



February 21, 2020

Via Email: [Jacey.cooper@dhcs.ca.gov](mailto:Jacey.cooper@dhcs.ca.gov)

Attention: Jacey Cooper, State Medicaid Director and Chief Deputy Director of Health Care Programs

California Department of Health Care Services

1501 Capitol Avenue, MS 4000

Sacramento, CA 95899

**RE: Behavioral Health Integration: Right Place, Right Care: screening, assessment, no wrong door, medical necessity, and administrative and clinical Integration**

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 Medi-Cal Healthier California for All (MHCA) 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 145 nationally accredited, private nonprofit agencies dedicated to achieving progressively better outcomes for vulnerable children, youth and families in public human services systems.

Our comments in this letter focus on items discussed at the January 29 and 30 Behavioral Health Workgroups including screening, assessment, no wrong door, medical necessity, and administrative and clinical integration priorities.

**Screening, Assessment and Pathways into Care**

In behavioral health - especially children's behavioral health - science and best practice agree: we must shift from a diagnosis-driven system to an approach that is responsive to the level of impairment and one that accounts for the impact of trauma, Adverse Childhood Experiences (ACES), and social determinants of health (SDOH) on long-term and mental health outcomes.

CCT and the California Alliance are in support of DHCS' proposal to move away from the current state requirement that a full assessment must be completed prior to providing care, given the resulting barriers to care. Initial screening, followed by a validated assessment within 30-60 days while services are provided to stabilize and begin treatment, is the most responsive approach and can avoid unnecessary emergent issues developing.

It is important to separate the discussions and decision-making processes for screening versus assessment tools. A screening tool is a brief questionnaire that would ask questions in order to determine if further behavioral health assessment is needed. CCT and the Alliance support the idea of using a universal screening tool (one for children and youth, one for adults) to determine if further assessment is needed, or to rule out the need for additional assessment. SAMHSA has several examples of screening tools that could be utilized for screening<sup>1</sup>, and several suggestions regarding screening tools currently used by MHPs/MCPs that were made during the Behavioral Health Workgroup could be considered.

Once a child, youth or adult is determined to be in need of further assessment, it would be helpful to have **a very limited number of assessment and level of care determination tools** throughout the state. Given that the Child and Adolescent Needs and Strengths (CANS) tools is currently being used by MHPs and child welfare departments throughout the state, it seems to make sense that we first consider its use to determine levels of care (LOC) for children and youth. If there is strong opposition to this, then CCT and the Alliance recommend that DHCS establish a workgroup or taskforce specifically focused on identifying the Level of Care tools for both mental health and substance use. There needs to be a thoughtful and organized approach to identifying research supported tools, especially if the goal is to have state-wide tools in use. **DHCS should have a specific group comprised of experts on children's clinical tools that develops these.**

Similarly for adults, if there is a tool being used currently by a large number of counties (e.g., ASAM for SUD) that is validated, it makes sense to move to one assessment tool across counties, and build in an evaluation process to determine if the tool is being used effectively over the course of several years.

Use of validated screening and assessment tools is the first step in best practice to determine what, if any, mental health services a person needs. Obviously, there are also urgent needs that require immediate response and risk assessment. Ensuring that all medical, access line or other

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<sup>1</sup> <https://www.integration.samhsa.gov/clinical-practice/screening-tools#sample%20screening%20forms>

“front door” personnel are trained in screening and initial risk assessment is critical to getting individuals to the right level of care at the right time.

Additionally, it is essential to think about the whole person (adult or child) within their social, economic and educational context. What are the social determinants associated with the mental health or substance use issue that is arising? Once a screening identifies a need for further assessment, the most effective assessment will include an approach similar to Wraparound in which all life domains are considered.

### **Adverse Childhood Experiences (ACEs)**

CCT and the Alliance support the idea of incorporating ACEs into the framework for determining medical necessity for specialty mental health services for children. In particular, where the child’s ACEs are determined by a clinician to have a significant impact on the child’s current mental health, we would support expanding eligibility to specifically name ACEs as part of eligibility for county specialty mental health services. We believe that utilizing ACE scores provides a method of ensuring that social determinants of health are being considered during assessment and determination of service need.

### **Ensuring High Risk Children and Youth Have Access to Care**

We believe the best way to ensure all high-risk kids (including foster youth) have streamlined access to specialty mental health care is to implement presumptive eligibility. This would remove the barrier that is currently in place for having to demonstrate moderate to severe impairments for clients to receive services from the MHP; or a method that assumes inclusion until a client is ruled out for SMHS. **Presumptive eligibility for youth in public systems, such as foster care or probation**, would be one approach to determining what youth would become eligible by virtue of their experiences. Universal trauma screening for children 0-5 would also allow for early detection of mental health needs and allow for presumptive eligibility to be applied based on the risk of entering foster care.

As we tackle the issue of MediCal eligibility for children and youth at high risk of behavioral health issues, it is critical to address the significant needs and gaps in the commercial insurance system. In the most desperate situations, we have seen families unable to access care result to relinquishing their children to child welfare in order to ensure that they have access to the full array of EPSDT services because these services are not available through their employer-based insurance.

### **No Wrong Door**

CCT and the Alliance support the No Wrong Door concept put forward by DHCS for both children and adults. 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. Unfortunately, no specific plan has been identified in the MHCA proposal or through the workgroups that can successfully accomplish this to date.

One approach that we recommend be considered, given both MCPs and MHPs need to pay for all EPSDT eligible services, is to pilot an administrative service entity that would serve a coordination, access, and service function for all Medi-Cal-eligible children and youth. This could be piloted for foster youth but could eventually be a system mechanism to better serve all children and youth. Further discussion is needed on this and could be accomplished through the Foster Youth Workgroup.

This kind of model would allow children and youth to be seen at a provider service organization, billed to the regional service entity, and the entity would then be responsible for identifying the payor and claiming for the service. We would like to see DHCS review other states models (e.g., New Jersey, Washington) that have developed approaches that ensure access to services through similar structures.

***MCPs must have full access to the EPSDT benefit claiming codes***

If there is not an alternative service delivery structure that is ultimately adopted, and California continues to use a bifurcated system of MCPs and MHPs, there must be access to EPSDT services and claiming on both sides of the system. In order to truly have a “No Wrong Door” approach to serving children and youth, we reiterate our recommendation from our January 28, 2020 letter regarding MCPs having full access to the EPSDT benefit claiming codes. Currently, many MCPs cannot utilize the necessary EPSDT claims codes for services outside of individual or group therapy. While the law may require that they provide the services, the mechanisms to claim for them must also be in place. It is critical to understand that the EPSDT benefit has not been implemented per federal law by the MCPs. For example, the EPSDT eligibility criteria was not considered as MCPs added children and youth into their systems. This has led to a lack of available services through MCPs, and as the recent auditors’ report indicated, “Despite the importance of these services, the use—or utilization rate—of preventive services by California’s children and youth in Medi-Cal has been consistently below 50 percent and is ranked 40th in the country—nearly 10 percentage points below the national average. In addition, despite efforts by the Department of Health Care Services (DHCS)—the state agency tasked with overseeing Medi-Cal—the utilization rate in California has not improved since fiscal year 2013–14.”

### ***Value of Peers and Unlicensed Staff in Improving Outcomes Must Not Be Overlooked***

In light of California's behavioral health workforce shortages, expanding our supply of behavioral health workers must be a top priority. We urge DHCS to keep this goal in mind when developing the No Wrong Door approach and integrating mental health and SUD administrative requirements. MediCal's non-clinical mental health provider categories such as Mental Health Rehabilitation Specialists and Other Qualified Providers, for example, offer effective mechanisms for not only extending California's behavioral health workforce, but are invaluable members of a service team. New integrated certification requirements should expand in particular the roles of peer support specialists. Studies demonstrate that the use of peer support specialists in comprehensive mental health or substance abuse treatment programs helps reduce client hospitalization, improve client functioning, increase client satisfaction, alleviate depression, and diversify the workforce.

### ***Artificial Limits on Clinical Staff in MCPs***

Additionally, not all MCPs will allow non-licensed but registered interns (ASW, MFTI) to provide and claim for services. While there is no federal or state limitation on this, MCPs have reported that the reason for this is that they are following Medicare standards which have these limitations. In fact, the Medi-Cal Manual on Psychological Services (August 2016 | Bulletin 491) indicates that "Marriage and family therapist interns, registered associate clinical social workers and psychology assistants may render psychotherapy services under a supervising clinician." Incentivizing and/or mandating that MCPs allow services to be provided by this broader group of trained clinicians would significantly increase the access to services available in their network.

### ***SUD System of Care for Youth***

As we tackle the No Wrong Door concept, we also must acknowledge the fact that there is not a SUD system of care for youth in California. This is an urgent issue. According to a 2018 report by the California Healthcare Foundation, thirteen percent (13%) of youth ages 12-17 reported using marijuana in the past month (for ages 18-15, 34%), and 9.1% report using alcohol (for ages 18-25, 54%). Given DHCS' and the Governor's desire to reduce the prevalence of behavioral health disorders, intervening earlier and ensuring access to the full range of SUDS and SMHS services is essential. According to NIMH, "[t]he likelihood of developing a substance use disorder is greatest for those who begin use in their early teens. For example, 15.2 percent of people who start drinking by age 14 eventually develop alcohol abuse or dependence (as compared to just 2.1 percent of those who wait until they are 21 or older)."

As DHCS moves to integrate SMHS and SUDS at the county level, it is critical that the EPSDT benefit is utilized to develop and ensure access to both SMHS and SUDS services based on the medical necessity definitions developed through the MHCA process. Any barriers to a child or youth accessing the full array of services to meet the EPSDT entitlement must be addressed through this process of integrating services under one system. **Specifically, we recommend that substance use treatment should be formally integrated into the EPSDT benefit and new resources should be provided by the State for the non-federal share of the expenses.**

### **Delivery System Recommendations**

Without clear expectations, accountability and personnel responsible for care coordination, it will be difficult to avoid a “ping-pong” effect between systems. As suggested, having a regional entity that is responsible to ensure that service delivery occurs and then works with the MHP/MCP to resolve payment, is one possible approach. We further underscore that having MCPs folded into the AB 2083 process that is currently being implemented could improve communication and coordination between systems. This process requires that all youth serving entities develop MOUs that ensure collaboration across systems.

Determining how to manage a child’s care between two very different systems (MCP and MHP) with varying levels of care is difficult at best, and will potentially result in less, not more and better care at worst. **One potential approach for sub-populations like foster care youth would be to build an integrated care system such as what the Inland Empire Health Plan (IEHP) has designed.** IEHP has liaison positions dedicated to working between the IEHP and the two MHPs (Riverside and San Bernardino) in their region. For youth in foster family care, it appears that this approach has improved access to healthcare for children and youth in the Inland Empire. While behavioral healthcare may need additional care coordination, this type of structure may be one to consider. The key to success is ensuring that the two systems are working closely together, which becomes much more difficult in counties where there may be as many as five MCPs operating.

### ***Schools are a first place for identification and screening***

Because children and youth may be first identified through school rather than at a doctor’s visit, it is important to identify how school personnel or service providers (CBOs providing mental health or support services) can screen and assist students and their families in accessing services. Given the number of youth whose behavioral health needs get identified at school, there must be a way to provide the needed behavioral health service at the school, without concern for how it will be paid for later. Currently, many school-based Specialty Mental Health Services providers are prevented from serving Medi-Cal eligible youth if their needs are

assessed as “mild or moderate”, because some counties require that these youth be referred to MCPs. The administrative service entity described above could ensure that all eligible students can be served at school. Alternatively, the MHP could be the “front door” for ensuring that services are rendered. Once it is determined which system is responsible financially for the child, the services are reimbursed. This would also **require that DHCS mandate that school-based behavioral health services be a covered benefit**. Critical to addressing the youth mental health crisis is increased funding for mental health and social-emotional supports for children and families in their communities. **This means a dramatic increase in the scope and nature of programs available in schools**. We urge DHCS to take full advantage of the opportunity that the Intergovernmental Transfer proposal offers by playing a leadership role in marshalling existing sources of state and local funds that could be used to earn additional federal Medicaid funds in school settings.

The coordination between systems will need different approaches for adults and children, simply because of the EPSDT entitlement. However, adults need to be able to access the right services to meet their individual needs regardless of which system they are engaged with first. Some of the same general approaches, such as liaisons between the two systems, can work both for adults and children and youth. In particular, for transition-aged youth, it is a critical time to be able to access care. The regional administrative service coordination entity approach could certainly work for adults as well. This coordination could be provided by a community-based organization, MHP, MCP, or other entity based on the region and community needs.

#### **Administrative and Clinical Integration:**

As DHCS moves forward in integrating SMHS and SUD services through one contract with MHPs, assessing comparability of service definitions, and considering billing and claiming changes, CCT and the Alliance urge DHCS to focus equal attention to service integration. This is our opportunity to consider the client’s experience in our system of care and build out a new system that is truly consumer centered.

#### ***Service Definitions and Coding***

As DHCS looks to build the SUD system of care for youth, DHCS should use claiming codes that work for youth receiving services for SMHS or SUD. This will simplify the process and allow the state, counties and providers the opportunity to begin providing services as quickly as possible. There may be some specific services for SUD that will need distinct codes (e.g., Narcotic Treatment Programs), but many of the current SMHS codes can be used for services to the SUD population.

Developing a complete crosswalk that allows for comparison of the various service definitions, and looking at areas in which comparable services such as day treatment and intensive outpatient could use the same code, will be essential in developing a detailed plan.

Additionally, there have been several requests for DHCS to provide a crosswalk between the current HCPCS codes used (Level 2) and HCPCS Level I/CPT codes. Without this level of detail provided within the context of the workgroups, it is not possible to have a full discussion of just how to ensure that there is a level of comparability needed to ensure that the full array of services can be claimed and billed as we make this transition.

### **Recommendations on Audits and Ensuring Quality of Care**

#### *Alternative Fraud Detection Strategies*

We applaud DHCS's goal of streamlining provider administrative burdens and we support alternative measures that enable DHCS to fulfill its responsibility to identify intentionally fraudulent billing patterns without imposing unnecessary paperwork burdens on providers. We recommend that DHCS **look first to the documentation and fraud detection measures it implements for medical services, and then add only those additional paperwork requirements that are clearly required by federal law.** Any administrative burdens beyond the processes used for medical and surgical claims would constitute a violation of federal mental health parity standards. The federal Mental Health Parity and Addiction Equity Act (MHPAEA) prohibits health plans from imposing "non-quantitative treatment limitations" (NQTLs) on mental health services that are more stringent than comparable limitations on medical and surgical services. Impermissible NQTLs include "processes" required for mental health services that create greater restrictions on the "scope or duration" of services (45 CFR §146.136(c)(4)). Because current SMHS documentation rules require mental health practitioners to spend significantly more time documenting their services, and therefore allow mental health staff much less time to deliver care, we believe current SMHS documentation requirements constitute NQTLs that violate MHPAEA.

To the extent DHCS is required to monitor Medi-Cal billing for evidence of fraud, **outlier claims analyses** should allow DHCS to identify evidence of potentially fraudulent billing. While current documentation requirements demand excessively detailed scrutiny of the documentation itself, outlier claims analysis constitutes a more objective tool better suited to finding evidence of purposely fraudulent activity.

#### ***Use of Performance Outcome Standards***



As DHCS moves towards a more client centered approach to services and reduced documentation burden, the use of outcome data is the best method of ensuring quality care. For children and youth, a POS workgroup was developed several years ago, but there has been little movement in implementing standards statewide. Using data from tools such as the CANS, data on penetration rates, and other outcome data will help DHCS to monitor quality of care. The reality is that currently, quality of care cannot be ascertained based on the documentation that is being provided.

### **Other Recommendations:**

#### ***Reimbursement Rates***

CCT and the Alliance strongly urge the state to ensure **transparency and stakeholder input on the rate structures as they are developed, as this is one of the most essential components of whether or not this transformation leads to better care, and greater access to care.** Given that IGT will change the way in which MHPs are reimbursed for services and that there will be the opportunity for savings to reinvest in the local MediCal services, we urge the state to incent MHPs to similarly allow service providers the ability to utilize savings to support their organizations' ability to invest in infrastructure, quality improvement and services not funded through current claiming processes. The current system of cost reimbursement results in providers not maximizing their contracts due to suppressed rates, and when the contracts are not fully utilized, they get reduced due to low productivity. If unit rates for services are not competitive, providers cannot pay competitive salaries, and then cannot maximize contracts.

#### ***Reimbursement for Staff Travel***

We strongly recommend that **staff travel for both mental health and behavioral health services be reimbursed at the same rate as the underlying service** provided. To ensure DCHS can gather data regarding service delivery time that is separate from travel time, providers could bill travel time with an "add-on" billing code that is linked to the underlying service.

Full compensation for staff travel time is essential to the success of any community-based service. This is particularly true for services such as Wraparound programs, because a high proportion of these interventions are delivered in the community, including family homes, schools, and neighborhood centers. Any restriction on compensation for time spent travelling would seriously impair the ability of staff to meet with clients and family members in locations that are accessible to them.

Lower rates for staff travel time would threaten access to care for foster youth in particular. Many foster youth in Wraparound programs, for example, have been placed outside their county of origin. As a result, staff working with these individuals often must travel especially long distances in order to meet with the youth and/or their family members.

**Mobile Crisis Response Team (MCT) programs similarly depend upon staff travel as a vital service component.** These programs run crisis hotlines, but whenever a crisis cannot be resolved over the phone, an MRT will travel promptly to the site of the crisis, wherever it may be, including a home, school, or emergency room. A member of the team can continue to talk with the family member or adolescent in crisis as they drive to the youth's location. MRTs are highly effective in helping youth stabilize in the least restrictive, most nurturing setting possible. The expenses of MRT programs, which include extensive travel time, have been proven cost-effective. One study, for example, found that a mobile crisis program, as compared to regular police intervention, demonstrated an average of 23% lowered costs to the system.<sup>2</sup>

In conclusion, CCT and the Alliance would like to thank DHCS for your consideration of our recommendations and feedback related to proposed MHCA reforms. We look forward to continuing to stay engaged in the process and ensure the final proposal reflects California's commitment to ensuring that young people are given everything they need to grow and thrive.

### **Timeline, Phases, and Communication**

We support DHCS' timeline in terms of the integration phases. We view this timeline as ambitious and as noted in previous comments, we believe that DHCS should prioritize several complimentary tasks that have the greatest potential to support the activities in each of the phases. Specifically:

- Implementation will be more successful if provider staff, county staff, MCP staff, and State staff all receive the same standardized education and training for application of medical necessity and level of care criteria;
  - Even with standardized training, there will be disagreements between providers and payers regarding the correct Level of Care for a particular client in a particular situation.
- California would benefit from having a committee and process continuously working**

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<sup>2</sup> Scott, R. L. (2000). Evaluation of a mobile crisis program: effectiveness, efficiency, and consumer satisfaction. *Psychiatric Services*, 51(9), 1153-1156.

**on interrater reliability and resolution disputes.** We strongly recommend that DHCS set up something like this.

Thank you for your consideration of the above feedback and recommendations, and for your leadership in making mental health and substance use disorder integration a priority under Medi-Cal Healthier California for All. This initiative, in combination with proposed reforms to Medical Necessity and Behavioral Health payment reform, will help California make meaningful progress in improving beneficiary experience, access to care, and outcomes for people with behavioral health conditions, consistent with the Administration's goals.

Restfully submitted,



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