



November 10, 2021

Michelle Baass, Director
Department of Health Care Services
1501 Capitol Ave
Sacramento, CA 95814

RE: Response to Behavioral Health Information Notice No: 21-XXX on Criteria for beneficiary access to Specialty Mental Health Services

Dear Director Baass,

The California Alliance of Child and Family Services (the Alliance), representing 157 community-based agencies serving children, youth, and families in public human services systems respectfully submits the following comments and recommendations on Draft Behavioral Health Information Notice No: 21-XXX regarding criteria for beneficiary access to specialty mental health services. We appreciate the collaboration from the Department of Health Care Services on this critical guidance related to the California Advancing and Innovating Medi-Cal (CalAIM) Initiative, as it has the potential to change our paradigm for serving children in specialty mental health programs, moving away from a diagnosis-driven system that pathologizes children, to one that serves children before a crisis point and focusses on strengths and wellness.

Trauma Screening

Request for Guidance on High-Risk vs High-Score. The guidance listed in the Draft Behavioral Health Information Notice No: 21-XXX for enrolled beneficiaries under 21 years of age (on page 4, criteria 1) states:

“Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) below:

- (1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.”

We want to stress here that the child may not necessarily need to have a “high risk range” score (i.e., 3 – 4 + on the PEARLS) on the trauma tool to place them at high risk for a mental health disorder. Specialty mental health services (SMHS) should be provided based on the child’s experience of trauma, which places the child at risk for a mental health disorder. The experience of trauma should be considered the condition. **We would like to request that DHCS release clear guidance on the difference between those two categories (high risk and high score).**

We suggest that DHCS clarify that, if a child has experienced trauma that is “evidenced by scoring in the high-risk range under a trauma screening tool” (or “significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional”) then that youth is eligible for SMHS, regardless of whether they have a current or suspected mental health disorder, as long as the Medi-Cal claim for the service provided cites a Z or V code that reflects the trauma the youth has experienced.

Children should be able to receive medically necessary services to help heal from their trauma without further diagnosis unless an additional diagnosis is warranted. For example, too often children in the child welfare system accumulate a long list of diagnoses that are stigmatizing, contradictory, and negatively impact them into adulthood. Children and youth have repeatedly raised the importance of not pathologizing them as a result of their trauma. Given the concerns about unnecessarily stigmatizing and pathologizing children who have experienced complex trauma, it is important to clarify that V and Z codes can and may also be used for children and youth receiving specialty mental health services based on criteria 1.

We strongly recommend that the State consider the Child and Adolescent Needs and Strengths Assessment (CANS), or related Crisis Assessment Tool (CAT) for use as approved trauma screening tools. The IP-50 includes trauma exposure items as well as adjustment to trauma, indicating trauma symptoms irrespective of number of traumas. Further, requiring a certain number of traumas, e.g., 3-4+ on the PEARLS does not take into account that a single traumatic incident could have a significant impact on a child's mental health. For example, we know from recent research that exposure to community violence is correlated with high mental health needs (just as high or higher than interpersonal traumas). As such, a simple count of ACEs isn't sufficient to determine the mental health impacts and needs resulting from trauma exposure. As DHCS considers the PEARLS, CANS, and other trauma screening tools, it is important to note that a simple count of traumas is not sufficient to indicate high-risk. Recent ACEs research suggests that assigning weights to ACE questionnaire items can improve utility of the tool.

Assessments of Trauma: Flexibility Given Severe Workforce Shortage

The Alliance recommends that, on page 5, under b) iii, that assessments to access SMHS do not just need to be completed by licensed or even licensed-eligible clinicians. Instead, if we can use the impact of trauma as a criterion for access, then we need to have a path forward where a peer support specialist and/or a mental health rehabilitation specialist (MHRS) can create the assessment that opens up services. We think it makes sense that it's "under the supervision" of a licensed or licensed-eligible person, but we should be thinking more expansively about who has the qualifications to assess the need for SMHS, especially in the midst of this workforce crisis. We believe this is the intent of this section, however, we request that guidance be provided by DHCS to clarify this point.

Request for Clarification on Claiming Codes for Children and Youth Receiving Specialty Mental Health Services based on Criteria (1)

In the section entitled, "Additional Coverage Requirements and Clarifications" there is no explicit guidance on the use of claiming codes (including V or Z codes) for Medi-Cal billing for children or youth who are provided specialty mental health services because they are at high-risk for a mental health condition based on their experience of trauma under criteria (1). The following sentence, as written, would seem to only apply to criteria (2)(b)(ii) or (2)(b)(iii):

"In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to significant trauma as noted above, options are available in the CMS approved ICD-10 diagnosis code list. Foreexample, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services" (i.e., Z codes)."

To avoid potential confusion, the BHIN could delete the word "significant" from the paragraph quoted above.

In addition, as discussed above, we strongly recommend adding a sentence to clarify that children or youth at high-risk for a mental health disorder due to their experience of trauma as described in criteria (1), do not need to have or receive a mental health diagnosis (apart from a Z or V code diagnosis) to receive ongoing specialty mental health services.

Recommend Broadening the Definition of Involvement in Child Welfare

We appreciate that the definition for juvenile justice involvement is not limited to youth with an open case, and strongly recommend the definition for child welfare involvement be similarly expanded. Children who have previously been involved in the child welfare system, including youth who subsequently reunified with parents, emancipated, or had a guardian appointed are left out from the current definition even though they have experienced significant trauma whether or not their case is open. We recommend the following for the definition, aligned with the Family First Prevention Services Act:

Involvement in child welfare means the following, “The beneficiary has an open child welfare services case, or a beneficiary who is identified in a prevention plan as being at imminent risk of entering foster care (same as current definition of candidacy), but who can remain safely in the child’s home or in a kinship placement as long as services available under the new title that are necessary to prevent the child’s entry into foster care are provided. This would also include a child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement.”

Juvenile Justice Involvement

Because the EPSDT entitlement covers youth up to age 21, we recommend the term “criminal justice system involvement” as the category since 18-21 year olds would be in the adult system, and some younger youth are charged as adults.

Recommend Broadening the Definition of Homelessness

We are also concerned about the narrow definition of homelessness as drafted especially as it pertains to youth, and feel that it will not fully capture those youth who are at risk of homelessness who our members are serving now. Therefore, we recommend the following definition which is taken from the [McKinney-Vento Homeless Assistance Act](#):

The term "homeless children and youths"--

(A) means individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1)); and

(B) includes--

*(i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals;**

(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C));



(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

Thank you for considering our comments and recommendations. Please contact Chris Stoner-Mertz, chris@cacfs.org, or Adrienne Shilton, ashilton@cacfs.org, with any questions or to follow up on any of the recommendations made here.

Sincerely,

A handwritten signature in black ink, appearing to read "Christine Stoner-Mertz", is positioned above the typed name.

Christine Stoner-Mertz, CEO
California Alliance of Child and Family Services

CC: Stephanie Welch, Deputy Secretary of Behavioral Health, Health and Human Services Agency

Kelly Pfeiffer, M.D., Deputy Director of Behavioral Health, California Department of Health Care Services