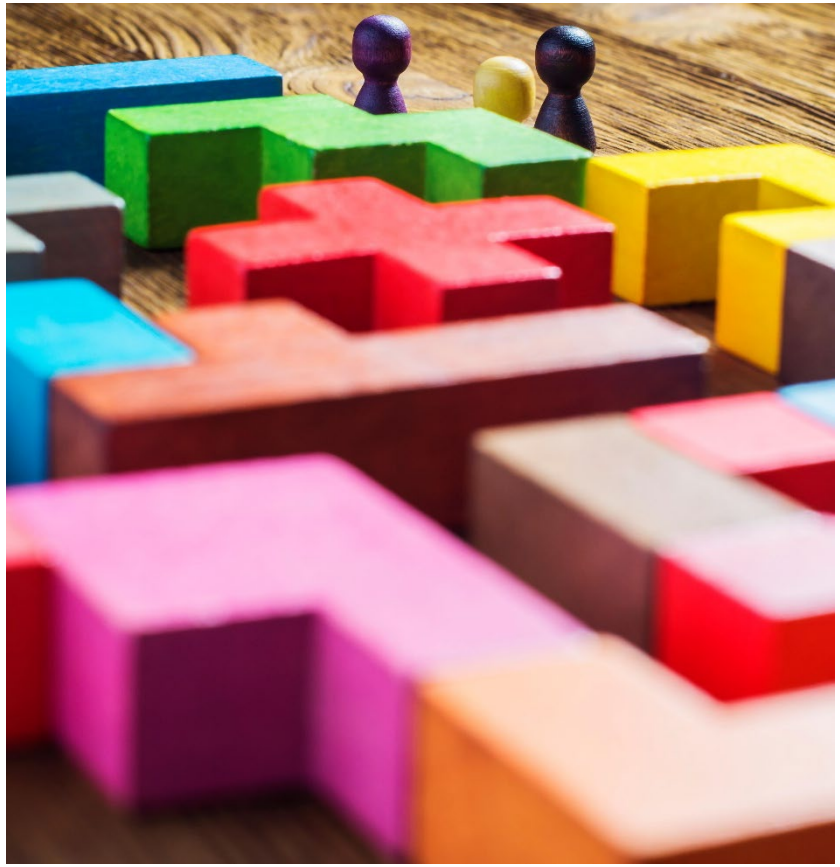
Reference: BHIN 22-011

CalAIM: Screening and Transition Tools

- Effective January 1, 2023, MCPs required to implement screening and transition tools for Medi-Cal Mental Health Services
- ***Screening Tool:***
- **Determines what system (MCP or MHP) a beneficiary should be served through**
- ***Transition Tool:***
- intended to ensure that Members who are receiving mental health services from one delivery system receive **timely and coordinated care** when either:

  (1) their existing services are being transitioned to the other delivery system; or

  (2) services are being added to their existing mental health treatment from the other delivery system consistent with the No Wrong Door policies regarding concurrent treatment



CalAIM: Payment Reform

- **Elements of Payment Reform Impacting County MHPs and Providers**
- **Change of coding and reimbursement process**
  - ✓ HCPCS codes to CPT codes
  - ✓ Codes are based on time of service and level of education of service provider
  - ✓ CPT codes are all inclusive and not clear if the changes will cover the act cost of providing services that include travel and documentation
- **Elimination of Cost Reimbursement and Cost Reporting**
  - ✓ County MHPs get Utilization Review reimbursed at cost and administrative costs above the service reimbursement rates
- **Current Status:**
  - ✓ Many challenges for counties and providers; still sorting out whether structure will work; more TA for counties and providers is needed
  - ✓ Varied approaches to implementing payment reform across the state concern about sustainability for many providers

Foster Care Strategies through CalAIM & BH-CONNECT

- **Goal: ensure that children and youth involved with the child welfare system have streamlined access to reliable, high-quality, integrated, trauma-informed, strength based, patient-centered, and family-centered care.**
  - Managed Care enrollment of foster youth in single plan counties
  - Enhanced Care Management (ECM) for foster youth (still have 44,000 foster youth in fee for service who are not eligible)
  - Incentive Payments for Counties and Plans that effectively coordinate
  - Dedicated Foster Care Liaison with MCP
  - Initial Behavioral Health Assessment at initial CW involvement
  - Activity Stipends for all foster youth
  - Aligning use of the Child and Adolescent Needs and Strengths (CANS) Assessment tool between CW and MHPs
  - Coordination between Family Urgent Response System (FURS) and new mandatory statewide Mobile Crisis benefit

Mental Health Services Act (now BHSA) Prevention and Early Intervention Services

- Requirement for 51% of Early Intervention funds to go to children and youth 0-25
- Requirement for 51% of statewide Prevention funds to focus on the 0-25 year old population
- Aligns EPSDT access language in BHSA
- Ability to use BHSA funds to match for federal dollars

Family First Prevention Services Act

- Statewide Prevention Program and County Prevention Plans
- Community Pathways
- CWC PEI Committee Taskforce on Community Supporting (vs Mandated Reporting)
- Implementation of Qualified Residential Treatment Programs (QRTP) – in CA, Short Term Residential Therapeutic Programs (STRTP)
- Aftercare provided for six months through High Fidelity Wraparound
- Qualified Individual must determine the need for residential treatment

Children and Youth Behavioral Health Initiative (CYBHI)

Virtual Platform:

- Education and access to immediate help
- Referrals to local behavioral health services

Focus on Schools as HUBs for services:

- Student Behavioral Health Incentive Program (SBHIP)
- Universal Fee Schedule (MCPs and Commercials Insurance payments)
- Wellness Coaches
- CalHOPE Student Support and Schools Initiative
- Peer to Peer Support

Grants that help to:

- Expand evidence-based and community-defined practices
- Strengthen workforce
- Increase behavioral health infrastructure (BH Continuum Infrastructure Program)

Other Initiatives Impacting Families In and at Risk of Child Welfare

- Community Schools
- Expanded Learning – afterschool and summer activities
- Expanded Childcare resources
- Childcare Bridge Program
- CalWORKs expansion

How Initiatives Can Work Together

- **Multiple "Doors" Through which a family should be able to access services**

School

Health plan (MCP)

Community-based Organization

Child Welfare

County Behavioral Health (MHP)

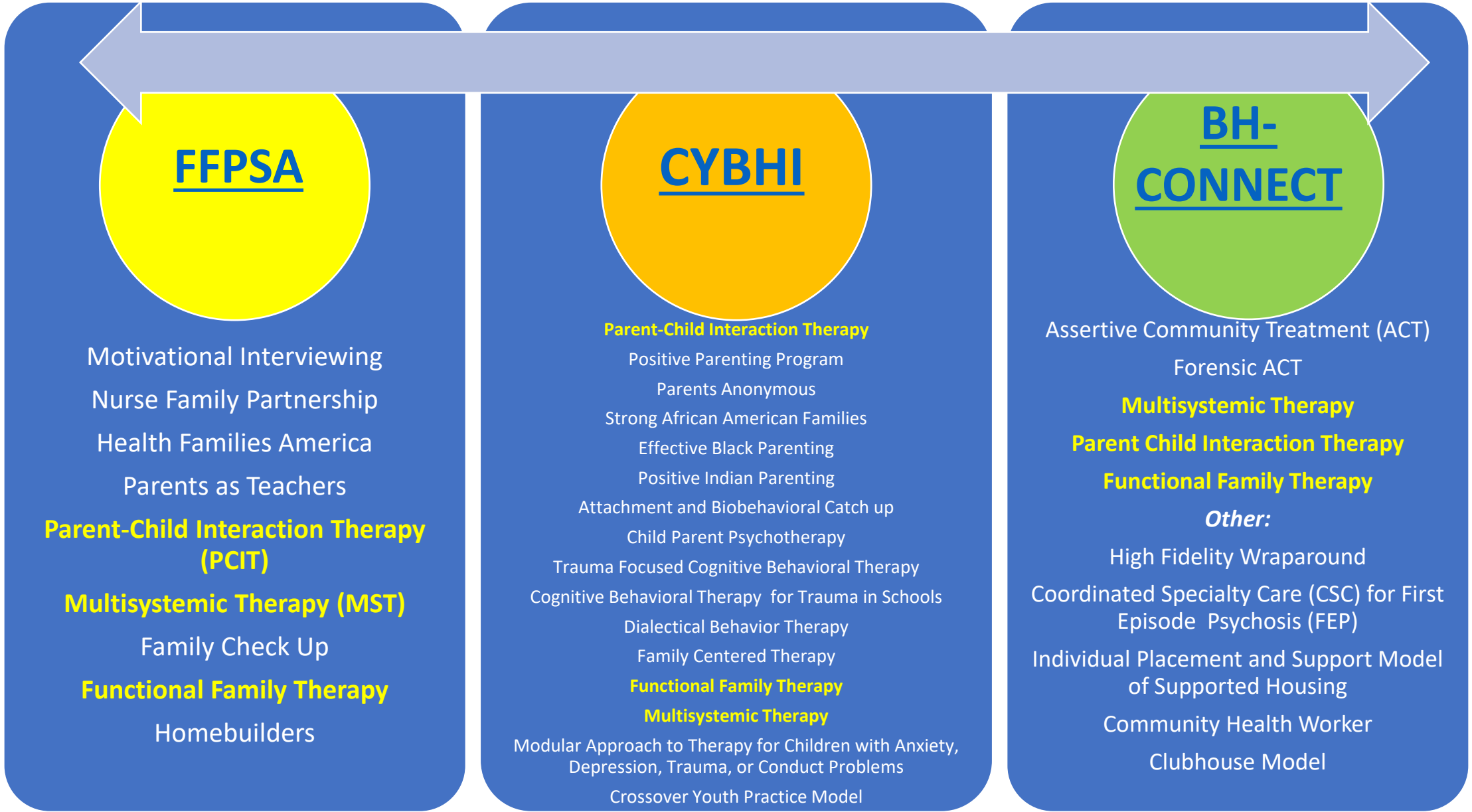
Regional Center

Interagency Leadership Team Develops Policies That Ensure Families Have Access to Services (2083 Team)

Pitfalls

- Systems that don't work together locally
- Contractual issues that limit CBOs from participating in providing services (e.g., Family Resource Center that doesn't have a contract with the MHP for Medi-Cal services)
- Financing Structures (Federal and State) do not match the vision for how services should be delivered
- Lack of focus on getting the services in place as quickly as possible
- Concerns about audits driving practice
- Bureaucracy results in significant lag time (referral, assessment, etc) to services
- WORKFORCE – simply not enough people providing services to make them as accessible as we need
- Children adopted out of foster care cannot access services easily to ensure they do not return to the system

Evidence Based Practices



Ideal World

Single Parent Mother has left 2 children (age 11 and 8) alone due to working two jobs and lacks childcare

- Connects with Family Resource Center at school
- BH assessment determines the need for supports for mother, father and children and services put in place within 30 days
- School-based services for 11-year-old
- Wraparound services and natural supports are built for whole family with 8-year-old as client
- Access to Expanded Learning for both children
- Family finding efforts identify additional family members that can support

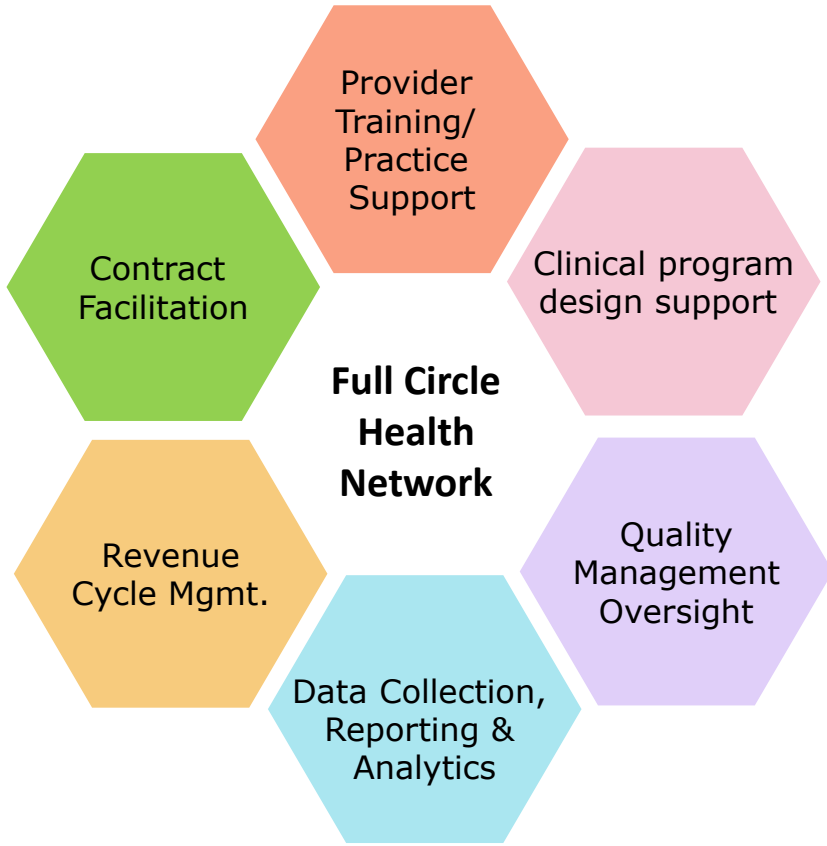
Our Current World

- Due to workforce issues, assessment for BH services takes over a month to schedule
- Integration of services between public agencies is limited
- Family finding is sparsely available throughout the state
- Contracts limit what organizations can provide services
- Payment reform rates implementation is resulting in CBOs having to limit travel time
- No seamless way for local child welfare, behavioral health (MHPs and MCPs) and education to work together
- Complexities of working across multiple systems

Full Circle exists so more Medi-Cal beneficiaries can access high quality care that addresses their whole-person and whole-family needs

Building a High Performing Integrated Specialty Network

- **Single contracting vehicle** for providers to enroll in Medi-Cal managed care plan networks.
- **Reduce admin burden for providers** so they can focus on core competencies of serving clients.
- **Improve coordination** between providers across multiple systems through technology infrastructure, training, and practice support.



Interoperable technology platform for multi-directional data sharing

Full Circle is Expanding our network into 32 Counties for all CalAIM Services

1. Alameda
2. Amador
3. Contra Costa
4. El Dorado
5. Fresno
6. Imperial
7. Kern
8. Kings
9. Los Angeles
10. Madera
11. Marin
12. Mariposa
13. Napa
14. Orange
15. Placer
16. Riverside
17. Sacramento
18. San Bernardino
19. San Diego
20. San Francisco
21. San Joaquin
22. San Mateo
23. Santa Clara
24. Santa Cruz
25. Solano
26. Sonoma
27. Stanislaus
28. Sutter
29. Tulare
30. Ventura
31. Yolo
32. Yuba

Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care for clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. This is a Medi-Cal benefit.

Community Supports	Community Supports are services or settings offered in place of (in lieu of) other services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. They are not a Medi-Cal "benefit."

Community Health Workers (CHW)*	CHW preventive services may be provided in an individual or group setting and are related to health and health promotion, which may include, but are not limited to: Health Education and Health Navigation

*DHCS: https://www.dhcs.ca.gov/services/medi-cal/Documents/CHW-Stakeholder-PowerPoint-02-04-2022.pdf

Improving Our Ability to Work Together to Reduce the Number of Children and Youth in Foster Care

- **Centralized statewide database for Foster Youth Services and Supports**
  - Matching children and youth to the services and supports they need
- **Work Across Systems and Know Your Partners**
- **Interagency Communication Enabled (including CBOs)**
  - The statewide initiative on data sharing
  - Robust Interagency Leadership Teams
- **Address Contractual Barriers to Service Access**
  - One contract with Behavioral Health and backfilled by Child Welfare/Probation
  - Multiyear contracts that can be easily amended as needed
- **Ensure a Full Array of Services is Available Regionally**
- **Statewide Technical Assistance on Blending and Braiding Funding and Contract Reform**