

April 19, 2017

Jennifer Kent, Director  
Department of Health Care Services  
MS 0000  
P.O. Box 997413  
Sacramento, CA 95814

Dear Director Kent:

The Medi-Cal Children's Health Advisory Panel (MCHAP) is an independent, statewide advisory board, legislatively authorized to advise the Department of Health Care Services (DHCS) on matters relevant to children enrolled in Medi-Cal and their families, including, but not limited to, emerging trends in the care of children, quality measurements, communications between DHCS and Medi-Cal families, provider network issues and Medi-Cal enrollment issues. The impact of care delivered through the Medi-Cal program is substantial with almost six million California children, more than half of all California's youth, currently served by the program.

MCHAP pursues in-depth review of critical issues related to children's health and access to services through review of relevant data, presentations by stakeholders and deliberation of issues and recommendations. The 15 members of the panel are recognized stakeholders/experts in their fields, practicing and/or certified medical professionals, advocates who represent the interest of children's health, and parent members who provide feedback on topics that impact children in Medi-Cal.

During meetings on September 13, 2016, November 15, 2016, and January 18, 2017, MCHAP engaged in a review of children's mental health and substance use services delivered through schools, primary care and specialty providers and county programs. Deep-dive presentations by Medi-Cal managed care plan executives, county mental health representatives, school administrators and providers, as well as DHCS staff, provided the panel with in-depth information about the structure, delivery systems, financing, needs and challenges of California's system of publicly financed care for youth. Recommendations were developed and reviewed by MCHAP members over the course of the three meetings.

Thank you for your efforts to date to expand coverage and improve care for California's children. These recommendations are forwarded with the aim of improving early, appropriate, on-going person centered mental health and substance use disorders prevention and treatment services. The Panel strongly believes in the importance of prevention and early intervention efforts and we anticipate another in-depth conversation on this topic soon. In addition, the Panel began a discussion about the historical carve-out of Mental Health and Substance Abuse services and its impact on integrated and continuous care. The Advisory Panel will continue to address behavioral health as a topic and may forward additional recommendations in the future.

Mental health and substance use prevention and treatment services to children and families are fragmented, complicated to understand, and difficult to navigate for families and providers. The need for integrated and easily accessible prevention and treatment services is significant. A review of both the national and international literature found that an average of 17 percent of young people experience an emotional, mental, or behavioral disorder at some point before the age of 17. Substance abuse or dependence was the most commonly diagnosed condition, followed by anxiety disorders, depressive disorders, and attention deficit hyperactivity disorder. In addition, the onset for 50 percent of adult mental health disorders occurs by age 14,

and for 75 percent of adults by age 24.<sup>1</sup> Estimates of California's prevalence rates define conditions more narrowly, with 7.6% of children experiencing serious emotional disturbance that limits participation in daily activities and an additional 2.7% with substance abuse needs (total 10.3%).<sup>2</sup>

MCHAP members appreciate the efforts of the leadership of DHCS to expand benefits for mild-to-moderate mental health services as a significant step forward. However, there is more to do to ensure identification of and timely and early access to a full continuum of mental health and substance use disorders prevention and treatment services for California's youth. Specific barriers to care include:

- A lack of providers, especially child psychiatrists, therapists, psychologists and psychiatric nurse practitioners
- Access to inpatient psychiatric beds for children and youth
- Providers, specifically for children and youth, who fluently speak languages other than English
- Difficulty achieving screening, early detection and early intervention
- Coordination of timely services across multiple systems of care
- Widespread stigma and lack of knowledge about available prevention and treatment services.

Myriad funding sources, categorical programs, and service settings result in barriers to care that require restructuring and innovation across the continuum of care to ensure the Early Periodic Screening, Diagnosis and Treatment program (EPSDT) mandate is achieved. Substance use services are funded through Drug Medi-Cal, the Substance Use Prevention and Treatment Block Grant, and State General Funds. Mental Health Services funding mechanisms include Medi-Cal, Substance Abuse and Mental Health Services Administration (SAMHSA) Grants, the 1991 Realignment funds, Mental Health Services Act, the 2011 Realignment, and the County General Funds. In addition to managed care plans and county mental health plans, services are provided through juvenile justice, probation, child welfare, schools and regional centers. The need to collaborate, share information and data, and integrate prevention and treatment services across multiple systems is the main focus on these recommendations.

### **Recommendations:**

#### **1. Collaborate with California Department of Education (CDE) to develop guidelines for mental health prevention and treatment services and clarify reimbursement and financial responsibilities.**

- a) Strengthen state-level collaboration to ensure a comprehensive continuum of prevention and treatment services and remove barriers to reimbursement across different programs available to school providers.
- b) Offer joint communication about how to develop, deliver and strengthen school-based prevention and treatment services through various funding and protection programs, including Early Periodic Screening, Diagnosis and Treatment program (EPSDT), School Based Medi-Cal Administrative Activities (MAA), Local Education Agency (LEA), the Individuals with Disabilities Education Act (IDEA), Section 504 of the

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<sup>1</sup> <http://youth.gov/youth-topics/youth-mental-health/prevalance-mental-health-disorders-among-youth>

<sup>2</sup> <http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf>;  
<http://www.dhcs.ca.gov/Documents/All%20chapters%20final%201-31-12.pdf>

- Rehabilitation Act, and other federal and state programs.<sup>3</sup> Develop a legally vetted model MOU between LEA entities and health services. Administration and reimbursement have been challenging due to rule changes and retrospective auditing.
- c) Complete the MOU between CDE and DHCS to facilitate services required by SB123 and consider a liaison from MCHAP to the advisory group on LEA for DHCS.<sup>4</sup>
  - d) Leverage and fully utilize all federal and state financing through more streamlined coordination of requirements, for example IDEA and Section 504, The Rehabilitation Act.
  - e) Identify mechanisms in schools to address linkages to the provision of substance use programs and services.<sup>5</sup>

**2. Issue guidance to establish consistent definitions of mild, moderate and severely mentally ill as well as roles, responsibilities and anticipated actions among local managed care entities and programs, especially as they affect children and youth.**

- a) Provide clarity regarding which entity should determine the level of the condition (mild, moderate, severe) and which system of care is responsible for services. Currently, families experience significant difficulty and delay in receiving services due to the multiple systems of care between EPSDT, Medi-Cal managed care, schools, county mental health and hospitals and the lack of clearly defined responsibility for different levels of children's mental health prevention and treatment services.
- b) Clarify continuity of care guidelines across systems including schools, county mental health and substance use systems, and Medi-Cal managed care plans. DHCS should require that behavioral health be included in Continuity of Care rules.
- c) Issue guidance about what constitutes a change in the level of condition and how to accomplish a transfer from school-based services to county mental health to Medi-Cal managed care health plan to hospital and vice versa when a level of condition changes in order to maintain continuity of care for the child and family. Guidance should anticipate how providers can operate seamlessly to ensure timely,

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<sup>3</sup> The Individuals with Disabilities Education Act (IDEA) is federal law that governs special education services and provides some funding to state and local education agencies to guarantee special education and related services for those students who meet the criteria for eligibility in a number of distinct categories of disability, each of which has its own criteria. Some kids with special needs do not receive services under IDEA, but are served under Section 504 of the Rehabilitation Act of 1973. Section 504, a civil rights law, prohibits discrimination on the basis of disabling conditions by programs and activities receiving or benefiting from federal financial assistance. This statute does not require the federal government to provide additional funding for students identified with special needs. Schools must provide these children with reasonable accommodations comparable to those provided to their peers under the rulings of Section 504. Although not a financing statute, Section 504 does provide for enforcement of the mandate: A school that is found by the Office of Civil Rights to be out of compliance with Section 504 may lose its federal financing. <http://www.ldonline.org/article/6086/>

<sup>4</sup> [https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201520160SB123](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB123) SB 123 enrolled in September 2016. This bill would require the department to enter into an interagency agreement or memorandum of understanding (MOU) with the State Department of Education to coordinate the efforts of both departments with respect to the LEA billing option and the School-Based Administrative Claiming process program. The bill would require the department to develop an appeals process, as specified, to contest an action of the department. This bill would require the department and the State Department of Education to establish and jointly administer a School-Based Health Program and Policy Workgroup, as specified, in order to assist the department in formulating state plan amendments required to implement the LEA billing option described above and for the purpose of advising the department on issues related to the delivery of school-based Medi-Cal services to students in the state, as specified. The bill would require the department to consult with the advisory group in connection with developing the interagency agreement or MOU described above.

<sup>5</sup> [http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/Mental%20Health%20Medi-Cal%20Billing%20Manual\\_FINAL\\_OCT\\_2013.pdf](http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/Mental%20Health%20Medi-Cal%20Billing%20Manual_FINAL_OCT_2013.pdf)

appropriate access across the system of care and support the need for navigation services. Guidance should also address possible obstacles and how to address them effectively.

- 3. Improve care coordination by clarifying legal requirements for information exchange and requiring data exchange between county programs, schools, hospitals, and Medi-Cal managed care plans.**
  - a) Develop new or adopt existing model language to enable data and information sharing of patient information between counties, school-based clinics, behavioral health services, other providers and health plans to better integrate and address the needs of children and families to the greatest degree possible under current laws.
  - b) Promote and adapt best practices for sharing information such as the Developmental Disability Regional Center's population exchange of information policies.
  - c) Promote the completion and tracking of mental health and substance use services at school sites through an All Plan Letter. Incorporate licensed school mental health providers into system of care.
  - d) Monitor and report standardized state-level mental health and substance use disorders service data, including medications and FQHC services billed directly to the state, to identify ongoing barriers and document improved access to prevention and treatment services.
  
- 4. Expand and align benefits and prevention and treatment services to improve access, quality and outcomes for children and youth.**
  - a) Mandate and reimburse school-based screening and parental education to address early intervention for mental health conditions, substance and tobacco use (as with current hearing and vision screenings). Include depression and substance use screening (including marijuana use) for all adolescent students.
  - b) Improve access to screening, assessment, and treatment by simplifying and authorizing reimbursement to primary care providers, school-based clinic providers and other school providers.
  - c) Issue guidance about the importance of parental screening for mental health conditions and maternal depression screening, especially in relation to post-partum depression.
  - d) Expand Medi-Cal benefits and reimbursement to achieve parity and best practices:
    - o respite care and residential crisis services to maintain children in their home setting
    - o family therapy, therapeutic parenting services and case management services for children, youth and their families across the continuum of care
    - o non-medication based therapeutic interventions to prevent over-reliance on medication treatments.
  - e) Develop strategies to significantly expand Substance Use Disorders service capacity to meet the needs specifically of children and youth including expansion of the workforce and service modalities.
  - f) Implement common metrics and outcome measures collecting this data and make it publicly available.
  
- 5. Improve timely, effective and evidence-based service delivery by removing barriers to innovative service delivery options and supporting training and care management.**
  - a) Ensure that telehealth services can be delivered and reimbursed through home, school and primary care settings.

- b) Promote the use of mental health e-consult/curbside consults/decision support for primary care providers.
- c) Recognize and expand the role of School Based Health Centers and school-based mental health programs as important partners in providing on-site mental health and substance use prevention and treatment services to children, youth and their families, and ensure reimbursement for covered benefits.
- d) Share and encourage use of evidence-based best practices with primary care providers, school-based clinics and Medi-Cal managed care plans to better understand the diagnosis and treatment of mental health conditions and substance use disorders as well as management of effective non-medication, medication, and combined treatments for children and youth.

**6. Raise awareness about prevention and treatment services and reduce stigma through provider and public education.**

- a) Develop a statewide public awareness campaign about children’s mental health and substance use disorders to educate families about how to access prevention and treatment services.
- b) Educate, engage and serve parents in a culturally and linguistically appropriate manner such as involving community health promoters/promotoras and youth health promoters.
- c) Educate providers of care to children and youth about mental health and substance use disorder prevention and treatment services and systems to increase referrals and knowledge about resources available across systems and how to access them.
- d) Target the teen years for outreach and education, case management, individual and family services and innovative models of peer education, support and empowerment.

Robust high quality systems of care that are culturally sensitive and easily accessed will improve the health and economic vitality of California. We look forward to continued collaboration with DHCS to improve the health of California’s children and families.

Respectfully,

Ellen Beck, M.D.  
 Chair, Medi-Cal Children’s Health Advisory Panel

cc: Diana Dooley, Secretary, California Health and Human Services Agency  
 Senator Richard Pan, M.D.  
 Senate Committee on Health  
 Senate Committee on Human Services  
 Senate Committee on Education  
 Senate Committee on Public Safety  
 Senate Mental Health Caucus  
 Senate Select Committee on Mental Health  
 Assembly Committee on Health  
 Assembly Committee on Human Services  
 Assembly Committee on Public Safety  
 Assembly Committee on Education