SYSTEMS OF CARE
FOR CHILDREN AND YOUTH

SYSTEM PROFILE:
SPECIALTY MENTAL HEALTH SERVICES*

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal). The Medi-Cal Specialty Mental Health Services (SMHS) program operates under the authority of a federal waiver provided under section 1915(b) of the Social Security Act. As the single state Medicaid agency, DHCS is responsible for administering the Medi-Cal SMHS Waiver, which provides SMHS to Medi-Cal beneficiaries through County Mental Health Plans (MHPs). The MHPs are required to provide or arrange for the provision of SMHS to beneficiaries, including children and youth, in their counties who meet SMHS medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals as documented in the beneficiaries' client plans. MHPs provide services directly, and contract with individual and organizational providers to provide SMHS.

MHPs provide or arrange for the provision of SMHS to children and youth up to age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which is mandated under the Medi-Cal program pursuant to federal law. MHPs are required to provide, or arrange for the provision of, SMHS to beneficiaries under age 21 who meet medical necessity criteria for those services and are eligible for the full scope of Medi-Cal services.

OVERVIEW

Our goal is simple: our programs must meet the needs of the children and youth we serve. These are our collective children, and they all deserve the very best.

We recognize that it is our obligation to ensure that the services we are providing are coordinated, timely, and trauma-informed. We must come together as one government to break down silos and build a culture that is focused on delivering services that are person-centered and not program-centered.

PURPOSE

As a resource to state, county, and local staff, we developed system profiles that provide an overview of the services offered by our various systems that all serve children and youth.

This is our compendium of resources available to children and youth served by are various systems. The system profiles outline how eligibility is determined, what the denial appeal processes entail, how the system interacts with other systems or programs, how information is shared, and how referrals are made

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For beneficiaries under age 21, there is no wrong door to receive mental health services due to less stringent impairment criteria as compared to the criteria for adults. Children under age 21 may meet criteria for specialty mental health services regardless of the level of severity of their mental health needs. As such, many children with impairments that may be considered mild or moderate meet medical necessity criteria to access SMHS, and these services are to be provided by MHPs.

Medi-Cal beneficiaries are considered "enrolled" in their county MHP and are entitled to receive SMHS if they meet medical necessity criteria. Beneficiaries may be referred by their primary care physician, other medical and behavioral health professionals, a social worker, a foster parent, a school, or other entity, or they may self-refer to the MHP for an assessment for SMHS.

Eligibility Criteria

Medi-Cal beneficiaries, including children and youth, must meet medical necessity criteria in order to receive SMHS. Medi-Cal necessity criteria for adults is established in Title 9, California Code of Regulations (CCR), Section 1830.205, and for children and youth under the age of 21 it is established in Title 9, CCR, Section 1830.210.

The medical necessity criteria for impairment and intervention for Medi-Cal SMHS differs between children and adults. Under EPSDT, the impairment criteria component of SMHS medical necessity is less stringent for children. To receive SMHS, Medi-Cal children and youth must have a covered diagnosis and meet the following criteria:

(1) Have a condition that would not be responsive to physical health care based treatment; and
(2) The services are necessary to correct or ameliorate a mental illness and condition discovered by a screening conducted by the MHP, the Child Health and Disability Prevention Program, or any qualified provider operating within the scope of his or her practice, as defined by state law regardless of whether or not that provider is a Medi-Cal provider.

SMHS available for children and youth under the age of 21 include the following:

- Mental health services (includes: assessment, plan development, rehabilitation, therapy (individual and group) and collateral)
- Crisis intervention services
- Crisis stabilization services
- Day treatment intensive services
- Day rehabilitation services
- Crisis residential treatment services
- Medication support services
- Psychiatric health facility services
- Psychiatric inpatient hospital services
- Targeted case management
- Therapeutic behavioral services
- Intensive care coordination
- Intensive home based services
- Therapeutic foster care

Note that these are broad service categories, and there are several service activities, or therapeutic modalities that may be provided within these categories.

Eligible children are entitled to receive SMHS based on their need for the services. SMHS are provided based on individual needs and treatment goals.

Denial of Services

If a child or youth does not meet medical necessity criteria for SMHS, the MHP is responsible for notifying the child or youth and/or the parents/legal guardian.

If the MHP determines that a beneficiary does not meet medical necessity criteria, or a service is denied, or a service is offered with less intensity than requested, etc. MHPs are required to send the beneficiary a Notice of Adverse Benefit Determination informing the beneficiary of the MHP's decision and providing information on how the beneficiary may appeal the MHP's decision.

For children or youth in the child welfare system or in juvenile probation who do not meet medical necessity criteria for SMHS, the child and family team should discuss available services that the child or youth and family may be eligible for, such as wraparound services, including services funded by Mental Health Services Act Funds (Proposition 63 of 2004).

Appeal Process

In accordance with Title 9, California Code of Regulations, Chapter 11, Subchapter 5, the MHP Contract, and MHSUDS Information Notice 18-010E, MHPs are required to have problem resolution processes that enable a beneficiary to resolve a problem or concern about any issue related to the MHP's performance, including the delivery of specialty mental health services. MHPs are required to meet specific timeframes and notification requirements related to each of these processes. MHPs must provide a written description of their problem resolution process to beneficiaries requesting services and it must be posted on the county MHP's website. Each MHP's beneficiary problem resolution processes include:

1. A Grievance Process

A grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the beneficiary's rights regardless of whether remedial action is requested, and the beneficiary's right to dispute an extension of time proposed by the MHP to make an authorization decision.

2. An Appeal Process

An appeal is a review by the MHP of an Adverse Benefit Determination.

3. An Expedited Appeal Process

The MHP must establish and maintain an expedited review process for appeals when the MHP determines (from a beneficiary request) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking time for a standard resolution could seriously jeopardize the beneficiary's mental health disorder condition and/or the beneficiary's ability to attain, maintain, or regain maximum function.

State Fair Hearing

If a beneficiary disagrees with the MHP's appeal or expedited appeal decision, the beneficiary may request a State Fair Hearing, or an Expedited State Fair Hearing. The beneficiary must exhaust the MHP's appeal process prior to requesting a State Fair Hearing.

Ombudsman

DHCS also has an Ombudsman that beneficiaries can call for assistance with access to specialty mental health services and other needs.

Department of Health Care Services Office of the Ombudsman

Hours of Operation: Monday through Friday, 8am to 5pm PST; excluding holidays

By Phone: 1-888-452-8609

By email*: MMCDOmbudsmanOffice@dhcs.ca.govFor more detailed information on the beneficiary problem resolution processes described here, and the DHCS Ombudsman, please see resources below:

- MHP Contract[1];
- MHSUDS IN 18-10E[2] (includes information about adverse benefit determination and notices of adverse benefit determination);
- State Fair Hearings[3]; and DHCS Ombudsman[4]

Program Interactions

Medi-Cal Managed Care – Effective January 1, 2014, Medi-Cal benefits were expanded to include certain outpatient mental health services for beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from any mental health condition defined by the current Diagnostic and Statistical Manual that do not meet SMHS medical necessity criteria. These services include the following:

- Individual and group mental health evaluation and treatment (psychotherapy);
- Psychological testing, when clinically indicated, to evaluate a mental health condition;
- Outpatient services for the purposes of monitoring drug therapy;
- Psychiatric consultation; and
- Outpatient laboratory, drugs, supplies and supplements (excluding medications as described in the Medi-Cal Provider Manual and All Plan Letter (APL) 13-021[5]).

Medi-Cal Managed Care Plans (MCPs) offer these services to enrollees under contract with DHCS. MCP primary care providers also continue to provide mental health services within their scopes of practice. APL 17-018[6] articulates the responsibilities of the MCPs regarding these services. In addition, Mental Health Substance Use Disorders Information Notice 16-061[7] articulates the role of the MHP.

MCPs and MHPs are required to have a Memorandum of Understanding (MOU) to address referrals from one plan to another, information exchange, care coordination, and other provisions. APL 18-015[8] articulates the responsibilities and content requirements of the MOU to be implemented by both parties.

Medi-Cal Fee-For-Service – While Medi-Cal Fee-for-Service (FFS) offers the same services as MCPs (as noted above), the SMHS program does not have a formal relationship or process for interacting with or referring to Medi-Cal FFS providers, as there is not a directory or comprehensive list of all Medi-Cal FFS providers.

Medi-Cal Specialty Mental Health/Substance Use Disorder Services – DHCS administers California's public Substance Use Disorder (SUD) system, including the Drug Medi-Cal

[1] MHP Contract
[2] MHSUDS IN 18-10E
[3] State Fair Hearings
[4] DHCS Ombudsman
[5] All Plan Letter (APL) 13-021
[6] APL 17-018
[7] Mental Health and Substance Use Disorders Information Notice 16-061
[8] APL 18-015

Program, Drug Medi-Cal Organized Delivery System Pilot (DMC-ODS Pilot).

In nearly all counties, SMHS and SUD services are provided by a single department. DHCS administers these services through contracts with counties or direct contracted providers, MHSUDS Information Letters, State law and regulation, and federal law and regulation. Further, individual counties have internal referral and care coordination policies and procedures operating at the local level.

Drug Medi-Cal Program: Generally, counties offer SUD services as provided under contract with DHCS. However, MCP primary care providers also provide certain alcohol misuse screening and behavioral interventions as articulated in APL 18-014[9] for enrollees who are 18 years of age and older. Further, MCPs are required to make referrals to the county department for alcohol and SUD, or a DHCS-certified treatment program.

EPSDT: Children up to age 21 who meet medical necessity criteria are eligible to receive Medi-Cal SUD services under the EPSDT benefit. Children and youth may receive a referral to treatment from health or mental health providers, foster caregivers, law enforcement, schools, child welfare/probation, other county departments, family members, or self-referral.

Drug Medi-Cal Pilot: All counties must contract with the department for the Drug Medi-Cal Program or choose to opt-into the DMC-ODS Pilot. As of July 2018, forty counties have submitted an expression of interest to participate in the DMC-ODS Pilot. As of January 2019, 24 counties are fully operational. These 24 counties represent over 75 percent of the Medi-Cal population statewide. Once fully implemented, more than 97 percent of Medi-Cal beneficiaries will have access to the DMC-ODS Pilot services

SMHS for Child Welfare and Probation Youth – Foster children/youth are entitled to Medi-Cal services and are automatically enrolled into Medi-Cal upon their placement into foster care, if they are not already enrolled. If a foster child/youth meets medical necessity, they are also entitled to receive SMHS under EPSDT.

For children and youth who receive SMHS and who are in foster care, have an open child welfare case or are involved with juvenile probation, a Child and Family Team (CFT) must be in place to guide planning of service delivery and identify the needs and strengths of the child, youth and their families.

For children and youth in the child welfare or probation systems, the placing agency is responsible for engaging members of the CFT. The CFT composition always includes the child or youth, family members, the current caregiver, a representative from the placing agency, and other individuals identified by the family as being important. A CFT shall also include a representative of the child or youth's tribe or Indian custodian, behavioral health staff, foster family agency social worker, or short -term residential therapeutic program (STRTP) representative, when applicable.

Other professionals that may be included are youth or parent partners, public health providers, Court Appointed Special Advocates, school personnel, or others. In addition to formal supports, effective CFT processes support and encourage family members to invite the participation of individuals who are part of their own network of informal support, such as extended family, friends, neighbors, coaches or clergy.

[9] APL 18-014

A CFT meeting is convened within 60 days of entering care to plan for the services, supports and placement of the child/youth. A CFT must also be convened to discuss any placement changes and service needs to prevent placement disruption. The team must always consider the least restrictive placement option. A CFT meeting may also be convened at the request of the child/youth or family.

Children and youth in child welfare services are screened for potential behavioral health needs by the placing agency (at intake and every year thereafter). When behavioral health issues are identified or are a concern, even if services are not presently being provided, referrals to the county MHP should be made so that the child or youth's needs can be assessed. Behavioral health professionals (which may include county staff or county contracted providers) are important CFT resources and their involvement is especially critical when:

- The team is unsure about a child or youth's need for SMHS; or whether the child or youth should continue receiving any SMHS;
- There is a need to provide information to the team or family regarding how the child or youth's behavior or functioning is impacted by their mental health status;
- The team is considering the need for placement for the child or youth in a family relative, non-related extended family member or any other family type setting, a STRTP, Foster Care, or Intensive Services Foster Care (ISFC);
- The team is considering a recommendation for Medi-Cal Therapeutic Foster Care (TFC) Services; and/or
- A child or youth is prescribed psychotropic medication(s) or psychotropic medication(s) is being considered for the child or youth.
- The child/youth may be placed out of county and a decision needs to be made regarding a waiver of presumptive transfer under AB 1299.

Regional Centers – Section 4696.1 of Welfare and Institutions Code requires MHPs and regional centers to have MOUs as noted in order to facilitate client services and coordination of services. SMHS can be included as part of an Individual Program Plan. In addition, APL 18-009[10] articulates the MOU requirements between a regional center and a MCP.

Early Start – There is no formal requirements in place other than the above referenced MOU requirement.

Rehabilitation– The Department of Rehabilitation (DOR) established Mental Health Cooperative Programs to provide an integrated, collaborative, and individualized approach for transitioning and supporting youth with mental illness in obtaining and maintaining job training and employment. DOR Mental Health Cooperative programs are administered through contracts that are developed locally between DOR and the county department responsible for mental health services, based on local services and available funding. The county department responsible for mental health and local DOR administration assess and establish need and evaluate the ability to develop local cooperative programs. Once a Mental Health Cooperative Program is established, county mental health staff work with youth nearing transition age to determine vocational readiness for participation in a DOR Mental Health Cooperative Program and refer youth to the program, as

[10] APL 18-009

appropriate. Local DOR staff involved with the youth's vocational training also participate as members of the CFT.

Schools – An Individualized Education Plan (IEP) is developed for each child or youth in public school who meets criteria for special education services. IEPs include the specific special education services and supports that the school will provide. Related to mental health, the IEP may include, but is not limited to one-on-one aide services and therapies; academic and behavioral goals; a behavior plan, if needed; and progress reports from teachers and therapists. The IEP is planned at an IEP meeting, and county mental health staff involved with the child or youth's care typically participate in IEP meetings.

The Local Education Authority (LEA) Program Billing Option Program (BOP) was established in 1993, in conjunction with the California Department of Education (CDE). The program allows LEAs to become Medi-Cal providers and bill the Medi-Cal program for medical health services provided by medical professionals they employ or have under contract. Under LEA BOP, the mental health services that are reimbursable include IEPs and Individual Family Services Plans; psychological assessments; psychosocial status assessments; psychology/counseling treatment; and targeted case management services. LEAs may enroll as a Medi-Cal provider through LEA BOP, and bill Medi-Cal for specific services provided to Medi-Cal enrollees. LEAs may also choose to contract with the local MHP to provide SMHS.

INFORMATION SHARING

DHCS and CDSS have also chosen the Child and Adolescent Needs and Strengths (CANS) functional assessment tool. CANS is a multi-purpose assessment tool developed to assess well-being, identify a range of social and behavioral healthcare needs, support care coordination and collaborative decision-making, and monitor outcomes of individuals, providers, and systems. The tool is designed to promote communication amongst the various individuals on the CFT. Clinicians may use the CANS to identify a client's most pressing needs and develop a mental health treatment plan to address those needs.

County placing agencies and county MHPs are jointly responsible for ensuring that a single Child Adolescent Needs and Strengths (CANS) tool is completed for each child, youth and non-minor dependent (NMD). As such, county placing agencies and MHPs must share with each other completed CANS assessments and their resulting identified outcomes for children assessed and/or served by both agencies to avoid unnecessary duplication and over-assessment of children, youth, and NMDs.

A person designated as a member of a CFT may receive and disclose relevant information and records within the CFT, subject to the child, youth, or Non-Minor Dependent (NMD), and/or their parent or guardian signing an authorization to release information, as required depending upon the type of information.

Completion of the CANS assessment requires effective engagement using a teaming approach. CFT members, including the youth and family, must inform the CANS. The CANS assessment results must be shared, discussed, and used within the CFT process to support case planning and care coordination.

If a current CANS assessment has been completed by a county MHP or their contracted provider, the CFT must use it. The placing agency is not required to conduct a new CANS, but should consider whether any updates to the CANS ratings are appropriate. Similarly, if a current CANS assessment is completed by or on behalf of the placing agency, the MHP must use it. In

this case, the MHP is not required to complete a new CANS but should consider whether any updates to the CANS ratings are appropriate.

The CANS must be completed prior to the completion of the family case plan, and the CANS results are intended to inform the CFT in several key areas.

When evaluating the application of the HIPAA Privacy Rule to CANS assessments, county MHPs are authorized to share CANS assessment information as allowed under 45 C.F.R. Section 164.506(c)(1), a section of the HIPAA Privacy Rule. This section states "[a] covered entity may use or disclose protected health information for its own treatment, payment or health care operations." For purposes of Section 164.506(c)(1) "[t]reatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party . . ." (45 C.F.R. Section 501.) Importantly, for the limited purpose of "coordination or management of health care" such third parties need not be covered entities. (See e.g. DHHS, Office for Civil Rights, HIPAA Privacy Rule and Sharing Information Related to Mental Health, pgs. 8-9, below. https://www.hhs.gov/sites/default/files/hipaa-privacy-rule-and-sharing-info-related-to-mental-health.pdf

See also Section 5328.04 of Welfare and Institutions Code, and Sections 56.10(c)(20) and 56.103 of Civil Code regarding HIPPA authorization.

When the child-placing agency has completed the CANS prior to the MHP, the child-placing agency must use the clarification described above to share the existing CANS assessment with the MHP as early as possible. Regardless of which county agency completes the CANS, a release of information must be obtained prior to sharing the CANS assessment with entities other than the county placing agency or MHP during a CFT meeting.

REFERRALS

While county placing agencies and county MHPs complete and share CANS assessments, each respective entity is expected to submit the CANS data to their respective lead State agencies. Specifically, county MHPs must submit the CANS data to DHCS for dually served children, along with the non-dually served children, in accordance with DHCS' data submission specifications described in DHCS MHSUDS Information Notice 17-052. This also applies to CANS assessments that are initially completed by a county placing agency and then provided to a county MHP. Upon referral for SMHS, the county MHP must ensure that the county placing agency's CANS, including any updates, is entered into the MHP's database for subsequent submission to DHCS.

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Our Systems of Care work has been accelerated by the implementation of Assembly Bill 2083 (Chapter 815, Statutes of 2018), which requires each county to develop and implement a Memorandum of Understanding outlining the roles and responsibilities of the various local entities that serve children and youth in foster care who have experienced severe trauma.

The legislation is focused on the child welfare system, but can and must be expanded to look at children and youth served by various other systems.

The legislation calls for the establishment of a Joint Interagency Resolution Team to provide guidance, support, and technical assistance

to counties with regard to trauma-informed care to foster children and youth.
We have identified the mission of the State Resolution Team to be:

1. Promote collaboration and communication across systems to meet the needs of children, youth and families;
2. Support timely access to trauma-informed services for children and youth; and
3. Resolve technical assistance requests by counties and partner agencies, as requested, to meet the needs of children and youth.

For additional system profiles, including mental health services, rehabilitation services, developmental services and education services, please visit our website at www.chhs.ca.gov.

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