At the June 28, 2017 meeting of the Medi-Cal Children's Health Advisory Panel (MCHAP), California Department of Health Care Services Director Jennifer Kent responded to an April 19, 2017 letter from MCHAP that made recommendations to improve behavioral health care for California's children. MCHAP members requested a written account of those responses.

This document includes the recommendations from the MCHAP letter, along with added text summarizing the Director's responses from the June 28, 2017 meeting.

Although MCHAP is an independent advisory body to the Department, DHCS is limited in its legal authority to implement many of the below recommendations proposed by the Panel. Finite resources also limit the Department's ability to implement the recommended actions.

The original recommendations are posted below in black print, while the Director's responses are labelled with her name and printed in red:

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 Rehabilitation Act, and other federal and state programs. 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.
   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.

Jennifer Kent: DHCS is in regular contact with CDE regarding issues of concern to both departments. Our working list recently has included work to develop better interagency agreements. Those conversations with CDE in the coming months also will include discussion of how we pay for services provided and who may authorize those services.

DHCS works closely with the Mental Health Oversight and Accountability Commission regarding prevention services that can be provided through Mental Health Services Act (MHSA) funding in the schools. DHCS also has a Youth Advisory Group (YAG) that addresses substance use prevention and treatment services. The YAG is developing a report on needs assessment for youth substance use disorder (SUD) treatment services and will provide information on youth treatment guidelines.

In addition, DHCS has an Interagency Prevention Advisory Committee (IPAC), which is a high-level council that consists of representatives from several state departments and organizations (including a representative from the CDE) who work collaboratively to prevent and reduce harm from behavioral health concerns, such as substance use disorders, suicide, and depression.

SB 123, cited by the Panel in recommendation 1(c), was vetoed by the Governor, who noted in his veto message that the Department already has an existing advisory committee and is "working well" to review and recommend improvements as related to school-based healthcare programs.

With regard to item 1(e), we are working with multiple counties that have begun providing the full continuum of substance use treatment services for both the adult and youth populations under the provisions of our Drug Medi-Cal –Organized Delivery System (DMC-ODS) waiver.

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, 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.

Jennifer Kent: We have provided guidance to the mental health plans that should clarify service delivery issues through Information Notice #16-061:

http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS_16-061.pdf

We have been refining the provision of data in our new data-collection system, the Performance Outcomes System (POS), in order to better understand the results of the Medi-Cal Specialty Mental Health Services (SMHS) services delivered to children and youth.

Several of the sub recommendations ask that the Department require school-based providers to contract with county mental health plans or Medi-Cal plans. The Department has no authority to require plans and providers to contract with each other, or to require school-based providers to follow a particular clinical standard.

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.

Jennifer Kent: Care coordination is an ongoing issue, with restrictions regarding who is able to view data and at what level information is exchanged. While there is clearly value in sharing information, DHCS is limited because we can only govern sharing of information for payment or coordination of medical care.

We also are not able to promote the completion and tracking of mental health and substance use services through an All Plan Letter, which is a tool specific to communicating with managed care plans, because plans are not required to contract or otherwise use school-based providers. Plans and providers should contract with each other when appropriate, but the Department's role does not include requiring such contracts. School-based providers need to demonstrate to health plans how their services are not otherwise duplicated in a plan's network and contract accordingly. Lastly, our Medi-Cal managed care plans are not responsible for the provision of substance use treatment or most mental health services for youth.

The State Health Information Guidance (SHIG) Information Notice 17-030 was developed to create an ongoing dialogue on how to improve appropriate sharing of health information. For more about what health information can be exchanged, please visit California Health & Human Services Agency's SHIG web page: http://www.chhs.ca.gov/ohii/pages/shig.aspx

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:

- respite care and residential crisis services to maintain children in their home setting
- family therapy, therapeutic parenting services and case management services for children, youth and their families across the continuum of care
- 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.

Jennifer Kent: A thoughtful and well-aligned expansion of benefits could improve care quality but can only be approached within a broader discussion of the Medi-Cal program as a whole and the state budget.

The Department's implementation of its Drug Medi-Cal waiver (DMC-ODS) is completely changing the service delivery system for substance use disorders, allowing for more local control and accountability and administrative oversight. To date, 38 counties have submitted plans to participate in this waiver and seven counties are currently providing these services.

We have been working with the Legislature and stakeholders to improve screening for trauma. We are assessing ways to incorporate childhood trauma screening into assessments and whether traumatic events are being recognized and treated appropriately by providers. Additionally, we also are looking into tailoring mental health services and screening for foster youth. Existing screening requirements for children (in age groupings) and tools can be found at this web page:

http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx#

The Department doesn't have the authority to mandate school-based screenings; this would be a statutory mandate that the Legislature would have to adopt. Medi-Cal then would have to develop a fiscal cost associated with the relevant population that is eligible for services.

Most children are enrolled in Medi-Cal managed care plans. School providers must have a valid contract with a contracting health plan in order to receive reimbursement for services to eligible children. Without such a contract, the Department cannot reimburse schools for services since it would represent a duplication of payments.

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.

Jennifer Kent: School-based centers are both convenient and appropriate for some populations. However, because the majority of Californians receive care through a managed care system, those centers need to contract for services with managed care plans (whether Medi-Cal or commercial) in order to be paid for services delivered in the school setting. The Department cannot contract with them independently since this would most likely represent a duplication of payments for Medi-Cal populations.

In addition, there are limits on the extent to which we can support school-based clinics because they are not broadly open to all Medi-Cal beneficiaries, only to children attending the schools.

The Department's coverage and reimbursement policies for telehealth align with the California Telehealth Advance Act of 2011 and federal regulations. Medi-Cal also complies with federal regulations for telehealth. Telehealth is available for reimbursement through Medi-Cal to school-based clinics that are otherwise qualified as Medi-Cal providers, which includes the Medi-Cal managed care contract relationships described above.

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.

Jennifer Kent: I couldn't agree more about raising awareness about prevention and treatment services. Through the MHSA funding, the joint powers authority (CalMHSA) conducted a public awareness and stigma reduction campaign using one-time funds. The counties, as the recipients of MHSA funding, are able to decide on a local level whether they wish to continue funding this effort.

To the extent that these are recommendations, this type of activity would require a specific budget allocation from the Legislature as well as a discussion as to the appropriate entity to engage in this activity. The Department is not necessarily the correct entity to conduct public awareness campaigns.