



January 3, 2020

Via Email: Jacey.cooper@dhcs.ca.gov

Attention: Jacey Cooper, Senior Advisor - Health Care Programs

California Department of Health Care Services

1501 Capitol Avenue, MS 4000, P.O. Box 997413

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Subject: CalAIM Medical Necessity, Level of Care and No Wrong Door Recommendations from the California Children's Trust and the California Alliance of Child and Family Services

Dear Ms. Cooper:

The California Children's Trust (CCT) and the California Alliance of Child and Family Services (Alliance) are pleased to submit comments in response to the California Advancing and Innovating Medi-Cal (CalAIM) initiative led by the Department of Health Care Services (DHCS). The CCT represents a broad statewide coalition of stakeholders committed to addressing the children's behavioral health crisis in California. The Alliance is a statewide association of more than 146 accredited, private nonprofit agencies dedicated to achieving progressively better outcomes for vulnerable children, youth and families in public human services systems.

Today our feedback addresses CalAIM's proposal concerning the definition of Medical Necessity, No Wrong Door, and Levels of Care Recommendations for Medi-Cal services for children and youth. Due to the holidays and challenges of the deadline for these recommendations, we do expect to continue to provide more detailed recommendations moving forward. These comments represent our high-level thinking with limited input from our constituents and minimal national research given the timeframe for submission.

The CCT and the Alliance support CalAIM's approach to modifying existing eligibility criteria for Medi-Cal outpatient and inpatient specialty mental health services in order to align with the

EPSDT federal entitlement. Science and best practices tell us that regarding behavioral health, especially children's behavioral health, we must shift from a diagnosis-driven system to an approach that is responsive to the level of impairment and reflects an understanding of the impact of trauma and social determinants of health (SDOH) on long-term health and mental health outcomes.

We strongly support CalAIM's recognition that Medi-Cal eligibility criteria should be driven not just by diagnosis, but also by "level of impairment or a set of factors across the biopsychosocial continuum" (CalAIM Proposal, p. 75). **We urge DHCS to clarify that level of impairment and/or biopsychosocial factors will drive not only the choice of delivery system, but also whether a Medi-Cal member is eligible for services.** Providers in either delivery system who identify youth who have emerging mental health conditions, exposure to trauma, and/or other SDOH must be reassured that they can be reimbursed for providing appropriate follow up assessments and interventions to address these factors before the youth's mental health challenges deteriorate into a diagnosable disorder.

In developing a statewide tool for children under age 21, the only criteria that should be required is the federal EPSDT criteria, now incorporated into state law, as all children are entitled to any mental health or SUD services that are necessary to correct or ameliorate their condition. Given the breadth of this federal obligation, the requirement that a child have a particular diagnosis or impairment level cannot be imposed if it prevents a child or youth from receiving such necessary services. This is particularly a problem given that many mental health services children and youth need, and are entitled to, can only be accessed through the SMHS "carved out" system and are not available from the MCPs. Given this, impairment level (e.g. mild, moderate or severe) or diagnosis cannot be determinative of whether a child can get access to the service.

Further, confusion is created related to determining medical necessity by the introduction of the designations of "mild, moderate and severe" that are established based on the adult system of care and the expansion of Medi-Cal services through the ACA. There continues to be confusion regarding this, and the CalAIM proposal continues to use this language to distinguish between service levels provided by MCPs and MHPs (CalAIM Proposal, p. 75), further exacerbating the confusion regarding children's access to services based on state and federal law. This is true for both mental health and substance use services for children and youth. DHCS has provided guidance on this, but there continues to be confusion in the delivery of services. Additional communication and training are clearly needed for MHPs, MCPS and providers to ensure that this mandate is clear. The state should immediately act to issue guidance to all

MHPs instructing them to approve any requests to provide EPSDT covered services when such services are medically necessary, as defined in federal law and newly enacted state law, codified in Welfare & Institutions Code § 14059.5(b)(1).

The current gaps in service access for children and youth exist due to several issues, beginning with the definition of medical necessity. Implementing and holding MHPs and MCPs accountable to the state and federal laws that govern the EPSDT benefit is the first step to closing the gap. Other structural issues that further limit access include (but are not limited to):

- MHPs' understanding that they are working under "capped" allocations through Realignment and therefore do not have the funding available to provide the full array of services to all resident children and youth that need them.
- Contract limitations (MHPs with service providers) that do not allow providers to serve children and youth widely. For example, a provider is contracted to serve a school, but if the provider is serving a child and identifies a sibling that needs service but does not attend that school, the service provider cannot provide services to that sibling.
- Contractual limitations (MHPs with service providers) that result in providers not being able to go over their contract amount even if they identify children in need of service within all of the other contract parameters. This is a clear violation of EPSDT law, but MHPs are under the fiscal scrutiny of their CAO and Boards of Supervisors with regard to staying within their realigned fiscal allocations.

There are limited options for addressing these gaps in the current structure of the behavioral health system and ensuring that all eligible children and youth can access the right service at the right level at the right time. While MOUs exist between MCPs and MHPs that should result in beneficiaries having access in one or the other system, there are widespread variations in how this gets applied throughout the state.

CCT and the Alliance urge DHCS to consider structures that ensure the full EPSDT benefit is available through both MCPs and MHPs. Coordination of these services could be improved if service providers were able to access consistent rates across both delivery systems. Currently, rates available through MHPs are generally higher than those available through MCPs. Organizational providers would certainly be interested in providing more services through MCPs if rates covered the costs of providing a service. As DHCS, through the CalAIM workgroup

process, develops more detail regarding payment reform across the Medi-Cal system, this will be a crucial point to discuss and resolve.

Recommendations Regarding Medical Necessity

1. Establish clear expectations and amend language in statute, State Plan Amendments, and contracts with MCPs and MHPs to require that all plans follow the laws governing the EPSDT benefit for mental health and SUDs

The EPSDT framework is centered on the principle of early intervention, as evident in the requirement that states provide “early and periodic screening, diagnostic and treatment services,” including all “necessary health care...to correct or ameliorate...mental illnesses and conditions” (42 USC 1396d(r)(1)). Unfortunately, current California statutes (e.g., Title 9), State Plan Amendments and the DHCS/MHP contracts have language that contradicts how this federal entitlement is enacted. As part of the CalAIM process of implementation, CCT and the Alliance recommend ensuring that all references that limit access to the EPSDT benefit for youth under 21 be removed to reduce any possible confusion moving forward.

2. Foster and justice-involved youth should be presumptively eligible for the full range of EPSDT services (mental health and SUDs)

Based on the level of trauma experienced by children and youth in foster care, and for most justice-involved youth, there should be an assumed eligibility for EPSDT services. An “opt-out” requirement would ensure that every child or youth in our public systems received, at minimum, a screening to determine their need for a behavioral health intervention. This type of screening should also occur regularly for these youth given that the child’s emotional growth and development may interact with a child’s response to trauma.

3. Establish a clear and standardized pathway from developmental and trauma screenings to further assessment and early intervention

Federal EPSDT law requires that all youth receive screenings pursuant to established periodicity schedules. These screenings enable practitioners to identify risk factors and indicators of problems associated with future onset of mental health disorders. Early detection provides a critical opportunity for preventative intervention, before risk factors or symptoms reach a diagnostic threshold. Therefore, we applaud California’s recent decision to provide Medi-Cal

coverage for trauma screens such as the Pediatric ACEs and Related Life Events Screener (PEARLS).

In order to ensure that PEARLS and other screens will bring tangible benefits to California's youth, DHCS must also ensure providers will be reimbursed for providing follow up assessments to better understand the challenges identified by these screenings. Unfortunately, currently, there is no standard pathway to ensure that screening results are used to intervene before risk factors and signs of distress become severe problems that interfere with a child's daily life and well-being. **We therefore recommend that DHCS create a clear pathway to follow-up assessments for youth with SDOH known to place the youth at risk for a mental health condition.** Drug Medi-Cal managed care plans already use a similar approach when evaluating substance use conditions: the American Society of Addiction Medicine (ASAM) Level of Care tool, which is used by all Drug Medi-Cal ODS plans, includes a "0.5" level of care that identifies youth "at risk" of developing a substance use condition.

4. Establish a condition-based eligibility category for Medi-Cal managed care and specialty mental health interventions

We applaud CalAIM's proposal to move away from diagnosis-based eligibility and towards a system in which a youth's eligibility for services is based upon their level of impairment and/or biopsychosocial factors. This shift away from diagnosis-dependent eligibility is mandated by federal law, which requires states to provide all services that are "necessary" to "correct or ameliorate" a child's mental health "condition."¹ EPSDT law does not require that the condition be severe enough to constitute a diagnosable disorder.

Robust implementation of this federal mandate is critical because it will enable providers to intervene early, when they have the opportunities to alleviate the effects of stressful circumstances or events that -- if left unaddressed -- are likely to cause mental health problems. We know, for example, that Adverse Childhood Experiences (ACEs) correlate with developmental delays, behavior problems, and injuries. Yet, the current diagnosis requirements prevent providers from addressing these factors until the youth's mental health has deteriorated to the point of meeting criteria for a mental health disorder. This systemic flaw is particularly evident in the case of children in foster care; even though all foster youth qualify for Medi-Cal -- and have endured significant trauma, such that most need behavioral health

¹ 42 USC Section 1396d(r)(5)

interventions -- only about one-half of foster youth receive any Medi-Cal Specialty Mental Health Services.

Intervening early to address emerging mental health challenges will not only alleviate or prevent mental health problems, but also bring long term cost savings. A joint analysis by the National Academies of Sciences, Engineering and Medicine determined that every **\$1 investment** in prevention and early intervention for mental health illness and addiction programs yields **\$2 to \$10 in savings** in health costs, criminal and juvenile justice costs, and low work productivity.

5. Ensure a broad range of providers beyond primary care are trained and equipped to deliver trauma screening for children

In order to reach children who may not be brought to a pediatrician for a well-child visit or who may exhibit signs of distress only at child care, school or in other areas of life, **we encourage DHCS to expand the providers able to deliver EPSDT-covered trauma screening to early childhood providers such as day-care providers and pre-school and K-12 teachers.** Schools represent some of the most effective opportunities for early detection and intervention at the first sign of struggle. Ensuring that the condition-based eligibility recommendations above are effective at triggering appropriate prevention and early intervention services is predicated on the opportunity to deliver screening, assessment and linkage services in early childcare settings and in schools.

6. CCT and the Alliance recommend that DHCS form an expert workgroup to develop criteria for an “at-risk” eligibility category that qualify youth for appropriate follow up assessments

We recommend that DHCS and the workgroup consider the following approaches to determining children who are “at-risk”:

- a. An “Intermediate Risk” Score on an ACEs screen, or referral pathway algorithm using the PEARLS, as was established in the CYW Adverse Childhood Experiences Questionnaire (CYW ACE-Q);
- b. A list of ICD-10 T- and Z-codes reflecting exposure to trauma and other SDOH, such as but not limited to child abuse (covered in 16 T-codes), and codes for problems identified by an ACEs screen (e.g. Z59.4 Food insecurity; Z63.0 Domestic violence; Z62.819 History of abuse; Z63.72 FH alcohol/drug abuse; Z81.8 FH mental disorder; Z63.32 Imprisonment).

Finally, **we recommend that plans be required to gather data regarding youth who have been identified as at risk of developing a mental health condition and to monitor whether they receive appropriate follow up assessments and interventions.** Plan reimbursement should be based in part on a plan's rates of success in ensuring these youth receive appropriate early interventions.

7. Offer guidance that includes representative examples of the types of mental health conditions that can qualify a youth for services

Although DHCS has acknowledged that EPSDT laws require youth to receive all services necessary to treat mental health "conditions" (CaAIM, p. 78), DHCS has not yet clarified for providers the types of conditions they may treat when the child does not have a diagnosis.

Without further guidance from DHCS regarding this question, the distinction between a "condition" and a diagnosable disorder remains poorly defined, and many providers will remain reluctant to deliver interventions that address emerging mental health challenges. In order to assure providers that they can be paid for delivering care to alleviate a mental health condition, we urge DHCS to provide representative examples of mental health conditions that could be addressed with a reimbursable Medi-Cal service. CCT and the Alliance recommend that DHCS form an expert workgroup to develop guidelines to define conditions that should entitle youth to services. This same workgroup can also be tasked with developing the "at-risk" criteria described further in the following recommendation.

One example of a mental health condition that should qualify a youth for services is a score of 2 or 3 on any need identified in the Child and Adolescent Needs and Strengths (CANS). On the CANS, a score of 2 on a need specifically indicates that "action [is] needed." Federal EPSDT law requires coverage of all services "necessary" to correct or ameliorate a mental health condition identified on a screen; DHCS therefore should clarify that services to address needs with a CANS score of 2 or 3 should be considered "necessary" and therefore reimbursable under EPSDT standards. Of course, a need identified on a CANS is just one example of a condition that must entitle a youth to services; problems identified on other empirically supported childhood assessment tools also must qualify a youth to services that address those needs.

Additionally, EPSDT requires coverage of all services that are "necessary" to address those conditions – not just treatments that are "medically necessary." As a result, DHCS should clarify that, depending on the need identified, reimbursable services to address that need can include

not only mental health care such as follow-up assessments and therapy, but also case management to link the youth and their family with economic supports and other community services.

Recommendations for Standardizing Level of Care Assessment Tools

1. *CCT and the Alliance recommend that CalAIM establish a workgroup or taskforce specifically focused on identifying the Level of Care tools*

- a. There needs to be a thoughtful and organized approach to identifying research supported tools, especially if the goal is to have statewide tools in use - DHCS should have a specific group comprised of experts on children's clinical tools that develops these**

Given how critical a decision-making tool this will be for beneficiaries and the broader system, it seems important that DHCS and its stakeholders garner the current knowledge on potential LOC tools, compare them, and bring stakeholders together to more fully discuss. The timeline for deciding on tools is tight, but it is essential to think carefully about what tools will most effectively determine the level of care needed for beneficiaries. The developers of specific tools should be excluded from the work group due to perceived conflict of interest. And the only LOC tools for consideration should be those validated by psychometric and data driven process.

Since the CANS is being implemented throughout the state, it should certainly be considered. Other potential LOC tools such as the LOCUS, CALOCUS, and the CASII should be compared and contrasted to the CANS, to determine their overall effectiveness as a LOC tool. Similarly, for Adults, the ANSA; and for adults and youth who are facing substance use issues, there are tools such as ASAM that could be considered. We also recognize that there is not a separate research supported tool specific to youth facing substance use issues. It is important, however, to ensure that we have identified the most effective tools that are also culturally responsive and easy to complete.

There does need to be greater development of these tools to shape how the scoring will determine a youth's level of care. Other states have done this, and it would be helpful for stakeholders to see an environmental scan of other states. One example of use of the CANS as a level of care tool is in New York's Health Homes for Children². It is our understanding that the

² <https://tcomconversations.org/2017/01/11/tcom-algorithms-for-decision-points-in-care/>

process of using the CANS in this way should be based on algorithms across the population of children and youth for whom the CANS has been administered.

b. There are tools being used across California now, and other states that could be reviewed and vetted fairly quickly

Given the state's goal of identifying tools and implementing the chosen assessment tool by January 2021, a short but intensive process makes sense to ensure that DHCS considers tools that California may not be using, or that are being used successfully in parts of the state.

c. Ensure that LOC tools are used only as needed to determine the need for higher level services

Throughout the discovery and review process, we encourage DHCS to remain cognizant of not placing additional administrative burdens on clinicians, providers, MHPs and MCPs to complete LOC tools for early intervention and outpatient services. As Dr. Pfeiffer suggested at the December 20 meeting, using these tools to determine the need for more intensive services such as day treatment or inpatient settings, makes sense. Using these tools when outpatient levels of service are not meeting beneficiaries' needs will limit additional paperwork burdens placed on service providers.

d. Develop Statewide tools for identifying both the medical necessity and service level for inpatient, Community Treatment Facilities, STRTPS and other hospital alternatives for children and youth

With the closure of inpatient facilities for children and youth, and the Continuum of Care Reform for children and youth in child welfare and probation systems, there is a dearth of available programs that to serve youth in acute crisis at the intensity and duration that is needed. And for youth that are identified through the MCP or MHP, many are often cycled through facilities multiple times rather than gaining the stability needed to move to a lower level of service. As with outpatient services, access to the full continuum of services needed is not consistent across counties or plans. For example, due to concerns about audit exposure based on audits in the early 2000s, MHPs have been reluctant to implement day treatment programs that may effectively reduce the need for residential care. This gap in the continuum has likely resulted in increased costs to counties, necessitating paying for these programs through other funding streams, despite the services being eligible for EPSDT reimbursement and federal financial participation.

2. Screening and assessment tools for SUDs must support the EPSDT medical necessity definition

An environmental scan of available services for youth with substance use issues would surely demonstrate the limited number of services throughout the state, and the need for a more robust continuum of services from early intervention to residential treatment programs. Without having completed a full review of providers, we are aware of at least two Bay Area providers who have closed their residential programs due to a lack of adequate funding and referrals from MHPs and MCPs in spite of steady numbers of youth involvement in drugs and alcohol. The California Healthcare Foundation’s 2017 publication, *California’s Public Substance Use Disorder Treatment System for Youth: An Overview*, outlines that 8% of youth (the same percentage as adults) have a diagnosable substance use disorder. Additionally, the authors indicate that “due to the complex nature of the state’s Medi-Cal program and the unique role of counties in administering components of it, including SUD treatment, accessing covered services has proven to be challenging for many youth and their families.”³ CHCF recommends use of the SBIRT for screening and use of the CRAFFT as an assessment tool.

3. Implementation of any new level of care tool must include funding for nonprofit providers

Previous implementation of assessment (e.g., CANS) and other tools has limited state budget allocations to funding counties in their implementation. Rarely have nonprofit service providers been given additional financial support to pay for the cost of implementing and maintaining the necessary infrastructure, staffing and training required to use these tools and report on their results. It is critical that this funding come with the current and any additional requirements placed on service providers.

4. Any level of care tool DHCS adopts must ensure that providers screen for and address Early risk factors and other social determinants of health

We urge DHCS to ensure that the Level of Care tool it chooses will guide mental health staff in screening for and addressing risk factors such as exposure to trauma and other Social Determinants of Health (SDOH). Assessment tools such as CANS, for example, explicitly direct clinicians to ask beneficiaries about key SDOH. In contrast, while the CALOCUS does allow providers to incorporate some SDOH information as part of its “Recovery Environment” scores, it does not require clinicians to ask beneficiaries about specific SDOH and it does not direct

³ California’s Public Substance Use Disorder Treatment System for Youth: An Overview, CHCF, 2017

clinicians to quantify associated needs individually, as the CANS does. As a result, practitioners using the CALOCUS are far less likely to identify and address needs related to exposure to trauma, economic stress, and other key SDOH. In addition, even the terminology used by the CALOCUS – such as “Recovery Environment” – results in a bias toward waiting to treat youth until after their mental health challenges have deteriorated to the point of requiring “recovery,” rather than focusing on early identification and treatment of emerging mental health conditions. We therefore urge DHCS to incorporate into the Level of Care tool it chooses components that require practitioners to gather information regarding key SDOH and to quantify needs associated with those risk factors.

Recommendations on “No Wrong Door”

A “no wrong door” approach is a step in the right direction but still reflects a fundamentally fragmented system approach for children and youth.

There is confusion throughout the system about whether a child in need of services should be referred to the managed care plan or the county mental health plan. While CalAIM has established the intention that all children, youth, and families would receive services through a “no wrong door” approach regardless of which system is ultimately responsible for their care, this does not address the fundamental fragmentation of multiple delivery systems nor the interoperability to make this happen.

1) DHCS should establish a workgroup specifically focused on the behavioral health system for children and youth

As has been stated in CalAIM workgroups, it is essential to distinguish between the adult and children’s systems as DHCS designs that statewide structure for the coming decades. Similarly, the design and development of a “no wrong door” approach will require focused review of successful models, and potentially testing of regional approaches to ensure that the necessary infrastructure and other system components do not serve as barriers to accessing services. To that end, CCT and the Alliance recommend that a separate workgroup be developed to focus on building this no wrong door approach that includes the expertise of provider organizations, CWDA, CBHDA, NHELP, and other children’s advocacy and parent groups who have interacted with the current system.

2) Explore a new approach for children and youth behavioral health: Regional Children and Youth Administrative Organizations

The most significant system reform in services for children and youth is the need to ensure that they receive timely access to services within the robust array that exists, as well as any additional services that are medically necessary. One approach, given both MCP and MHPs need to pay for all EPSDT eligible services, is to design a regional entity, such as an Administrative Services Organization (ASO), for all Medi-Cal-eligible children and youth. This is similar to the model adopted by New Jersey for its children's system of care, which could be piloted in California for foster youth (see below recommendations for the foster care workgroup proposed by DHCS) but would ideally be a system mechanism to better serve all children and youth.

An ASO model would allow children and youth to be seen at a provider service organization, billed to the ASO, and the ASO would be responsible for identifying the payor and claiming for the service. Rejected claims would be reviewed by the ASO, and a determination made regarding next steps (e.g., consult with DHCS on MCP/MHP denial when child meets EPSDT criteria). Washington and New Jersey have developed statewide models for children's Medicaid funding and distribution that California could use as a model, after careful consideration of the pros and cons and whether this model would be appropriate for California's children.

Additionally, these regional entities could contract for the Enhanced Care Management for children and youth. Given the expertise needed to navigate the complexities of children's systems, having these entities provide child-specific ECM would be of significant benefit to children and youth.

Clearly, a full planning process for a system that truly meets the physical and behavioral health needs of children and youth is critical given the federal entitlement and financing mechanisms.

Next Behavioral Health Workgroup Meeting

At the December 20 Behavioral Health work group, the question was posed "What research and/or deliverables should DHCS prepare for the next meeting?" CCT and the Alliance recommend that DHCS provide background and research on the following:

- Any feedback from other states that have successfully increased access to services through amending their definition of medical necessity? Additionally, any states that have successfully met the EPSDT benefit requirements, and how they have done this.

- DHCS should provide research from other states on their level of care tools (for both mental health and SUDS/adult and youth), their success, and whether these tools have increased access to services or further limited them.

Thank you for your consideration of these recommendations and comments, and for your work to improve our state's most important safety net for children and families. We look forward to continuing to stay engaged in the CalAIM process and ensure the final proposal reflects California's commitment to ensuring that young people are given everything they need to grow and thrive.

Sincerely,



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