



Access to Mental Health Services for Children with Special Health Care Needs

Analysis and Recommendations

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Children with special health care needs (CSHCN) are a particularly vulnerable population who use an array of mental health services.¹ CSHCN are at increased risk for chronic physical, developmental, behavioral or emotional conditions and require health and related services beyond that required by children generally.²

In the fall of 2016, with funding from the Lucile Packard Foundation for Children's Health, the National Health Law Program (NHeLP), with the assistance of consultant Andrea Berger, PhD, surveyed a targeted group of those who work to provide access to services for CSHCN in California. As described in more detail below, the survey identified access to mental health care and counseling as the service most difficult for CSHCN in California to access.

NHeLP has identified three potentially overlapping groups of children who are most likely to be CSHCN who experience difficulty accessing mental health care and counseling. They are children under 21 in Medi-Cal who are: (1) receiving specialty mental health services from a County Mental Health Plan; (2) involved in multiple systems, such as juvenile justice, child welfare, developmental disability, and special education; or (3) receiving mental health services from, or prescribed psychotropic or anti-psychotic medication by their Medi-Cal managed care plan or other health coverage provider for a period of six months or more.

On May 18, 2017, NHeLP brought together stakeholders from around California to discuss the survey findings, and identify opportunities to improve access for CSHCN, with a particular focus on legal interventions. The goals of the convening were threefold: (1) to more clearly identify the primary barriers CSHCN face in accessing mental health care and counseling; (2) to identify the source of those barriers; and (3) make recommendations for addressing those barriers. This document sets forth the survey findings and the legal framework for access to mental health services for children in California, and proposes initial recommendations that helped guide the convening to meet those goals.

SURVEY ON THE COORDINATION OF SERVICES FOR CALIFORNIA CHILDREN WITH SPECIAL HEALTH CARE NEEDS: HIGHLIGHTS

Overview

NHeLP, with the assistance of consultant Andrea Berger, PhD, surveyed a targeted group of stakeholders, including legal advocates, child advocates, and family representatives who work to provide access to services for CSHCN in California. The survey aimed to capture the most serious needs, contributing factors, and possible solutions.

Survey Design

The survey was developed specifically for this project and covered:

- The level of challenge involved in procuring services,
- The barriers to procuring services,³
- Recommendations for improvement, and
- Participant demographics and background.

New survey items were pilot tested by six individuals to ensure that the items conveyed the intended meaning.

Survey Sample and Administration

This survey did not use a random sample. Instead, the goal was to include input from a broader group of individuals than could be invited to the convening. Therefore, the survey data are useful for understanding the concerns for these respondents, but are not necessarily representative of the population of advocates working with CSHCN in California.

The survey was administered online from October 7th through November 21st, 2016. NHeLP sent email invitations to a purposeful sample of 237 legal, family, and policy advocates working in California. These advocates were either known to NHeLP or recommended by others in the field. During the administration period, participants received reminder emails and phone calls. Of the 207 successful email invitations (i.e., emails that did not bounce back), 90 individuals started the survey (43 percent) and 65 individuals completed the survey (31 percent).

Appendix A includes demographic and professional background data for all respondents with completed surveys.

Key Findings

Respondents rated the degree of difficulty families in California have in obtaining various services for CSHCN (Table 1). Ten services were rated as difficult or very difficult, on average, to arrange. The service rated as most difficult to arrange, on average, was private duty nursing (mean = 4.5). Mental health services were also rated as difficult to obtain (means = 4.0).

Several respondents used the write-in section to express that degree of difficulty varies depending on factors such as: type of insurance, type of specialty, and geographic region.

Table 1. How difficult is it for California families to obtain the following services for their children with special health care needs?

Service	Me an
<i>Private Duty Nursing</i>	4.5
<i>Home Health Agency Services</i>	4.4
<i>Orthodontic Care</i>	4.3
<i>Respite Care</i>	4.2
<i>Personal Care Services (e.g., IHSS)</i>	4.2
<i>Other Dental Care</i>	4.1
<i>Other Home Health Care</i>	4.0
<i>Behavioral Health Therapy Services (e.g., ABA Therapy)</i>	4.0
<i>Mental Health Care or Counseling</i>	4.0
<i>Durable Medical Equipment</i>	4.0
Communication Aids or Devices	3.9
Specialty Care: Other	3.9
Specialty Care: Neurology	3.8
Physical, Occupational, or Speech Therapy	3.8
Genetic Counseling	3.8
Substance Abuse Treatment or Counseling	3.7
Specialty Care: Urology	3.7
Mobility Aids or Devices	3.7
Specialty Care: Oncology	3.4
Hearing Aids or Hearing Care	3.4
Preventive Dental Care	3.4
Prescription Medications	3.2
Eyeglasses or Vision Care	3.1
Well Child Check Up	2.5

N= 65

Notes: Response options ranged from 1 (Very Easy) to 5 (Very Difficult). Write in responses included: PTSD counseling, mental health services other than "talk therapy," child care that implements medical orders, medical services in school settings (pre-school through postsecondary), and treatment for eating disorders.

Respondents were asked to choose one service that they found to be the most difficult for families to obtain (Table 2). The most commonly selected services was mental health care,

selected by 15 respondents.⁴ The remaining findings in this report will include only the respondents who selected this service as the most difficult. These findings will focus on the barriers and possible solutions for arranging mental health care or counseling.

Table 2. Which service is most difficult to obtain for California children with special health care needs and their families?

Service	N
<i>Mental Health Care or Counseling</i>	15
Behavioral Health Therapy Services (e.g., ABA Therapy)	10
Private Duty Nursing	6
Specialty Care: Neurology	5
Respite Care	4
Personal Care Services (e.g., IHSS)	3
Orthodontic Care	3
Durable Medical Equipment	2
Physical, Occupational, or Speech Therapy	2
Communication Aids or Devices	1
Eyeglasses or Vision Care	1
Home Health Agency Services	1
Mobility Aids or Devices	1
Substance Abuse Treatment or Counseling	1
Prescription Medications	1
Preventive Dental Care	1

N= 65

NOTE: In the item instructions, respondents were told that subsequent survey items would be based on the one "most difficult" service they selected in this item. Five respondents wrote in that they could not pick just one service, one wrote in that medically trained child care was the most difficult, and one wrote in that care coordination was most difficult. Respondents were given the following options, but no one selected them as most difficult: Specialty Care: Oncology; Specialty Care: Urology; Specialty Care: Other; Other Dental Care; Other Home Health Care; Hearing Aids or Hearing Care; Genetic Counseling; Well Child Check Up.

Appendix A includes the demographic and professional background data for the respondents who chose mental health services as the most difficult for families to obtain.

Respondents rated the degree to which they felt various barriers contributed to the challenge in obtaining mental health services (Table 3). For the respondents who thought that mental health services were the most difficult to obtain, the lack of a responsible person or program was rated as the most challenging barrier (mean = 3.6).

Table 3. How much of a barrier is each of the following for California families attempting to access this service?

Barrier	Mean
No one person or program responsible for ensuring access	3.6
Disagreements about who is responsible for providing or paying	3.3
Service authorization delays	3.2
Disputes about the extent of coverage	2.8
Program eligibility criteria	2.7
Program medical necessity criteria	2.6
No entitlement to service due to gaps between program coverage areas	2.2

Mental Health: n = 15

Notes: Response options ranged from 1 (Not a barrier) to 4 (Extreme Barrier). Write-in responses included lack of providers, long waitlists, finding specific expertise, and overall system complexity.

Of the respondents for mental health barriers, almost all reported that Medi-Cal managed care plans were involved in obtaining services (87%; Table 4). In addition, over half reported that county mental health plans (80%) and school districts (73%) were involved. For the mental health respondents, the child welfare system was also typically involved (53%).

Table 4. What entities are typically involved in obtaining this service in California?

Barrier	Percent of Respondents
Medi-Cal managed care plans	87%
County mental health plans	80%
School district	73%
Child welfare system	53%
Medi-Cal fee-for-service provider(s)	47%
Regional centers	40%
Juvenile justice system	40%
Private insurance plans	27%
Medicare	13%
CCS (Cal Children Services Program)	7%

Mental Health: n = 15

Respondents were given the opportunity to describe how the barriers and entities interacted to create difficulties for families in obtaining mental health services. Appendix B provides the full-text responses and Table 5 includes a summary of responses. Many respondents found the

long waits to be a barrier (33%) and also the difficulty in navigating bureaucracy (42%). Other commonly reported challenges include delays in coverage and no one entity in charge.

Table 5. Describe how the barriers and entities you typically encounter interact to make this service so difficult for families to obtain.

Coded Barriers	Percent of Respondents
Difficulty navigating bureaucracy	42%
Long waits/Shortage of providers	33%
Delays in coverage	33%
No one entity in charge	33%
Not right specialty	17%
School district	8%
Therapists leave	8%

Mental Health: n = 12

Notes: Codes based on write-in responses. Only includes codes that appeared more than once. Percentages sum to greater than 100 percent due to write-in responses.

When asked which advocacy strategies would best help with the challenges, respondents most commonly selected administrative advocacy (20%; Table 6). Eight respondents wrote in responses including improving provider availability and using a combination of strategies.

Table 6. Which advocacy strategy do you think would best address barriers to meeting the needs of California children with special health care needs?

Strategies	Percent of Respondents
Administrative advocacy	20%
Litigation	13%
Additional agency guidance	13%
Legislative changes	7%
Consumer education	7%
More providers/Encourage providers to stay/ Incentives to providers	7%
Combination of strategies	20%

Mental Health: n = 15

Note: Only write in responses with n = 2 or greater are included. Percentages sum to over 100 due to write-in responses.

Summary

Key findings from this survey include:

- **Degree of Difficulty-** Mental health care was rated in the top 10 degree of difficulty for families to obtain.
- **Most Difficult-** Respondents most frequently selected mental health care as the one service that was the most difficult to obtain.
- **Barriers-** For the respondents who thought that mental health services were the most difficult to obtain, the lack of a responsible person or program was rated as the most challenging barrier.
- **Contributing Factors-** Many respondents found the long waits (due to the shortage of providers), difficulty in navigating bureaucracy, delays in coverage, and no one entity in charge to be contributing factors to the difficulty in arranging for mental health services.
- **Advocacy-** Respondents most commonly recommended administrative advocacy, though a sizable portion recommended a combination of strategies.

LEGAL FRAMEWORK FOR PROVIDING MENTAL HEALTH SERVICES TO CHILDREN WITH SPECIAL HEALTH CARE NEEDS IN CALIFORNIA

Many public entities, including jails, courts, schools, private health insurance plans, and regional centers may provide mental health care and counseling services to CSHCN in California. But Medicaid—known as Medi-Cal in California—is a predominant source of coverage for CSHCN.⁵ Moreover, Medi-Cal provides a strong legal entitlement to enrolled CSHCN to ensure they have access to care, including mental health care, that they need. Thus, NHeLP has identified three potentially overlapping groups of children who are most likely to be CSHCN who experience difficulty accessing mental health care and counseling, which served as the population of focus for the convening. They are children under 21 in Medi-Cal who are: (1) receiving specialty mental health services from a County Mental Health Plan; (2) involved in multiple systems, such as juvenile justice, child welfare, developmental disability, and special education; and (3) receiving mental health services from, or prescribed psychotropic or anti-psychotic medication by their Medi-Cal managed care plan or other health coverage provider for a period of six months or more.

The current state Medi-Cal system can lead to fragmented, inefficient care that does not always meet the needs of CSHCN. Thirty-seven percent of California children who need mental health treatment fail to receive it.⁶ Recent data from the Department of Health Care Services (DHCS) indicates that only 6.6% of white children and 3.8% of Hispanic children enrolled in Medi-Cal received at least one specialty mental health visit from 2014-15, despite the fact that 13%-20% of children in the United States experience a mental disorder in a given year.⁷ The data is even more bleak when we look at sustained access to services: only 5.1% of white children and 2.9% of Hispanic children received five or more specialty mental health

visits.⁸ This data suggests that there is a significant access gap in terms of children's access to mental health care and counseling, and that the gap may be even more pronounced for children of color, who are more likely to rely on Medi-Cal for coverage of these services.

Medi-Cal Mental Health Services

The California Medi-Cal program must provide mental health services to beneficiaries under age 21 pursuant to the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate of the Medicaid Act.⁹ Since 1995, California has met this obligation in part through a 1915b ("Freedom of Choice") Medicaid Waiver that allows the state to provide Specialty Mental Health Services (SMHS) through a separate closed managed care system where Medi-Cal beneficiaries must receive mental health services through a single Mental Health Plan (MHP), in most cases administered by each county.¹⁰ California most recently renewed its 1915b waiver for a five-year period starting on July 1, 2015.¹¹

Consistent with the federal EPSDT mandate, MHPs must provide a broader array of medically necessary services to Medi-Cal beneficiaries under age 21. Specifically, MHPs must provide services when they are necessary to correct or ameliorate a child's illness or condition.¹² In addition, the law requires MHPs to provide mental health diagnostic services and treatment to enrollees under 21 when they meet those medical necessity criteria, even when requested services are "not otherwise covered ... specialty mental health services."¹³ In practice, however, new services are rarely covered as SMHS unless they are established pursuant to a lawsuit.

In 2014, as part of the Affordable Care Act implementation, California expanded the availability of mental health benefits in Medi-Cal for adults and brought the Medi-Cal scope of benefits in line with benefits offered in private health plans.¹⁴ California requires Medi-Cal health plans (MCPs) to cover outpatient mental health services to adult beneficiaries with "mild to moderate" impairment of mental, emotional, or behavioral functioning.¹⁵ There has been a great deal of confusion about the "mild to moderate" standard among providers and Medi-Cal enrollees alike.

The expansion of the scope of mental health benefits available to adult Medi-Cal enrollees complicated the delivery and access to mental health care. Some mental health services are offered through the Medi-Cal health plans (MCPs), while other services are only available through County Mental Health Plans (MHPs), and other services are only available on a fee-for-service basis. DHCS's renewed 1915b Waiver clarifies the relationship between MHPs and MCPs and introduces "mild to moderate" language to define the care MCPs are obligated to cover, language that has not appeared in prior versions of the waiver.¹⁶ The expansion of mental health services in the MCPs in 2014 also resulted in some additional mental health services (non-SMHS) for children being covered by the MCPs – namely individual and group

mental health evaluation and treatment (psychotherapy); outpatient services for the purposes of monitoring drug therapy; and psychiatric consultation.¹⁷

However, as far as children are concerned, DHCS's guidance has clarified that the SMHS services must be covered by MHPs regardless of the level of impairment, when they services are medically necessary¹⁸ Nevertheless, lack of coordination between these different entities, and confusion surrounding the role of each entity, translates to CSHCN being at risk of going without care or receiving less care than their condition requires.

Memorandums of Understanding

Memorandums of Understanding (MOUs) between the MCPs and MHPs are the primary vehicle for coordinating access to necessary and appropriate mental health services for children enrolled in MCPs and MHPs. MHPs are required by regulation to maintain MOUs with each MCP that cover a variety of elements concerning the coordination of beneficiaries' care.¹⁹ Unfortunately, California's MOUs vary widely in content, detail, and structure between counties and fail to meet the minimum requirements of the law. For example, in a recent survey, one-third (33) of all MOUs fail to discuss one or more required topics, more than 20% failed to cover two or more topics, and nearly 10% failed to cover three or more topics.²⁰ While coordination between the MCP and MHP is crucial, few county MOUs cover the topic in great detail and most MOUs simply require each plan to identify a person responsible for care coordination.²¹ DHCS has provided minimal oversight of the MOUs and the coordination between MHPs and MCPs. Disconnects between the two systems result in children being referred back and forth between the MCP and MHP, experiencing gaps in service or being forced to change providers when the severity of the condition changes.

Grievance & Appeal System

Differences in the appeal and grievance systems between MCPs and MHPs has further complicated navigating gaps for consumers and advocates. For example, consumers have been required to exhaust the MHP internal appeal process before requesting a state fair hearing, which only in the last month became a requirement for MCPs. In addition, MHPs are not licensed by the Department of Managed Health Care (DMHC), which licenses most MCPs. Thus, the DMHC independent medical review (IMR) process—which provides an external clinical review process for denials of care by licensed plans—is not available when MHPs deny care. In addition, the DMHC complaint process, which can provide external review of network adequacy or access concerns, is not available for MHPs.

The MOUs with MCPs are required to address a dispute resolution process and the provision of medically necessary services pending resolution of disputes.²² The MOUs are also required to include a process for resolving clinical and administrative differences of opinion between the MCP and MHP (including dispute resolution).²³ These processes are not easily navigable and

the differences in the dispute process between MCPs and MHPs have not been explained to beneficiaries. Moreover, without the IMR process for denials of care by MHPs, CSHCN may be left without adequate recourse to address serious issues.

CONVENING OF STAKEHOLDERS: SUMMARY AND HIGHLIGHTS

On May 18, 2017, NHeLP convened 21 advocates representing 17 organizations in Los Angeles to discuss: (1) the barriers that impede access to mental health services and counseling for CSHCN; and (2) solutions to address those barriers. Attendees represented legal services organizations, policy advocacy organizations, and family advocates.

The convening began by reviewing the findings of the survey and identifying major themes. Then, attendees broke up into small groups to discuss the specific barriers they encountered. In those small groups, attendees identified underlying causes of the barriers they identified, and categorized them into the following categories: gaps in existing law or policy, lack of enforcement of existing law or policy, education or training deficits, and need for clearer guidance on existing law or policy. After the small group discussion, attendees reconvened and we discussed the findings of each group, and began to identify common themes.

While attendees broke for lunch, NHeLP staff analyzed the results of the morning discussion and grouped the barriers identified into four main areas: (1) lack of coordination and continuity of care; (2) lack of knowledge / confusion navigating the system; (3) lack of timely access and appropriate specialists, inadequate screenings; and (4) lack of notice and transparency. When attendees reconvened, we discussed this grouping and obtained feedback on it. Attendees then again broke into four small groups, each small group tasked with tackling one of the identified barriers. The small groups were asked to identify the best ways to address the barrier, focusing on who needs to take what action to make a change.

Attendees then reconvened to share their findings and get feedback from other groups. NHeLP then facilitated a discussion among the attendees to synthesize their recommendations, and obtain input about which action steps could be implemented short term, medium term, and long term. We closed the convening by briefly discussing what NHeLP would be doing to memorialize the findings from the day.

As described above, convening participants identified four major areas that create barriers to access to mental health services and counseling by CSHCN: (1) lack of coordination and continuity of care; (2) lack of knowledge / confusion navigating the system; (3) lack of timely access and appropriate specialists, inadequate screenings; and (4) lack of notice and transparency. We will discuss each of these areas in more detail.

Lack of coordination and continuity of care

As described in detail above, Medi-Cal mental health services are delivered by two different entities—the MCPs and the MHPs. In some cases, CSHCN also receive mental health services from their schools or Regional Centers. Because different services are provided by different entities, each of which has different—but sometimes overlapping—legal obligations, coordination and continuity is key to ensuring that CSHCN get the full range of mental health services that they need. Unfortunately, too often, the various entities do not work together in a coordinated way, and fail to ensure continuity of care. In our discussion, we identified four specific ways that the lack of coordination and continuity poses a barrier to access for CSHCN.

First, the entities fail to make complete and adequate referrals among themselves. For example, a parent may suspect that his child has a mental health issue, and seek help from the MHP. The MHP performs an initial screen of the child, and determines that the child is not eligible for specialty mental health services. The MHP tells the parent that it cannot help his child, but does not explain that the MCP (or school or Regional Center) may be able to provide other mental health services to address the child’s need. Often, even if the MHP makes a referral to another entity, it fails to provide a warm hand-off, or to give the parent or child sufficient information to follow-through on the referral. The worst case scenario is when the MHP refers the family to the MCP, and the child seeks care from the MCP, only to be told to go back to the MHP for care. There are not adequate systems and structures in place to prevent this kind of referring back and forth, nor is there one centralized entity responsible for handling initial screening and referrals. Little, if any, data is kept by any of the entities involved to track whether referrals are successfully completed. The referral problem is caused by a lack of clear guidance about how the process should work and who is responsible for what, exacerbated by a lack of monitoring and oversight.

Second, a related problem is that the entities themselves do not seem to share an understanding of their scope of responsibility. In other words, it is not clear who is responsible for what. This problem often causes problems with referrals, but it also creates gaps and barriers more broadly. In terms of Medi-Cal, before and after 2014, MHPs have been responsible for providing all specialty mental health services to beneficiaries when such services are medically necessary. Nevertheless, confusion arose when MCP covered mental health benefits were expanded in 2014, and DHCS issued guidance indicating MCPs were now responsible for providing mental health services to beneficiaries with “mild to moderate” mental health conditions. Under the EPSDT mandate that applies to children under age 21, children are entitled to all medically necessary services to correct or ameliorate a mental health condition. Many of those services are only available as specialty mental health services through the MHPs. DHCS subsequently clarified through policy guidance to MHPs that specialty mental health services must be provided to children when medically necessary, without respect to any severity test or screening tool employed by the MCPs and MHPs.²⁴

Third, where there is overlapping responsibility to provide a service (perhaps the service could be provided by an MCP or a school district), there is often confusion about which entity is responsible first. This is especially true for children who have complex medical conditions, such as eating disorders, that require a highly integrated and well-coordinated plan of care and treatment. Often in these cases highly specialized (residential) treatment services may also be needed which provide both a medical and mental health component. In these cases it is very common for beneficiaries (and their parents/guardians) to be denied services by multiple entities, each claiming it is the responsibility of another, causing delays in necessary care and leaving families unsure where to turn for assistance. These types of cases have arisen across the state and have frequently only been resolved through the state DHCS' dispute resolution process, yet the state has not provided any overarching guidance on how the various entities involved should divide responsibility.

Fourth, there are few mechanisms in place to ensure that CSHCN can receive continuous care from the same provider when their circumstances change. For example, MCPs and MHPs that cover the same Medi-Cal service type (e.g. psychotherapy / counseling) are not required to have an overlapping or congruent network of providers. Having the same network of providers for such services ensures that beneficiaries do not have to change providers in the middle of a course of treatment when the severity of their condition improves or worsens. Currently, enrollees in MCPs have a right to continue care with their existing out-of-network providers in certain circumstances.²⁵ Thus, in some cases where Medi-Cal beneficiaries have been receiving care from a MHP contracted provider, and the severity of their condition decreases, they will be eligible to continue seeing that provider from the MHP, even if the MCP is now responsible for their care and does not contract with that provider. This right is not clearly specified in regulation or policy, however. Moreover, there is no policy whatsoever regarding continuity of care for beneficiaries whose care (within the same service type) moves from the MCP to the MHP.

Lack of knowledge /confusion navigating the system

Given the lack of coordination among entities responsible for providing mental health services and counseling to CSHCN as described above, it is no surprise that children and families struggle to understand the system and navigate it effectively. In this area, we identified two major barriers to CSHCN's access to mental health services.

First, there is little educational material available for children and families to explain basic information about how to access mental health care and counseling. There also is not an entity or agency charged with providing training or education to families. Indeed, the entities that serve youth and families—including child welfare agencies, juvenile justice organizations, schools, and regional centers—often do not understand themselves how the system works,

which entities are responsible for providing mental health services and counseling under what circumstances, and what steps families can take to access those services. As a result they cannot educate the children and families with whom they interact, and often give them misinformation. Children and families are left without basic information needed to access mental health care and counseling.

Second, families lack assistance in navigating the system. Again, there is no entity charged with helping families obtain the mental health services they need, nor is any entity responsible for assisting families in identifying the options and choices for their child given their particular circumstances. To the extent that some entities—a child’s MCP, for example—might have a legal obligation to provide some information or assistance to children and their families—they rarely provide sufficient information or assistance.

Lack of timely access & appropriate specialists, screenings are inadequate

Another problem arises when CSHCN are able to get to an entity that provides mental health services and counseling: the entity fails to deliver the needed services. We identified three primary barriers that happen at the point of service: lack of independent screenings, lack of timely access, and a shortage of appropriate specialists.

First, when a CSHCN presents at an entity seeking services, the screening tools used to determine which entity is responsible for providing services, and sometimes, what level of service is appropriate, and sometimes, are often inadequate and independent. These screening tools are used to determine the severity of a child’s need, and medical necessity for services, which determines the entity that is appropriate to provide needed services. But the state provides little oversight of the screening tools used by MCPs and MHPs, resulting in a multitude of inconsistent tools used throughout the state. Moreover, there is no clear guidance as to who should perform the screening; they are often performed by plan employees who have a financial incentive to recommend the least amount of treatment possible or even to assess a child’s condition in a way that makes another entity responsible for serving the child. Moreover, if a child or family member disagrees with the result of the screening, there is often no clear way to appeal the screening or obtain a second opinion from another clinician.

Second, when a CSHCN is referred for mental health care or counseling, often the wait for services is lengthy—finding a provider and making an appointment can take weeks or months. The MCPs are subject to timely access standards—they are supposed to make mental health appointments available within 10 business days—but compliance with these standards is not consistently monitored or enforced. MHPs will have to comply with timely access standards by next year—DHCS has proposed to use the same 10 business day metric. Convening participants generally agreed that 10 business days is an appropriate timeline for access to services. Yet unless the standard is monitored and enforced, and consumers know that they

may complain and appeal if a plan fails to make services available within the timeline, access will not improve.

Third, one reason that timely access is a problem is that there are not enough mental health providers in California—especially in certain regions—who accept Medi-Cal.²⁶ Convening participants identified one cause of this barrier as reimbursement mechanisms that limit providers' ability to contract with multiple plans or serve children in multiple settings.²⁷ Another cause of this barrier is an overall provider shortage: in many parts of the state, there simply are not many mental health providers. The shortage is particularly acute for providers with advanced training, like psychiatrists and psychologists.

Lack of notice & transparency

When CSHCN request mental health services, they often do not get written notice when their request is denied or modified. As a result, there is little transparency about who is getting services when, and what proportion of children who request services are ultimately getting those services. We identified two main ways this issue arises.

First, sometimes the entity from which a child or family requests services does not issue any written notice when it makes a decision to deny the service. This often happens when a family makes an initial inquiry about the availability of services; the entity (usually the MHP, but sometimes the MCP) performs some kind of screen and determines that the child does not meet the medical necessity criteria for services. The family may be orally informed that the child does not meet the criteria, but does not receive any information in writing. Sometimes, this same problem occurs later in the process. For example, when a child has been receiving mental health services, but the treating provider determines that the child's condition has improved and the child no longer requires services. Again, this information may be conveyed to the child or family verbally, but no written notice is provided. Without written notice, families do not understand the decision that is made, and do not know they can appeal it if they disagree.

Second, sometimes the notice goes to the wrong place. This is a particular problem for CSHCN in the foster care system, since the notice often issues to the child's biological family, but not the foster family with whom the child is living. Current notice protocols require the notice to be sent to the child's biological family, which creates this confusion.

FINAL RECOMMENDATIONS FOR IMPROVING ACCESS TO MENTAL HEALTH SERVICES AND COUNSELING FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

After the convening, NHeLP took back the information and suggestions provided by participants, and worked to craft them into the series of formal recommendations that follow, grouped by the time frame in which the recommendation can be implemented (short-term –

within 6 months to one year; medium-term – within one to three years; or long-term – more than three years). The recommendations are further sorted by the four types of barriers convening participants identified.

Short-term recommendations

Our recommendations for the next six to twelve months follow:

1. Lack of coordination and continuity of care

1.a. Advocates should work with DHCS to issue and reaffirm guidance on overlapping responsibility.

DHCS Medi-Cal Managed Care Division has previously issued guidance to clarify the roles and responsibilities of MCPs relative to other entities that serve children enrolled in Medi-Cal.²⁸ In addition, DHCS' Mental Health Division recently put out clarifying guidance to the MHPs explaining their responsibilities relative to the MCPs in providing mental health services to children enrolled in Medi-Cal.²⁹ While these guidance letters have provided significant clarity in terms of the responsibilities of the various entities that provide mental health services and counseling to CSHCN, confusion remains and MCPs and MHPs are often given conflicting guidance by different Divisions within DHCS responsible for overseeing the different types of plans. Short-term advocacy is needed to persuade DHCS to further clarify, in a consistent manner, responsibilities of the entities involved in providing mental health services and counseling to CSHCN, as a pathway to more consistent enforcement of those responsibilities.

1.b. Advocates should work with DHCS to reaffirm and enforce guidance on continuity of care for MCPs

Similarly, DHCS has previously issued numerous guidance letters about MCPs' duty to provide enrollees with continuity of care in a variety of circumstances.³⁰ Yet, CSHCN frequently experience gaps in care, even in situations under which they should be entitled continuity of care under existing law and guidance. In the next year, advocates should work with DHCS to affirm its prior guidance, monitor plan practices, and take enforcement action as needed when plans fail to comply with that guidance, to ensure that CSHCN do not experience unnecessary gaps in their care. Enforcement actions could include immediate corrective action, increased monitoring and reporting requirements on the plan for a period of time, and financial penalties.

2. Lack of knowledge / confusion navigating the system

2.a. Support organizations that are already educating and training children and families

The need for training and education of CSHCN and their families is nothing new. Over the last several years, many organizations have developed expertise in servicing CSHCN and their families, and providing them assistance in navigating the mental health care system to access the services they need. Rather than creating new programs to assist CSHCN and their families to understand the system, we should amplify existing efforts. Immediately, funders, DHCS,

MCPs, MHPs, schools, Regional Centers, and others must provide support and collaboration with organizations that have this expertise.

3. Lack of timely access & appropriate specialists, screenings are inadequate

3.a. Study best practices in screening tools

As described above, some county screening practices hamper CSHCN from accessing the mental health services and counseling they need. Yet other counties have fine-tuned their screening processes and the tools they use to determine which entity should serve a child based on the services they need and the severity of their mental health condition. Recently, after a comprehensive study by UCLA, DHCS decided to require the statewide adoption of the Child and Adolescent Needs and Strengths (CANS) screening and use of the Pediatric Symptom Checklist – 35 (PSC-35) to measure outcomes by all MHPs in 2018. But there has been no similar effort on to ensure that MCPs and MHPs use consistent and appropriate screening tools on the front end—at the time a child presents for services. Thus, we recommend convening a working group to systematically review existing practices and tools, to identify those that work well. These best practices should be promoted for adoption around the state.

3.b. Work with DHCS to monitor screenings and take enforcement action

As described in more detail above, too often counties' screening processes themselves are inadequate. Immediately, advocates should work with DHCS to identify deficiencies and take enforcement action as appropriate. Enforcement action in this context could include immediate corrective action, requiring the county to change its screening tools or protocols, requiring the county to participate in increased monitoring and reporting for a period of time, and financial penalties. Advocates should also encourage DHCS to develop robust monitoring protocols to regularly review counties' screening processes and correct problems.

4. Lack of notice & transparency

4.a. Ensure DHCS enforces existing rules about notice

Many of the issues identified at the convening related to notice appear to run afoul of existing, long-established rules about due process. Immediately, advocates should work with DHCS to enforce those existing rules by taking action against MCPs and MHPs that fail to provide timely and adequate notice. Enforcement actions could include requiring plans to take corrective action, increased audits of non-compliant plans over a period of time, requiring the plan to participate in increased monitoring and reporting for a period of time, and financial penalties.

Medium-term recommendations

Our recommendations achievable within 12 to 36 months follow:

1. Lack of coordination and continuity of care

1.a. Work with DHCS to issue guidance on referrals and include model practices

As detailed above, the various entities involved in providing mental health services and counseling to CSHCN often do not have robust referral protocols in place. As a result, when a family requests services from an entity that does not have the capacity to serve a CSHCN's specific needs, too often they are simply told no, but not referred to another entity that might have the capacity to help. Over the next three years, DHCS could address this problem in two ways. First, it should issue additional guidance, perhaps including model MOU language, to clarify MCP and MHP obligations related to referrals.³¹ Second, it should collect model practices and encourage all MCPs and MHPs to adopt those practices. Advocates should work with DHCS to provide this guidance.

1.b. Work with DHCS to issue more detailed guidance on the scope of responsibility for children's mental health services between MHPs and MCPs

As discussed above, in 2016, DHCS released basic guidance on the roles of MHPs and MCPs in providing mental health services and counseling to children.³² Advocates should work with DHCS in the medium term, however, to issue more detailed guidance that addresses common areas of confusion, and where collaboration between MCPs and MHPs is needed to ensure that children receive all the services they need. For example, children with complex mental health conditions, such as eating disorders, often need highly coordinated services that include a range of mental health services and counseling, and related physical health services. DHCS should address common scenarios that require multiple entities to work together to deliver services to CSHCN to reduce confusion among those entities, which frequently delays the delivery of appropriate services.

1.c. Work with DHCS to monitor and enforce MCP's primary responsibility where there is overlap

One of our short term recommendations is to work with DHCS to clarify its existing guidance that states that, for children enrolled in MCPs, the MCP is responsible for coordinating all of their health care needs, even when services are delivered by another entity.³³ Once DHCS issues such guidance, advocates should work with the agency to monitor and enforce MCP's primary role. Advocates should push DHCS to work closely with its contracted MCPs to ensure that enrolled CSHCN are receiving the full range of necessary services, including mental health care and counseling services, from all entities obligated to serve them. DHCS should work with the MCPs to develop protocols to oversee such services and work with other entities involved in service delivery to coordinate.

2. Lack of knowledge / confusion navigating the system

2.a. Convene a working group to develop model educational materials and training that can be used and replicated in a variety of settings

One of our short term recommendations suggested providing more support to entities that are already providing training and assistance to CSHCN and their families. Over the medium term, we recommend bringing these organizations together to collaborate and develop model materials and trainings. By developing a set of templates with common language that can be used across the state and in a variety of settings (at Family Resource Centers, with Foster Agencies, in Pediatrician's Offices, at Legal Aid Organizations, etc.), a working group could eliminate significant confusion, and provide training to CSHCN, their families, and those who serve them, more efficiently and effectively.

3. Lack of timely access & appropriate specialists, screenings are inadequate

3.a. Work with DHCS to issue guidance on screenings tools for MCPs

Once advocates have identified best practices in screening tools, they should work with DHCS in the medium term to provide more guidance to MHPs and MCPs on consistent and effective screening. DHCS should require, or at least recommend, that MCPs and MHPs use the same, effective tools for their initial screenings and referrals, and collaborate with each other to ensure that they are using those tools consistently across plans. This guidance might include recommending local best practices for collaboration, where DHCS or advocates have identified a county that has a good process in place.

3.b. Work with DHCS to monitor and enforce existing network adequacy standards

DHCS is in the process of developing new network adequacy standards that will apply to both MHPs and MCPs starting in July 2018. Advocates have been intimately involved in this process and have given DHCS significant feedback on its proposed standards. When the new standards become effective next year, Advocates should continue to work with DHCS to monitor and enforce them, to ensure that CSHCN have the access to mental health services and counseling to which they are entitled under the rules. Advocates should ensure that DHCS is regularly surveying plans networks for compliance with geographic access and timely access standards, and requiring corrective action when it identifies problems, including requiring plans to pay for out-of-network care when no appropriate in-network provider is available, requiring the plan to participate in increased monitoring and reporting for a period of time, and financial penalties.

4. Lack of notice & transparency

4.a. Legislative change to allow notice to go to foster parents in certain situations

As described above, existing law prevents notices to go to foster parents in situations where a child's biological family retains the right to make decisions about the child's health care. As a result, foster parents sometimes miss important information about changes to a foster child's services. Advocates should work with the legislature to address this problem in statute, and

ensuring that foster families receive copies of any notice about health care services for a child in their care.

4.b. Work with DHCS to publicly post deficiencies and corrective action plans

As advocates work with DHCS to better monitor and enforce compliance with existing due process rules, they should encourage DHCS to be more transparent about its processes. We recommend that advocates work with DHCS to post any findings of due process problems on its website, along with any corrective action it requires of a MHP or MCP. By making these findings and decisions public, DHCS will increase public confidence in its role as overseer of the plans, and will also provide consumers and advocates with useful information that could inform consumers' choices regarding plan enrollment and handling of grievances and appeals.

LONG-TERM RECOMMENDATIONS

Our recommendations achievable in more than 36 months follow:

1. Lack of coordination and continuity of care

1.a. Legislation to mandate referral protocols

In the long term, to address the referral issues described in more detail above, we recommend that advocates work with the legislature to enact legislation requiring MCPs and MHPs to follow set referral protocols. The legislation should proscribe MCPs and MHPs to perform a thorough assessment of a child's needs and the resources available, and provide a warm hand-off, with follow-up to any other entity found to be responsible for providing some of the services the child needs.

1.b. Legislation to expand availability of Continuity of Care

As described above, existing law and rules do not capture all of the situations where children experience gaps in care. We recommend that over the next several years, advocates work with the legislature to identify the various scenarios that lead to discontinuity and gaps, and enact legislation to broaden the scope of the protections available.

1.c. Legislation and guidance to address contract and reimbursement limitations

One of the issues convening participants identified as hampering providers from ensuring continuity of care for their patients are contract restrictions (e.g., a provider group enters an exclusive contract with the MHP, and will not permit participating providers to provide services through local MCPs, even to provide continuity for those who previously received care through the MHP), and differences in reimbursement mechanisms (e.g., facility-based reimbursement vs. provider-based reimbursement). NHeLP has conducted a preliminary investigation into the legal context for these limitations, but additional research is needed. Based on our preliminary research, we believe that legislative changes will be necessary to address some of these limits, and others may be changed through administrative policy or guidance. Over the next

few years, we recommend that some entity dedicate resources to more thoroughly investigate these limitations or barriers, and work with the legislature and DHCS to address them.

2. Lack of knowledge / confusion navigating the system

2.a. Funding for navigators or consumer assisters

One of the great successes of the Affordable Care Act was the use of navigators and consumer assisters to help consumers identify what programs they were eligible for and how to access and enroll in them. Given the complexity of the mental health system in California (arguably even more complex than the health care coverage system), a similar program to help CSHCN identify available resources and avail themselves of the services they need could significantly decrease many of the barriers CSHCN and their families encounter. Like the ACA navigator and consumer assistance programs, a program aimed at access to mental health services for children should build on existing organizational expertise and community relationships. Over the long term, we recommend identifying funding for such a program and developing a plan to implement it—possibly starting as a pilot program in certain counties.

3. Lack of timely access & appropriate specialists, screenings are inadequate

3.a. Increase reimbursement rates for mental health providers

Part of the reason that CSHCN experience access problems is that there are not enough providers to serve them. Overall, California tends to have fewer mental health professionals per capita compared to other states.³⁴ And only a portion of those providers participate in Medi-Cal.³⁵ Low reimbursement rates are frequently cited as a reason that providers do not accept Medi-Cal.³⁶ This year, the legislature allocated funds to increase payment rates for certain psychiatry services in Medi-Cal.³⁷ We recommend that advocates work with providers over the next several years to incrementally increase reimbursement rates for all Medi-Cal mental health services. Increased rates will attract more providers to the program and will allow for increased access.

3.c. Work across the health system to create and fund more training programs for both licensed and unlicensed mental health providers

Finally, as described above, there are simply not enough providers to serve the mental health needs of California's CSHCN. A final long-term solution to this problem is to work with training programs and universities to increase the number of slots available for people to seek training to enter this field, and funding to encourage them to work with low-income, Medi-Cal-eligible clients. Advocates and counties might start by working with California's public colleges and universities to identify opportunities to increase the number of students entering training to practice in the mental health field. These efforts should not be limited to psychiatrists, but also attempt to increase the number of other licensed professionals, mental health rehab specialists, and other qualified providers such as parent partners and youth mentors.

4. Lack of notice & transparency

4.a. Develop a data system to monitor and track compliance with notice rules

Over the long term, more data, and better systems will be needed to ensure that MCPs and MHPs comply with state and federal notice rules. Advocates should work with the state to develop a set of protocols to monitor and track adverse benefit determinations related to mental health services for children, and notices associated with each decision by a MHP or MCP. Advocates should work with DHCS to develop a database to implement these protocols systematically and ensure that the data is captured over time. Advocates can then work with DHCS to use the data to monitor MHPs and MCPs and take appropriate compliance action.

CONCLUSION

California's CSHCN face serious barriers in accessing mental health services and counseling. NHeLP's work with legal advocates, policy advocates, and family advocates identified four types of barriers that most hamper access: (1) lack of coordination and continuity of care; (2) lack of knowledge / confusion navigating the system; (3) lack of timely access and appropriate specialists, inadequate screenings; and (4) lack of notice and transparency. The recommendations above can guide funders, advocates, and policymakers in addressing these barriers and improving access for CSHCN in California. Changes are desperately needed to ensure that CSHCN in California have full access to the mental health services and counseling that they need.

ENDNOTES

¹ For the purposes of this document, we define “children with special health care needs (CSHCN)” using the Health Research Services Agency definition: children who “have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.” See Health Res. Servs. Agency, Children with Special Health Care Needs, <https://mchb.hrsa.gov/maternal-child-health-topics/children-and-youth-special-health-needs> (last visited Aug. 21, 2017).

² MARYBETH MUSUMECI, KAISER FAMILY FOUND., MEDICAID AND CHILDREN WITH SPECIAL HEALTH CARE NEEDS (2017), <http://files.kff.org/attachment/Issue-Brief-Medicaid-and-Children-with-Special-Health-Care-Needs>.

³ See DATA RES. CTR. FOR CHILD & ADOLESCENT HEALTH, NATIONAL SURVEY OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS, 2009-10 at 4-5 (2011), childhealthdata.org/docs/cshcn/guide_to_topic_questions_asked_09_10_nscshcn_apr_2011-pdf.pdf?sfvrsn=5.

⁴ Behavioral health therapy for children with autism spectrum disorders was ranked second as the service most difficult for families to obtain, selected by 10 respondents. While behavioral health therapy is sometimes considered a mental health service—for example, for purposes of mental health parity—it is delivered separately from other mental health services. Thus, we will not include findings on behavioral health therapy here, though there may be some overlap with our findings on access to mental health care and counseling.

⁵ MUSUMECI, *supra* note 2 (nationally, Medicaid is the sole source of coverage for over one-third of CSHCN. An additional 8% have public insurance, like Medicaid, to supplement their private coverage).

⁶ Lucile Packard Found. for Children’s Health, *1/3 of CA children who need mental health treatment fail to receive it* (May 3, 2017, 1:20 PM), www.kidsdata.org/blog/?p=7861.

⁷ CAL. DEP’T. OF HEALTH CARE SERVS., STATEWIDE AGGREGATE SPECIALTY MENTAL HEALTH SERVICES PERFORMANCE DASHBOARD 9 (2016), [hereinafter DHCS DASHBOARD 2016] www.dhcs.ca.gov/services/MH/Documents/StatewideSMHSDashboardReport%2012.23.16.pdf ; see also Ctr. for Disease Control and Prevention, *Mental Health Surveillance Among Children- United States, 2005-201*, 62 MORBIDITY AND MORTALITY WEEKLY REPORT 1-1 (2013), <https://www.cdc.gov/mmwr/pdf/other/su6202.pdf>.

⁸ DHCS DASHBOARD 2016, *supra* note 7, at 11.

⁹ 42 U.S.C. 1396d(r); CAL. WELF. & INST. CODE § 14132(v); see also Letter from Cal. Dep’t of Health Care Servs. to All Medi-Cal Managed Care Health Plans (Dec. 12, 2014) (APL 14-017), <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf>.

¹⁰ See Cal. Dep’t Health Care Servs., Medi-Cal Specialty Mental Health Services, http://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx (last visited Aug. 21, 2017).

¹¹ Letter from Hye Sun Lee, Ctrs. Medicare & Medicaid Servs., to Mari Cantwell, Cal. Dep’t Health Care Servs. (June 24, 2015), http://www.dhcs.ca.gov/services/MH/Documents/Ltr_1915-b_Waiver_Amend_01_10_14.pdf

¹² See CAL. CODE REGS., tit. 9, § 1810.215 (requiring MHPs to comply with 22 CCR §§ 51340(e)(3) & (f) and 42 U.S.C. § 1396d(r)); see also Cal. Dep’t Health Care Servs., MHSUDS Information Notice No. 16-061 at 2-3 (2016) [hereinafter MHSUDS Notice 16-061], http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS_16-061.pdf

¹³ CAL. CODE REGS., tit. 9, § 1810.215.

¹⁴ Senate Bill X1 1 (Hernandez, Chapter 4, Statutes of 2013) (encoded at Cal. Welf. & Inst. Code § 14132.03).

¹⁵ See Letter from Margaret Tatar, Deputy Dir. Health Care Delivery Sys., Cal. Dept. Health Care Servs., to All Medi-Cal Managed Care Health Plans 3-4 (Dec. 13, 2013) [hereinafter APL 13-021], <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-021.pdf> (Explaining “mild to moderate” services are individual and group mental health evaluation and treatment (psychotherapy), psychological testing when clinically indicated, outpatient services for the purpose of monitoring drug therapy, outpatient laboratory, drugs, supplies, and supplements, and, psychiatric consultation).

¹⁶ Cal. Dep’t Health Care Servs., Section 1915(B) Waiver Proposal for MCO, PIHP, PAHP, PCCM Programs and FFS Selective Contracting Programs 21-24 (2015), [http://www.dhcs.ca.gov/services/MH/Documents/1915\(%20b\)_SMHC_Waiver.pdf](http://www.dhcs.ca.gov/services/MH/Documents/1915(%20b)_SMHC_Waiver.pdf)

¹⁷ APL 13-021 at 4. These services are also covered in fee-for-service for beneficiaries who are not enrolled in a Medi-Cal plan. See CAL. WELF. & INST. CODE § 14132.03. For a detailed comparison of what services are covered by what entity in Medi-Cal, see Appendix D. 13-021

¹⁸ MHSUDS Notice 16-061, *supra* note 12, at 2-3.

¹⁹ Cal. Code Regs., tit. 9, § 1810.370 (Explaining that MOUs must include elements on beneficiary care coordination, including referral protocols, clinical consultation, care management, information sharing, provisions of prescription drugs and laboratory services, emergency care and transportation); *see also* CAL. HEALTH CARE FOUND., THE CIRCLE EXPANDS: UNDERSTANDING MEDI-CAL COVERAGE OF MILD-TO-MODERATE MENTAL HEALTH CONDITIONS 5 (2016) (describing the MOU process), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CircleMediCalMentalHealth.pdf>.

²⁰ See KIM LEWIS & ABBI COURSOLE, NATIONAL HEALTH LAW PROGRAM, MENTAL HEALTH SERVICES IN MEDI-CAL 7 (2017), www.healthlaw.org/about/staff/abbi-coursolle/all-publications/Mental-Health-Services-in-Medi-Cal.

²¹ *See, e.g.*, SACRAMENTO-HEALTH NET MOU at 4 (requiring “[a]n identified point of contact from each party who will initiate, provide, and maintain ongoing care coordination as mutually agree ... [and r]egular meetings to review referral, care coordination, and information exchange protocols and processes”) (on file with NHeLP-LA).

²² Cal. Code Regs., tit. 9, §§ 1850.505, 1850.525.

²³ MHSUDS Notice 16-061, *supra* note 12, at 2.

²⁴ *Id.* at 2-3.

²⁵ Cal. Health & Safety Code § 1373.96; *see also* CAL. DEP’T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR TWO-PLAN COUNTIES, Ex. A, Att. 9 § 16.B (2014) (requiring plans in two-plan counties to comply with Health & Safety Code § 1373.96), <http://www.dhcs.ca.gov/provgovpart/Documents/ImpRegSB2PlanBp32014.pdf>; CAL. DEP’T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR GEOGRAPHIC MANAGED CARE, Ex. A, Att. 9 § 16.B (2014) (requiring plans in GMC counties to comply with Health & Safety Code § 1373.96), <http://www.dhcs.ca.gov/provgovpart/Documents/GMCBoilerplate032014.pdf>. Most COHS plans are not Knox-Keene licensed, and unlicensed plans are not subject to Knox-Keene COC requirements by contract. Instead they are simply exhorted to describe their activities “designed to assure the provision of . . . coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.” CAL. DEP’T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR COUNTY ORGANIZED HEALTH SYSTEMS, Ex. A, Att. 4 § 7.I (2014), <http://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf>;

APL 15-019. For additional discussion of these provisions, see ABBI COURSOLE, & SHYAAM SUBRAMANIAN, NAT'L HEALTH LAW PROG., CONTINUITY OF CARE IN MEDI-CAL MANAGED CARE (2016), <http://healthconsumer.org/wp/wp-content/uploads/2016/10/6-012016-ManagedCareinCaliforniaSeries-6-continuityofcareinmedi-cal.pdf>.

²⁶ See LEN FINOCCHIO *ET AL.*, IMPROVING MENTAL HEALTH SERVICES INTEGRATION IN MEDI-CAL: STRATEGIES FOR CONSIDERATION 9 (2017), http://static1.1.sqspcdn.com/static/f/675504/27611440/1498768966757/BSCG_BSCF_Behavioral_Health_Integration_Report_May_2017.pdf?token=sdtiXCVGqkqGW0TUt0S6D9zAXiw=.

²⁷ See *id.* at 10-11.

²⁸ APL 14-017, *supra* note 9.

²⁹ MHSUDS Notice 16-061, *supra* note 12.

³⁰ APL 17-007; APL 15-019; APL 14-021; APL 13-023.

³¹ See FINOCCHIO *ET AL.*, *supra* note 26, at 18.

³² MHSUDS Notice 16-061, *supra* note 12.

³³ See APL 14-017, *supra* note 9.

³⁴ See CAL. HEALTH CARE FOUND., MENTAL HEALTH CARE IN CALIFORNIA: PAINTING A PICTURE 33 (2013), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MentalHealthPaintingPicture.pdf>.

³⁵ See, e.g., CAL. DEP'T HEALTH CARE SERVS., CALIFORNIA'S FEE-FOR-SERVICE MEDI-CAL PROGRAM HEALTH CARE ACCESS MONITORING PLAN 107-09 (2016) (number of mental health providers participating in Medi-Cal fee for service), <https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/ca-amrp-16.pdf>.

³⁶ See, e.g., Steven Ross Johnson, *Payment headaches hinder progress on mental health access*, MOD. HEALTH CARE, Oct. 8, 2016, <http://www.modernhealthcare.com/article/20161008/MAGAZINE/310089981>; Virgil Dickenson, *Medicaid plans struggle to provide mental health services*, MOD. HEALTH CARE, Jul. 4, 2015, <http://www.modernhealthcare.com/article/20150704/MAGAZINE/307049979>.

³⁷ See CAL. DEPT. HEALTH CARE SERVS., NOTICE OF GENERAL PUBLIC INTEREST: PROPOSED ONE-YEAR SUPPLEMENTAL PAYMENT FOR CERTAIN PHYSICIAN SERVICES (2017), http://www.dhcs.ca.gov/provgovpart/Documents/Public%20Notices/SPA_17-030_Certain_Physician_Services.pdf.