



**Performance Outcomes System Plan
for
Medi-Cal Specialty Mental Health Services for
Children & Youth**

October 31, 2014

Submitted by the Department of Health Care Services
In Partial Fulfillment of a Requirement of
Senate Bill (SB) 1009 (Chapter 34, Statutes of 2012),
Assembly Bill (AB) 82 (Chapter 23, Statutes of 2013)
SB X1-1 (Chapter 4, Statutes of 2013)

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Executive Summary

This update on the Department of Health Care Services (DHCS) Performance Outcomes System Plan for Medi-Cal Specialty Mental Health Services for Children & Youth (hereafter called the “System Plan”)¹ contains the original concepts and framework from the previous System Plan and also includes an update on project efforts from November 2013 to date. DHCS continues to make progress in the areas of working with stakeholders on the development of Performance Outcomes System domains, indicators and measures; identifying appropriate functional assessment tools; developing quality improvement (QI) plans; and establishing mechanisms to monitor the continuum of care between Medi-Cal managed care plans (MCPs) and mental health plans (MHPs). These and other Performance Outcomes System activities are described below and in more detail in later sections of the System Plan.

Impact of Legislation on Performance Outcomes System Efforts

In 2012, the state enacted a process for DHCS to develop a plan for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services to support the improvement of outcomes at the individual, program and system levels and to inform fiscal decision-making related to the purchase of services.² Specifically, the passage of Senate Bill [SB] 1009, Statutes of 2012, added Welfare and Institutions (W&I) Code, Section 14707.5, which set forth three major requirements: 1) convene a stakeholder advisory committee no later than September 1, 2012; 2) submit to the Legislature by October 1, 2013, a Performance Outcomes System Plan; and, 3) to submit to the Legislature by January 10, 2014, a Performance Outcomes System Implementation Plan.³ To date, each of these requirements have been met.

In June 2013, Assembly Bill [AB] 82 was enacted into law, which amended W&I Code, Section 14707.5, by adding sub-section (e) mandating DHCS to convene a stakeholder advisory committee (comprised of advocates for and representatives of child and youth clients, family members, MCPs, providers, counties, and the Legislature) to develop methods to routinely measure, assess, and communicate program information regarding informing, identifying, screening, assessing, referring, and linking Medi-Cal eligible beneficiaries to mental health services and support. It also requires reviews of health plan screenings for mental health illness, health plan referrals to Medi-Cal fee-for-service providers, and health plan referrals to county MHPs, among others. The amended statute also requires DHCS to update the System Plan by October 1, 2014, and to update the System Implementation Plan by January 10, 2015. This report is the update to the System Plan.

¹ For simplicity, the Performance Outcomes System Plan is referred to as the System Plan and the Performance Outcomes System Implementation Plan is referred to as the System Implementation Plan.

² Welfare and Institutions Code, Section 14707.5 (Senate Bill [SB] 1009, Committee on Budget and Fiscal Review, Chapter 34, Statutes of 2012). The complete language of the Legislation is included in Appendix A, Legislation, in the previous Performance Outcomes System Plan dated November 1, 2013.

³ Ibid.

Coordination of Medi-Cal Managed Care Plans and Mental Health Plans for the Continuum of Care

As California embarked on its efforts to develop an EPSDT Performance Outcomes System to improve the quality of mental health services for specialty mental health services, other federal regulations and state laws were promulgated to expand mental health services to Medi-Cal beneficiaries, and to ensure that mental health services and substance use disorder beneficiaries received timely access, quality treatment and services, and a continuum of care between MCPs and MHPs. Specifically, the Affordable Care Act (i.e., “ACA”; Public Law 11-148) expanded the essential health benefit package to include mental health services and substance use disorder services for MCPs. Senate Bill X1-1 (SB X1-1, Hernandez, Chapter 4, Statutes of 2013) was the state law that carried out the ACA plan to expand mental health services provided by the Medi-Cal MCPs and fee-for-service delivery systems. Since the goals and requirements of these federal regulations and state laws for MCPs are consistent with the requirements and objectives for the EPSDT Performance Outcomes System, and both align with federal and state regulation, managed care activities continue to be included as an integral component of the System Plan.

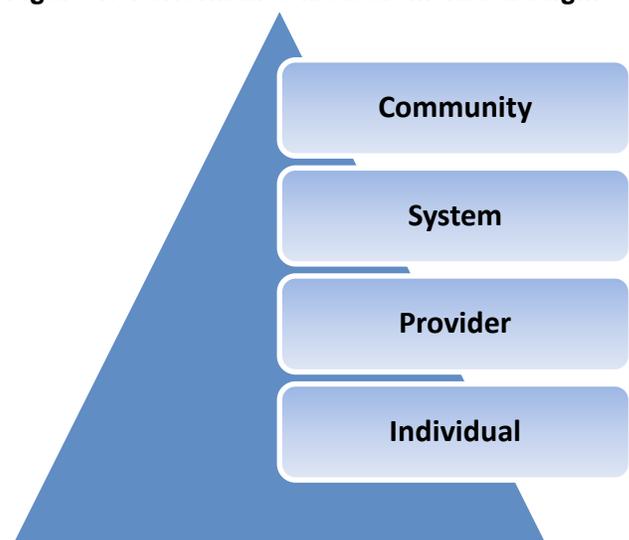
California’s Performance Outcomes System Plan

As set forth in the 2013 System Plan, DHCS continues to approach the evaluation of California’s specialty mental health services for children and youth from a broad-based perspective that seeks to satisfy the intent of Senate Bill 1009, AB 82 and support other important evaluation efforts such as the Mental Health Services Oversight and Accountability Commission’s (MHSOAC) Evaluation Master Plan and Katie A. implementation activities. Also, as described above, given that the requirements and goals of the Medi-Cal Managed Care initiatives for the continuum of care are aligned with the Performance Outcomes System, information regarding the Medi-Cal Managed Care efforts continue to be included in this System Plan, as well.

The DHCS Performance Measurement Paradigm, which is being used to guide the Performance Outcomes System, builds upon the Mental Health Services Act measurement paradigm, and specifies that outcomes be measured at four levels: Individual (youth/family), Provider, System, and Community (public) (see Figure 1).

DHCS, working with stakeholders and partners, established a framework for outcomes measurement by identifying seven domains as key areas to assess under this paradigm:

Figure 1. Performance Measurement Paradigm



- ✓ Access;
- ✓ Engagement;
- ✓ Service appropriateness to need;
- ✓ Service effectiveness;
- ✓ Linkages;
- ✓ Cost effectiveness; and,
- ✓ Satisfaction.

Not only did the System Plan establish a framework from which specialty mental health services outcomes may be measured, it also described steps that must be taken to develop and complete the evaluation methodology (e.g., specifying the evaluation questions, identifying the target population, selecting valid and reliable measurement tools) and to develop a continuous QI process using Performance Outcomes System-generated reports.

Thus far, DHCS has identified data elements within existing data systems to measure the domain of “service access,” which is likely to be the focus of the first Performance Outcomes System report. These reports will be expanded as DHCS reviews additional data elements contained within the existing data systems. Data integrity will be addressed jointly with the counties, and DHCS will work with stakeholders to identify and mitigate data gaps.

DHCS Performance Outcomes System

System Plan Progress

Progress continues to be made on the implementation of the Performance Outcomes System. These implementation efforts are critical to the development and establishment of the Performance Outcomes System and must be maintained for the system to become a reality. Thus, while the plan itself has not changed since its first iteration, there are updates to the Performance Outcomes System Milestones and Timeline that this document addresses.

Stakeholder Involvement: Impact on the Performance Outcomes System Methodology

Establishing the methodology for the Performance Outcomes System continues to be a primary task for stakeholders and DHCS project staff. Through feedback and advisement from the work groups established for the Performance Outcomes System (i.e., Stakeholder Advisory Committee (SAC), Subject Matter Expert (SME) Workgroup, and Measures Task Force), the specific methodology for the Performance Outcomes System implementation continues to be developed. In 2014, the SME Workgroup discussed topics including standardized data collection, data collection tools, and defining domain indicators and measures. During the July 15, 2014, SME Workgroup meeting, however, participants determined that a separate, smaller workgroup is required that should be composed of county providers who can provide expert practical and

technical guidance for defining the measures. Consequently, SME members and additional county members identified for this separate workgroup joined the existing Measures Task Force. The input and feedback obtained from the SMEs to date on establishing a methodology for the Performance Outcomes System has been invaluable in moving the project forward and it is anticipated that the Measures Task Force will contribute similarly. Currently, the Measures Task Force is reviewing a matrix of domains and potential measures for the Performance Outcomes System that was compiled by the SMEs. The matrix will be reviewed and updated by the Measures Task Force starting at their next meeting, October 9, 2014. A formal report documenting the methodology to be utilized for the Performance Outcomes System (known as the Performance Outcomes System Protocol) is scheduled to be completed in February 2015.

Initial Performance Outcomes Reporting: Existing DHCS Databases

Review of existing DHCS databases for data elements that correspond to Performance Outcomes System indicators began in May 2014 and was conducted across a number of DHCS databases. This review also included an assessment of data integrity of the data elements within, and across, the databases for comparability. During this review, data quality issues were identified for specific data elements (e.g., race/ethnicity). Additionally, data error reports from other agencies and states were reviewed by DHCS staff for ease of use and understanding, and a format for reporting to counties on data issues was selected. Starting in October 2014, prioritized data elements will be shared with counties through County Data Quality Improvement Reports that will highlight problematic data elements, as well as identify means to remedy the identified errors. The data elements selected for inclusion in the initial reporting process were chosen because they were easily accessible within an existing DHCS database and would provide relevant information to the counties regarding the population being served. The sharing of these reports with counties will begin a bidirectional feedback process whereby specific data elements are “cleaned” in order to improve overall data quality.

Performance Outcomes System reporting using data from existing DHCS databases is scheduled to begin starting in December 2014. The templates for these reports are being developed based on outcomes reporting templates established by other counties, states, and organizations. Input on the template for reporting will be obtained from the SAC and other DHCS partners/stakeholders to ensure it best meets the Performance Outcomes System goals of providing useful and meaningful information at the State and county-levels.

Additionally, in January 2014 DHCS implemented a [Medi-Cal Managed Care Performance Dashboard](#). As mental health data are collected from the MCPs, DHCS will continue updating the dashboard quarterly with mental health reporting data. The Dashboard reports on a variety of measures including enrollment, health care utilization, appeals and grievances, network adequacy,

and quality of care. DHCS is currently working on adding mental health continuity of care requests and grievances and appeals data to the next iteration of the Dashboard. By the end of 2014, data reported by the MCPs will be incorporated into the Dashboard, and by October 2015, mental health utilization metrics will be added.

Comprehensive Performance Outcomes Reporting: Expanded Data Collection

Starting in Fiscal Year (FY) 2015-16, statewide and county reporting on comprehensive performance outcomes using both existing and expanded data is scheduled to occur. Identifying and selecting which data elements to include as part of the expanded, comprehensive reporting process, as well as defining and selecting appropriate measures for each indicator, is currently being engaged in by the members of the Measures Task Force. This process, at present, has been confined to relying on already existing data elements, but is expected to be expanded to include the identification of additional data elements to capture child/youth functional assessment information.

To assist in this process, DHCS submitted a Request for Information (RFI) to various academic institutions for the purpose of securing a researcher to produce a recommendation for the best approach to gather outcomes information to evaluate if child/youth functioning is improving as a result of Medi-Cal specialty mental health services. The findings from this study will assist the state in identifying best practices in measuring functional outcomes which, optimally, will inform the development of a strategy for gathering and using standardized information without putting undue burden on the counties. Using this information, coupled with the current county data collection efforts, the researcher will recommend methods that are most likely to be successfully implemented in California to track functional change.

Simultaneously, DHCS staff are reviewing outcomes reporting produced by other states and organizations (e.g., dashboards, formal reports) to identify the best mechanisms for presenting the information. DHCS plans to assemble a template for reporting using the best features of these established systems, which is anticipated will be presented to the SAC in Summer 2015. Once a template has been agreed upon by the SAC, statewide and county-level comprehensive performance outcomes reporting will begin, which is slated for FY 2015-16.

Continuous Quality Improvement Using Performance Outcomes Reports

Starting in Summer 2015, QI Plans will be provided to the counties, with the provision of DHCS support and monitoring to assist counties with their QI process as an ongoing feature. In 2014, DHCS conducted focused interviews with representatives from different states, MHPs, and local provider organizations to identify QI best practices. To date, DHCS has interviewed 20 states, 7 California counties, and 5 provider organizations on their QI structure,

processes and recommendations. From this process we learned that the majority of state entities contacted are in the process of developing a QI system and only a few that were interviewed (i.e., Indiana and Louisiana) have components of a QI structure already in place. Some of the California MHPs, however, do have QI activities and processes in place that could be built upon in the future. To support the system, entities with successful QI processes emphasized a standardized data and mental health information collection method; consistent stakeholder involvement; pilot projects to get the system development started; and the need for sufficient resources in terms of workforce and funding.

The information gained from this process will be used to develop a template for QI Plans that will be vetted through the SAC. Once the SAC has approved the template, which is anticipated in Spring 2015, the QI reports will start to be provided to the counties in Summer 2015. Additionally, trainings will be given by DHCS staff to the counties starting in January 2015 on how to interpret the initial performance outcomes reports.

Continuum of Care: Screenings and Referrals

With new legislative mandates requiring coordination amongst the MCPs and MHPs, the Performance Outcomes System has worked to establish mechanisms to monitor this continuum of care. Currently, MCPs' screenings and referrals data are reported in aggregate form and may contain duplicate counts within a single item (i.e., a single person may be counted more than once in a given measure), which limits the utility of the data (i.e., there is currently no ability to match data between the MCPs and MHPs). While it is possible to use this data for understanding group-level behavior (e.g., how many youth were referred to a MHP in a given month) and processes, it is not possible to break it down to a lower level to begin to examine individual behavior and processes within the group (e.g., did person Y receive a referral to a MHP in a given month). Thus, staff from the DHCS Mental Health Services Division are working closely with staff from the DHCS Managed Care Division to better understand the MCP data collection processes. This includes assessing if other data may eventually be captured (i.e., individual level "encounter" data), which is necessary to determine if children and youth who are screened and referred for specialty mental health services actually are received by the county MHPs, and vice-versa.

Conclusion

Through continued collaboration with partners/stakeholders and subject matter experts, and with input from the SAC, DHCS continues to develop Performance Outcomes System implementation strategies, which will be used to provide details on the implementation schedule, communication plan, risks/issues, and the assumptions/constraints for the updated System Implementation Plan, which will be submitted to the Legislature by January 10, 2015. With this document, DHCS has completed its commitment to develop an updated System Plan by October 31, 2014. In addition, the update to the System Plan marks DHCS' ongoing commitment to continue

to meet the goals of the continuum of care for Medi-Cal beneficiaries as part of the Performance Outcomes System. While activities on the Performance Outcomes System implementation continue to progress, adjustments to some project timelines have been made to accommodate additional work efforts that were unknown to DHCS as of the last Legislative report (January 10, 2014). These adjustments are reflected in the timeline presented in the report and are not anticipated to significantly impact the implementation of the Performance Outcomes System and, in fact, the majority of project deadlines and deliverables are still in place or have been met.

I. Background

Legislation Overview

Welfare and Institutions [\[W&I\] Code, Section 14707.5](#) (added by Senate Bill [SB] 1009, Statutes of 2012, and amended by Assembly Bill [AB] 82, Statutes of 2013) requires DHCS, in collaboration with the California Health and Human Services Agency and in consultation with the Mental Health Services Oversight and Accountability Commission (MHSOAC), to create a plan for a Performance Outcomes System for Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) mental health services.⁴ The statute requires that a Performance Outcomes System for Medi-Cal specialty mental health services for children and youth be developed to improve outcomes at the individual, program, and system levels and to inform fiscal decision-making related to the purchase of services. Another aspect of W&I Code, Section 14707.5 (e), requires the development of measures to screen and refer Medi-Cal eligible beneficiaries to managed care mental health services and supports, and to make recommendations regarding performance and outcome measures. For the complete text of W&I Code, Section 14707.5, refer to Appendix A, the Performance Outcomes System Statute.

The primary objectives of the System Plan are to: 1) promote high quality and accessible services for children and youth; 2) provide information that improves practice at the individual, program, and system levels; 3) minimize Performance Outcomes System costs by utilizing existing resources to the fullest extent possible; and, 4) use reliable data that are collected and analyzed in a timely fashion.

In addition to state statute, the federal Affordable Care Act (ACA) and Medicaid requirements (i.e., [Title 42, Code of Federal Regulations, Part 438, §438.200 through §438.242](#)) requires health plans, including California's Medi-Cal program, to expand the essential health benefits package to include mental health services, starting January 1, 2014. SB X1-1 (i.e., Hernandez, Chapter 4, Statutes of 2013) implemented provisions of the ACA, including expanded mental health services provided by the Medi-Cal managed care and fee-for-service delivery systems.

Medi-Cal managed care mental health services were expanded to include non-specialty services for mild to moderate mental health conditions⁵ while mental health plans (MHP) are still responsible for mental health services for serious or acute conditions and episodes while both MHPs and managed care plans (MCP) will provide information, screen, assess, and refer patients. To coordinate the linkages between the MHPs and MCPs, a Memorandum of Understandings (MOU) was developed between the two which contained provisions for care coordination, referrals, information sharing, and mutually agreed upon screening tools. Stakeholder engagement and input drove the MOU requirements between the MCPs and MHPs. The Performance Outcomes System

⁴ In this System Plan, the phrase "Medi-Cal specialty mental health services for children and youth" is used instead of EPSDT, as EPSDT is a benefit that extends beyond mental health services.

⁵ Effective January 1, 2014, these services are also now available through the fee-for-service Medi-Cal program.

SME workgroup also provided feedback on the Staying Healthy Assessment (SHA) tool and mental health reporting template, which aims to track referrals and continuity of care requests.

This System Plan reiterates the System Plan submitted to the Legislature in November 2013, which provided a framework for the DHCS Performance Outcomes System, and is a predecessor to the required System Implementation Plan, which is due to the Legislature on January 10, 2015. Both this System Plan and the January 2015 version of the System Implementation Plan are updated versions of the plans submitted to the Legislature in November 2013 and January 2014, respectively. While this System Plan describes the conceptual framework for the Performance Outcomes System envisioned by DHCS and stakeholders, the System Implementation Plan describes the steps necessary to achieve the operational system.

Coordination of Medi-Cal Managed Care Plans and Mental Health Plans for the Continuum of Care

In 2012 and 2013, state statutes such as SB 1009 and AB 82 were enacted requiring the establishment of an EPSDT Performance Outcomes System for specialty mental health services. At the same time, other federal regulations and state laws were being promulgated to expand mental health services to Medi-cal beneficiaries, ensure that mental health services and substance use disorder beneficiaries received timely access, quality treatment and services, and that there was a continuum of care between the mental health care plans for Medi-Cal and fee-for-service beneficiaries. Specifically, SBX1-1 was the state law which carried out the ACA plan to expand mental health services provided by the Medi-Cal managed care and fee-for-service delivery systems. Since the goals and requirements of these federal regulations and state laws for managed care plans are consistent with the requirements and objectives for the EPSDT Performance Outcomes System and both align with federal and state regulation, managed care activities have been included in the System Plan.

II. Framework for the Performance Outcomes System

The purpose of the Performance Outcomes System is to promote and encourage improvements to California's mental health system. The goals are to provide information and subsequent system improvements that strive to ensure children and youth receive the Medi-Cal specialty mental health services they need, that help providers and MHPs achieve positive outcomes on behalf of children and youth, and provides transparent reporting on the performance of the California Medi-Cal specialty mental health system. An effective system may be used by the State, counties, providers, consumers, and the public to ascertain whether the services and systems are achieving the desired outcomes, to encourage and reward systems that demonstrate positive outcomes, and to provide incentives for improving for those that do not.

While the focus of the Performance Outcomes System is children and youth receiving Medi-Cal specialty mental health services, DHCS is taking a more comprehensive view and developing the system with the potential to expand and address additional

important mental health outcomes evaluations. Targets include the assessment of performance and outcomes for other populations of children such as children in foster care receiving non-Medi-Cal mental health services. The Performance Outcomes System will also be synchronized with and support the MHSOAC Evaluation Master Plan and EQRO annual reporting to allow each to focus on areas of strength and specialty. Also, as described above, since the requirements and goals of the Medi-Cal Managed Care initiatives for the continuum of care are aligned with the Performance Outcomes System, information regarding the Medi-Cal Managed Care efforts are, therefore, included in this System Plan. Other areas which the Performance Outcomes System may be able to support include Full Service Partnership evaluation, MHSD oversight reviews, and evaluation efforts for substance use disorder and physical health systems.

Conceptual Framework: The Performance Measurement Paradigm

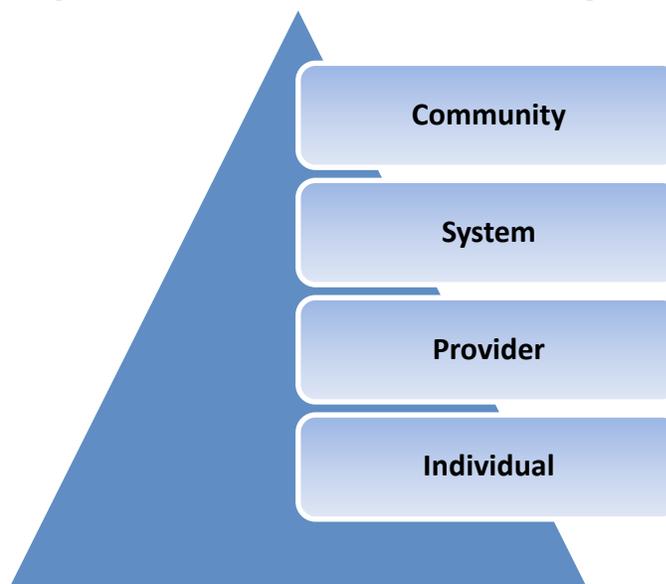
Key to the development of a Performance Outcomes System is a strong conceptual framework from which a variety indicators and measures are identified and may be expanded over time. Based on prior services evaluation efforts for the Mental Health Services Act, DHCS developed such a conceptual framework, the Performance Measurement Paradigm, for the MHSD.

The DHCS Performance Measurement Paradigm specifies that outcomes be measured at four levels: Individual (youth/family), Provider, System, and Community (public) (see Figure 1).

DHCS, working with stakeholders and partners, established a framework for outcomes measurement by identifying seven domains as key areas to assess under this paradigm:

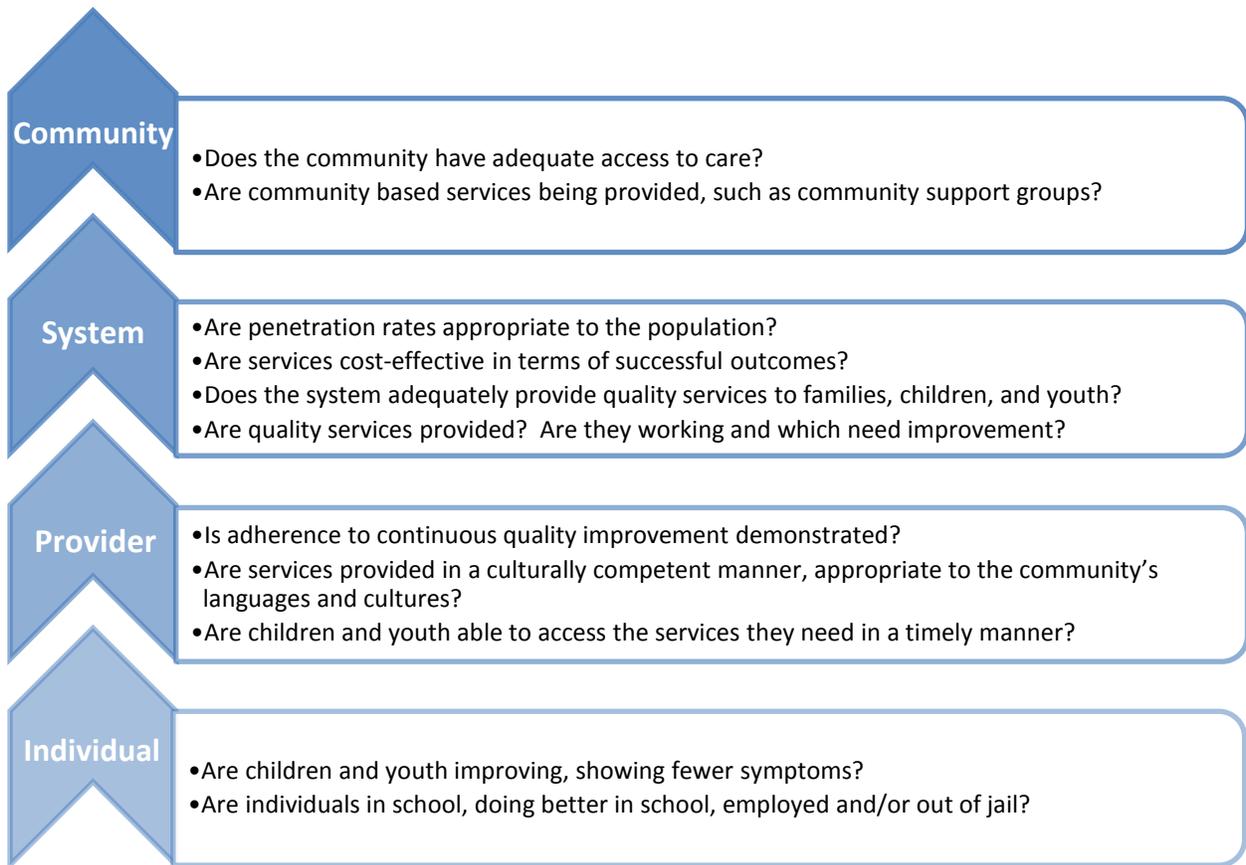
- ✓ Access;
- ✓ Engagement;
- ✓ Service appropriateness to need;
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- ✓ Cost effectiveness; and,
- ✓ Satisfaction.

Figure 1. Performance Measurement Paradigm



Not only did the System Plan establish a framework from which specialty mental health services outcomes may be measured, it also described steps that must be taken to develop and complete the evaluation methodology (e.g., specifying the evaluation questions, identifying the target population, selecting valid and reliable measurement tools) and to develop a continuous QI process using Performance Outcomes System-generated reports

Figure 2: Example Performance Measurement Paradigm Evaluation Questions



Performance Outcomes System Domains

There are seven domains that anchor the Performance Outcomes System, which reflect those established at the national level by Substance Abuse and Mental Health Services Administration (SAMHSA). The Performance Outcomes System will be used to evaluate access, engagement, service appropriateness to need, service effectiveness, linkages, cost effectiveness and satisfaction. The first five domains are conceptualized as a series of decision points which are encountered across an episode of care. The decision points typically unfold in sequence and continue throughout the care experience. Client experience at each decision point has implications for both the process and outcome of care. Domains may cross more than one level, thus service effectiveness could provide information about the provider, system and public/community levels.

The following is a list of the seven domains, along with a brief description:

1. Access

Access is the feasibility and delivery of care and coordination of services to the child/youth. Sample domain categories are children and youth being served or not being served, timeliness of services being delivered, and denial of services.

2. Engagement

Engagement is the participation and empowerment by the child/youth and caregivers with treatment and services. Sample domain categories are participation of children and caregivers in services and the maintenance of services.

3. Service Appropriateness to Need

Service Appropriateness to Need is the determination of whether services match the individual child/youth's needs and strengths in accordance with system-of-care values and scientifically derived standards of care. Sample domain categories are the standard of quality of care, consistency with treatment and treatment plan, the clinical status of the youth/child, functional status, modality of care or care options, the fidelity of the treatment model to the practice standard, and psychotropic medication.

4. Service Effectiveness

Service Effectiveness is the influence of treatment on a child/youth's mental health symptoms and functioning at home, in school, and in the community. Sample domain categories are the symptomology of the child/youth, the functioning level of the child/youth, the support and social integration, the relationship with family mental health/substance abuse and the child/youth, housing situation, educational progress, juvenile justice involvement, employment, and overall child/youth safety.

5. Linkages

Linkages are the fostering, coordinating, and monitoring of connections with groups outside of the mental health system. This includes academia, public health, healthcare, education, social services, and corrections, with the goal of building on the services and programs for the child/youth. A sample domain category is success in dual program services.

6. Cost-Effectiveness

Cost-Effectiveness is measuring whether the dollars invested have produced the best outcomes possible. A sample domain category is reduced cost to the state by youth being in school, employed, and out of jail. Another would be comparing the costs of treatments to identify those that are most successful and cost-effective.

7. Satisfaction

Satisfaction is the perception that the child/youth's needs are being met. A sample domain category is the integration and coordination of care as it relates to enhancing the ability to meet child/youth mental health needs.

Guiding Principles

The system is being established through the use of objective, standardized and uniformly applied performance outcomes measures. While current measures for the same domain may vary statewide, the Performance Outcomes System will use standard measures and equivalent measures, where proven and practical. The reported information will be available to the public, policymakers and clients for the purpose of reviewing the effectiveness of care across mental health programs within California. DHCS, working together with our partners and stakeholders, is building a robust Performance Outcomes System over the next few years that includes development of routine performance outcomes reports accompanied with technical assistance to ensure a process of continuous QI.

Guiding principles for the Performance Outcomes System include:

- Data must be gathered to reflect the experiences of children and youth who are served by the public mental health system;
- The differing needs for data/indicators for the state, counties (large and small), providers, advocates, family and/or caregivers, and youth must be recognized and considered;
- Feasibility (e.g., estimation of cost, additional workload for rendering counties, clinicians, and other impacts) must be established and acknowledged.
- Data collected must be valid and reliable;
- HIPAA/confidentiality requirements for data collection and sharing must be met; and,

- Data and reports must be current and relevant for reporting for administrative, quality assurance and other purposes.

III. System Plan Progress

Developing the Performance Outcomes System is a multi-layered effort and implementing it includes stakeholders, data, and technology capabilities. To date, DHCS is building its capacity for data mapping and analysis, report development, and training and technical support for the MHPs. DHCS is also undertaking a review of the capacity of current information technology systems to support Performance Outcomes System activities. What follows is an update on the progress made on the Performance Outcomes System to date along with a listing of the key stakeholder groups and the activities each group has undertaken to move the project forward.

Continued Stakeholder/Partner Involvement

The continuous collaboration between DHCS and stakeholders/partners is critical to the development and maintenance of the Performance Outcomes System. Stakeholders/partners include representatives and advocates of child and youth clients; family members and/or caregivers; county staff; child/youth advocates; other California state-level entities, including representatives of the Legislature, and the MHSOAC; as well as other members of the interested public.

To ensure that the Performance Outcomes System reflects the needs and values of all partners and stakeholders and that it aligns with the legislative mandate for this project, DHCS established an inclusive stakeholder process that began with the formation of a Stakeholder Advisory Committee (SAC). To support the SAC, the following three working subgroups were formed: the Subject Matter Expert (SME) Workgroup the Measures Task Force, and the Information Technology (IT)/Data Workgroup.⁶ These working subgroups are designed to develop and present work products to the SAC members, who, in turn, review and provide their comments/feedback.⁷ Appendix B, Stakeholder Advisory Committee Members, provides a list of organizations represented on the Stakeholder Advisory Committee. Appendix C, Subject Matter Expert Workgroup and Measures Task Force Members, provides a list of members and organizations represented in the subgroups.

Stakeholder Advisory Committee

The SAC is comprised of members who represent providers, academia and researchers, counties, MHPs, advocates of child and youth clients, family members and/or caregivers. Representatives from the Legislature and other State

⁶ After the Measures Task Force completes its work, DHCS plans to transition this task force to the Report Design Workgroup, and after the IT/Data workgroup is complete, this group will be transitioned into the Data Integrity Workgroup.

⁷ The Measures Task Force has not yet presented any products for review to the SME workgroup or SAC since participants are still working on their assigned tasks. Updates have been provided, but not specific products.

entities such as the California Department of Social Services, and the Department of Finance are also included. Representatives from Behavioral Health Concepts, which will conduct the EQRO reviews for Medi-Cal specialty mental health services, and the MHSOAC are also committee participants.

During the December 2013 and April 2014 meetings, DHCS staff provided updates to the committee members on implementation plans for the Performance Outcomes System and the ongoing efforts being made to address the continuum of care for children and youth who receive Medi-Cal Specialty Mental Health Services (SMHS) as an integral component as a piece of this project. The Performance Outcomes System plan identifies the goal of improving the continuum of care for this population between MCPs and MHPs.

Subject Matter Expert (SME) Workgroup

The primary objective of the SME Workgroup, comprised of SAC members who represent counties, academia, the EQRO, the MHSOAC, and child/youth advocates, is to develop an over-arching vision for the Performance Outcomes System. SME Workgroup participants have extensive experience in prior and/or current local and national efforts on the development and establishment of outcomes and quality improvement measures. The SME Workgroup meets approximately two times per month.

The primary function of the SME Workgroup has been to provide DHCS and the SAC with recommendations, including their rationale, for defining the domains and indicators necessary to evaluate system performance and youth outcomes in order to quantify the effectiveness and efficiency of programs and services provided to children and youth to meet their mental health and well-being goals.

In 2014, the SME Workgroup continued to identify and define the indicators and measures for the performance outcomes domains. During the July 15, 2014, SME Workgroup meeting, participants determined that a separate, smaller workgroup is required that should include additional county providers who can provide expert practical and technical guidance to match existing data to the identified indicators. This decision expanded the scope of the task force and required additional county members be added to the existing group to accomplish this task. Each workgroup member selected for participation in the Measures Taskforce, both the original and the newly expanded group, has expertise and a strong working familiarity with the data elements being examined for inclusion in the Performance Outcomes System, which is needed to appropriately match these data elements to relevant indicators for reporting purposes. Their expertise will also be used to identify where gaps exist in the data and potential resources that can be used to provide this missing information as well as any other limitations that exist with the data being used. Additionally, the wealth of practical knowledge the members bring to the group will assist the Performance Outcomes System project and the eventual reporting produced by maintaining the focus of the group on providing user-friendly, relevant and meaningful data that will inform practice at multiple levels.

Measures Task Force

The Measures Task Force was originally established to review tools currently used by specialty mental health professionals to assess client clinical and functional status over time. Members are experts familiar with the primary screening and assessment tools used by counties and their providers. The Measures Task Force's role, and membership, has expanded to include the identification of relevant child/youth and provider-level mental health measures that are currently tracked by counties, including whether or not gaps exist in current data collection that will need to be addressed in the future. The goal of selecting the appropriate measures is to ensure that child/youth progress and provider performance is accurately assessed. The work of this task force will support the larger SME Workgroup's efforts of development of the Performance Outcomes System SMHS reports, including QI of data outcomes.

Report Design Workgroup

After the Measures Task Force completes defining and development of the Performance Outcomes System domain measures and indicators and progresses to focus on the data reports that are to be generated, this group will transition to the Report Design Workgroup, as described in the Performance Outcomes System Implementation Plan. This workgroup will include representation of stakeholders who will use the performance outcomes information, including DHCS staff, county QI and data staff, as well as children/youth clients (if possible) and their family members and advocates. The goal of this workgroup is to ensure that the data reports developed are informative, user-friendly, and useful.

Information Technology (IT)/Data Workgroup/Data Integrity Workgroup

The objective of this Workgroup is to support the development of reports that may be used by the State, counties, providers, families and advocates to better understand and compare system performance and child/youth outcomes. In addition, this Workgroup will assist in proposing modifications to existing state data systems, as well as identifying alternative data systems that could be used to capture additional outcomes data.

In the future, the membership of the Workgroup will be expanded to include county data experts and the EQRO, and will transition into the Data Integrity Workgroup. Beyond the initial focus of this group as described above, it is anticipated that this group will participate in ongoing data improvements through the QI process.

Establishing a Performance Outcomes System Methodology

Establishment of a clear methodology is at the core of any successful evaluation. Broadly, this involves specifying the questions to be answered (e.g., are Medi-Cal specialty mental health services resulting in improved functioning for children/youth); identifying the target population (e.g., children and youth who receive Medi-Cal specialty mental health services); determining what tool(s) will be used to capture information to answer the questions (e.g., CANS); evaluating the psychometric properties of these

tools (e.g., functional assessment tools that are valid, reliable, and sensitive to change); determining how often data should be collected (e.g., three months, six months, annually); identifying what mechanisms will be used to capture and transmit data (i.e., a data system infrastructure); and designing the final reports. The importance of these methodological components cannot be understated as each exerts an impact on the final results/reports that will be used to inform decision-makers as they work to address important mental health issues. The activities and efforts described below have been undertaken to assist the project in being able to complete this task.

Identifying an Assessment to Evaluate Child and Youth Functioning

DHCS submitted a Request for Information (RFI) to various academic institutions for the purpose of securing a researcher to produce a recommendation for the best approach to gather outcomes information to evaluate if child/youth functioning is improving as a result of Medi-Cal specialty mental health services. The findings from this study will assist the state in identifying best practices in measuring functional outcomes which, optimally, will inform the development of a strategy for gathering and using standardized information without putting undue burden on the counties. Using this information, coupled with the current county data collection efforts, the researcher will recommend methods that are most likely to be successfully implemented in California to track functional change.

DHCS Data Systems

In an effort to determine what data are currently available to measure identified performance outcomes indicators, DHCS is currently conducting a comprehensive review of existing DHCS databases. For a brief overview of each DHCS data system, along with a brief description of the type of information captured, refer to the November 1, 2013, version of the Performance Outcomes System Plan.

DHCS Staff Resources for Performance Outcomes System Project

For the short- and long-term success of the Performance Outcomes System development and implementation to continue to occur, adequate and appropriate staff resources must be in place. Research and information technology staff are needed to support the development of the Performance Outcomes System evaluation methodology, as well as to extract, compile and analyze the data necessary to produce reports for the State and counties. Furthermore, technical assistance and QI staff are required to provide counties with the support that is necessary to interpret reports and develop strategies to monitor and improve local performance and outcomes. To accomplish these goals, DHCS was approved to hire the following four positions for Fiscal Year (FY) 2014-2015: 1.0 FT, permanent Research Program Specialist (RPS) III, 1.0 FT, permanent Staff Programmer Analyst (SPA), 1.0 FT, permanent Health Program Specialist (HPS) II, and 1.0 FT, permanent Consulting Psychologist (CP). To date, DHCS has hired the RPS III and the SPA, and both are working at DHCS. DHCS is currently actively recruiting for the HPS II and the CP. When these hires are in place, the foundation will be

established for maintaining and progressing the Performance Outcomes System's implementation efforts. As the project continues to grow in scope and complexity (e.g., with expansion of data collection efforts, with new legislative mandates being added) however, there will be additional staffing resources needed to address the multi-faceted efforts of the Performance Outcomes System.

Initial Performance Outcomes Reporting: Existing DHCS Databases

DHCS and the SAC Workgroup and subgroups will develop a standardized report(s) template. The specific data system areas that will be reviewed are data collection and reporting times, quality, and uniformity. Performance Outcomes System reporting using data from existing DHCS databases is scheduled to begin starting in December 2014. To facilitate reporting, review of existing DHCS databases for data elements that correspond to Performance Outcomes System indicators began in May 2014 and was conducted across a number of DHCS databases. This review also included an assessment of data integrity of the data elements within, and across, the databases for comparability. During this review, data quality issues were identified for specific data elements (e.g., race/ethnicity). Additionally, data error reports from other agencies and states were reviewed by DHCS staff for ease of use and understanding, and a format for reporting to counties on data issues was selected.

Prioritized data elements will be shared with counties starting in October 2014 through County Data Quality Improvement Reports that will highlight problematic data elements, as well as identify means to remedy the identified errors. The data elements selected for inclusion in the initial reporting process were chosen because they were easily accessible within an existing DHCS database and would provide relevant information to the counties regarding the population being served. The sharing of these reports with counties will begin a bidirectional feedback process whereby specific data elements are "cleaned" This review is important to ensuring that the report(s) can be useful for all stakeholders and can be comparable statewide and countywide.

The specific types of report(s) and the frequency of report(s) deliverables will be included in the implementation plan. A general review of DHCS's data systems suggest that there are some common standardized data elements that are reported and can be used to generate immediate system-level information to stakeholders. The primary goals of the report(s) are to show the impact of mental health services and programs and to identify areas that need improvement. The usefulness of the report(s) to stakeholders and partners is important and DHCS understands the need for continuous stakeholder and partner input in the development, analysis, and enhancement of the report(s) product. DHCS will make the report(s) available to the public via accessible locations, such as the DHCS website.

In January 2014, DHCS implemented a [Medi-Cal Managed Care Performance Dashboard](#) as part of an effort to report information to stakeholders, partners, and the public. As mental health data are collected from the MCPs, DHCS will continue updating the dashboard quarterly with mental health reporting data. The Dashboard reports on a variety of measures including enrollment, health care utilization, appeals and

grievances, network adequacy, and quality of care. DHCS is currently working on adding mental health continuity of care requests and grievances and appeals data to the next iteration of the Dashboard. Some of the new data to be added include the reason for grievances, number of grievances resolved within 30 days, total number of continuity of care denials, and denial reason. By the end of 2014, data reported by the MCPs will be incorporated into the Dashboard, and by August 2015, mental health utilization metrics will be added.

Comprehensive Performance Outcomes Reporting: Expanded Data Collection

Starting in FY 2015-16, Statewide and county reporting to the Performance Outcomes System on expanded data is scheduled to occur. Identifying and selecting which data elements to include as part of the comprehensive reporting process, as well as defining and selecting appropriate measures for each outcome, is currently being engaged in by the members of the Measures Task Force. This process, at present, has been confined to relying on existing data elements, but will be expanded to include additional data elements, as well as those which are not currently available. Additionally, at the same time, DCHS staff are reviewing outcomes reporting done by other states (e.g., dashboards, formal reports) and organizations to identify the best mechanisms for reporting this information. DHCS staff will assemble a template for reporting based on this review process that incorporates the best features from each and present this template for review to the SAC in Summer 2015. Once a template has been agreed upon by the SAC, Statewide and county-level comprehensive performance outcomes reporting will begin starting in FY 2015.

Continuous Quality Improvement Using Performance Outcomes Reports

Per W&I Code 14707.5, DHCS will leverage existing processes to develop a quality assurance and improvement process. The primary objectives of the process will be to ensure that consistent, high-quality, and fiscally effective services are delivered to children/youth and their families and to improve the functioning in all areas affecting the lives of children and youth such as school performance, home environment, child safety and involvement with the juvenile justice system. DHCS's ultimate goal is to implement and maintain a statewide quality assurance and improvement process that allows DHCS to evaluate the effectiveness of service provision, promote continuous improvement, and support opportunities for continuous learning.

DHCS staff are currently in the process of developing a QI process and structure using research information from other states, various MHPs and provider organizations, as well as information from other countries. Ultimately, the QI process will be designed to enhance the state's ability to provide appropriate technical assistance to MHPs and provider organizations regarding standardized data collection methods, use of electronic health records, continuous QI and workforce development.

Toward these efforts, DHCS conducted interviews with other states, counties and local provider organizations to discuss their QI processes and lessons learned during the development of their performance and outcomes system. Thus far, the major findings are as follows:

- Twenty states (Indiana, Massachusetts, New York, Florida, Washington, Oregon, Hawaii, Vermont, Wyoming, Ohio, Alaska, Nebraska, Montana, Kentucky, Minnesota, Georgia, Pennsylvania, Louisiana, North Carolina and Colorado), seven counties (San Diego, Los Angeles, Sonoma, San Francisco, Ventura, Orange and Imperial) and five provider organizations (Seneca Center, Casa Pacifica Centers for Children and Families, Hathaway-Sycamore Child and Family Services, EMQ Families First and San Diego Center) have answered questions regarding the type and mode of performance and outcome data collection, as well as specifying how the information is used to improve the quality and delivery of mental health services.
- The majority of state entities contacted are in the process of developing a QI system and only a few that were interviewed (i.e., Indiana and Louisiana) have components of a QI structure already in place. The exchange of information has been very helpful in identifying future components of an appropriate QI process.
- Some of the California MHPs do have QI activities and processes in place that could be built upon in the future. The QI structure includes the review of mental health services outcome information by clinicians, administrators and families and clients, where appropriate.
- To support the system, entities with successful QI processes emphasized:
 - a standardized data and mental health information collection method;
 - consistent stakeholder involvement;
 - pilot projects to get the system development started; and
 - the need for sufficient resources in terms of workforce and funding.
- The entities contacted recommended using a QI structure involving a state interagency QI committee that allows for interdepartmental discussion and sharing of pertinent data. The entities also emphasized the need to have consistent stakeholder and provider involvement to ensure mental health communities are informed and support data collection and QI efforts. Finally, it was recommended to have performance-based incentive contracts with providers in place in order to collect pertinent mental health services information.
- DHCS has begun to conceptualize a QI Committee (QIC) structure which will consist of an overarching MHSD QIC and four sub-committees. It is proposed that the sub-committees will each have a primary concentration on one of the following areas: outcome monitoring, workforce development, mental health plan technical assistance and information technology. The department is planning to have regional technical assistance conference calls and onsite trainings using

the existing regional MHP Quality Improvement Work Groups (BayQIC, Central QIC, SoQIC, and NorQIC) to facilitate discussion, improvements and implementation of best practice mental health services.

The department will continue its Performance Outcome Measurement and Quality Improvement research efforts and link the results to DHCS' overall Quality Improvement Strategy to enhance access to effective and efficient mental health services.

Continuum of Care: Screenings and Referrals

Per the ACA and state law, MCPs are now responsible for covering mild to moderate mental health services to enrolled beneficiaries. MHPs continue to be responsible for the treatment of beneficiaries that meet existing Medi-Cal specialty mental health services program medical necessity criteria (i.e., Title 9, California Code of Regulations (CCR), Chapter 11, Sections 1820.205, 1830.205, and 1830.210). With the addition of mental health services to MCPs and the requirement to link Medi-Cal eligible beneficiaries to mental health services and supports, the need to ensure that beneficiaries receive seamless transitions between MCPs and MHPs and maintain access to timely care has become even more critical. Coordination efforts between the MCPs and MHPs are key when determining how best to refer beneficiaries to each other in a timely manner. DHCS continues to foster communication between the two different health plan systems through the convening of various Workgroups and Committees.

DHCS required MCPs to report mental health data beginning in May of 2014. This reporting aims to capture two-way referrals between MCPs and MHPs, in addition to continuity of care requests and grievances and appeals filed with MCPs. These data provide DHCS with insights into how coordination amongst the two different health plan systems is occurring. They also assist the Department with determining which types of technical assistance would be helpful for MCPs and MHPs to further best practices around care coordination. These data, however, have limitations which are not optimal for the Performance Outcomes System. Specifically, the screenings and referrals data that are received on behalf of the MCPs is aggregate and may contain duplicate counts. Individual-level data are most desirable for the Performance Outcomes System. It is anticipated that encounter data (i.e., data measuring each "contact" with the system) may eventually be available to bridge the gap between the aggregate-level data currently reported by MCPs and the individual-level data needed by the Performance Outcomes System. By Fiscal Year (FY) 2016-2017, DHCS intends to use managed care encounter data to analyze mental health utilization trends and monitor and improve timely access to appropriate care for Medi-Cal eligible beneficiaries and to incorporate these data into Performance Outcomes System reporting.

IV. Timeline to Build the Performance Outcomes System

Table 1 reflects the high-level milestones and timeframes required to build a comprehensive, statewide Performance Outcomes System.⁸ Additional SAC meetings will take place.

Table 1. Timeline to Build the Performance Outcomes System

| Milestones | Date | Status |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------|
| System Plan and System Implementation Plan | | |
| Deliverable: System Plan | October 1, 2013 | COMPLETED <i>November 1, 2013</i> |
| Draft System Implementation Plan | November 2013 | COMPLETED |
| Obtain Input on the final draft Implementation Plan from the Stakeholder Advisory Committee | December 2013 | COMPLETED |
| Deliverable: System Implementation Plan | January 10, 2014 | COMPLETED |
| Deliverable: Performance Outcomes System Plan Update | October 1, 2014 | COMPLETED <i>October 31, 2014</i> |
| Deliverable: Performance Outcomes System Implementation Plan Update | January 10, 2015 | |
| Establish Performance Outcomes System Methodology | | |
| Facilitate stakeholder input on the performance outcomes system evaluation methodology (e.g., including standardized data sources and data collection tools used) | October 2014 | COMPLETED |
| Obtain Input on the performance outcomes system methodology protocol from the Performance Outcomes System Stakeholder Advisory Committee | December 2014 | COMPLETED |
| Deliverable: Performance Outcomes System Protocol | February 2015 | |
| Initial Performance Outcomes Reporting: Existing DHCS Databases | | |
| Identify Performance Outcomes Data Elements in Existing DHCS Databases | May 2014 | COMPLETED |
| Assess Data Integrity | July 2014 | COMPLETED |
| Develop County Data Quality Improvement | October 2014 | |

⁸ The implementation schedule, communication plan, risks / issues, and assumptions / constraints will be detailed in the System Implementation Plan.

| Milestones | Date | Status |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------|
| Reports | | |
| Counties Remedy Data Quality Issues | Ongoing Beginning in October 2014 | Ongoing |
| Develop Performance Outcomes Report Template(s) | November 2014 | |
| Obtain Input on the Report Template(s) from the Stakeholder Advisory Committee | December 2014 | |
| Deliverable: Statewide and County Reports on Initial Performance Outcomes Using Data from Existing DHCS Databases | Ongoing Beginning in December 2014 | |
| Continuum of Care: Screenings and Referrals | | |
| Obtain Input on screening and referral information needed for the Performance Outcomes System from the Stakeholder Advisory Committee | February 2014 | COMPLETED |
| Data reported by the MCPs added to the Medi-Cal Managed Care Performance Dashboard | December 2014 | |
| Mental Health Utilization Metrics added to the Medi-Cal Managed Care Performance Dashboard | October 2015 | |
| Update the SHA to improve assessment of patients' behavioral health and timely detection of any mental health disorders, based on meetings with MCPs and stakeholders | FY 2015-2016 | |

| Milestones | Date | Status |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------|
| Comprehensive Performance Outcomes Reporting: Expanded Data Collection | | |
| The activities associated with this task are dependent on the number and scope of additional data elements adopted as part of the Performance Outcomes System Methodology. | FY 2014-2015 | |
| Obtain Input on the Report Template(s) from the Stakeholder Advisory Committee | Summer 2015 | |
| Deliverable: Statewide and County Reports on Comprehensive Performance Outcomes Using Existing and Expanded Data | FY 2015-2016 | |
| Continuous Quality Improvement Using Performance Outcomes Reports | | |
| Develop Trainings to Support Interpretation of the Performance Outcomes Reports (Initial and Comprehensive) | Ongoing Beginning in January 2015 | |
| Develop Quality Improvement Plan Template(s) | Ongoing Beginning in March 2015 | |
| Obtain Input on the Quality Improvement Plan Template(s) from the Stakeholder Advisory Committee | Spring 2015 | |
| Deliverable: Quality Improvement Plans | Summer 2015 | |
| Support and Monitoring of Quality Improvement Plans | Ongoing | |

V. Conclusion

DHCS, working in close collaboration with the EPSDT Performance Outcomes System SAC and subgroups, is continuing the work of defining what the Performance Outcomes System will do and how it will do it. Through continued collaboration, DHCS will continue to explore implementation strategies and activities in the upcoming few months, which will be used to provide more detail on fiscal and programmatic impact in the updated System Implementation Plan in the next report, which is due to the Legislature on January 10, 2015.

Appendix A

Performance Outcomes System Statute

Welfare and Institutions [W&I] Code, Section 14707.5, added by Senate Bill [SB] 1009, Committee on Budget and Fiscal Review, Chapter 34, Statutes of 2012, amended by Assembly Bill [AB] 82, Committee on Budget, Chapter 23, Statutes of 2013.

W&I Code, Section 14707.5.

(a) It is the intent of the Legislature to develop a performance outcome system for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services that will improve outcomes at the individual and system levels and will inform fiscal decision making related to the purchase of services.

(b) The State Department of Health Care Services, in collaboration with the California Health and Human Services Agency, and in consultation with the Mental Health Services Oversight and Accountability Commission, shall create a plan for a performance outcome system for EPSDT mental health services provided to eligible Medi-Cal beneficiaries under the age of 21 pursuant to 42 U.S.C. Section 1396d(a)(4)(B).

(1) Commencing no later than September 1, 2012, the department shall convene a stakeholder advisory committee comprised of representatives of child and youth clients, family members, providers, counties, and the Legislature. This consultation shall inform the creation of a plan for a performance outcome system for EPSDT mental health services.

(2) In developing a plan for a performance outcomes system for EPSDT mental health services, the department shall consider the following objectives, among others:

(A) High quality and accessible EPSDT mental health services for eligible children and youth, consistent with federal law.

(B) Information that improves practice at the individual, program, and system levels.

(C) Minimization of costs by building upon existing resources to the fullest extent possible.

(D) Reliable data that are collected and analyzed in a timely fashion.

(3) At a minimum, the plan for a performance outcome system for EPSDT mental health services shall consider evidence-based models for performance outcome systems, such as the Child and Adolescent Needs and Strengths (CANS), federal requirements, including the review by the External Quality Review Organization (EQRO), and, timelines for implementation at the provider, county, and state levels.

(c) The State Department of Health Care Services shall provide the performance outcomes system plan, including milestones and timelines, for EPSDT mental health services described in subdivision (a) to all fiscal committees and appropriate policy committees of the Legislature no later than October 1, 2013.

(d) The State Department of Health Care Services shall propose how to implement the performance outcomes system plan for EPSDT mental health services described in subdivision (a) no later than January 10, 2014.

(e) Commencing no later than February 1, 2014, the department shall convene a stakeholder advisory committee comprised of advocates for and representatives of, child and youth clients, family members, managed care health plans, providers, counties, and the Legislature. The committee shall develop methods to routinely measure, assess, and communicate program information regarding informing, identifying, screening, assessing, referring, and linking Medi-Cal eligible beneficiaries to mental health services and supports. The committee shall also review health plan screenings for mental health illness, health plan referrals to Medi-Cal fee-for-service providers, and health plan referrals to county mental health plans, among others. The committee shall make recommendations to the department regarding performance and outcome measures that will contribute to improving timely access to appropriate care for Medi-Cal eligible beneficiaries.

(1) The department shall incorporate into the performance outcomes system established pursuant to this section the screenings and referrals described in this subdivision, including milestones and timelines, and shall provide an updated performance outcomes system plan to all fiscal committees and the appropriate policy committees of the Legislature no later than October 1, 2014.

(2) The department shall propose how to implement the updated performance systems outcome plan described in paragraph (1) no later than January 10, 2015.

W&I Code, Section 14132.03, added by Senate Bill [SB] X1-1, Fiscal Committee, Chapter 4, Statutes of 2013

W&I Code, Section 14132.03.

(a) The following shall be covered Medi-Cal benefits effective January 1, 2014:

(1) Mental health services included in the essential health benefits package adopted by the state pursuant to Section 1367.005 of the Health and Safety Code and Section 10112.27 of the Insurance Code and approved by the United States Secretary of Health and Human Services under Section 18022 of Title 42 of the United States Code. To the extent behavioral health treatment services are considered mental health services pursuant to the essential health benefits package, these services shall only be provided to individuals who receive services through federally approved waivers or state plan amendments pursuant to the Lanterman Developmental Disability Services Act, at Division 4.5 (commencing with Section 4500).

(2) Substance use disorder services included in the essential health benefits package adopted by the state pursuant to Section 1367.005 of the Health and Safety Code and Section 10112.27 of the Insurance Code and approved by the United States Secretary of Health and Human Services under Section 18022 of Title 42 of the United States Code.

(b) The department may seek approval of any necessary state plan amendments to implement this section.

(c) This section shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 30.

Article 5.9 (commencing with Section 14189) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.9. Medi-Cal Managed Care Plan Mental Health Benefits

W&I Code, Section 14189.

Medi-Cal managed care plans shall provide mental health benefits covered in the state plan excluding those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver. The department may require the managed care plans to cover mental health pharmacy benefits to the extent provided in the contracts between the department and the Medi-Cal managed care plans.

Appendix B Stakeholder Advisory Committee Meeting Participants⁹

| Partner/Stakeholder |
|--------------------------------------------------------------------------------------|
| Alameda County Health Care |
| Alameda County Mental Health |
| Behavioral Health Concepts - California External Quality Review Organization (CEQRO) |
| Butte County Behavioral Health |
| California Academy of Child & Adolescent Psychiatry (CAL- ACAP) |
| California Alliance of Child & Family Services |
| California Council of Community Mental Health Agencies (CCCMHA) |
| California Department of Alcohol & Drugs Program (ADP) |
| California Department of Social Services (CDSS) |
| California Health Care Foundation |
| California Health & Human Services Agency (CHHS) |
| California Institute for Behavioral Health Solutions (CIBHS) |
| California Mental Health Directors Association (CMHDA) |
| California Mental Health Planning Council (CMHPC) |
| California State Assembly |
| Calaveras County |
| CAIOptima |
| Cambria Solutions |
| Chapin Hall at the University of Chicago |
| Child Welfare Services |
| Children Now |
| Children's Bureau Southern CA |
| Children's Institute |
| Contra Costa County Public Health Department |
| Contra Costa Health Services |
| County of Santa Cruz Health Services Agency |
| County Welfare Directors Association of California (CWDA) |
| Crittenden Services |
| Department of Finance |
| Department of Health Care Services (DHCS) |
| Department of Social Services/Child Welfare Services (CDSS/CWS) |
| Disability Rights Counsel CA |
| Early Childhood Mental Health Program |
| Eastfield Ming Quong Families First (EMQFF) |
| Family Member |
| Families First |
| Family SOUP |
| Five Acres |
| Fred Finch Youth Center |
| Fresno County Mental Health |
| Gov. Policy & Strategies |
| Hathaway Sycamores |

⁹ These meetings were held in Sacramento and both WebEx and conference call options were available to participants. Materials were provided in advance to participants. Materials are posted on the DHCS Internet site before meetings at:

<http://www.dhcs.ca.gov/individuals/Pages/PerformanceandOutcomesSystemforMedi-CalSpecialtyMentalHealthServices-StakeholderAdvisoryCommittee.aspx>

| Partner/Stakeholder |
|-----------------------------------------------------------------------------|
| Health Net |
| Humboldt County Mental Health |
| Imperial County Mental Health |
| John Perez, California State Assembly Member |
| Kern County Mental Health |
| Kings View Behavioral Health |
| Lake County Mental Health |
| Lassen County Health |
| Lincoln Child Center |
| Local Health Plans of California (LHPC) |
| Los Angeles County Department of Children and Family Services (LACDCFS) |
| Los Angeles County Mental Health |
| Madera County Mental Health |
| Marin County Mental Health |
| Mental Health Association California |
| Mental Health Services Oversight and Accountability Commission (MHSOAC) |
| Merced County Mental Health |
| Momentum for Mental Health |
| Monterey County Behavioral Health |
| Napa County Mental Health |
| National Alliance on Mental Illness (NAMI) CA |
| National Health Law Program |
| Nevada County |
| Online Archive of CA (OAC) |
| Orange County Health Care Agency |
| Pacific Clinics |
| Placer County |
| Planning Council |
| Rebekah Children's Services |
| River Oak Center for Children |
| Riverside County Department of Mental Health |
| Sacramento County Mental Health |
| San Benito County |
| San Bernardino County |
| San Diego Health and Human Services Agency Child Welfare Services (HHSACWS) |
| San Diego County Mental Health |
| San Francisco Department of Public Health |
| San Luis Obispo County |
| Santa Clara |
| Santa Cruz County/CMHDA |
| San Joaquin County Behavior Health Services |
| Santa Barbara County Mental Health |
| SBC Social Services |
| Senate Budget Committee |
| Senate Office of Research |
| Senate Staffer for Darrel Steinberg |
| Seneca Center |
| Shasta County Mental Health |
| Sierra Forever Families |
| Siskiyou County Human Services Agency |
| SLC Consulting |

| Partner/Stakeholder |
|----------------------------------------------------|
| Solano County Mental Health |
| Sonoma County |
| Star View Children & Family & Services |
| St. Anne's |
| Stanislaus Behavioral Health and Recovery Services |
| Sunny Hills Services |
| Sutter County |
| Sutter-Yuba Mental Health |
| Tehama County Health Services Agency (TCHSA) |
| Tuolumne County Behavioral Health |
| University of California at Davis |
| University of California at Los Angeles |
| University of California at San Francisco |
| Ventura County Mental Health |
| Victor Community Support Services |
| Voice 4 Families |
| West Coast Children's Clinic |
| Yolo County |
| Young Minds Advocacy Project |
| Youth for Change |
| Yuba City County Mental Health |

Appendix C

Subject Matter Expert Workgroup and Measures Task Force Members

| Participant | Organization | Membership | |
|----------------------|---------------------------------------------------------------|-----------------------------------------------|-----------------------------------|
| | | Subject Matter Expert Workgroup ¹⁰ | Measures Task Force ¹¹ |
| Twyla Abraham | Placer County | X | X |
| Jane Adcock | California Mental Health Planning Council (CMHPC) | X | X |
| Renay Bradley | MHSOAC | X | X |
| Patricia Costales | The Guidance Center | X | |
| Lorie DeScala | Behavioral Health Concepts | X | X |
| Linda Dickerson | CMHPC | X | X |
| Patrick Gardner | Young Minds Advocacy Project | X | X |
| Bridget Hoffman | Behavioral Health Concepts | X | X |
| William Holcomb | Behavioral Health Concepts | X | X |
| David Horner | Orange County Health Care Agency | X | X |
| Debbie Innes-Gomberg | Los Angeles County Mental Health | X | X |
| Nathaniel Israel | Chapin Hall at the University of Chicago | X | X |
| Ellie Jones | California Department of Social Services (CDSS) | X | |
| Don Kingdon | CBHDA | X | X |
| Penny Knapp | University of California at Davis | X | X |
| Amy McCurry | Behavioral Health Concepts | X | X |
| Dave McDowell | CDSS | X | |
| Amie Miller | Monterey County Behavioral Health | X | X |
| Cricket Mitchell | CIBHS | X | X |
| Abram Rosenblatt | University of San Francisco | X | X |
| Rusty Selix | Coalition for Mental Health | X | |
| Wesley Sheffield | Young Minds Advocacy Project | X | |
| Suzanne Tavano | Marin County Mental Health | X | X |
| Catherine Teare | California Health Care Foundation | X | |
| Lynn Thull | California Alliance of Child & Family Services | X | X |
| Bill Ullom | Behavioral Health Concepts | X | X |
| Laura Williams | Butte County Behavioral Health | X | X |
| Shanna Zanolini | Ventura County | X | |
| Carrie Allison | DHCS, Medi-Cal Managed Care Division (MMCD) | X | |
| Dilara Boring | DHCS, Fiscal Management and Outcomes Reporting Branch (FMORB) | X | |
| Sarah Brooks | DHCS, MMCD | X | |
| Teresa Castillo | DHCS, Program Policy & Quality | X | |

¹⁰ Subject Matter Expert Workgroup (SME) meetings were held in Sacramento. WebEx and conference call options were available to participants. Materials were provided in advance, and were shared among members and updated between meetings.

¹¹ Measures Task Force meetings were held primarily via WebEx and conference calls. Materials were provided in advance to participants. Materials were provided in advance, and were shared among members and updated between meetings.

| | Assurance Branch (PPQAB) | | |
|----------------------|------------------------------------------------------|---------------------------------|---------------------|
| Participant | Organization | Membership | |
| | | Subject Matter Expert Workgroup | Measures Task Force |
| Brenda Grealish | DHCS, Mental Health Services Division (MHSD) | X | |
| Richard Hildebrand | DHCS, PPQAB | X | |
| Randy Jose | DHCS, FMORB | X | |
| Jennifer Kent | Local Health Plans of California (LHPC) | X | |
| Susan Kinoshita | DHCS, FMORB | X | X |
| Dina Kokkos-Gonzales | DHCS, PPQAB | X | X |
| Natalia Krasnodemsky | DHCS, PPQAB | X | |
| Camille Kustin | DHCS, MMCD | X | |
| John Lessley | DHCS, QA Section | X | X |
| Dionne Maxwell | DHCS, FMORB | X | X |
| Rita McCabe | DHCS, Program Oversight and Compliance Branch (POCB) | X | |
| Janet McKinley | DHCS, PCOB | X | |
| Sean Mulvey | DHCS, QA Unit | X | X |
| Muhammad Nawaz | DHCS, MMCD | X | |
| Minerva Reyes | DHCS, FMORB | X | X |
| Julia Rojas | DHCS, PPQAB | X | |
| Carol Sakai | DHCS, PCOB | X | |
| Reem Shahrouri | DHCS, QA Unit | X | X |
| Susan Stackhouse | DHCS, QA Unit | X | |
| Jennifer Taylor | DHCS, FMORB | X | X |
| Dorothy Uzoh | DHCS, Pharmacy Policy | X | |
| Mike Wofford | DHCS, Pharmacy Policy | X | |
| Molly Yang | DHCS, PPQAB | X | X |
| Gerald Zipay | DHCS, FMORB | X | |
| Bambi Cisneros | DHCS, MMCD | | X |
| Kris Dubble | DHCS, FMORB | | |
| Efrat Eilat | DHCS, Director's Office | X | X |
| Monika Grass | DHCS, Quality Assurance (QA) Unit | X | X |