EXHIBIT D

STATE RESPONSES TO
INTERIM REVIEW CRITERIA FOR CHILDREN WITH SPECIAL NEEDS

(Health Care Financing Administration (HCFA) criteria statements and questions are shown in italics.)

When addressing these criteria, please provide the following information by each appropriate subset of children with special needs:

The State's responsibilities in managed care programs enrolling children with special needs.

The State's requirements for Managed Care Organizations (MCOs) /Prepaid Health Plans (PHPs) enrolling children with special health care needs.

How the State monitors its own actions and that of its contracting MCOs and PHPs.

For foster-care children only, the provisions that address the broader, unique issues occurring because of out-of-home, out-of-geographic area placement.

State's Responsibilities in Managed Care Programs Enrolling Children with Special Needs

Please note that the Medi-Cal Specialty Mental Health Services Consolidation waiver program is a specialty mental health carve out program. The program focuses on the specialty mental health needs of children—regardless of their placement in the identified special needs categories. Please note also that the waiver program is not capitated. Mental health plans (MHPs) participating in the program receive cost based reimbursement from the State for all specialty mental health services, with the exception of psychiatric inpatient hospital services, delivered to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible children above the mental health plans' baseline expenditures for these services. Federal financial participation (FFP) is also provided on the basis of cost. Because of historical underutilization of services by EPSDT eligible children, costs of these services under the waiver and costs without the waiver are considered equal, so there is no waiver cost-effectiveness issue. The traditional managed care concern that capitation creates a financial incentive to deny services does not exist in this program.

Public Process

The State has in place a public process for the involvement of relevant parties (e.g., advocates, providers, consumer groups) during the development of the waiver program and has sought their participation in that process.

The public planning process for Medi-Cal specialty mental health services began in early 1994, consisting of a Managed Care Steering Committee and subcommittees. This process has continued through the present time. Steering Committee meetings are scheduled as needed to obtain input on the development of policies related to the waiver and regulations. A copy of the Steering Committee membership list is included as **APPENDIX A** to this document. Advocates, providers, consumer and family member organizations, county mental health plans, and other state departments are represented. The State maintains an extensive mailing list (about 190 listings) of interested members of the public, who receive meeting notices and may also attend.

On April 25, 2000, the Department of Mental Health (DMH) mailed copies of the State's draft response to HCFA's additional information request (AIR), including the initial draft of this document, to the Steering Committee mailing list. The mailing advised that public input would be accepted on the draft through May 25, 2000, and that there would be a meeting of the Steering Committee on May 8, 2000, to discuss the document.

The State has also integrated public input into the ongoing operation of the program through four important advisory committees to DMH: the State Quality Improvement Committee (SQIC), the Compliance Advisory Committee, the Cultural Competence Advisory Committee and the Client and Family Member Task Force. Information about these committees is provided in the main response to HCFA's additional information request at pages 2 through 4 and related Attachments 3 through 6. These committees provide ongoing input to the State regarding the performance of the State and the MHPs in the operation of the waiver program.

Definition of Children with Special Needs

The State has a definition of children with special needs that includes the following subsets:

1. *Blind/Disabled Children and Related Populations (eligible for SSI under Title XVI);*
2. *Eligible under Section 1902(e)(3) of the Social Security Act;*
3. *In foster care or other out-of-home placement;*
4. *Receiving adoption assistance; or*
5. *Receiving services through a family-centered, community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V,*

as is defined by the State in terms of either program participant or special health care needs.

Children with special needs, for the purposes of the Medi-Cal Specialty Mental Health Services Consolidation waiver program, are

1. Blind/Disabled Children and Related Populations (eligible for SSI under Title XVI);
2. Children eligible under Section 1902(e)(3) of the Social Security Act (in California, these are children participating in the model waiver, a SSA 1915(c) home and community based services waiver program);
3. Children in foster care or other out-of-home placement;
4. Children receiving adoption assistance; or
5. Children receiving services through a family-centered, community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as is defined by the State in terms of either program participant or special health care needs (in California, these are children receiving services through the California Children's Services program).

Enrollment in MHPs contracting with DMH under the Medi-Cal Specialty Mental Health Services Consolidation waiver program is mandatory for all Medi-Cal beneficiaries. Mandatory enrollment includes children who are Medi-Cal beneficiaries in all five subsets described above.

Identification

The State identifies and/or requires MCOs/PHPs to identify children with special needs. The State collects, or requires MCOs/PHPs to collect specific data on children with special needs. The State explains the processes it has for identifying each of the special needs groups described above.

All Medi-Cal children in California are mandatorily enrolled in the MHP in the child's county of residence. This includes all children who fit the five special needs categories listed above. Children who meet medical necessity criteria in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205 and 1830.210 are entitled to receive Medi-Cal specialty mental health services.

The State identifies blind/disabled children and related populations by aid codes assigned by the eligibility system and available through the Medi-Cal Eligibility Data System (MEDS). The State has the ability to sort the service data reported by the MHPs to identify services provided to these children.

The State identifies children eligible for the model waiver through the use of aid codes and MEDS. The State has designed an edit in the fiscal intermediary's claims processing system that exempts services delivered through the model waiver from the lock-out applicable to specialty mental health services that are

the responsibility of the MHPs. This edit ensures that access to waiver program services will not be hindered by the Medi-Cal Specialty Mental Health Services Consolidation waiver program. The State has the ability to sort the service data reported by the MHPs to identify services provided to these children.

The State identifies children in foster care placement primarily through the use of aid codes and MEDS. This system does always not identify children placed with relatives as foster children. The State is developing a separate indicator code that will identify children placed with relatives, but a completion date for this project has not yet been set. The State has the ability to sort the service data reported by the MHPs to identify services provided to children in foster care who can be identified by aid code. DMH is currently working with researchers to develop a way to separate service data on foster children who are placed in their home county from foster children who are placed in other counties to allow comparisons of the two populations. The State has a particular interest in monitoring MHP access for children placed out of county.

The State identifies children eligible under the adoption assistance program by aid code and MEDS. The State has the ability to sort the service data reported by the MHPs to identify services provided to these children. DMH has included data for children in this group in the study of children placed outside their home county.

The State does not directly identify children eligible for the CCS program, since the CCS program does not maintain a formal eligibility system. The State has designed an edit in the Medi-Cal fiscal intermediary's claims processing system that exempts services delivered through the CCS program from the lock-out applicable to specialty mental health services that are the responsibility of the MHPs. This edit ensures that access to CCS program services, including CCS authorized specialty mental health services, will not be hindered by the Medi-Cal Specialty Mental Health Services Consolidation waiver program. If the CCS program identifies a CCS eligible child with specialty mental health needs, the program may either provide the services through the CCS program or refer the child to the MHP. It is possible to identify children who receive services authorized by the CCS program and specialty mental health waiver services within given time periods, although the State has not done this to date.

<u>Enrollment/Disenrollment</u>

The State performs functions in the enrollment/disenrollment process for children with special needs, including:

Outreach activities to reach potential children with special needs and their families, providers, and other interested parties regarding the managed care program.

In the Medi-Cal Specialty Mental Health Services Consolidation waiver program, enrollment is mandatory and automatically occurs when the child becomes Medi-Cal eligible. The process is the same for each category of children with special needs. No action is required on the part of the beneficiary or the MHP. The State sent notices to each Medi-Cal residence when the program was implemented. Notices are available to new applicants and eligibles at county welfare offices. An updated notice is scheduled to be sent later this year. Although Medi-Cal eligibility based on SSI eligibility is not done through the county welfare offices, new SSI eligibles are directed to the county welfare offices for information on the Medi-Cal program. Other outreach activities to reach children who may need specialty mental health services are delegated to the MHP in each county as described below. DMH provided MHPs considerable flexibility in designing their outreach systems, resulting in considerable variation among MHPs in methods and intensity of outreach activities not specifically required by DMH.

MHPs are required by state regulation at Title 9, CCR, Section 1810.360(c) to provide beneficiaries and their families with a brochure upon request or when a beneficiary first accesses services. The brochure contains a description of the services available, the process for obtaining services, and the MHP's problem resolution process. The State also must approve an Implementation Plan and a Cultural Competence Plan from each MHP. The Implementation Plan includes components that require the MHP to describe their system of outreach to enable beneficiaries and providers to access mental health services. The Cultural Competence Plan requires each MHP to address outreach to beneficiaries according to the demographics of that county, based on data on ethnicity, age, gender, and primary language spoken. Copies of the requirements for the Implementation Plan and Cultural Competence Plan are provided as **APPENDIX C** and **APPENDIX D** respectively. The State has not established separate requirements for children in the special needs categories, so these requirements apply equally to each subset. Copies of MHP Implementation Plans and Cultural Competence Plans are available on request.

MHPs have jointly developed a system to ensure access for foster children and children on adoption assistance who are placed out of their home county and to simplify the administrative work of providers who serve these children. The system involves each MHP contracting with the California Mental Health Directors Association (CMHDA), a statewide organization representing county mental health departments. CMHDA in turn contracts with ValueOptions (VO), a behavioral health managed care plan, to serve as an administrative service organization (ASO) to credential and contract with direct service providers and to authorize and pay for services to children in the foster care and adoption assistance categories of children with special needs. CMHDA and VO worked with foster care and group home associations to ensure their members were aware of VO and how services might be accessed for children/youth residing in their homes. Information regarding VO and specific steps for accessing care was

provided to the associations for inclusion in their policy and procedure manuals. MHPs assumed the responsibility to provide information to local social services agencies and probation departments, since those are the agencies most often involved in placement decisions. As mentioned above, this arrangement was developed by the MHPs and is not mandated by the State; however, all MHPs with the exception of the MHPs in Alpine, Contra Costa County, Inyo, and Modoc Counties are participating. The MHPs in Alpine, Inyo and Modoc Counties elected not to participate because they are so small that out-of-county placements are rare. The MHP in Contra Costa County may participate in the future.

The State's public health and mental health systems, which are operated primarily through county government, also include components that serve as outreach for identifying children with varying kinds of special needs. The State's decision to give counties the right of first refusal for MHP contracts under the waiver and county acceptance of these contracts helps facilitate linkages between these outreach mechanisms and the MHP service delivery systems. These outreach mechanisms include:

1. The State's special education program, which requires Local Education Agencies (LEA) to refer children to county mental health departments for mental health assessment when the LEA suspects that mental health issues are preventing the child's educational benefit. If an assessment by the county mental health department supports this suspicion, county mental health departments provide services to the child and the child's family pursuant to the state statute and regulations that implement the federal Individuals with Disabilities Education Act. LEAs are required by state and federal law to "search for and serve" individuals with exceptional needs. The LEA's responsibilities are the same regardless of Medi-Cal eligibility or the State's Medi-Cal criteria for special needs children, but this outreach process does result in the referral of some Medi-Cal eligible children to the MHPs.

2. The DMH Children's System of Care (CSOC) grant program, which focuses on children who are seriously emotionally disturbed (SED) as defined in Welfare and Institutions Code, Section 5600.3 (a copy is provided as **APPENDIX B**), involves linkages among county social services, probation, mental health and school programs that result in the referral of some Medi-Cal eligible children, including children in the special needs categories, to the MHPs. Currently 45 of the 56 county mental health departments participating in the waiver program receive CSOC grants from DMH. The State Budget for fiscal year 2000-01 provides an additional $15.5 million in grant funds, which is expected to result in full CSOC funding for programs in all counties.

3. Foster care reform in California requires that all counties who are "fully funded" under the CSOC must provide mental health screening to all foster children residing within the county. The county mental health department then

provides a full mental health assessment to those children identified by the screen as having the need for mental health intervention. Children in foster care are automatically enrolled in Medi-Cal by the social worker or probation officer who places the child in the care and custody of the state on behalf of the juvenile court. In fiscal year 1999-00, 21 counties participating in the waiver program were considered fully funded. As mentioned in item 2 above, the fiscal year 2000-01 State Budget includes $15.5 million, which will allow full funding for all counties (see **APPENDIX G** for additional funding information).

Enrollment selection counselors have information and training to assist special populations and children with special health care needs in selecting appropriate MCO/PHPs and providers based on their medical needs.

Since enrollment in the Medi-Cal specialty mental health services program is mandatory and the program operates under contracts with a single MHP in each county, enrollment selection counseling is not applicable to this program. The State, however, required that MHPs describe their process for screening, referral, and coordination of services for special populations in their Implementation Plans. This process includes coordination with other services, including providers required to address a child's medical and other special health care needs. The contract between DMH and the MHP requires that the MHP comply with its Implementation Plan. Copies of MHP Implementation Plans will be provided on request.

Auto-assignment process assigns children with special health care needs to an MCO/PHO that includes their current provider or to an MCO/PHP that is capable of serving their particular needs.

As described above, enrollment in this program is mandatory and automatic. MHPs are responsible to ensure that children's specialty mental health needs are addressed through services they provide or for which they contract. MHPs are also required by regulation, at Title 9, CCR, Section 1810.415, to coordinate specialty mental health services with other health care service providers, based on a child's assessed needs. For most of the children in each of the specialty needs categories, their current primary provider will not be a specialty mental health provider. The children's access to these providers, therefore, will not be affected by the waiver program. MHPs were required to include in their Implementation Plans a process for ensuring a smooth transition for beneficiaries at the start-up of the outpatient component of the program (between November 1997 and July 1998). Most MHPs met this requirement by contracting with any willing Medi-Cal provider and allowing beneficiaries to continue with these providers at least until the MHP could assess the beneficiaries' needs. Copies of the MHP Implementation Plans will be provided on request.

A child with special needs can disenroll and re-enroll in another MCO/PHP for good cause.

Since enrollment is mandatory in a single MHP, beneficiaries, including children in the special needs categories, cannot disenroll or re-enroll with another MHP. Whenever feasible, the MHPs are required to give the beneficiary an initial choice of the person who will provide services, as well as an opportunity to change providers, as specified in Title 9, CCR, Section 1830.225. In most cases, MHPs assign beneficiaries to their initial outpatient providers based on the MHPs' assessment of the types of services the beneficiary may need. If beneficiaries are not satisfied, they may request a change. Situations in which a change may not be feasible might include limited availability of child psychiatrists or too few beneficiaries to form an additional therapy groups or, in rare instances, because it is clinically contraindicated.

If an MCO/PHP requests to disenroll or transfer enrollment of an enrollee to another, the reasons for reassignment are not discriminatory in any way – including adverse change in an enrollee's health status and non-compliant behavior for individuals with mental health and substance abuse diagnosis – against the enrollee.

Disenrolling or transferring a Medi-Cal beneficiary to another MHP is not an option in the Medi-Cal Specialty Mental Health Services Consolidation waiver program, unless the beneficiary moves voluntarily from one county to another. When the beneficiary does move voluntarily from one county to another, enrollment in the new MHP is triggered when the beneficiary or the beneficiary's parent or legal guardian reports an address change for Medi-Cal, SSI or Temporary Assistance for Needy Families eligibility.

Regarding reassignment to a different provider within an MHP, providers may request reassignment, but this is normally done only when the provider/client relationship is such that the provider can not give effective care to the beneficiary. Adverse change in the client's health status and non-compliant behavior alone are not valid reasons a provider-initiated changes in provider. Conversely, whenever feasible, the MHP is required to give the beneficiary an initial choice of the person who will provide outpatient services, as well as an opportunity to change providers, as specified in Title 9, CCR, Section 1830.225.

Provider Capacity

The State ensures that the MCOs/PHPs in a geographic area have sufficient experienced providers to serve the enrolled children with special needs (e.g., provider experienced in serving foster care children, children with mental health care needs, children with HIV/AIDS, etc.).

The Medi-Cal Specialty Mental Health Services Consolidation waiver program is a mental health carve-out program. Essentially all providers are mental health specialists. It is unclear, but appears likely that HCFA intended these criteria to apply to primary care physicians, since questions specific to specialists are asked below. In any case, the State has not required MHPs to report provider experience with children in the specialty needs categories, since this criteria did not exist at the time the waiver program was designed. The Implementation Plan submitted by each MHP and approved by DMH must describe how access to Medi-Cal specialty mental health services will be maintained, including geographical access to services, and how the MHP will ensure adequate service capacity for Medi-Cal beneficiaries under age 21 years. Additionally, MHP Cultural Competence Plans must describe how the MHP has analyzed the demographics of the county, including geographic and socioeconomic factors, by ethnicity, age, gender, and primary language spoken, in determining service needs. MHPs are required to comply with these plans. Copies of MHP Implementation and Cultural Competence Plans will be provided on request.

The State monitors experienced provider's capacity.

The contract between DMH and each MHP requires that the MHP ensure the availability and accessibility of adequate numbers of providers to deliver medically necessary services. Since the Medi-Cal Specialty Mental Health Services Consolidation waiver program operates under a freedom of choice waiver, MHPs are allowed to contract with selected providers, based on provider selection criteria and provider contracting requirements as set forth in CCR, Title 9, Sections 1810.425, 1810.435, and 1810.436. You may refer to **EXHIBIT C** (Sole Source Request), **ATTACHMENT 1**, for the text of these regulations. The MHPs are responsible to ensure the experience and capacity of their providers is consistent with service needs.

The State does not directly monitor individual provider capacity, but conducts a number of activities to monitor for adequate access. DMH has established an Ombudsman's Office that maintains a toll-free telephone line to assist Medi-Cal beneficiaries with obtaining needed services and resolving problems. The Ombudsman's Office works collaboratively with MHPs to resolve beneficiary service issues. The annual on-site reviews include review of access issues within the MHPs, including availability of services to treat urgent conditions, out-of-county access, availability of provider lists to beneficiaries on request, systems for allowing beneficiaries to make an initial choice of provider or request a change of provider. Beginning this year, the on-site review will include a review of the quality improvement workplan activities to improve appointment waiting times. A copy of the current on-site review protocol is provided as **EXHIBIT B** of the AIR responses; see pages 2 through 7. When problems are identified with MHP service capacity by the Ombudsman's Office or through the annual on-site reviews, DMH Technical Assistance and Training assists MHPs further in clarifying policies and arriving at solutions.

Specialists

The State has set capacity standards for specialists.

Since each community has different demographics and, therefore, different service needs, there are no specific statewide criteria for the capacity of a specialty mental health service provider. Capacity standards, if applicable, are determined by the MHP, since MHPs have flexibility to determine how many and what types of providers with which to contract. As stated in the preceding response, the DMH contract with MHPs requires that the MHP ensure an adequate number of providers to deliver all medically necessary services.

The State monitors access to specialists.

The DMH contract with each MHP requires the MHP to ensure the availability and accessibility of adequate numbers of specialty mental health providers to deliver medically necessary services. DMH conducts an annual onsite Medi-Cal oversight review of each MHP, at which time the State reviews MHP information to determine whether the MHP access to services is in compliance with regulatory standards. **EXHIBIT B** of the State's response to HCFA's AIR contains the protocol used in the Medi-Cal oversight reviews. DMH also requires MHPs to establish complaint and grievance processes, as well as an annual grievance summary report from each MHP, which is compiled into the statewide summary as shown in **ATTACHMENT 8** of the AIR responses. DMH also examines grievance logs during the onsite Medi-Cal oversight review of each MHP, and has established an Ombudsman's Office, as described above, to assist beneficiaries in accessing the services they need.

The State has provisions in MCOs'/PHPs' contracts which allows children with special needs who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs or be allowed direct access to specialists for the needed care.

The Medi-Cal Specialty Mental Health Services Consolidation waiver program is a specialty mental health carve-out program and does not provide primary care services. Children in the special needs categories who are receiving services from the MHP would typically have a separate primary care provider in the fee-for-service Medi-Cal program or in a Medi-Cal physical health managed care plan. The separate mental health waiver program ensures that these children have direct access to mental health specialists. The mental health waiver program does not cover mental health specialists serving as primary care providers, however. In the case of many mental health specialists, this would be outside their scope of practice, e.g., psychologists, licensed clinical social workers (LCSWs) and marriage and family therapists (MFTs). Although psychiatrists are permitted under scope of practice laws to serve as primary care

providers, it is not typically their area of expertise or an effective use of scarce resources.

It is not uncommon for children who are eligible for SSI because of mental illness and children in foster care to require frequent and intensive specialty mental health services. EPSDT funding since 1995 has expanded the resources available to enable MHPs to provide children and adolescents with the services they need, regardless of the frequency they need to utilize mental health specialists. See **ATTACHMENT 11** of the AIR responses for data on increases in utilization and penetration rate for these children.

The State requires particular specialist types to be included in the MCO/PHP network. If specialist types are not involved in the MCO/PHP network, arrangements are made for enrollees to access these services (for waiver covered services only).

The Medi-Cal Specialty Mental Health Services Consolidation waiver program does not require the MHPs to have any particular types of mental health specialists in their networks. Since the program is solely a specialty mental health program and all providers are specialists, such requirements appeared unnecessary. MHP networks include psychiatrists, psychologists, LCSWs, MFTs, and registered nurses. Specific types of licensed and certified facilities also deliver services. Services may also be provided by non-licensed persons under appropriate direction.

The arranging for adequate access to child psychiatrists is one of the more difficult tasks for MHPs with respect to special needs children. Recruitment and retention efforts are ongoing, as well as the development of strategies to extend existing expertise by using child psychiatrists as consultants to other psychiatrists or nurse practitioners. Examples of such efforts are provided in **APPENDIX H**. The ASO process described on pages 5 and 7 that links foster care and adoption assistance children to providers has included special efforts to recruit providers, including child psychiatrists. The ASO did outreach activities to practitioners and potential practitioners in the form of initial mailings announcing the program and soliciting provider enrollment and follow up mailings if the initial mailing did not result in an provider application. Special outreach efforts were made to enroll providers who could provide appropriate cultural, linguistic and geographic access. The ASO must also conduct outreach activities to meet the needs of individual cases and is authorized to pay increased rates for services when access cannot be found at the standard rates, an option that is particularly necessary to find child psychiatrists.

Coordination

The State requires an assessment of each child's needs and implementation of a treatment plan based on their assessment.

California's primary program for assessing the health care needs of children is the Child Health and Disability Prevention (CHDP) program. The CHDP program provides direct assessment services to Medi-Cal eligible children who are part of the Medi-Cal Specialty Mental Health Services Consolidation waiver program and part of the fee-for-service Medi-Cal program or enrolled in a county organized health systems (COHSs) in Santa Barbara, Orange, and Napa Counties. When Medi-Cal eligible children are enrolled in other Medi-Cal managed care waiver programs, the managed care plan provides the CHDP assessment. These Medi-Cal managed care waiver programs include the Two-Plan Model in twelve counties, Geographic Managed Care in Sacramento and San Diego, COHSs in Monterey and Santa Cruz Counties, and Fee-For-Service Managed Care Networks in Sonoma and Placer Counties.

County welfare offices refer new Medi-Cal eligibles to the CHDP program. When eligibility is determined outside the county welfare system (e.g., for SSI eligible children), the State advises new eligibles to contact the county welfare office for information about Medi-Cal benefits when the State sends the Medi-Cal beneficiary identification card to them. Medi-Cal managed care plans are required to provide initial health assessments to new members within 120 days of enrollment.

The CHDP assessment generally follows guidelines established by the American Academy of Pediatrics for periodic assessments of children in relation to their total health care needs. The assessment includes a developmental assessment and age-appropriate anticipatory guidance that serve to identify mental health care needs. Referral for treatment needs identified by the CHDP assessment is an integral component of the CHDP process. The CHDP program as operated in each county and Medi-Cal managed care plans also serve to link children to primary care providers who may identify mental health issues as a part of an ongoing relationship with the child and make appropriate referrals.

MHPs are required to assess all Medi-Cal beneficiaries are referred or who self-refer to the MHP for medical necessity. If the assessment determines that the beneficiary meets medical necessity, the MHP is required to ensure that the beneficiary receives specialty mental health services that meet the beneficiary's needs. MHPs meet this requirement by referring the beneficiary to an MHP contract or employed provider or providers who conduct a more thorough assessment of the beneficiary's needs, develop a client plan, and provide the services included in the client plan. These MHP assessment and treatment obligations are described in Title 9, CCR, Section 1810.345, and in Attachment C of the contract between DMH and the MHP (copies are provided as **APPENDIX E**). If the MHP's assessment determines that the beneficiary does not meet the medical necessity criteria, the MHP is required to provide a notice of action informing the beneficiary of the MHP's decision and advising the beneficiary that the beneficiary is entitled to request assistance from the MHP to

find an appropriate provider outside the MHP, to request a second opinion from the MHP, to file a grievance with the MHP, and/or to request a State fair hearing on the issue.

The outreach efforts described earlier in this document (pages 4 through 7) result in children in the special needs categories being referred to the MHPs, but also involve an assessment of children for specialty mental health needs that may find that the child does not require MHP services. These assessment processes include assessments of public school children by LEAs to determine if mental health issues stand in the way of the child's education and assessments by the foster care system to determine if a foster child has mental health needs (a copy of the screening tool is provided as **APPENDIX F**).

The State has required the MCOs/PHPs to provide case management services to children with special needs.

Medical case management of children with special needs is typically provided by the child's primary care provider, who may be a traditional primary care physician, a pediatrician or, in the case of some children with special needs, a physical health care specialist in the area of the child's particular condition, e.g., an oncologist for a child with cancer. The Medi-Cal Specialty Mental Health Services Consolidation waiver program is a mental health carve-out program and does not include this type of case management. The State provides medical case management to children in the special needs categories in a number of ways. The CHDP program, in addition to arranging for well-child assessments and immunizations, plays a significant role in linking children to primary care providers who then provide medical case management. The CCS program links all CCS eligible children to providers who then provide medical case management of the child's condition. Medi-Cal physical health care managed care plans are required to provide medical case management for all enrollees. Children in the model waiver program receive medical case management, which includes evaluation of the child, consultation with the primary care physician, and linkages to community resources, from a registered nurse as a part of the model waiver program.

MHPs are required to ensure continuity of care and coordination with physical health care. This means that the MHP must ensure that its providers manage the specialty mental health needs of their clients. Collaboration between specialty mental health providers and physical healthcare providers is required by Title 9, CCR, Section 1810.370. These requirements include Memoranda of Understanding (MOU) between MHPs and managed care plans, processes for referrals between plans, and clinical consultation and training.

The State covers targeted case management (TCM) services under the state plan. TCM services are available by diagnostic category or special problem areas, including mental illness (now covered primarily by the MHPs under this

waiver program), rather than by aid categories. County health departments are typically the providers of TCM services and are required to provide for coordination of all care as a part of the TCM plan. TCM services are also available as an EPSDT supplemental service to EPSDT eligible children, which covers the children in all the special needs categories. Medi-Cal physical health care plans cover EPSDT TCM services if TCM services are not already being provided through another program. TCM services are covered by the MHP, but are not specifically required for all children in the special needs categories. MHPs have discretion to determine which types of services are appropriate for each beneficiary, based on the client's assessed needs and coordination with other services that may be provided. TCM services from the MHP are part of the treatment plan for many children with SED, who may be included in any of the special needs categories. Collaboration with educational, social welfare, and juvenile probation aspects of care is required.

The State has developed and implemented a process to collaborate and coordinate with agencies and advocates which serve special needs children and their families.

The Children's Mental Health Services Act, as set forth in Welfare and Institutions Code, Section 5850 et seq., created a children's comprehensive mental health services system, based on coordination of care and interagency collaboration by all publicly funded agencies serving the needs of children with serious emotional disturbances. This systems has helped facilitate collaboration between mental health, social services, school, juvenile justice, and other systems of services in addressing the needs of children with SED, who may be included in any of the special needs categories.

The State worked internally to establish the carve-out of home and community based waiver services and services authorized by the CCS program to ensure that the needs of children in these categories were met. Although the State is unaware of agencies or advocates that are exclusively devoted to any of the special needs categories, the State involved agencies and advocates for children generally in its pre-implementation and ongoing public planning process (see **APPENDIX A** for the Managed Care Steering Committee membership list). As HCFA may be aware, Protection and Advocacy, Inc. (PAI), which advocates for individuals with disabilities, including many children in the SSI and foster child special needs categories, has been particularly active in providing input to the State. PAI has provided HCFA with copies of the material provided to the State; however, the State will provide additional copies on request.

The State has also participated in efforts initiated by others. Both DHS and DMH regularly attend meetings of the Northern California Managed Care for Foster Children Task Force, which includes representatives from county CHDP programs and social services departments, providers, MHPs, and Medi-Cal health plans among others. HCFA Region IX staff attend as well. This group

was formed several years ago to address the expansion of the Two-Plan Model into Bay Area counties, but has focused on Medi-Cal specialty mental health issues beginning in September 1998. These meetings have provided the State with an opportunity to share information and receive input from a wide range of stakeholders who might not otherwise have input to the waiver program.

The State has a process for coordination with other systems of care (for example, Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds) or State/local funding sources.

The State requires the MCO/PHP to coordinate health care services for special needs children with: providers of mental health, substance abuse, local health department, transportation, home and community based waiver, developmental disabilities, and Title V services.

The State has established systems to ensure that there is no overlap in services and payments between the Medicare and Medicaid systems. Coordination of care between the systems must occur at the provider level, however, since Medicare claims information is not available to the State, except indirectly through crossover claims. For other federal/state/local funding sources, the State has insured coordination with these sources by choosing to contract with county mental health departments as the Medi-Cal MHPs. County mental health departments serve children with SED regardless of their Medi-Cal eligibility status. State law requires counties to have MOUs with Regional Centers, the primary source of services for individuals with developmental disabilities, to address the needs of beneficiaries who have both mental illness and developmental disabilities. Counties must maximize their ability to coordinate multiple funding sources to ensure the availability of an adequate service delivery system.

DMH requires MHPs to enter into MOUs with any Medi-Cal managed care plan that enrolls beneficiaries covered by the MHP, per Title 9, CCR, Section 1810.370. Many MHPs also have developed MOUs and Interagency Agreements with regional centers (serving persons with developmental disabilities), schools, rehabilitation agencies, social services agencies, and others. The majority of county mental health departments, which serve as MHPs, also have responsibility for substance abuse services.

Quality of Care

The State has some specific performance measures for children with special needs (for example, CAHPS for children with special needs, HEDIS measures stratified by special needs children, etc.)

DMH implemented a children's performance outcome system on April 1, 1998. There are approximately 62,000 children per year (ages 0 to 17) in the target population (those youth receiving services for 60 days or longer) for administration of the children's performance outcomes instruments. Here is a summary of the data counts we have received to date:

Instrument Administration Counts - Children's Performance Outcome System
(as of 4/20/2000)

	Statewide	Bay Area	Central	Southern	Superior
CAFAS	95,152	14,274	18,604	56,288	5,985
CBCL	51,242	9,157	8,996	34,847	4,969
YSR	37,376	6,527	7,036	20,446	6,812
CLEP	87,490	16,677	20,364	43,908	6,535
CSQ-8	18,172	4,205	3,015	9,638	1,314

CAFAS = Child and Adolescent Functional Assessment Scale (completed by clinician for youth aged 7-18)
CBCL = Child Behavior Checklist (completed by parent/caregiver for youth aged 4-18)
YSR = Youth Self-Report (completed by youth from 11 to 18 year of age)
CLEP = Client Living Environment Profile (completed by clinician/other staff for all youth)
CSQ-8 = Client Satisfaction Questionnaire (completed by parent/caregiver for all youth)

This performance outcome system is not directly targeted at the Medi-Cal population or at children in the special needs categories identified by the State, but does provide information about how county mental health systems are working as a whole.

The State has also produced reports on utilization of services by EPSDT eligible children that includes penetration rate, cost per client per year, cost per beneficiary per year, and unduplicated client counts by MHP and is using these reports to develop an targeted oversight system for EPSDT services (see **ATTACHMENT 11** of the AIR responses. The State will produce similar reports for children in special needs categories that can be identified by aid code on MEDS, if HCFA requests. Data for categories that cannot be identified through MEDS would be more difficult to produce. The State has currently chosen to concentrate on all EPSDT services to provide a reliable picture of each MHPs' system as a whole. DMH experience with the reports developed for the SQIC is that reporting on all data points that may be of interest produces such a large volume of reports as to be unmanageable for decision making.

The State has specific performance improvement projects that address issues for children with special health care needs.

Please refer to the response to the previous question. DMH is also reviewing performance indicator information with the SQIC. The SQIC will use the performance outcome information as a management information tool to guide future policy development, and will develop recommendations for performance improvement based on that analysis.

BBA Safeguards

To the extent appropriate, the State has adequately addressed the Balanced Budget Act (BBA) guidance that HCFA has issued to date.

The State has reviewed the Balanced Budget Act (BBA) guidance provided by HCFA through State Medicaid Directors' Letters. As far as the State has been able to determine, the waiver program, because it involved partial risk prepaid health plans, rather than comprehensive managed care entities, is not directly impacted by the managed care provisions of the BBA. The State expects the program to be covered as soon as the proposed federal regulations that will extend these BBA provisions to prepaid health plans become final. The State, at HCFA Region IX's request, attempted to deal with these issues in our waiver renewal request. HCFA, however, in their formal AIR, has indicated that these issues should be dealt with after the regulations become final.

Payment Methodology

The State develops a payment methodology that accounts for special needs populations enrolled in capitated managed care.

The Medi-Cal specialty mental health services consolidation waiver program is not capitated. Although there is a component of risk in the MHP contracts, there is currently no financial risk for services, other than psychiatric inpatient hospital services, provided to children in the special needs categories. MHPs receive full FFP for services provided to children under 21 and full state general funds above a maintenance of effort amount up to the MHPs' costs through a special EPSDT funding arrangement. Additionally, a portion of the EPSDT state general funds are paid “up front” to enable MHPs to establish the infrastructure to provide services to children and adolescents who qualify for EPSDT.

Monitoring

The State has in place a process for monitoring children with special needs enrolled in MCOs/PHPs for access to services, quality of care, coordination of care and enrollee satisfaction.

DMH conducts an annual onsite Medi-Cal oversight review of each MHP, at which time the State reviews MHP information to determine whether access to services, quality of care, and coordination with physical health care by the MHP

is in compliance with regulatory standards. **EXHIBIT B** of the State's responses to the AIR contains the protocol used in the Medi-Cal oversight reviews. During the annual on-site reviews, DMH conducts focus groups with beneficiaries and family members, including parents of children, to solicit direct consumer feedback on the access to services and beneficiary protection program provided by the MHP. DMH also conducts intensive on-site reviews (sometimes called focused reviews) of MHPs when issues requiring special attention are identified by DMH staff or by referral from beneficiaries, advocates or other stakeholders.

When compliance problems are identified, the State has the authority to take appropriate action to correct the problems. Sanction authority includes the authority to require the MHP to submit a plan of correction, to withhold all or a portion of the payments due to the MHP; to impose fines from $25 to $5,000 per violation, depending on the issue; to require MHPs to meet additional requirements in problem areas, to terminate the MHP contract; and to take other actions necessary to ensure compliance.

The State has standards or efforts in place regarding MCOs'/PHPs' compliance with ADA access requirements for enrollees with physical disabilities

MHPs are contractually bound to comply with all applicable federal requirements. The DMH annual Medi-Cal oversight review of each MHP includes a component that reviews MHP contracts with direct care providers. State regulations at Title 9, CCR, Section 1810.436 require contracts to contain provisions that ensure the provider conforms all federal requirements described in 42 Code of Federal Regulations, Section 434.6, Title IX of the Social Security Act, as well as all other applicable federal and state statutes and regulations. MHPs found to be out of compliance with these standards must submit a plan of correction in response to the oversight review report.

The State defines medical necessity for MCOs/PHPs and the State monitors the MCOs/PHPs to assure that it is applied by the MCOs/PHPs in their service authorizations.

State regulations at Title 9, CCR, Sections 1820.205, 1830.205, and 1830.210 define medical necessity requirements for reimbursement of psychiatric inpatient hospital services and other specialty mental health services. These requirements are applied statewide. For the children in the special needs categories, all of whom are EPSDT eligible, medical necessity for services, other than psychiatric inpatient hospital services, is met if the child has one of the diagnoses covered by the MHP, the diagnosis would not be responsive to physical health care based treatment, and the specialty mental health service would correct or ameliorate the child's condition. MHPs are not at financial risk for the services provided to EPSDT eligible children, which includes all children in the special needs categories, so there is no financial incentive for MHPs to deny care inappropriately. DMH annual on-site reviews look at MHP

authorization processes generally, the relationship to the MHP utilization management function and the process for issuing notices of action if services are denied (see **EXHIBIT B**, pages 8 through 10) and, beginning this year, will review a sample of beneficiary charts for a number of issues, including medical necessity (see **EXHIBIT B**, pages 27 through 31).