



February 11, 2022

Dana Durham
Chief, Managed Care Quality and Monitoring Division
Department of Health Care Services
Via Email: Dana.Durham@dhcs.ca.gov

Re: Response to DRAFT APL 22-XXX: MEDI-CAL MANAGED CARE HEALTH PLAN RESPONSIBILITIES FOR NON-SPECIALTY MENTAL HEALTH SERVICES

Dear Dana Durham,

On behalf of The Children's Partnership, the California Alliance of Child and Family Services, California Children's Trust, and National Health Law Program, we thank you for the opportunity to comment on the Department of Health Care Services Draft All Plan Letter regarding Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services. Our organizations have come together to ensure children and families on Medi-Cal, especially from communities of color, have access to all the support and services they need to be healthy and well, particularly as it relates to their mental health.

While we appreciate the Department's efforts in improving access to mental health care for children and youth on Medi-Cal, the reality is that the state still has far to go to meet that goal. California ranks 34th in the nation for children without access to mental health care who have a need. According to the Center for Medicaid Services, California's children on Medicaid showed some of the steepest declines in mental health service use by youth since the pandemic began compared to other state's children. DHCS's own data on preventive services showed that less than 14% of children and youth have received a screening for depression and a follow up plan in 2020, indicating a huge gap in the number of children who theoretically should have received a positive screen and referrals to mental health services and who actually did during the initial surges of the pandemic when social isolation was at its peak. This persistent gap in care is multifactorial and can be addressed through a redoubling of effort by the Department to ensure managed care plans (MCPs) eliminate remaining barriers to care for children and youth and are required to be proactive in facilitating their access to culturally-responsive care.

We provide the following recommendations to adjust the current APL in the spirit of partnership and a joint commitment to serving our state's children and youth:

Add greater clarity around eligibility for non-specialty mental health services

The information notice remains unclear regarding who meets criteria for non-specialty mental health services for children. The draft Information Notice begins with background about the EPSDT benefit but does little to clarify the responsibilities and interaction between MHPs and MCPs and the critical changes to medical necessity achieved under the reformed Family Therapy Benefit and the recently approved 1915b waiver. This entire section of non specialty criteria is vague and needs more clarity to be meaningful to plans and implementable on the ground. The Provider Manual answers many of these questions as to the Family Therapy benefit, for example, but this letter does not.

The Information Notice should directly and specifically clarify that diagnosis is no longer required to access NSMHS for youth and young adults under 21, and that qualifying criteria include the expanded definition of ACES including housing instability and an experience of racial discrimination with specific reference to the new Z codes. The elimination of diagnosis as a requirement to access care for children and young people reflects the groundbreaking reimagining of the definition of medical necessity DHCS has created. Shifting from strict diagnostic criteria reimagines behavioral health as a support for healthy development (not simply a response to pathology), and will require culture and practice change that the Notice needs to name and highlight.

We think the information notice must specify and emphasize these qualifying criteria and specify that z65.9 is the ICD 10 code for all of them. We recommend the Notice highlight these two specific citations from the provider manual:

The child under age 21 has a history of at least one of the risk factors below. Claims for family therapy for these children must be billed with ICD-10 code Z65.9:
Separation from a parent/guardian due to incarceration or immigration – Death of a parent/guardian – Foster home placement – Food insecurity, housing instability – Exposure to domestic violence or other traumatic events – Maltreatment – Severe and persistent bullying – Experience of discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences or disability

The child under age 21 has a parent/guardian with one of the risk factors below. Claims for family therapy for these children must be billed with ICD-10 code Z65.9: – A serious illness or disability – A history of incarceration – Depression or other mood disorder – PTSD or other anxiety disorder – Psychotic disorder under treatment – Substance use disorder – A history of intimate partner violence or interpersonal violence – Is a teen parent.

Use expansive language and broaden provider qualifications to improve access to the benefit

We agree with the Department in ensuring that every child and youth receives a mental health screening through MCPs. Still, we feel that the guidance unnecessarily limits screenings to Primary Care Providers (PCPs), making access to NSMHS prohibitively limited for children and

youth, especially those from marginalized communities. Further, under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate, a screening can be conducted by any qualified provider, even providers not enrolled in Medi-Cal. DHCS should explicitly include references to additional examples of members of a mental health team who may also administer screenings within their scopes of practice beyond the Primary Care Provider (PCP), such as, but not limited to: family and peer support specialists, mental health rehabilitation specialists, case managers, and community health workers. These professionals may have more frequent contact with families than PCPs and present an opportunity for MCP's to provide more culturally-responsive access to care. In particular, children and youth may feel especially vulnerable discussing or answering screening questions about their mental health with a physician but may be willing to open up to a community provider who feels more approachable.

Require regular by-plan reporting on access measures and penetration rate

DHCS should require MCPs report on access, utilization, and outcomes of services for children and youth, including services accessed through sub-contracted Managed Behavioral Health Organizations. This reporting should be broken down by important age groups (0-3; 4-5; 6-8; 8-12; 12-17; 18-21, 21+ years) along with race, ethnicity, language, disability status, sexual orientation, and gender identity to allow plans, the state, advocates, and the public to identify equity gaps in access and utilization across a variety of important and historically marginalized communities. The state should also set and monitor the expected level of access (penetration rate) by plan. DHCS should further disaggregate data by child serving system involvement (including Juvenile Justice, Child Welfare, Regional Center) and overlap with MHP utilization.

Rates and concerns about Medi-Cal Provider Rates

The current rate structure for NSMHS is too low to attract current SMHS providers into contractual relationships with MCP's or their BHO sub contractors. This has led to MCP panels being dominated by solo practitioners.

CBOs contracted with counties will not be able to contract for rates lower than their county rates. This will impact their network adequacy and constrain an already dire provider shortage in children's behavioral health. We have been in conversations with DHCS about this , and once again request guidance for the field.

Addressing the disparity in rates (and providing guidance in how to construct and administer blended contracts) is essential to growing MCP access and penetration rates.

Explore ways of incentivizing MCP's to contract with SMHS providers

We support incentivizing MCPs to make efforts to contract with existing SMHS providers in their county. However, DHCS must clear up Medi-Cal rate disparities for this to occur. Clarification from DHCS is needed related to billing practices that are becoming problematic for service

providers that are contracting with various entities – including MHPs, and MCPs – for the provision of mental health services. As we continue to move forward in expanding the range of potential contractual agreements that service providers will be needing to enter, this issue is becoming critical to address. We again request formal guidance from DHCS on this matter.

Create models and incentives to blend NSMHS with care coordination contracts for kids

Almost all NSMH services are paid FFS for CPT codes associated with clinical interventions. There is no reimbursement for the brokerage, care coordination, and case management requirements of effective behavioral health practice. Blending the care coordination obligation of plans with FFS NSMHS reimbursement will create a more realistic and attractive reimbursement landscape to attract SMHS providers into NSMHS contracts.

Require MCP's to engage with parents, caregivers and youth members regarding mental health care experiences

While the state gathers input from Medi-Cal managed care beneficiaries about their experiences in the physical healthcare system through Consumer Assessment of Healthcare Provider and Systems surveys, and County Specialty Mental Health Plans assess behavioral health experiences for consumers, there is no similar qualitative assessment required for NSMHS. In particular, hearing directly from parents, caregivers, and even youth beneficiaries themselves could uncover systemic barriers to mental health care that would inform MCP and state-level strategies to improve access and outcomes. DHCS should work with MCPs, community stakeholders, families, and youth to establish local children and youth-centered advisories that facilitate regular MCP dialogue with families and youth about their experiences with the NSMHS, with specific attention to families with infants and toddlers as well as children in the K12 system. These advisories would serve as an important feedback loop to ensure MCPs effectively synthesize and articulate feedback into actionable strategies to improve mental health care access and quality for children and youth.

Strengthen MCP outreach and education efforts specifically on the mental health benefit

There remains an exceptional gap in the knowledge that families with children and youth with mental and behavioral health needs have around the NSMHS benefit. Outreach and education is also a fundamental part of EPSDT. Given the soaring mental health crisis in children and youth during the global health and economic devastation, it is essential that MCPs make every effort to educate and inform beneficiaries regularly about their mental health benefits for children and youth under 21. DHCS should require MCPs submit behavioral health marketing plans specific to children and youth services that are culturally appropriate and linguistically accessible to parent, caregiver, and youth beneficiaries. These marketing plans should be informed by robust stakeholder (including youth) engagement, utilize stigma reduction best practices, and clearly identify care access points and contact information. These plans should also clearly distinguish NSMHS from SMHS and how to access them so that families and youth understand which system to approach based on their needs.

In addition to educating families and youth about NSMHS benefits, DHCS should develop and execute a statewide outreach and information campaign to educate other key players in the state's mental health system of care of these benefits, with special attention paid to highlighting new policies related to the elimination of a diagnosis for receiving mental or behavioral health care through either the NSMHS or the SMHS system. Primary care providers, school counselors and administrators, and child care providers represent three of the essential target audiences for these campaigns as they represent a high proportion of screenings, assessments, and referrals for mental health care for children and youth. DHCS should work with representatives from these professional groups and others that are connected to the community mental health system of care, along with families and youth to ensure the statewide campaign conveys the right messages in accessible ways across diverse communities.

Clarify time rules for the Family Therapy benefit to bring it into alignment with the rest of the NSMHS Benefit:

The Current Procedural Terminology (CPT) time rule allows for the altering of the time requirement for certain time-based services, and psychotherapy is one of those services. The CPT book contains instructions directly beneath each of the family psychotherapy codes stating that the code excludes service times of less than 26 minutes, indicating that if 26 minutes or more of the time spent rendering the service was rendered and documented for, the code(s) can compliantly be reported. The American Psychological Association also advises that a provider may apply the CPT "time rule", and choose the code closest to the actual time of the session, noting that 26 minutes or more can be used for CPT codes 90846 and 90847 (family psychotherapy codes).

In the most recent released Medi-Cal guidance for NSMHS, family therapy billing codes are limited to a maximum of 50 minutes when a patient is not present or a maximum of 110 minutes when the patient is present. There is no indication of a minimum time requirement, leading us to believe that a 50 minute family therapy session must be rendered, to bill for the service. If this is so, and with consideration to the challenges a 50 minute family therapy session would pose in the primary care setting where psychotherapy can now be rendered for prevention, ***Medi-Cal should adopt the CPT time rule and allow for the compliant billing of the family psychotherapy codes when 26 minutes or more was spent rendering the service.***

Medi-Cal did adopt the time rule for another non-specialty service and its guidance was very clear as oppose to the family therapy guidance (in case we want this for a little leverage) – for prolonged psychotherapy service (CPT code: 99354), The code description advises that an additional 1 hour of service must be rendered to bill for the service, but Medi-Cal released guidelines advising that it can be reported when an additional 30 minutes of service was rendered.

Conclusion

We appreciate the opportunity to share our recommendations and uplift opportunities for improving access to care and secure positive mental health outcomes for children on Medi-Cal. For more information, please contact Angela M. Vázquez, MSW avazquez@childrenspartnership.org and Adrienne Shilton ashilton@cacfs.org

Sincerely,

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