



MCHAP September 13, 2016

Mental Health & Substance Use Disorder Services



Presentation

- State-level Mental Health and Substance Use Disorder Services (MHSUDS) Administration
 - California's Historical Milestones: 50 Years
 - Federal and State Funding Mechanisms
 - Substance Use Disorder Services
 - Specialty Mental Health Services (SMHS)
-



MHSUD Administration

- In 2012 through 2013, CA transferred the former Department of Mental Health and the Alcohol and Drug Programs Departments to the Department of Health Care Services (DHCS)
- DHCS established MHSUDS Division
- MHSUDS Division is under one Deputy Director who reports directly to the Director of DHCS
 - Substance Use Disorder Services
 - Specialty Mental Health Services
- In 2014 California expanded the substance use and mental health benefit for mental health and substance use disorder services. The provision of these services was placed under Health Care Delivery Systems within DHCS
- DHCS is California's single state agency (SSA) for Medi-Cal, California's Medicaid Program



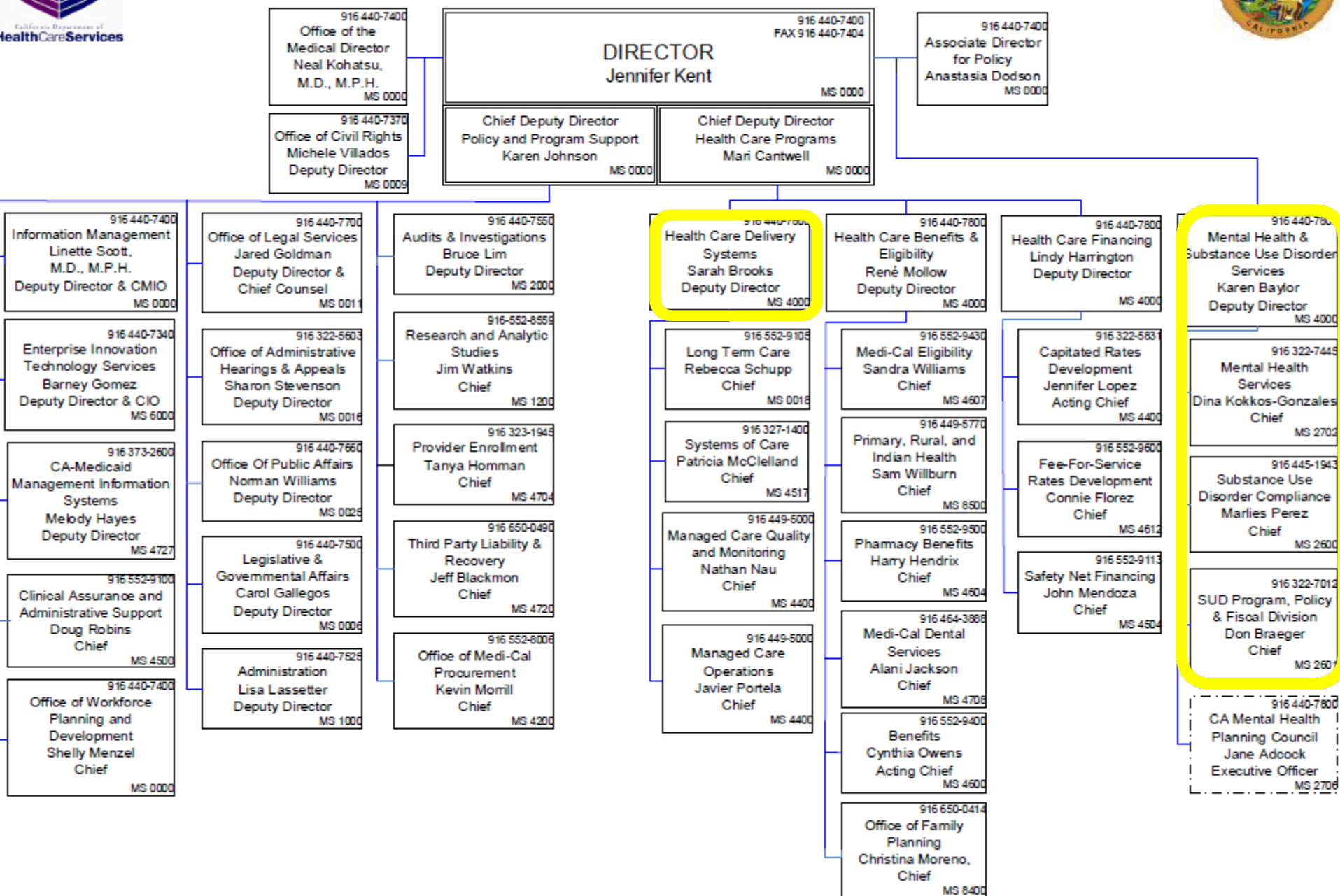


Department of Health Care Services

June 14, 2016



California Department of
Health Care Services



History

1957	California State legislature enacts the Short-Doyle Act <ul style="list-style-type: none">By the end of this year, there was a total of 14 state hospitals with a population of 36,319
1966	Medi-Cal is established <ul style="list-style-type: none">Title XIX of the Social Security Act authorized the Federal Government to reimburse states for the costs.The Act requires states to share in the costs of Medicaid expenditures and permits state and local governments to participate in financing the non-federal share of Medicaid expenditures
1971	Traditional Medi-Cal benefits expand to include Short-Doyle/Medi-Cal (SD/MC) community mental health services which allowed counties to obtain federal funds to match their own funding. <ul style="list-style-type: none">SD/MC offered a broader range of mental health services
1972-3	Governor Reagan vetoed provisions to use savings from state hospitals closures to fund community mental health programs



History

1974	Legislature requires all counties to have mental health programs
1978	Legislature combined the Governor's Office of Alcoholism and the California Department of Health Services Division of Substance Use
1984	AB 3632 (McGuire) assigns county mental health departments the responsibility to provide special education students with mental health services
1991	Bronzan-Wright-McCorquodale Realignment Act of 1991 <ul style="list-style-type: none">• An effort to stabilize local SMHS budgets



Mental Health Funding Landscape

On-going funding challenges prior to 1991

- Annual state budget shortfalls
- Historically, there was no dedicated funding stream for mental health
- Programs were funded on a year to year basis subject to appropriation by the Legislature
- Result was that funding was unpredictable which made it difficult to plan



1991 Realignment

Provided greater stability in the provision and payment of mental health services for those in need

- Established three dedicated revenue sources to fund county mental health programs
 - ❖ ½ cent of state sales tax
 - ❖ state vehicle license fees
 - ❖ state vehicle license fee collections
- Shifts authority from state to counties for mental health programs
- To the extent resources are available, mental health funds should be to serve target populations



1991 Realignment

Target Populations:

- **Seriously and emotionally disturbed children or adolescents**
- **Adults with DSM diagnosis other than a substance use disorder or developmental disorder or Traumatic Brain Injury (TBI)**



1991 Realignment

Stabilized an array of services to be provided to children and adults (to the extent resources are available):

- Pre-crisis and Crisis
- Comprehensive Evaluation and Assessment
- Individual Service Plan
- Medication Education and Management
- Case Management
- Twenty-Four Hour Treatment



History

1993	California adopts the Medicaid Rehabilitation Option to expand community mental health services (State Plan Amendment)
1994	Sobky v. Smoley lawsuit which ended limits on utilization of Drug Medi-Cal by ruling that drug treatment is an entitlement.
1995	Medi-Cal Managed Care is implemented. <ul style="list-style-type: none">• 1915(b) SMHS Waiver
1995	California institutes Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT)



Early and Periodic Screening Diagnosis and Treatment

- “..The right care to the right child at the right time in the right setting.”
- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services
- As part of the lawsuit (T.L. v Belshe), the state agreed to provide state general fund to counties as the match for these expanded services
- Counties assumed responsibility for providing these services which included SMHS



1915(b) Specialty Mental Health Services Waiver

- Consolidated the Psychiatric Inpatient Hospital services provided through the fee-for-service (FFS) delivery system and the Short Doyle/Medi-Cal system (SD/MC).
- County mental health departments became responsible for both FFS and SD/MC psychiatric hospital systems for the first time.
- All Medi-Cal beneficiaries must receive SMHS through the county: The 1915(b) Medicaid waiver waives “freedom of choice” for the beneficiary.
- This resulted in the risk for this entitlement program shifting from the state to the counties.



History

**1995
through
1998**

- Consolidated Fee For Service and Short-Doyle Medi-Cal Programs into one “carved out” specialty mental health managed care program via a phase-in waiver process
- Consolidation allowed for more flexibility in the use of state funding by the counties and enabled more integrated and coordinated care
- Local governments must certify that the expenditures are eligible for Federal Financial Participation (FFP)



History

2003	Passage of Proposition 36 Substance Abuse and Crime Prevention Act
2004	Voters approve the Mental Health Services Act (Proposition 63)
2008	The US Mental Health Parity and Addiction Equity Act of 2008 requires group health insurance plans to offer coverage for mental illness and SUD
2010	The Patient Protection and Affordable Care Act (ACA)



History

October 1, 2011	Assembly Bill 109 – began “Public Safety” Realignment
2012	Assembly Bill 114 (Carter) transferred responsibility for educationally related mental health services (formerly AB 3632) to local education agencies (LEAs)
November, 2012	Constitutional Amendment - Proposition 30
January 1, 2014	MH and SUD benefits were expanded in CA. APL 13-021
June 24, 2015	CMS approved 9 th 1915(b) SMHS Waiver Renewal
August 13, 2015	CMS approved the 1115 Waiver for the Drug Medi-Cal Organized Delivery System



2011 Mental Health Funding Landscape

Motivating Factors:

- \$26 billion budget gap and expiring taxes
- Federal 3 Judge Panel on prison overcrowding
- Move government closer to the people where the services are delivered



2011 Realignment

Benefits

- California could build on previous success of state-county realignment
- Realignment funding is constitutionally protected
- Funded with 1.0625 cent sales tax until 2017, state constitutionally obligated to pay equivalent thereafter



2011 Realignment

In addition to mental health services, California realigned

- Drug Medi-Cal,
- Women and Children’s Residential Treatment Services
- Drug Court
- A Realignment Behavioral Health Subaccount was created, funded through sales tax revenue and distributed to counties



2011 Realignment

- There are no separate accounts for the realigned programs within the Behavioral Health Subaccount
- All BH realigned programs must be funded through this subaccount
- Realignment “superstructure” language
 - Created separate accounts between the Support Services (Health and Human Services) and Law Enforcement Service Accounts



2011 Realignment

- Any Medi-Cal beneficiary (adults and children) who meets medical necessity criteria is entitled to receive SMHS
 - DSM Diagnosis (with some exceptions)
 - Significant impairment or probability of significant deterioration in an important area of life



Summary of Funding Mechanisms

Substance Use Disorders

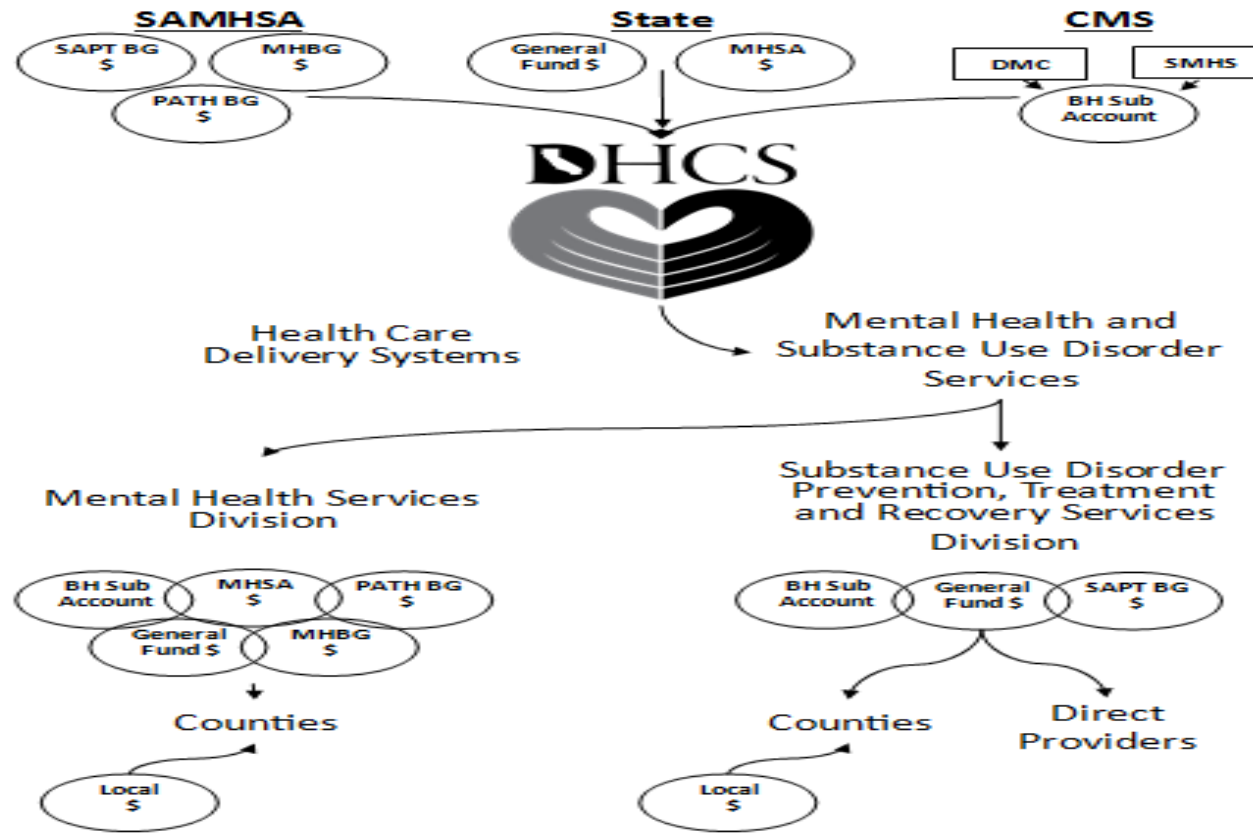
- Drug Medi-Cal
- Substance Use Prevention and Treatment Block Grant
- State General Funds (expansion population)

Mental Health Services

- Medi-Cal (includes EPSDT)
- SAMHSA Grants
- 1991 Realignment
- Mental Health Services Act
- 2011 Realignment
- County General Funds



At A Glance: Federal, State & County Funding





MCHAP September 13, 2016

Substance Use Disorder Services



CMS Demographics

- 12% of adult Medicaid beneficiaries have a Substance Use Disorder
- 15% of uninsured individuals who may be newly eligible in the new adult group have an SUD
- Two of the top reasons for Medicaid 30-day hospital readmissions are SUD-related
- Drug overdose is now the leading cause of injury or death, causing more deaths than traffic crashes



SUD State Plan Services

- Modalities
 - Outpatient Drug Free (ODF) - all populations
 - Narcotic Treatment Programs (NTP) - all populations
 - Residential - perinatal only in facilities that are not Institutes for Mental Disease (IMDs)
 - Intensive Outpatient Therapy (IOT) - perinatal only
- NTP 34 percent of beneficiaries served
- ODF 58 percent of beneficiaries served



ACA Expansion

- Increased Eligible Beneficiaries (Expanded Population)
- California chose to expand modalities
 - Intensive Outpatient Treatment (for Mandatory and Expanded Populations)
 - Residential (for Mandatory and Expanded Populations)



Residential Restrictions

- Residential needed in the continuum of care
- Restricted due to the IMD exclusion
- Ninety percent of California's residential bed capacity is considered an IMD
- Clients in IMD's restricted from all Medi-Cal services
- Without the DMC-ODS Waiver Pilot, California cannot provide residential services



CMS SMD #15-003

- CMS issued a guidance letter July 27, 2015 to inform states of opportunities to design and test innovative policy and delivery approaches for individuals with SUD
- California is the first state to receive approval under this guidance



ODS Waiver Goals

- The goal is to improve SUD services for California beneficiaries
- Authority to select quality providers
- Consumer-focused; use evidence based practices to improve program quality outcomes
- Support coordination and integration across systems



ODS Waiver Goals

- Reduce emergency rooms and hospital inpatient visits
- Ensure access to SUD services
- Increase program oversight and integrity
- Place client in the least restrictive level of care utilizing The American Society of Addiction Medicine (ASAM) Criteria



Standard Terms and Conditions

- Pilot provides a framework that allows for innovative efforts
- Tremendous system changes at all levels
- Partnership at the county, state and federal levels of government to make the pilot successful



Standard Terms and Conditions

- DMC-ODS part of Medi-Cal 2020
- Counties choose to opt-in
- Counties act as managed care plan for SUD services
- ODS is for adult and youth services
- Beneficiaries must reside in opt-in county
- Five-year demonstration



Early and Periodic Screening Diagnosis and Treatment

- Current SUD benefit
- All beneficiaries under age 21 are eligible
- Most SUD services have been rendered in outpatient and/or school settings
- Nothing in the ODS waiver overrides any EPSDT requirements



Standard Terms and Conditions

- Comprehensive evidence-based benefit design:
Continuum of Care
 - Required services: Outpatient, Intensive Outpatient, Residential, Narcotic Treatment Program, Withdrawal Management, Recovery Services, Case Management, Physician Consultation
 - Optional services: Partial Hospitalization, Additional Medication Assisted Treatment



Standard Terms and Conditions

- Appropriate Standards of Care: Utilization of The ASAM Criteria
 - Providers must be trained in ASAM
 - Residential providers must receive DHCS issued ASAM Designation for Levels 3.1, 3.3 and/or 3.5
 - Beneficiaries must meet ASAM Criteria definition of medical necessity



Standard Terms and Conditions

- Care Coordination
 - MOUs with Managed Care Plans and counties
 - Coordination of case management responsibilities
 - Comprehensive substance use, physical and mental health screening
 - Process for dispute resolution
 - Provide care transitions including aftercare and recovery support services
 - Collaboration with Physical and Mental Health services



Standard Terms and Conditions

- Integration of Physical Health and SUD
 - Specify an integration approach: April 2016
 - Integration concept design: Oct 2016
 - Implementation goal: April 2017
 - Two Pilot Themes: Health Information Exchange and Payment Reform



Standard Terms and Conditions

- Program Integrity Safeguards
 - State monitoring efforts
 - High risk screening
- Strong Network Development for Access
 - Developing access standards with Mental Health
 - Requiring Narcotic Treatment Programs
 - Expanding workforce with LPHAs



Standard Terms and Conditions

- Benefit Management-Utilization Reviews
 - Prior authorization for residential services
 - Triennial Reviews
 - External Quality Review Organizations
- Reporting of Quality Measures
 - Counties will report data to DHCS
 - Quality Improvement Plan required for counties
 - UCLA evaluation of DMC-ODS



Standard Terms and Conditions

- Strategies to Address Opioid Use Disorder
 - Meets two of the US Department HHS Secretary's three priority issues:
 1. Expanded use and distribution of naloxone and
 2. Expansion of Medication Assisted Treatment (MAT)
 - Expanding MAT in various settings
 - Removing barriers to MAT expansion



Intersection with Other Efforts

- SBIRT: Screening, Brief Intervention and Referral to Treatment efforts
- Health Homes
- Whole Person Care Pilot: Medi-Cal 2020
- Specialty Mental Health 1915(b) waiver
- Criminal Justice System
- Foster Care



Training and Technical Assistance

- DHCS secured a contractor in January 2016 to provide training and TA in key focus areas
 - ASAM Training
 - Selective Contracting
 - Quality Assurance Processes
 - Medication Assisted Treatment
 - Continuum of Care



External Quality Review

- EQRO contractor secured in January 2016
- Rolling out EQR's in phases
- EQR requirements must be phased in within 12 months of approved county plan
- Connecting and collaborating with UCLA and Mental Health EQRO efforts



UCLA Evaluation

- Multiple baseline design
- Utilizing quantitative and qualitative data
- Use existing data where possible
- Supplement with new data collection while attempting to minimize the burden on stakeholders



UCLA Evaluation

Evaluate the Organized Delivery System

- Access to care
 - Quality of care
 - Coordination of care
 - Within SUD continuum of care
 - With recovery support services
 - With mental and physical health services
 - Costs
-



Implementation Phases

Phase I – Bay Area (May 2015)

Phase II – Southern California (Nov 2015)

Phase III – Central Valley (March 2016)

Phase IV – Northern California

Phase V – Tribal Delivery System



More Information

- DHCS website
 - FAQs and Fact Sheets
 - ASAM Designation
 - Approval Documents
- <http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx>





Specialty Mental Health Services

MCHAP September 13, 2016



DHCS-MHSUDS ORGANIZATIONAL CHART

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1915(b) SMHS Waiver

- The State Plan and the 1915(b) Specialty Mental Health Services (SMHS) Waiver is California's agreement between Centers for Medicare and Medicaid Services (CMS) and DHCS, as the SSA, for the administration of the SMHS program.
- 1915(b) SMHS Waiver allows for the delivery of SMHS through a managed care delivery system.
- Through California's 1915(b) SMHS Waiver, 56 local county mental health plans (MHPs) are responsible for the local administration and provision of SMHS.



Section 1915(b) SMHS Waiver

Federal Requirements Waived:

- **Freedom of Choice:** Each beneficiary must have a choice of providers
- **Statewideness:** Benefits must be available throughout the state
- **Comparability of Services:** Services must be comparable for individuals (i.e., equal in amount, scope, duration for all beneficiaries in a covered group)



Section 1915(b) SMHS Waiver

Section 1915(b) Waiver Authority:

- Allows states to implement managed care delivery systems, or otherwise limit individual choice of provider
- May not be used to expand eligibility to individuals not eligible under the approved Medicaid state plan
- Cannot negatively impact beneficiary access, quality of care, and must be cost effective



1915(b) SMHS Waiver Renewal

- Current SMHS waiver term: July 1, 2015 - June 30, 2020
- SMHS Waiver approved with Special Terms and Conditions (STCs)



1915(b) SMHS Waiver Sections (A-D)

Section A: Program Description

- Describes the delivery system, geographic areas served, populations served, access standards, quality standards, and program operations (e.g. marketing, enrollee rights, grievance system, etc.)

Section B: Monitoring Plan

- Describes the monitoring activities planned for the upcoming waiver term

Section C: Monitoring Results

- Describes monitoring results for the most recent waiver term

Section D: Cost Effectiveness

- Projects waiver expenditures for the upcoming waiver term



Mental Health Plan Contract

- Contract required pursuant to state and federal law.
- Delineates the MHPs' and DHCS' responsibilities and requirements in the provision and administration of SMHS.
- Conforms with federal requirements for Prepaid Inpatient Health Plans (PIHPs). MHPs are considered PIHPs and must comply with federal managed care requirements (Title 42, CFR, Part 438) that apply to PIHPs.
- Current MHP contract term: May 1, 2013-June 30, 2018.

<http://www.dhcs.ca.gov/services/MH/Pages/POCB-MentalHealth-Overview.aspx>



Medicaid State Plan

- The official contract between the Single State Agency (DHCS) and CMS by which a state ensures compliance with federal Medicaid requirements to be eligible for federal funding.
- Developed by DHCS and approved by CMS.
- Describes the nature and scope of Medicaid programs and gives assurances that it will be administered in accordance with the requirements of Title XIX of the Social Security Act, Code of Federal Regulations, and other applicable federal/state laws.

<http://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx>



MHP Compliance Reviews

DHCS conducts compliance activities to ensure that MHPs and their contract providers comply with federal and state laws, regulations and the MHP contract requirements.

- **Triennial onsite reviews**
 - **System reviews**
 - Review evidence of compliance related to consolidated SMHS and other funded services
 - **Outpatient chart reviews**
 - Verify medical necessity and other requirements are met
 - **Inpatient Short-Doyle Medi-Cal chart reviews**
 - Verify medical necessity criteria have been met for each hospital day that a beneficiary is in a psychiatric unit or hospital



Quality Assurance Monitoring

- Validating Plans of Correction
- 24/7 Test Calls
- Reviewing Quality Improvement Plans
- Reviewing Annual Grievance and Appeal Reports
- Reviewing EQRO MHP Specific Reports
- County Technical Assistance



External Quality Review Organization

- Required by Title 42, Code of Federal Regulations, Section 438, Subpart E
- Validates federally required quality improvement activities
- Analyzes and validates information related to quality, timeliness, and access to SMHS provided by MHPs and their subcontractors
- Conducts site reviews
 - Beneficiary and family member focus groups
 - Staff focus groups
 - Data analysis and reporting
 - Information system reviews
 - Performance Improvement Project evaluation



Mental Health Services Responsibilities

Dimension	Medi-Cal MCP	MHP Outpatient	MHP Inpatient
Services	<p>Mental health services when provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license:</p> <ul style="list-style-type: none"> • 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 medication therapy • Outpatient laboratory, medications, supplies, and supplements • Psychiatric consultation 	<p>Medi-Cal SMHS:</p> <ul style="list-style-type: none"> • Mental Health Services <ul style="list-style-type: none"> o Assessment o Plan development o Therapy o Rehabilitation o Collateral • Medication Support Services • Day Treatment Intensive • Day Rehabilitation • Crisis Residential • Adult Crisis Residential • Crisis Intervention • Crisis Stabilization • Targeted Case Management 	<ul style="list-style-type: none"> • Acute psychiatric inpatient hospital services • Psychiatric Health Facility Services • Psychiatric Inpatient Hospital Professional Services if the beneficiary is in fee-for-service hospital

Memorandum of Understanding (MOU)

Locally MHPs and Managed Care Plans (MCPs) use memoranda of understanding (MOU) to ensure the coordination of mental health services to meet the needs of beneficiaries

Objectives:

- Ensure coordination between the MCPs and MHPs
- Promote local flexibility that exists at the county level

Core elements:

- Basic Requirements
- Covered Services and Populations
- Oversight Responsibilities of the MCP and MHP
- Screening, Assessment, and Referral
- Care Coordination
- Information Exchange
- Reporting and Quality Improvement Requirements
- Dispute Resolution
- After-Hours Policies and Procedures
- Member and Provider Education

Statutes and Regulations

- Title 42, Code of Federal Regulations
<http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR>
- California Welfare and Institutions Code commencing with 14700 et seq.
<http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=wic>
- Title 9, California Code of Regulations, chapter 11, Medi-Cal Specialty Mental Health Services, commencing with 1810.100 et seq.
<http://www.oal.ca.gov/CCR.htm>
- DHCS SMHS Waiver Website
[http://www.dhcs.ca.gov/services/MH/Pages/1915\(b\)_Medi-cal_Specialty_Mental_Health_Waiver.aspx](http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx)



1915(b) SMHS WAIVER: SPECIAL TERMS AND CONDITIONS



Special Terms and Conditions

1. On an annual basis, the state must make readily available to beneficiaries, providers, and other interested stakeholders, a mental health plan **dashboard** that is **based on performance data of each county mental health plan** included in the annual CalEQRO technical report and/or other appropriate resources. Each county mental health plan dashboard must be posted on the state's and the county mental health plan website. Each dashboard will present an easily understandable summary of **quality, access, timeliness, and translation/interpretation capabilities** regarding the performance of each participating mental health plan. The dashboards must include the performance of subcontracted providers. The state will determine how the data on the performance of subcontracted providers will be collected and the associated timeframe. The state will update CMS on this process. Between July 1, 2015 and July 1, 2016, the state and CMS will collaborate on developing the format for the dashboard. The first dashboard is due on September 1, 2016, and may not include information on the subcontracted providers; however, that information should be included in subsequent dashboards. The state will note when a plan doesn't have subcontractors, or if a plan is unable to report on subcontractors on a particular dashboard.



Special Terms and Conditions

2. The state must require each county mental health plan to commit to having **a system in place for tracking and measuring timeliness of care, including wait times to assessments and wait time to providers.** The state needs to **establish a baseline** of each and all counties that **includes the number of days and an average range of time it takes to access services in their county.** If county mental health plans are **not able to provide this information** so that the state can establish a baseline, this will be accomplished through the use of a statewide performance improvement project (**PIP**) for all county mental health plans. In addition, a **PIP to measure timeliness of care will be required for those counties who are not meeting specified criteria.** The criteria will be developed collaboratively between the state and CMS. This has significant potential for improving patient care, population health, and reducing per capita Medicaid expenditures.



Special Terms and Conditions

3. The state will provide the **CalEQRO's quarterly and annual reports** regarding the required PIPs to CMS, and discuss these findings during monthly monitoring calls.
4. The state will **publish on its website** the county mental health plans' **Plan of Correction (POC)** as a result of the state compliance reviews. The state and county mental health plans will publish the county mental health Quality Improvement Plan. The intent is to be able to identify the county mental health plan's goals for quality improvement and compliance.
5. The state and the county mental health plans will provide to CMS the **annual grievance and appeals reports by November 1st of each year**. Since DHCS is in the process of revising the reporting form, the first report will be provided by January 31, 2016. The state will notify CMS by December 1, 2015 if it is unable to meet the January 31, 2016 deadline.
6. All information required to be published pursuant to these STCs, will be placed in a standardized and easily accessible location on the state's website.
 - [http://www.dhcs.ca.gov/services/MH/Pages/1915\(b\)_Medical_Specialty_Mental_Health_Waiver.aspx](http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medical_Specialty_Mental_Health_Waiver.aspx)
7. The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this waiver approval period, unless the provision being changed is expressly waived or identified as not applicable.



Current Mental Health Efforts Related to Children and Youth



Continuum of Care Reform

DHCS as a Partner



WHAT IS THE CONTINUUM OF CARE REFORM (CCR)?

CCR draws together a series of existing and new reforms to child welfare services designed out of an understanding that children who must live apart from their biological parents do best when they are cared for in committed nurturing family home

AB 403/AB 1997 provides the statutory and policy framework to ensure services and supports provided to the child or youth and his or her family are tailored toward the ultimate goal of maintaining a stable permanent family

Reliance on congregate care should be limited to short-term, therapeutic interventions that are just one part of a continuum of care available for children, youth and young adults



CCR

- Changes to licensure and rate structures for group homes and Foster Family Agencies (FFAs).
- Group care will be primarily utilized only for Short-term Residential Therapeutic Programs (STRTPs) that provide intensive treatment interventions.
- Foster Family Agencies (FFA) are re-envisioned to provide various levels of care to meet a broader range of individual child needs



CCR

- Statewide implementation of the Resource Family Approval (RFA) process will improve selection, training and support of families under a streamlined, family friendly process for approving families (including relatives) seeking to care for a child in foster care, whether on an emergency, temporary or permanent basis. All families will receive training
- Services and supports will be tailored to the strengths and needs of a child and delivered to the child/youth in a family-based environment. These services and supports will be informed by an assessment and developed through a child and family team process.



CCR

- <http://www.cdss.ca.gov/ccr/>



Katie A. History and Background



Katie A.

- A 14-year-old girl in 2002
- In foster care for 10 years
- Moved through 37 different placements:
 - Placed in 4 group homes
 - 9 stays at psychiatric facilities
 - A two-year stay at the Metropolitan State Hospital &
 - 7 different stays at MacLaren Children's Center
- A victim of trauma and needed intensive trauma treatment, and supportive services for her caregiver



Katie A. Settlement Agreement

In December 2011, a Settlement Agreement was reached in the case. The objectives were to:

- Facilitate the provision comprehensive, community-based services
- Support the development and delivery of a service structure and a fiscal system
- Support effective and sustainable standards/methods
- Address the need for subclass members with more intensive needs to receive medically necessary mental health services in their own homes, or the most home-like settings



Pathways to Well-Being

- Jurisdiction over the Katie A. Settlement Agreement ended in December 2014
- De-branded from referring to "Katie A." to using the term *Pathways to Mental Health Services*
- Now transitioning to *Pathways to Well-being*



Pathways to Well-Being

- Children and youth who have greater needs, requiring more intensive services
- Eligible to receive Specialty Mental Health Services (SMHS):
 - Intensive Care Coordination (ICC)
 - Intensive Home Based Services (IHBS)
 - Therapeutic Foster Care (TFC) Services





**THERAPEUTIC
FOSTER CARE (TFC)
Service Model**

TFC SERVICE MODEL

-
- **The TFC Service Model is intended for children and youth who require intensive and frequent mental health support in a one-on-one environment.**
 - **It allows for the provision of certain Medi-Cal Specialty Mental Health Services (SMHS) components (plan development, rehabilitation and collateral) available under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit as a home-based alternative to high level care in institutional settings such as group homes, and in the future, as an alternative to Short Term Residential Treatment Placements (STRTPs). TFC homes may also serve as a step down from STRTPs.**
 - **This service model is but one service option in the continuum of care for eligible children and youth.**



Eligibility Criteria

Available as an EPSDT benefit to:

- **Full scope Medi-Cal children & youth (up to age 21) who have more complex emotional and mental health needs; AND**
- **Who meet medical necessity criteria for SMHS per California Code of Regulations (CCR), Title 9, Chapter 11, Section 1830.205 or Section 1830.210**

****DHCS is in process of establishing specific service criteria***



Next Steps

- **Finalize and release the TFC Service Model, TFC Parent Qualifications, and FAQs**
- **Update Medi-Cal Manual for ICC and IHBS to include TFC**
- **Trainings**



Helpful Resources

References:

- **Joint Information Notices:**
 - **CDSS ACIN #1-06-16/MHSUDS IN #16-002**
 - **CDSS ACIN # I-52-16E/MHSUDS IN #16-031E**
- **MHSUDS IN #16-004**
- **[CDSS Resource Family Approval Fact Sheet](#)**
- **CIBHS TFC Website:**
<http://www.cibhs.org/therapeutic-foster-care-tfc-services>



Crisis Services



Crisis Services for Children and Youth

- Pursuant to Title 9, California Code of Regulations, children and youth who are eligible to receive Medi-Cal SMHS in crisis are entitled to receive the following medically necessary services:
 - Crisis Residential Treatment Service (Title 9, §1810.208),
 - Crisis Intervention (§1810.209),
 - Crisis Stabilization (§1810.210),
 - Psychiatric Health Facility (§1810.237),
 - Psychiatric Inpatient Hospital (§1810.238), and
 - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (Title 42, United States Code (USC), Section 1396d(r)).
- MHPs are required to provide and arrange for such services pursuant to their contractual requirements.



Addressing Crisis Services for Children and Youth

- Improving access to a full continuum of crisis services available for children, youth, and families
- Increasing mobile and community-based services
- Availability of acute psychiatric beds
- Geographical challenges impacting access to timely crisis services
- Utilization of Emergency Rooms/Emergency Department
- Licensure requirement for Crisis residential treatment services programs is social rehabilitation facilities (SRF). By definition, SRFs only provide services to adults.
- Capacity



DHCS Efforts To Address the Challenges

- DHCS completed a survey on county MHPs capacity and availability to provide and arrange for crisis and inpatient services in county, countywide, and if accessible 24 hours a day, 7 days week for all ages.
- DHCS identified gaps in the analysis and further efforts are currently underway:
 - Collaboration with the Mental Health Services Oversight and Accountability Commission (MHSOAC) to develop strategies and processes to improve crisis services,
 - Identify innovative program designs and service delivery models supported by evidence-based practices (diversion, full service partnerships, field-based service, drop-in centers, wellness centers, intensive home-based, etc.),
 - Explore challenges and barriers MHPs experience in providing a continuum of crisis services and provide technical assistance
 - Address how DHCS can improve monitoring and oversight of crisis services to track outcomes and provide technical assistance to counties.



Other Efforts to Improve Crisis Services

- **MHSOAC Report: Improving Crisis Services for California's Children and Youth**
 - Develop recommendations for improving the delivery of crisis services
 - Identify outcomes and strategies to measure for children, youth, and families accessing crisis services
 - Develop new strategies and/or identify existing models to improve access to effective crisis services for children and youth
- **Senate Bill 82**
 - Investment in Mental Health Wellness Act 2013 established a competitive grant program to disburse funds to California counties to their nonprofit or public agency designees for the purpose of developing mental health crisis support programs.
 - Since, April 2014 an estimated total funding awarded in four rounds was \$114,777,576 to the following programs: crisis residential, crisis stabilization, mobile crisis, and mobile crisis (personnel funding). The fifth round allocates an additional estimated total grant funding of \$31,775,383.



Thank you!

