

MEETING THE MOMENT

Understanding EPSDT and Improving Implementation
in California to Address Growing Mental Health Needs



Kim Lewis

National Health Law Program

Rachel Velcoff Hults

National Center for Youth Law



**California
Children's
Trust**



Acknowledgements

This paper was prepared in partnership with the California Children's Trust.

The following individuals provided valuable input and feedback on this paper: Jane Perkins, National Health Law Program; Rebecca Gudeman, Alice Abrokwa, Leecia Welch, and Logan Miller, National Center for Youth Law; Alex Briscoe and Claudia Page, California Children's Trust; Tara Ford, Stanford Youth and Education Law Project; and Patrick Gardner, Young Minds Advocacy. All shortcomings remain our own.

ABOUT CALIFORNIA CHILDREN'S TRUST

The California Children's Trust (The Trust) is a statewide initiative to reinvent our state's approach to children's social, emotional, and developmental health. We work to transform the administration, delivery, and financing of child-serving systems to ensure that they are equity driven and accountable for improved outcomes. The Trust regularly presents its Framework for Solutions and policy recommendations in statewide and national forums.

Learn more at cchildrenstrust.org.

ABOUT NATIONAL CENTER FOR YOUTH LAW

The National Center for Youth Law (NCYL) advances justice through research, community collaboration, impact litigation, and policy advocacy that fundamentally transforms our nation's approach to education, health, immigration, foster care, and youth justice. Our mission is to amplify youth power, dismantle racism and other structural inequities, and build just policies, practices, and culture in support of young people.

Learn more at www.youthlaw.org.

ABOUT NATIONAL HEALTH LAW PROGRAM

The National Health Law Program, founded in 1969, protects and advances health rights of low-income and underserved individuals and families. We advocate, educate and litigate at the federal and state levels to advance health and civil rights in the U.S.

Learn more at www.healthlaw.org

Table of Contents

Introductory Letter	4
Executive Summary	5
Introduction and Background.....	6
Overview of Medicaid’s EPSDT Entitlement to Screening and Treatment for Mental Health Conditions	8
California’s Mental Health System and Delivery of EPSDT Services.....	12
Data on Access to Mental Health Services ..	17
Recommendations	19
Conclusion and Next Steps	23
Appendix	24
Endnotes	25

This paper is essential reading for all of us interested and engaged in supporting and protecting the health and welfare of children in California.

This paper purposefully packs in a lot. It includes more than 150 source citations and fully and faithfully tracks the winding and inconsistent interpretation of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) entitlement in California with a particular focus on the support for the social, emotional, and behavioral health of children in Medi-Cal.

A key take-away is the absence of clear accountability, which in practical terms means *when everyone is responsible, no one is*. After more than 30 years of federal waiver extensions, contradictory and inconsistent guidance, unsuccessful legislative remedies, and a culture of finger pointing among and between child serving systems—largely driven by a desire to mitigate budget exposure—we now must accept our state’s collective failure to meet a promise made to low-income children in 1967 in the first major amendment to the Social Security Act.

The illusion of a comprehensive benefit, lingering just out of reach for the people it is intended to serve, is how structural racism works, and it must be confronted. More than half of our state’s children—5 million and growing—are enrolled in Medi-Cal, and 81% of these young people are non-white.

The lack of clarity over what the benefit is and who is responsible for paying for it has imprisoned us in our collective failure to effectively support the health and welfare of marginalized communities.

The unresolved debates with well-meaning people using the same words to mean different things need to be definitively resolved. They have stymied our efforts to access federal funds and move beyond a diagnosis driven system that does not reflect the reality of children and families covered by Medi-Cal.

A common understanding and strategic leveraging of the unique and uncapped federal EPSDT entitlement are essential to any solution at scale to reimagine mental health as a support for healthy development and not a response to pathology. This paper provides the history and facts for that collective reimagining.

The California Children’s Trust collaborated with a coalition of more than 400 leaders and organizations to create a Framework for Solutions that centers equity and justice as

essential goals of a reformed safety net for children. This paper is a critical building block and necessary precursor for the sustainable reform articulated through the framework.

CCT FRAMEWORK FOR SOLUTIONS



CCT’s Framework for Solutions suggests strategies to generate significant new federal revenue to expand access to services and supports that do not require a diagnosis. It calls on us to rethink who delivers services, where they are delivered, and the beneficiaries’ agency and inclusion in improving access and delivery of services. The framework calls for accountability and transparency among and between systems and levels of government.

The state must clarify the roles and responsibilities of child-serving systems (with a particular focus on who pays for what) and public systems must show far greater courage and humility in framing “medical necessity” in the voice and experience of beneficiaries. More simply, we must stop designing health care systems for the people who administer them instead of the people who access care in them.

The Children’s Trust is grateful to The National Center for Youth Law and The National Health Law Program for expertise and partnership in this work. We encourage everyone to take the time to read and reflect on this groundbreaking and foundational work. It will be a seminal reference for future change.

Alex Briscoe, Principal, California Children’s Trust

Executive Summary

Children and youth across the country are facing an escalating mental health crisis. The events of 2020 have added new and complex stressors, exacerbating mental health challenges while also creating new barriers to accessing care. Unmet mental health needs have grave consequences for individuals, their families, and entire communities. Now more than ever, it is crucial that we have robust, well-functioning systems in place to identify and respond to children’s needs early, effectively, and equitably.

One important component of this effort is ensuring that vulnerable children and youth receive the full array of services that they need and are legally entitled to under federal law. Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides Medicaid-eligible children with a broad entitlement to mental health care. This includes a right to regular screening to identify needs and to receive services necessary to “correct or ameliorate” a child’s condition. When Congress enacted EPSDT more than a half-century ago, it recognized the unique needs of children and the importance of promoting children’s healthy development through this early identification and treatment of needs. States are tasked with carrying out this vision.

California operates the country’s largest Medicaid program, Medi-Cal. Medi-Cal provides a critical safety net to millions of children and families. But historically, California has struggled to fully implement the federal EPSDT entitlement to mental health care. A number of factors—including a complex, fragmented delivery system and the State’s misconstrued application of EPSDT requirements—have hampered progress. As a result, many children and youth are still not receiving the mental health screenings and services that they are owed.

While recognizing the need for a broader re-imagining of how we think about and deliver mental health care, we offer several recommendations for how California can move closer towards meeting the promise of EPSDT in the short term. These include recommendations aimed at ensuring that needs are identified and



addressed as early as possible, consistent with the intent of EPSDT.

- ✓ Require Medi-Cal Managed Care Plans to offer Adverse Childhood Experiences (ACEs) / trauma screenings to all enrolled children and youth, and to develop and implement treatment plans to address the needs identified through these screenings.
- ✓ Conduct, and require Managed Care Plans to conduct, more robust outreach to inform families of children’s rights to EPSDT-covered screenings and services, and how to access them.
- ✓ Implement clear, consistent processes for how children’s mental health needs are identified and addressed, and for improved data sharing, referral tracking, and robust case management across plans.
- ✓ Clearly divide the scope of mental health services covered by plans to avoid overlaps that lead to coverage disputes and delays in care.
- ✓ Implement a “no wrong door” approach to ensure children and youth receive all of the services they need, without delay, regardless of where they enter the system.
- ✓ Eliminate requirements that children and youth must have a specific diagnosis, or any diagnosis, prior to accessing mental health services and supports that a provider deems medically necessary.

Section 1. Introduction and Background

Children and youth in the United States are facing a growing mental health crisis. Even before the COVID-19 pandemic began, one in six children experienced a mental health disorder.¹ Rates of inpatient visits for suicide, suicidal ideation, and self-injury were rising, as were mental health hospitalization days for youth.² Although the vast majority of American children and youth have health insurance,³ many do not receive the mental health support that they need. In 2017, for example, approximately 60% of adolescents ages 12 to 17 experiencing a major depressive episode received no treatment.⁴ Another study found that about half of youth under age 17 who have at least one treatable mental health disorder fail to receive treatment.⁵ Additionally, experiencing poverty has a profound effect on whether children get access to the mental health services they need. For example, according to one estimate, less than 15% of children experiencing poverty who need mental health services actually receive them.⁶

While any youth can experience mental health issues,⁷ children’s risk for developing many common mental health conditions is influenced by adverse childhood experiences (ACEs) and social determinants of health. ACEs are potentially stressful or traumatic events during childhood that increase health risk; examples include witnessing violence and experiencing abuse or neglect.⁸ Social determinants of health are the social, economic, and physical environments in which we are born, live, and grow.⁹ For instance, about 37% of children experience either short-term or long-term poverty.¹⁰ Childhood poverty contributes to health disparities in several ways, including by increasing exposure to toxic stress.¹¹ The American Academy of Pediatrics also identifies the impact of racism as a “core social determinant of health,” noting that it is linked to chronic stress and disparities in mental health problems in children and adolescents.¹² Race, ethnicity, socioeconomic status, and other factors such as juvenile justice and child welfare system involvement also impact identification of needs and access to services, creating significant equity gaps in pediatric mental health care.

Against this backdrop of worsening children’s mental health trends and equity issues, the last eight months have layered on new and complex challenges for children and youth. The COVID-19 pandemic has imposed a multitude of new stressors on youth and families, ranging from social isolation to fears regarding illness and death to food, economic, educational, and housing insecurity. This is compounded for Black children, in particular, because of the disproportionate number of COVID-19 deaths among Black Americans¹³, and because of the additional stresses, both chronic and acute, that have surfaced during this period in response to the continued killings of Black

ACRONYMS

AAP = American Academy of Pediatrics	FFS = Fee-for-Service
ACEs = Adverse Childhood Experiences	IHBS = Intensive Home-Based Services
APL = All Plan Letter	ICC = Intensive Care Coordination
CaAIM = California Advancing and Innovating Medi-Cal	LEA = Local Education Agency
CCR = California Code of Regulations	MHP = Mental Health Plan
CFR = Code of Federal Regulations	MCP = Managed Care Plan
CHDP = California Child Health and Disability Prevention Program	PMPM = Payment per member per month
CMS = Centers for Medicare & Medicaid	SHA = Staying Healthy Assessment
CPE = Certified Public Expenditure	SMHS = Specialty Mental Health Services
DHCS = California Department of Health Care Services	TBS = Therapeutic behavioral services
DSM = Diagnostic and Statistical Manual of Mental Disorders	TCM = Targeted case management
EPSDT = Early and Periodic Screening, Diagnostic, and Treatment	TFC = Therapeutic foster care
FFP = Federal Financial Participation	USC = United States Code
	WIC = California Welfare & Institutions Code

Americans by police and others. At the same time, the pandemic has created new barriers to accessing care. Although we do not yet know the full impact on children’s mental health, early data show that U.S. adults have reported increased mental health issues, with young adults ages 18 to 24 experiencing “disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation.”¹⁴ The CDC recently reported that there has been an increase in the proportion of pediatric mental health-related emergency department visits, relative to all pediatric emergency department visits, as compared to 2019.¹⁵ Researchers have also expressed concern about a potential uptick in youth suicide.¹⁶

It is crucial that we have a robust, well-functioning system in place to identify and treat childhood mental health needs. Early identification and intervention can help alleviate suffering, improve children’s lives, and strengthen the outlook for their mental health as adults.¹⁷ In contrast, unmet mental health needs can have grave consequences for individual youth, for their families, and for entire communities. Mental illness is linked to higher rates of certain physical conditions (such as cardiovascular and metabolic diseases), as well as increased risk of negative outcomes like school drop-out, unemployment, incarceration, unnecessary institutionalization, and homelessness.¹⁸ The long-term economic impact of insufficient mental health care is difficult to quantify, but by one estimate, the direct and indirect costs of emotional and behavioral disorders is \$247 billion per year.¹⁹

There are many contributing factors to the mental health challenges that children and youth are currently facing. Effectively addressing these challenges will require reform and greater collaboration amongst child-serving systems, as well as a shift in how we collectively think about mental illness. Within this broader context, it is important to understand the critical role that affordable health insurance coverage and access to mental health services plays in impacting children’s health outcomes. We know that Medicaid provides a critical safety-net for the most at-risk groups - including low-income children and families.²⁰

Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides Medicaid-eligible children with a broad entitlement to health care services, including mental health screening, diagnosis, and treatment. California operates the country’s largest Medicaid program, with approximately 5.2 million children enrolled in Medi-Cal.²¹ Despite this

entitlement, California has struggled to effectively implement EPSDT. According to a 2019 state audit, millions of California children do not receive the preventive health services they are entitled to, placing California 40th among states.²² A recent ranking of state health system performance found that California was one of the lowest-performing states for providing needed mental health care to children.²³

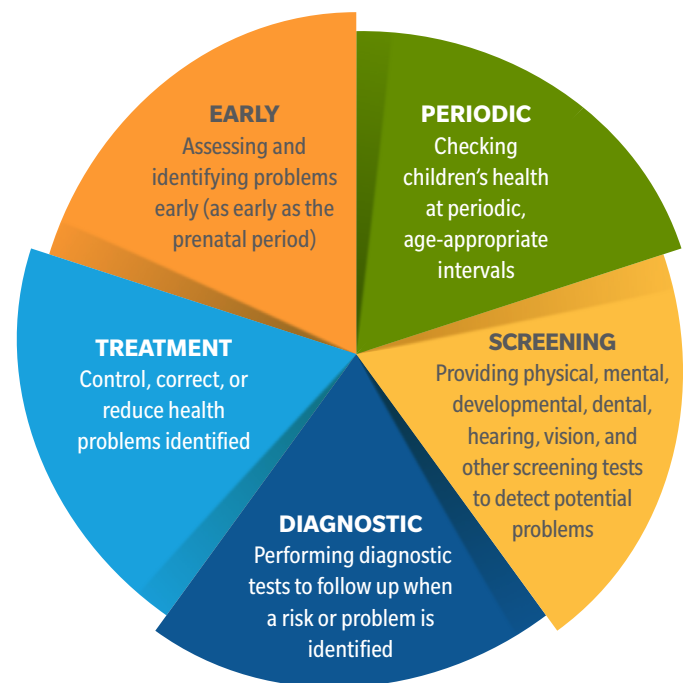
In this paper we will examine the legal entitlement that children have under Medicaid and how it is intended to ensure children and youth have access to mental health prevention, early intervention, and treatment under federal law. We provide a brief overview of the federal entitlement and a summary of implementation in California, identifying where California’s current laws and policies have fallen short in meeting the federal mandate. We then explore how the Medicaid entitlement can be better leveraged to support children’s and youth’s needs in California. We conclude by offering some initial recommendations for how California can better meet the requirements and promise of EPSDT, both in identifying needs and providing effective mental health services. While the events of 2020 present new and complex challenges, we hope they also serve as a call to action to California policymakers to take long overdue steps to ensure children are receiving the support that they need and deserve.

Section 2. Overview of Medicaid’s EPSDT Entitlement to Screening and Treatment for Mental Health Conditions

Medicaid is the largest healthcare program in the country in terms of numbers, insuring millions of low-income individuals and families each year. It was enacted in 1965, under Title XIX of the Social Security Act, as a jointly funded federal-state cooperative program intended to expand access to health care for low-income individuals and families.²⁴ Federal statutes and regulations establish overarching requirements for state Medicaid programs, and states then enter into agreements, called state plans, with the federal government specifying how the state will administer its program consistent with those requirements.²⁵ The Medicaid EPSDT entitlement was created in 1967, as part of a reform package intended to improve pediatric health care. It came on the heels of a government study finding that a third of young men drafted into the military were being rejected, many due to treatable physical, mental, and developmental health conditions that had gone unidentified and untreated.²⁶ Amendments to EPSDT in 1972 and 1981 added outreach and family support components, and in 1989, EPSDT was broadened to include a comprehensive range of pediatric preventive and treatment services, whether or not such services were otherwise covered under a state’s Medicaid plan.²⁷

From the outset, EPSDT emphasized the importance of prevention and early intervention in children’s health issues. In introducing the legislation to Congress, President Lyndon Johnson explained: “The problem is to discover, as early as possible, the ills that handicap our children. There must be continuing follow-up treatment so that handicaps do not go untreated....”²⁸ EPSDT coverage for children is intentionally “more robust” than the benefits for Medicaid-eligible adults and is “designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.”²⁹ Courts considering EPSDT have frequently noted this history and recognized that the entitlement was “crafted with the intent that it be ‘the nation’s largest preventive health program for children.’”³⁰ This focus on intervening early is key, as Medicaid-eligible children “are more likely to be born with low birth weights, have poor health, have developmental delays or learning disorders” that benefit from proactive identification and treatment.³¹

Oversight of the EPSDT entitlement lies with the Centers for Medicare & Medicaid Services (CMS), part of the federal Department of Health and Human Services. CMS is responsible for implementing federal laws regarding Medicaid, including issuing regulations and guidance, and reviewing, approving, and monitoring implementation of states’ Medicaid plans.³² CMS describes EPSDT as providing “comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid,” encompassing the following characteristics and components:³³



As explained by CMS: “The goal of EPSDT is to assure that individual children get the health care they need when they need it—the right care to the right child at the right time in the right setting.”³⁴

The core categories of EPSDT services are described in the Medicaid statute at 42 U.S.C. § 1396d(r): screening services, vision services, dental services, hearing services, and “[s]uch other necessary health care, diagnostic services, treatment, and other measures described in [42 U.S.C. § 1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.”³⁵ We focus here on the entitlement to screening and treatment of mental health conditions.³⁶

Screening services for mental health

EPSDT provides children and youth with an entitlement to proactive pediatric health and mental health screening services, which are a crucial step in identifying needs and spurring early connections to services and supports. The statute lays out minimum requirements for the screenings, including “a comprehensive health and developmental history (including assessment of both physical and mental health development)” and “health education (including anticipatory guidance).”³⁷ Screenings are to be provided “at intervals which meet reasonable standards of medical and dental practice” (i.e., periodic screenings) and “at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions” (i.e., interperiodic screenings).³⁸

Federal regulations further specify that the screening requirements, including regular mental health evaluations, “must be provided in accordance with reasonable standards of medical and dental practice determined by the agency after consultation with recognized medical and dental organizations involved in child health care.”³⁹ The regulations further require the agency to “implement a periodicity schedule” for providing services that is consistent with such standards.⁴⁰

While federal law does not prescribe a specific periodicity schedule, CMS has highlighted, and most states (including California) have adopted, the American Academy of Pediatrics Bright Futures Schedule (AAP/Bright Futures).⁴¹ The schedule provides recommendations for a series of screenings, assessments, and procedures at various stages of childhood (prenatal, infancy, early childhood, middle childhood, and adolescence through age 21) across several domains. In the “developmental/behavioral health” domain, AAP/Bright Futures recommends:

Developmental screening	at 9 months, 18 months, and 30 months of age
Autism spectrum disorder screening	at 18 months and 24 months of age
Developmental surveillance	at nearly every interval from newborn to age 21
Psychosocial/behavioral assessment	at every interval from newborn to age 21

Tobacco, alcohol, or drug use assessment	at every interval from age 12 to 21
Depression screening	at every interval from age 12 to 21
Maternal depression screening	at several points during the infancy stage ⁴²

The psychosocial/behavioral assessment “should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health.”⁴³ AAP/Bright Futures also recommends that “anticipatory guidance” be provided at every interval, from prenatal through age 21.⁴⁴ The health education (oral and written) and anticipatory guidance required under EPSDT should be provided to parents/caregivers and to children to help them “understand what to expect in terms of the child’s development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.”⁴⁵

EPSDT also provides for interperiodic screenings—screenings that do not coincide with a set schedule but rather are “required based on an indication of medical need” related to a new or existing illness or condition.⁴⁶ States may not place limitations on the number of medically necessary screenings a child may receive, and the need for an interperiodic screening is largely up to the judgment of the individual provider.⁴⁷ The “provider” recommending screening may be the child’s physician, or “a health, developmental, or educational professional who comes into contact with a child outside of the formal health care system.”⁴⁸ It need not be a Medicaid provider.

Other necessary services to “correct or ameliorate” mental illnesses or conditions

EPSDT provides an entitlement to “[s]uch other necessary health care, diagnostic services, treatment, and other measures described in [42 U.S.C. § 1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.”⁴⁹ Federal statutes, regulations, and case law provide some guidance on what this means, including the range of services due and how to interpret the concept of necessity.

The internal reference in the statute to subsection (a) “and other measures described in [42 U.S.C. § 1396d(a)]” incorporates a list of specific categories of

services that constitute “medical assistance” under the Medicaid statute.⁵⁰ Mental health services fall under several of these enumerated categories; examples include hospital and clinic services and services provided by a physician or other licensed professional (e.g., a psychologist).

Mental health services may also fall within subsection (a)(13): “other diagnostic, screening, preventive, and rehabilitative services, including A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force... [and](C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level...”⁵¹ Federal regulations define *preventive services* broadly as “services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to (1) Prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health efficiency.”⁵²

CMS has noted that *rehabilitative services* “can be particularly critical for children with mental health and substance use issues” and need not consist of services to cure or restore the child’s functional level, so long as they are ameliorative.⁵³ Such services include, but are not limited to, community-based crisis services, individualized mental health services and supports provided in either clinical or non-clinical settings (e.g. school-based or home-based), counseling or therapy “to eliminate psychological barriers that would impede development of community living skills,” and intensive care coordination services.⁵⁴ Home- and community-based mental health services may also include family and youth peer support services, which may be covered as a rehabilitative service or under the “other licensed practitioner” category.⁵⁵ Family and youth peer support is “a service provided by an individual who has received mental health services or who is the parent [or caretaker] of a child who received mental health services and supports, to help the family build self-advocacy skills to address the needs of the child.”⁵⁶

The list also includes case management services (see subsection (a)(19)), defined by 42 U.S.C. § 1396n(g) (2) as “services which will assist individuals eligible under the plan in gaining access to needed medical,

social, educational and other services.”⁵⁷ This encompasses (1) an assessment to identify service needs, including seeking input from “family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual,” (2) development of a “specific care plan... that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual...,” (3) referrals “and related activities” to obtain services and provide linkages to “medical, social, educational providers or other programs and services that are capable of providing needed services...” (4) monitoring and follow-up around effective implementation of the plan.⁵⁸

As noted above, the Medicaid statute provides an entitlement to “necessary” care, services, treatment and other measures. The “necessary” standard is built into 42 U.S.C. § 1396d(r)(5): states must provide services necessary to “correct or ameliorate” a child’s condition.⁵⁹ Courts considering EPSDT medical necessity questions have emphasized the term “early” and considered the meaning of “ameliorate,”⁶⁰ interpreting the latter to mean “to make better or more tolerable.”⁶¹ They have found that “so long as a competent medical provider finds specific care to be ‘medically necessary’ to improve or ameliorate a child’s condition, the 1989 amendments to the Medicaid statute require a participating state to cover it.”⁶²

CMS emphasizes that the medical necessity determination should be made on a “case-by-case basis, taking into account the particular needs of the child” in both the immediate and long-term, and considering “all aspects of a child’s needs, including nutritional, social development, and mental health and substance use disorders.”⁶³ It also recognizes a high level of discretion for medical providers in determining medical necessity—the “treating health care provider has a responsibility for determining and recommending that a particular covered service is needed to correct or ameliorate the child’s condition”—while also noting that the state has a role.⁶⁴ States have the option of setting parameters around medical necessity determinations, though such “parameters may not contradict or be more restrictive than the federal statutory requirement.”⁶⁵ Given the individualized nature of medical necessity determinations, states may not impose “flat limits or hard limits based on a monetary cap or budgetary constraints” on EPSDT services.⁶⁶ Nor may states allow narrower definitions of medical necessity in the managed care context: “Managed care entities may not use a definition of medical necessity

for children that is more restrictive than the state’s definition.”⁶⁷

Related obligations of states under EPSDT

Federal statutes make clear, and courts have affirmed, that states must take a proactive approach to providing EPSDT screenings and services. Section 1396a(43) of 42 U.S.C. specifies that states have an obligation to (a) inform Medicaid-eligible children of the EPSDT services available to them, to (b) provide or arrange for the provision of screening services requested, and to (c) arrange for the corrective treatment needed.⁶⁸

State Medicaid agencies must inform all eligible families about the benefits of preventive health care, including EPSDT services, and how to obtain them within 60 days of a child’s Medicaid eligibility determination.⁶⁹ They must also annually inform all families that have not used EPSDT services of their availability.⁷⁰ Notice to families must include information that these services are available at no cost and include transportation and scheduling assistance.⁷¹ States also need to ensure communications are widely accessible, including to families with limited English proficiency: states should use both written and oral communication methods with “clear and nontechnical language” and “effectively” inform individuals who “cannot read or understand the English language.”⁷²

As part of their obligations, “states may need to take affirmative steps to ensure that providers are available, such as recruiting new providers, entering single service agreements with willing providers, and contract with out-of-state providers.”⁷³ States are also responsible for ensuring that “EPSDT services provided are ‘reasonably effective,’ and, while they may delegate provision of such services to other organizations, ‘the ultimate responsibility to ensure treatment remains with the state.’”⁷⁴ EPSDT also includes a reporting requirement; states must provide annual data on their EPSDT program, including the number of children screened and the number of children referred for treatment.⁷⁵

Since its inception in 1967, the EPSDT entitlement has played a critical role in providing healthcare to millions of American children. However, many states have struggled to fully implement EPSDT, and children continue to fall through the cracks of states’ flawed service delivery systems. We turn next to examining EPSDT implementation in California.

Section 3. California’s Mental Health System and Delivery of EPSDT Services

California’s Medicaid program, Medi-Cal, has been operating since 1966 and is administered by the state’s Medicaid agency, the Department of Health Care Services (DHCS).⁷⁶ As a participant in Medicaid, California is required to serve children and youth with the full array of EPSDT services provided for in the Medicaid statute, across the continuum from screening services to treatment.⁷⁷

Medi-Cal has a critically important role to play in ensuring the state’s children and youth receive the mental health support they need. The program has undergone important improvements and changes over time. Some of this change has been driven by litigation. For example, a 1995 settlement in *T.L. v. Belshe* led California to provide significantly expanded EPSDT mental health services, beyond covered services for adults.⁷⁸ *Emily Q. v. Belshe*, which reached settlement in 2001, established a service covered under EPSDT—therapeutic behavioral services (TBS)—for children and youth.⁷⁹ And a 2011 settlement agreement in *Katie A. v. Bonta* required the State to implement intensive wraparound mental health services for children and youth in California’s foster care system or at risk of foster care placement.⁸⁰ The State subsequently agreed to provide necessary intensive home-based services and intensive care coordination and therapeutic foster care to Medi-Cal eligible children across the State, regardless of their involvement in the foster care system.⁸¹

However, a number of factors—among others, a complex, fragmented delivery system, misconstrued application of EPSDT coverage requirements, insufficient access to providers, and inadequate state oversight—have hampered progress. As a result, many children and youth are still not receiving the EPSDT mental health screening and services that they are legally entitled to.

Overview of Medi-Cal’s children’s mental health delivery structure

COUNTY MENTAL HEALTH PLANS (MHPS)

EPSDT mental health services for Medi-Cal-enrolled children and youth are delivered primarily through two parallel systems. County Mental Health Plans (MHPs) are responsible for providing Specialty Mental Health Services (SMHS). Medi-Cal Managed Care Plans (MCPs), or fee-for-service (FFS) providers for those children and youth not enrolled in managed care, are responsible for providing non-Specialty Mental Health Services (SMHS).⁸² This structure exists through two Medicaid waivers that California obtained from CMS.⁸³ The first is California’s long-standing Section 1115 waiver, which allows the State to require Medicaid beneficiaries to receive covered medical services—including but not limited to mental health services—through mandatory Medi-Cal MCPs. The other waiver is California’s 1915(b) waiver, originally granted in 1995 and extended several times since, which specifically waives Medi-Cal beneficiaries’ right to freedom of choice of providers⁸⁴ and thereby “carves out” SMHS as a category of services to be delivered by a single MHP (in every county) instead of through MCPs or FFS.⁸⁵

California state regulations define SMHS—the category of services delivered by MHPs—to include rehabilitative mental health services (including mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, and psychiatric health facility services); psychiatric inpatient hospital services; targeted case management; psychiatric services; psychologist services; EPSDT supplemental specialty mental health services; and psychiatrist nursing facility services.⁸⁶ Litigation has established that other EPSDT SMHS that MHPs must provide also include intensive care coordination (ICC), intensive home-based services (IHBS), therapeutic foster care (TFC), and therapeutic behavioral services (TBS).⁸⁷

Despite the broad EPSDT mandate to cover all services necessary to “correct or ameliorate” a mental health condition, the 1915(b) waiver establishes a set of inappropriate and often confusing criteria for what is required to receive SMHS. Specifically, the waiver

states that in order to be eligible for SMHS, a beneficiary must have an enumerated “included” DSM diagnosis; examples include schizophrenia, mood disorders, and anxiety disorders.⁸⁸ The diagnosis must also lead to a certain impairment. For outpatient SMHS for a child, this is described as “a reasonable probability that the child will not progress developmentally as individually appropriate or when specialty mental health services are necessary to correct or ameliorate a defect, mental illness, or condition of a child.” The intervention must be intended “to address the impairment/condition,” and there must be an expectation that it will “significantly diminish the impairment,” “prevent significant deterioration in an important area of life functioning,” or “allow the child to progress developmentally as individually appropriate.” The condition must also be one that “would not be responsive to physical health care based treatment.”⁸⁹ The waiver then describes a separate set of medical necessity criteria for children and youth who are “eligible for EPSDT supplemental specialty mental health services, and *who do not meet the medical necessity requirements for outpatient SMHS*” (emphasis added). The child or youth is still required to meet one of the enumerated included diagnoses, and the condition must be one that “would not be responsive to physical health care based treatment.” In addition, the mental disorder must meet the requirements of 22 CCR Section 51340(e)(3)(A) (which references the federal standard that “[t]he services are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services...”), or must be a targeted case management service intended to lead to accessing services that are medically necessary under 22 CCR Sections 1830.205 or 22 CCR 51340(e)(3)(A) and that meets the requirements of 22 CCR 51340(f).⁹⁰ The waiver also includes an ambiguously worded reference to “mild to moderate impairment” level being a basis for exclusion from medical necessity for SMHS.⁹¹ This criteria (discussed further below) has been imported into policy and practice and applied to determine whether the MHP is responsible for providing a beneficiary’s mental health services.⁹² Notwithstanding this confusion, MHPs must provide specialty mental health services to beneficiaries under 21 when they are medically necessary, regardless of impairment level.⁹³

Under the terms of the State’s 1915(b) waiver, any treatment for children who do not meet the described medical necessity standards is excluded from the waiver program, and children can instead receive services through MCPs or through Fee-For-Services Medi-Cal (FFS)—though, as discussed below, there are gaps in

services.⁹⁴ The waiver also specifies that MHPs “are not responsible for the screening function of EPSDT,” though they “may perform the diagnosis function through assessments of beneficiaries requesting services.”⁹⁵ With respect to the requirements of 42 U.S.C 1396a(a)(43)—the section of the Medicaid statute that obligates states to inform children and youth of EPSDT services, provide or arrange for screening services and corrective treatment, and report on EPSDT services—the waiver states that MHPs “are responsible only for arranging for or providing ‘corrective treatment’ identified by a screening and referral or by the MHP’s own assessment process.”⁹⁶

The terms of the 1915(b) waiver and the State’s “EPSDT Supplemental Services” and medical necessity regulations⁹⁷ have been the source of significant confusion, and are legally problematic. The diagnostic and medical necessity criteria imposed through the 1915(b) waiver are inconsistent with current federal and state law defining medical necessity, and with the broad federal EPSDT “correct or ameliorate” standard.⁹⁸ Moreover, as discussed further below, California’s attempt to bifurcate and limit children’s mental health services based on impairment level—*i.e.*, serving higher-needs children through MHPs and apparent “mild-to-moderate” needs through MCPs/fee-for-service providers that offer more limited services—is also inconsistent with EPSDT. The effect is that children and youth have been, and continue to be, denied medically necessary SMHS. In 2018, California’s Welfare & Institutions Code was amended to bring the State’s medical necessity definition into compliance with federal law.⁹⁹ Section 14059.5(b)(1) of the Welfare & Institutions Code now states that “[f]or individuals under 21 years of age, a service is ‘medically necessary’ or a ‘medical necessity’ if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.”¹⁰⁰ The legislation requires the State to update all state guidance, as well as to revise state regulations to reflect this, by July 1, 2022.¹⁰¹

MEDI-CAL MANAGED CARE PLANS (MCPS)

Managed care organizations are licensed health plans that contract with the State to provide services on a capitated (fixed payment per member per month) basis.¹⁰² Over the last several decades, California has increasingly moved towards a managed care model, and most Medi-Cal enrollees now receive health care services through managed care.¹⁰³ Currently, Medi-Cal MCPs have primary responsibility for coordinating enrolled children’s mental health screening and care and for providing children and youth with non-SMHS

services that meet medical necessity.¹⁰⁴

With respect to EPSDT screening services, MCPs are required to use the AAP Bright Futures periodicity schedule and guidelines,¹⁰⁵ and MCPs are “strongly encouraged” to use DHCS’s Individual Health Education Behavior Assessment, called the Staying Healthy Assessment (SHA), as part of the Initial Health Assessment. However, they may opt to use an AAP Bright Futures assessment or seek the State’s prior approval to use an alternative tool. The SHA consists of a series of questionnaires for specific age ranges (0-6 months, 7-12 months, 1-2 years, 3-4 years, 5-8 years, 9-11 years, 12-17 years, and “adult”).¹⁰⁶

In 2014, as a result of the federal Affordable Care Act’s Essential Health Benefits mandate to cover mental health and substance use disorder services for the adult Medicaid expansion population, California expanded the role of MCPs in providing mental health services to adult Medi-Cal beneficiaries, who previously had very limited access to outpatient mental health services.¹⁰⁷ MCPs became responsible for providing outpatient mental health services to adults with “mild to moderate impairment of mental, emotional, or behavioral functioning resulting from any mental health condition” defined by the DSM.¹⁰⁸ According to the existing contracts and state guidance, the only outpatient mental health services that MCPs are responsible to provide are the following: individual and group mental health evaluation and treatment (psychotherapy); psychological testing, when clinically indicated to evaluate a mental health condition; outpatient services for drug therapy monitoring; psychiatric consultation; and outpatient laboratory, supplies, and supplements (with some exceptions).¹⁰⁹ Because of this history and framework, MCP mental health services, including for children, are often referred to as “mild-to-moderate” services. However, note that under EPSDT, children and youth under age 21 are legally entitled to receive services necessary to correct or ameliorate their conditions regardless of whether their impairment level is “mild-to-moderate” or not.

In an All Plan Letter (APL),¹¹⁰ DHCS explained MCPs’ responsibilities as follows: “For members under the age of 21, MCPs are required to provide and cover all medically necessary EPSDT services, defined as any service that meets the standards set forth in Title 42 of the USC Section 1396d(r)(5), unless otherwise carved out of the MCP’s contract, regardless of whether such services are covered under California’s Medicaid State Plan for adults, when the services are determined to be

medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.”¹¹¹ As discussed above, SMHS are carved out under the State’s 1915(b) waiver, meaning that MCPs must “provide and cover all medically necessary service, except for SMHS listed in CCR, Title 9, Section 1810.247 for beneficiaries that meet the medical necessity criteria for SMHS as specified in... CCR, Title 9, Sections 1820.205, 1830.205, or 1830.210 that must be provided by an MHP. If an MCP beneficiary with a mental health diagnosis is not eligible for MHP services because they do not meet the medical necessity criteria for SMHS, then the MCP is required to ensure the provision of outpatient mental health services [as listed in the MCP contract and in Attachment 1 to APL 17-018], or other appropriate services within the scope of the MCP’s covered services.”¹¹² While this language suggests that any medically necessary services not provided to a child by an MHP should be delivered by an MCP, there is a problematic gap here. If a child is denied SMHS by the MHP based on the incorrect medical necessity standard in the waiver (for example, if the child is denied SMHS because he or she does not have a specific included diagnosis or meet certain impairment levels), the MCP is unlikely to offer the child anything beyond the more limited list of services that are specifically enumerated in its contract. The resulting gap in access to services conflicts with the EPSDT entitlement.

Relatedly, the way that California has attempted to bifurcate children’s mental health services based on impairment level—*i.e.*, serving higher-needs children through MHPs and apparent “mild-to-moderate” needs children through MCPs—is also inconsistent with EPSDT. If MHPs and MCPs offered the same set of medically necessary services for all Medicaid-eligible children, a child’s impairment level could be a legally appropriate way of determining which delivery system children should receive services through. However, as noted above, in California, MCPs generally provide only five types of mental health services—a menu of services created with the needs of adults in mind, not in consideration of children or the broad scope of the federal EPSDT mandate. As discussed in Section 2, EPSDT requires that a child receive all necessary services “to correct or ameliorate defects and physical and mental illnesses and conditions... whether or not such services are covered under the State plan.” If a provider makes an individualized determination that a child needs an SMHS that is available only through an MHP because it is not part of the MCP’s covered benefits package, the child is entitled to that service under EPSDT, regardless of whether their impairment

level falls into the mild, moderate, or severe/significant categories that the state has created. While impairment level may be a factor in a provider's determination, it is not a legal proxy for medical necessity, and allowing it to play a gatekeeper function undermines the individualized medical necessity determination that EPSDT requires. It can also have the effect of denying children access to needed services until their mental health issues have reached a higher level of severity, which runs directly counter to Congress's intent in enacting EPSDT: to promote prevention and early intervention in children's health issues.

For example, consider a child in foster care who has experienced complex trauma. The child is experiencing some symptoms of stress and anxiety and is receiving therapy services from her MCP provider, but is managing relatively well and is considered "mild-to-moderate." An unexpected disruption occurs in the child's placement, and her provider recognizes that this challenging transition may likely trigger an escalation in her mental health symptoms. The provider makes a determination that this escalation could be mitigated, and her symptoms ameliorated, by providing her with intensive care coordination (ICC) or intensive home-based services (IHBS), which are only available through the county MHP. If the child is denied access to ICC or IHBS by the MHP, either because she does not have one of the eligible diagnoses that qualifies her to receive SMHS under the State's Section 1915(b) waiver or because her current impairment level is not considered severe enough, she would be denied necessary services and supports that could avert a potential mental health crisis. Only after an escalation or crisis that could have been avoided would the child then receive SMHS because of her apparent change of impairment level along with a required included diagnosis.

In addition to directly providing services, MCPs are also responsible for the coordination of EPSDT services, including "carved-out and linked services and referral to appropriate community resources and other agencies," and for ensuring that case management services are arranged for and provided when needed.¹¹³ Coordination includes, for example, working with Local Education Agencies (LEAs) to ensure that the child receives all medically necessary services, without duplication.¹¹⁴ Case management is intended to connect children and youth to "necessary medical, social, educational and other services."¹¹⁵ California provides EPSDT covered case management services through a variety of sources, including the DHCS Targeted Case Management program (TCM),

Regional Centers, individual contractors, and through contracts with MHPs.¹¹⁶ MCPs are responsible for ensuring coverage of TCM services by determining whether the child requires TCM and making referrals to Regional Centers (RC) or local governmental health programs for these services.¹¹⁷ The MCP must then coordinate care with the TCM provider, and is responsible "for determining the medical necessity of diagnostic and treatment services that are covered under the MCP's contract that are recommended by the TCM provider."¹¹⁸ If a child is found not to qualify for TCM, the MCP is required to ensure they receive "access to services that are comparable to EPSDT TCM services."¹¹⁹

MCPs must also ensure that children and youth are provided "timely access to all medically necessary EPSDT services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days" following the screening or need identification.¹²⁰ MCPs are also responsible for providing assistance with scheduling appointments and transportation to access care.¹²¹ In addition, MCPs must ensure that children and families are proactively informed about EPSDT preventive and care services and how to access them. They also carry the responsibility for providing health education and anticipatory guidance—part of the screening component of EPSDT—to children and their families, in the child's primary language and at an accessible reading level.¹²²

Consistent with federal law, and despite managed care being a capitated system, decisions made by MCPs regarding medical necessity may not be subject to "[f]at or hard limits based on a monetary cap or budgetary constraints," and MCPs may not limit EPSDT services for any reason other than the individualized medical necessity determination.¹²³ This includes, for instance, a prohibition against limiting the number of visits for mental health services.¹²⁴

FEE-FOR-SERVICE MEDICAL

A fee-for-service delivery model is generally one in which individual providers deliver services to Medi-Cal beneficiaries outside of managed care, and then submit a claim to the State for payment. California has largely moved away from this model, though some fee-for-service options continue, primarily for Medi-Cal enrollees who are either exempt or not required to enroll in managed care and for specific services that are outside the scope of managed care programs.¹²⁵ For example, children and youth in foster care are generally not required to enroll in an MCP, except in certain

counties, although they may be voluntarily enrolled if the county child welfare agency, in consultation with the caregiver, believes it is in their best interest.¹²⁶ DHCS estimates that approximately 45% of children with an out-of-home child welfare or probation placement receive FFS Medi-Cal services, while approximately 55% are enrolled in managed care.¹²⁷ In addition, most antipsychotic medications prescribed by a provider within an MHP or an MCP are provided through fee-for-service Medi-Cal.¹²⁸

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

California's Child Health and Disability Prevention Program (CHDP), which operates through local health departments, also plays a role in EPSDT screening and service delivery.¹²⁹ CHDP was established before Medi-Cal was primarily administered by MCPs, to oversee screening and follow-up care. Currently, it serves as an entry point for children and youth to access EPSDT services before enrolling in Medi-Cal. Once Medi-Cal enrollment is complete, CHDP services are then provided through the MCP or the FFS Medi-Cal provider.¹³⁰ CHDP played a larger role in the past, before California moved from a primarily FFS system to a system in which most beneficiaries are enrolled in managed care.

MEDI-CAL FINANCING

Medi-Cal's children's mental health service delivery structure is coupled with financing structures and reimbursement processes that are also complex, and that have contributed to significant confusion and frustration in the field. Medicaid can reimburse for services provided through various child-serving systems.¹³¹ While this paper does not delve deeply into the mechanics of Medicaid financing, we note generally that MHP and MCP Medicaid funding and reimbursement structures are incongruent, that these structures have changed over time, (including as a result of 2011/2012 Realignment, as discussed below), and that the lack of congruence impacts how these entities interact with one another and provide services to children.

As discussed above in Section 2, Medicaid is a cooperative, jointly funded state-federal program, with states generally receiving reimbursement for a portion of their Medicaid eligible costs through "federal financial participation" (FFP).¹³² Under California's funding formula, the state and federal government each must pay 50%. In California, the county MHPs are responsible for paying the State's 50% match.

The MHPs pay for their portion of the match using non-federal funding sources, then submit a claim to the State for reimbursement by certifying their costs (known as "certified public expenditures" or "CPEs"), and DHCS reimburses MHPs the non-county (federal) share of the amount the MHP certifies as a public expenditure for each claim.¹³³

In 1991 and 2011, California underwent a "Realignment" that significantly impacted how its mental health system is financed and governed.¹³⁴ As a result of the 2011 Realignment, counties are responsible for the non-federal portion of costs for delivering SMHS, including EPSDT services.¹³⁵ However, there is an exclusion for "newer mandated costs." Under Proposition 30, counties bear the increased financial responsibility for new state requirements imposed after September 30, 2012, only if the State provides funding to support this.¹³⁶ While the non-federal portion of the funding mostly comes from Realignment funds, counties also rely on the state Mental Health Services Act (MHSA) via Proposition 63, state and county General Fund dollars, as well as federal block grants as other sources to provide SMHS.¹³⁷

In contrast, Medi-Cal MCPs, which operate through contracts with the State, are funded based on capitation, meaning they receive a set amount of funding per enrollee, often referred to as a payment per member per month or PMPM. Although MCPs are not allowed to limit EPSDT services for any reason other than the individualized medical necessity determination (as discussed above), there are inherent tensions between this financing model and implementation of a broad benefit like EPSDT. For example, MCPs receive PMPM based on the number of children and youth who enroll in their plan, while MHPs do not. The economy also impacts the funding of plans differently, given MCP enrollees will likely grow during a recession, as more children and youth become Medi-Cal eligible, while MHP realignment funding depends on state sales tax and vehicle license fees that decline during economic downturns.

Section 4. Data on Access to Mental Health Services

Both state-level data reports and the experiences of advocates in the field provide a window into how children and youth on Medi-Cal are receiving physical as well as mental health services, and indicate that many needs are going unidentified and unmet. Strikingly, a 2019 analysis by the State Auditor that reviewed DHCS data from Fiscal Years 2013-14 through 2017-18 found that, “[b]ecause of a variety of problems, an annual average of 2.4 million children who were enrolled in Medi-Cal... have not received all of the preventive health services that the State has committed to provide to them.”¹³⁸ The analysis found that the statewide utilization rate for preventive care was below 50%.¹³⁹

Data specific to children’s mental health services confirms that penetration rates for accessing care are low. Between Fiscal Years 2013-14 and 2016-17, the annual penetration rate for any SMHS—that is, the percentage of children on Medi-Cal who had at least one “visit” for SMHS—ranged between 4.1 and 4.4 percent. The annual penetration rate for five or more SMHS “visits” for the same time period ranged from 3 to 3.3 percent.¹⁴⁰ MCPs maintain their data differently, calculating visits in “Mild to Moderate Mental Health Visits per 1,000 Member Months.”¹⁴¹ According to a 2019 data report, for beneficiaries ages 0 to 18, there were 11.1 “Mild to Moderate Mental Health Visits per 1,000 Member Months.”¹⁴² (For the next age category, ages 19 to 39, there were 25.5 such visits.)¹⁴³

Given the different ways that data is tracked (e.g., with SMHS penetration rates calculated based on all eligible Medi-Cal beneficiaries, and MCPs focusing on services provided only to their member populations), it is difficult to draw a precise and meaningful comparison of penetration rates for MHP and MCP services. That said, the most recently available statewide data published by DHCS shows that while significantly more children are receiving mental health services from MHPs than from MCPs, the number of children and youth receiving some mental health services from their MCPs has grown in recent years. For example, in Fiscal Year 2016-17, 74,555 children under age 21 received psychosocial services from their MCP, and another 10,049 received services from both systems, whereas in Fiscal Year 2017-18, 91,089 children under age 21 received psychosocial services from their MCP, and another 11,909 children received psychosocial

services from both their MCP and MHP.¹⁴⁴ Although the numbers of children receiving SMHS services is higher—for example, 267,088 children under age 21 received one or more SMHS “visits” during Fiscal Year 2017-18—the penetration rate of at least one SMHS visit for Medi-Cal-eligible beneficiaries has not fluctuated significantly in the last few years, hovering around 4%.¹⁴⁵

Advocates’ experience on the ground confirms that California’s children and families are experiencing significant barriers to mental health care. For example, in 2017, the National Health Law Program conducted a survey of legal, policy, and family advocates in California that found that mental health care and counseling were the most difficult service for children with special health care needs to access.¹⁴⁶ Conversations with experts in the field indicate that whether EPSDT required services are provided too often comes down to whether the child or youth has a parent, caregiver, or other supportive adult who has the knowledge and capacity to advocate on their behalf. This creates inequities for already vulnerable youth and families, including those with limited English proficiency.

While California’s system of care provides critical mental health services for many youth, it also creates challenges for families trying to navigate access to services and for individual providers trying to offer those services. Although MHPs and MCPs enter into memoranda of understanding (MOUs) regarding how they will work together to ensure mental health services are provided, the bifurcated structure leads to significant problems with care coordination, referrals, and dispute resolution,¹⁴⁷ as well as challenges with information-sharing across multiple data systems.¹⁴⁸ These and many other factors—confusion regarding the meaning of medical necessity under EPSDT, a shortage of Medi-Cal mental health providers, insufficient outreach to inform families of EPSDT services, among others—contribute to gaps in screening, treatment, and care coordination. Advocates also report significant differences in access to screening and services amongst counties, creating geographical inequities in both needs identification and treatment. The result is that many youth are falling through the cracks of the system, either not accessing the care they need or experiencing delays in access during which their mental health may worsen.

The State is aware of the need for reform and improvement in many areas of Medi-Cal. In the fall of 2019, DHCS launched the California Advancing and Innovating Medi-Cal (CalAIM) Initiative, stating that its goals were to “[i]dentify and manage member risk and need through Whole Person Care Approaches and addressing the Social Determinants of Health,” to “[m]ove Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility,” and to “[i]mprove quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.”¹⁴⁹ With respect to mental health, the State’s initial proposal indicated interest in reforming medical necessity criteria for SMHS to align with state and federal requirements, in revisiting the availability of services prior to diagnosis, and in standardizing assessment tools.¹⁵⁰ The CalAIM proposal also noted the broader scope of services that children and youth are entitled to under EPSDT and recognized the challenges that the State’s bifurcated service delivery system can create.¹⁵¹ Acknowledging this system infrastructure problem, the State also created a CalAIM work group to address the need for fully integrating physical, oral, and mental health care under one contracted managed care entity.¹⁵² However, CalAIM was put on hold for the most part in early 2020 due to the COVID-19 pandemic and the resulting state budget crisis.¹⁵³

Now more than ever, it is crucial that California fulfill its legal obligation to identify and meet the mental health needs of children and youth. Below we provide some recommendations for steps California can take to move closer towards meeting the federal EPSDT mandates. These include recommendations aimed at ensuring that needs are identified and addressed as early as possible, consistent with the preventive thrust of EPSDT.

Section 5. Recommendations

SCREENING AND ASSESSING NEEDS OF CHILDREN AND YOUTH



RECOMMENDATION:

Medi-Cal Managed Care Plans (MCPs) should be required to annually conduct an Adverse Childhood Experiences

(ACEs) screening of all enrolled children and youth and offer services and supports to address the needs identified.

As California has recognized, “[d]etecting ACEs early and connecting patients to interventions, resources, and other supports can improve the health and well-being” of children and their families.¹⁵⁴ ACEs are strongly associated with many common and serious health conditions in the U.S., including at least nine of the ten leading causes of death.¹⁵⁵ The screening is particularly important if California is to address health equity. Data shows that Black and Hispanic children experience ACEs at higher rates than white non-Hispanic and Asian non-Hispanic children.¹⁵⁶

DHCS and the California Office of the Surgeon General recently developed and launched a protocol to screen for ACEs.¹⁵⁷ Through this initiative, Medi-Cal providers are “encouraged” to undergo training on how to conduct ACEs screenings, and may receive \$29 per trauma screening for children with Medi-Cal coverage.¹⁵⁸ DHCS recently announced that approximately 14,000 health care providers, a majority of whom were eligible Medi-Cal providers, had completed an ACEs training.¹⁵⁹

Despite these important steps forward, DHCS does not require MCPs to conduct such annual screenings. Offering these screenings should be required, not merely encouraged, as part of the MCP contract obligations. As discussed above in Sections 2 and 3, EPSDT includes a robust screening requirement, and California already mandates use of the AAP/Bright Futures periodicity schedule. Requiring MCPs to also conduct an ACEs/trauma screening is consistent with EPSDT screening obligations of states.¹⁶⁰ Further, the MCPs should be required to develop a treatment plan and follow up with appropriate and timely treatment, including a referral for appropriate behavioral health care, as needed, when a member’s toxic stress risk assessment indicates a patient is at risk. Consistent with EPSDT case management services obligations, MCPs should also be required to use findings from the ACEs screening to inform connections

to social and educational services necessary to support the youth’s mental health.¹⁶¹

It is crucial that ACEs screenings are administered as part of a youth- and family-centered approach¹⁶² that increases early identification of needs and early access to services, but that does not re-traumatize youth who have experienced ACEs or pathologize external factors in their lives, such as the experience of foster care or child poverty. DHCS and the Office of the Surgeon General should work closely with MCPs to ensure that all providers who will be administering the screenings receive the training, tools, and support needed to ensure this. This should include training regarding the social determinants of mental health.

As with other important periodic and interperiodic screenings required under EPSDT, ACEs screenings are particularly critical to improving equity in access to mental health prevention and early intervention, given the number of low-income Black and Brown children on Medi-Cal. Among other things, there should be training and ongoing monitoring to ensure that ACEs screenings will be culturally and linguistically accessible.



RECOMMENDATION:

There should be a clear and consistent determination of how children’s mental health needs are identified and addressed.

Universal Screening Tool: As noted above, EPSDT includes a robust screening requirement, and California has already mandated use of the AAP/Bright Futures periodicity schedule. To ensure consistent, equitable access to screenings, all MCPs and MHPs should be required to utilize a universal screening tool to determine the mental health needs of Medi-Cal beneficiaries under age 21. One screening tool for adults and children cannot be utilized, given both the unique needs of children/youth, as well as the broader entitlement and medical necessity standard that must be used for children under age 21 pursuant to the EPSDT benefit. Furthermore, the screening tool for children and youth must allow for children’s and youth’s needs for services to be identified in whichever delivery system the child and family seek care (either the MCP or MHP). (See “No wrong door” recommendation below.) If the screening shows that a child needs a service offered only by the other plan—for example, if the child enters via the MCP but needs an SMHS provided by

the MHP—the MCP must coordinate this and ensure the child actually receives those SMHS, along with any needed services provided by the MCP. Further, screening should not be required again to receive SMHS when a beneficiary is already receiving mental health services from the MCP or is referred by the MCP to the MHP after such screening has already taken place.

Assessment: A single standardized (short) mental health assessment tool for use with children and youth up to age 21 should be developed and required to be utilized by MHPs and MCPs across the state. Such a tool is needed to reduce the current wide variation of assessments and inconsistent application of eligibility for mental health services by such plans. DHCS should require standardized training on the tool to ensure consistent application of its use. The tool should also be required to be used by MHPs when any beneficiary screens positive for behavioral health needs by an MCP or by another child serving system (e.g. child welfare agency). A single assessment tool for all ages is not appropriate. The tool must also be culturally competent and meet the linguistic needs of children and families with limited English proficiency.

Treatment planning and case management: Further, as with the ACEs screen, the MCPs should be required to develop a treatment plan and follow up with appropriate treatment, including a referral for appropriate behavioral health care. Consistent with EPSDT and contractual obligations, as discussed in Sections 2 and 3, MCPs must ensure that children and youth receive robust case management and ensure that all needed services, whether or not directly provided by the MCP, are coordinated. This is particularly important given the complex and fragmented nature of California’s children’s mental health delivery system. If children and families are made to bear the burden of navigating this system without effective support, it undermines the intent of EPSDT, amplifies structural inequities in access to care, and risks adding new stressors for families on top of existing mental health needs. DHCS has recognized the importance of the case management and care coordination functions of EPSDT.¹⁶³ It should continue to emphasize this obligation and take proactive steps to ensure that these functions are occurring through effective oversight and monitoring. MCPs and MHPs should also be required to utilize findings from the screening to inform connections to a wide array of medical, social, and educational services necessary to support the youth’s mental health.¹⁶⁴

Data sharing: For an assessment to be reliable and accurate, there must also be utilization (claims) data and administrative data sharing, in real time if possible, between plans who serve the medical and mental health needs of beneficiaries under age 21. This is necessary to ensure plans are informed of the needs and services of their mutual members and these beneficiaries are not repeatedly asked for the same information or re-assessed each time they are referred or transferred to another delivery system for care.¹⁶⁵ At the same time, it is crucial to do this sharing in a way that honors the critical importance of privacy and patient provider confidentiality.

Timely referral and tracking: It is critical that all beneficiaries screened must be timely provided or referred for services when a need is identified, as well as tracked through the system. Current Medi-Cal managed care contracts require MCPs to “ensure appropriate EPSDT services are initiated in a timely manner, as soon as possible, *but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up*” (emphasis added).¹⁶⁶ While this requires services to be initiated in a timely manner, on the one hand, on the other it allows plans to take up to 60 days to initiate such services, which does not meet timely access standards under network adequacy rules (an appointment must be available within 10 days of the request for routine outpatient mental health services, or 15 days for psychiatry).¹⁶⁷ These requirements must be modified to comply with state law and federal regulations, to ensure children and youth who need mental health services get them timely, when they are needed.

Additionally, DHCS should require both MCPs and MHPs to conduct referral tracking, collect and report data on the referrals, as well as track the time it takes to access care after the referral. This information must be consistently collected in order to monitor adequate and appropriate access to mental health services by beneficiaries. To that end, we strongly recommend DHCS develop and require a single standardized referral tracking tool to be utilized by plans. The data to be tracked should also include plan-specific data regarding disputes over which plan is responsible for the services. Too often these disputes result in a denial of timely care and leave the beneficiary without any care when both plans claim they are not responsible.



RECOMMENDATION:
DHCS and Managed Care Plans should be required to engage in more specific outreach and informing on EPSDT-covered services, including mental health services.

As discussed above in Section 2, states are required to take a proactive approach to providing EPSDT services. The state Medicaid agency must inform all eligible families about the benefits of preventive health care, the services available under EPSDT, and how to obtain them within 60 days of a child’s initial Medicaid eligibility determination.¹⁶⁸ States are also required to annually inform families that have not used EPSDT services of their availability. The State must also inform families that these services are available without cost, and that transportation and scheduling assistance are available.¹⁶⁹ As explained by CMS: The state Medicaid agency and its contractors “should inform eligible individuals about the EPSDT benefit with a combination of written and oral methods ‘using clear and nontechnical language’ and ‘effectively inform those individuals who . . . cannot read or understand the English language.’”¹⁷⁰ Moreover, both state Medicaid agencies and managed care plans must ensure “covered services are delivered to children without a language barrier,” and must “take ‘reasonable steps’ to assure that individuals who are limited English proficient have meaningful access to Medicaid services.”¹⁷¹

While there is some information about EPSDT available on the DHCS website, and limited information is offered through a publication that is supposed to be provided when a child or youth is enrolled in Medi-Cal,¹⁷² additional outreach and education efforts should be undertaken to inform families on Medi-Cal about the benefit, and specifically the coverage and availability of EPSDT mental health services. This is particularly important given the confusion resulting from a bifurcated and confusing delivery system for these services. Additionally, while MCPs and MHPs are required to provide plan beneficiary handbooks to enrollees, including information about what services are covered, plans should be required to do more specific outreach and education to members regarding the coverage of EPSDT services and how to access them, and not merely rely on these documents alone, even if they do get into the hands of beneficiaries.¹⁷³ The MCP and MHP contracts do not go far enough to make this requirement meaningful to members under age 21. Furthermore, Medi-Cal eligible children and their families do not receive a beneficiary handbook from the MHP regarding covered SMHS until they actually qualify for services in the first place, so few

families know about what SMHS they can receive or request. DHCS should develop standalone information about Medi-Cal mental health benefits available under EPSDT and require this information be distributed to all Medi-Cal eligible beneficiaries under age 21 by MCPs and MHPs, regardless of whether the family has individually sought services. Finally, specific targeted outreach is needed to address families and children who are experiencing the greatest health disparities, and worse health outcomes based on a demonstrated lack of access to services.¹⁷⁴

PROVIDING MENTAL HEALTH SERVICES TO CHILDREN AND YOUTH



RECOMMENDATION:
DHCS should clearly divide the scope of mental health services covered by plans.

As discussed in Section 3, California’s current system for delivering children’s mental health services bifurcates responsibilities between MHPs and MCPs in a way that creates complexities for families and leads to gaps in services and coverage. DHCS should clearly divide the responsibility for mental health services that are covered by different plans to make it clear which plan is responsible for which service, and to avoid overlapping services that lead to disputes between plans over coverage. For example, MCPs currently cover by contract the following services: individual/group mental health evaluation and treatment (psychotherapy); psychological testing; outpatient services for monitoring drug therapy; outpatient laboratory, supplies, and supplements; and psychiatric consultation. The SMHS covered by the MHPs should not also include these same services because it causes confusion for beneficiaries as to which plan is responsible to provide them and can result in both plans denying covered services and disputing their responsibility to serve their members. This can be remedied if DHCS clearly divides up these services so only one plan is responsible to provide them to children and youth under age 21, so non-SMHS and SMHS are distinct. This must be accompanied by clear, consistent direction from DHCS to MHPs and MCPs that children are entitled to receive all medically necessary services, whether non-SMHS or SMHS, regardless of impairment level, and can receive services from both systems when needed.



RECOMMENDATION:
A “no wrong door” approach should be implemented to ensure children and youth receive all mental health services they need.

DHCS should implement a “no wrong door” approach to ensure that no child is turned away or experiences delays in care based on which entry point they use. The plan in which the child seeks out care should be responsible for assessing their needs and providing care or, if the child needs services offered only by another plan, ensuring the child actually receives those services in a timely manner. As another measure to prevent gaps and delays in services, children and youth must be allowed to receive non-specialty mental health services from the MCP as well as SMHS from the MHP at the same time to the same child, if such services are necessary. This is critical to ensure necessary services are provided and continuity of care is practiced when a child or youth needs multiple services to meet their needs and different delivery systems do not provide all EPSDT covered Medi-Cal services. Additionally, children and youth should not be required to change providers solely due to the impairment level if the service they are receiving (e.g., psychotherapy) is covered by both plans. The child or youth must be allowed to remain in care with their existing provider throughout the course of treatment. This is also required under existing continuity of care rules, which are not being followed by many plans today.¹⁷⁵ A “no wrong door approach” would be much easier to implement if the services MCPs and MHPs provide are clearly divided (see above). For example, if a child needs psychotherapy as well as crisis services, the psychotherapy services could be provided by the MCP while the crisis services would be provided by the MHP.



RECOMMENDATION:

A specific diagnosis should not be required prior to obtaining medically needed mental health or specialty mental health services.

As discussed above in Section 2, Medicaid’s medical necessity standard for children and youth under age 21 is the standard stated in federal law.¹⁷⁶ The Medicaid Act itself defines EPSDT services as the following items and services: “(5) Such other necessary health care, diagnostic services, treatment, and other measures ... to correct or ameliorate defects and physical and mental illnesses and conditions *discovered by the screening services*, whether or not such services are covered under the State plan” (emphasis added).¹⁷⁷ CMS has also made clear that states “must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services.”¹⁷⁸ Yet the current SMHS delivery system,

as well as state regulations (in Title 9 of the California Code of Regulations) and plan contracts continue to create confusion and are inconsistent with state and federal law and CMS guidance. The 1915(b) waiver and existing state regulations require children and youth to meet both specific diagnostic and medical necessity criteria that do not comport with the federal and state law Medicaid standards and only serve to deny children and youth medically necessary SMHS. CMS has stated: “Programs should not result in a label or premature diagnosis of a child. Providers should report only that a condition was referred or that a type of diagnostic or treatment service is needed. Results of initial screening should not be accepted as conclusions and do not represent a diagnosis.”¹⁷⁹

It is critical to make clear that mental health services should be provided when necessary to correct or ameliorate a condition, based on a screening of a child or youth. Those services must be provided as necessary, even prior to a child having a specific diagnosis. DHCS must make clear these requirements in both MHPs and MCP contracts and guidance, and ensure they are consistently complied with throughout the state. For example, there should be no policy that allows a child or youth to be refused necessary care or treatment simply because a specific diagnosis is not present, or because there is not a diagnosis established. Further, arbitrary requirements that payment will not be allowed for treatment after a set number of visits due to the absence of a diagnosis similarly violates the EPSDT statute and the individualized determination of medical necessity by an appropriate qualified provider that EPSDT contemplates. DHCS must revise MCP and MHP contracts, provider manuals and plan guidance to follow these rules. While providing diagnostic services is clearly contemplated by the EPSDT statute, it was never intended as an obstacle for children and youth to receive necessary services or treatment based on a screening of that child or youth.

Finally, DHCS needs to repeal the antiquated and outdated Title 9 diagnostic and medical necessity regulations that are inconsistent with both state and federal EPSDT standards. The State should also remove all references to Title 9 in its 1915(b) waiver. EPSDT standards are set by federal law and clearly outlined by CMS in its EPSDT state guide and the State Medicaid Manual. The State and its contracting MHPs must be required to follow this federal law and guidance, and not outdated and legally deficient state regulations. These regulations were required to be repealed or modified by the Legislature through SB 1287, but that has not yet been done.¹⁸⁰

Section 6. Conclusion and Next Steps

The State must take additional steps to ensure that children and youth on Medicaid have access to all of the screening, assessment, diagnostic, and treatment services required by federal law. While there have been some improvements, numerous obstacles remain in place that prevent children and youth from getting what they need, from appropriate early developmental and other related screening of mental health conditions to treatment that is necessary as a result of such screenings. The low number of children and youth on Medi-Cal getting any mental health services at all demonstrates such deficiencies. Further, the complicated and fragmented delivery system in California only makes access more difficult. Multiple plans (22 MCPs and 56 MHPs) are responsible for mental health services, and confusion across the system continues given that plans have inconsistent policies and practices and that State oversight and monitoring of these plans is inadequate.

Changes to the system are needed, including moving towards more physical and behavioral health integration at the administrative, financial, and clinical levels to ensure beneficiaries and families do not continue to face roadblocks when trying to access care, and to promote and achieve better outcomes for children and youth. Such changes have only begun to be discussed and considered, despite decades of fragmentation that have not changed. Yet until that integration is realized, the State can and should do more to meet its commitment to providing children and youth on Medi-Cal with the services contemplated and promised by Congress since EPSDT was originally enacted in 1969, and enhancements were made through the Omnibus Budget Reconciliation Act of 1989 to reinvest in that promise.

Appendix

Key Federal EPSDT Statutes and Regulations

42 USC § 1396a: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

42 USC § 1396d: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm

42 CFR § 441.50 et seq: <https://www.law.cornell.edu/cfr/text/42/part-441/subpart-B>

EPSDT Resources

Federal Medicaid EPSDT page: <https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html>

California DHCS EPSDT page: <https://www.dhcs.ca.gov/services/medi-cal/Documents/Medi-Cal-Coverage-for-EPSDT.pdf>, <https://www.dhcs.ca.gov/services/Pages/EPSDT.aspx>

Bright Futures Periodicity Schedule: <https://brightfutures.aap.org/Pages/default.aspx>

Centers for Medicare & Medicaid EPSDT Guide: https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf

National Health Law Program (NHeLP) EPSDT Resources

Fact Sheet: EPSDT Litigation Trends and Docket: <https://healthlaw.org/resource/fact-sheet-epsdt-litigation-trends-docket/>

Community-based services under EPSDT: <https://healthlaw.org/resource/childrens-mental-health-services-the-right-to-community-based-care/>

California's Mental Health System: <https://healthlaw.org/resource/navigating-the-challenges-of-medi-cals-mental-health-services-in-california-an-examination-of-care-coordination-referrals-and-dispute-resolution/>

<https://healthlaw.org/resource/an-advocates-guide-to-medi-cal-services/>

EPSDT Issue Briefs: <https://healthlaw.org/resource/epsdt-is-essential/>

<https://healthlaw.org/resource/issue-brief-medicaid-early-and-periodic-screening-diagnosis-and-treatment-as-source-of-funding/>

<https://healthlaw.org/resource/medicaid-early-and-periodic-screening-diagnosis-and-treatment-fact-sheet-oct/>

<https://healthlaw.org/resource/medicaid-services-for-children-whats-covered/>

<https://healthlaw.org/resource/health-advocate-early-and-periodic-screening-diagnosis-and-treatment-epsdt/>

Timely Access / Rosie D. amicus brief / History of EPSDT: <https://healthlaw.org/a-medicaid-promise-to-children-timely-treatment-services/>

<https://healthlaw.org/wp-content/uploads/2020/01/Amicus-Br.-NHeLP-AAP-et-al..pdf>

This document provides general legal information, not legal advice. Readers are encouraged to consult their legal counsel for legal advice on these topics. The legal information in this paper is current as of September 2020.

Endnotes

- 1** Daniel G. Whitney & Mark D. Peterson, *Research Letter: US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children*, 173(4) *JAMA Pediatrics* 389, 389 (2019), available at <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2724377>.
- 2** California Children's Trust, *Healing Centered Schools: Financing Justice and Equity at the Nexus of Public Health and Public Education*, slide 4 (July 1, 2020), available at <https://cchildrenstrust.org/wp-content/uploads/2020/07/Healing-Centered-Schools-FINAL.pdf>.
- 3** Joan Alker & Lauren Roygardner, Georgetown University Health Policy Institute Center for Children and Families, *The Number of Uninsured Children Is on the Rise*, 2 (October 2019), available at <https://ccf.georgetown.edu/wp-content/uploads/2019/10/Uninsured-Kids-Report.pdf> (approximately 5% of children do not have health insurance).
- 4** National Institute of Mental Health, *Major Depression*, Figure 6 (Past Year Treatment Received Among Adolescents with Major Depressive Episode (2017)), available at <https://www.nimh.nih.gov/health/statistics/major-depression.shtml> (citing SAMHSA data).
- 5** Beata Mostafavi, *Half of U.S. Children with Mental Health Disorders Are Not Treated*, Univ. of Michigan Health Lab: Rounds, p. 9 (Feb. 18, 2019), available at <https://lablog.uofmhealth.org/rounds/half-of-us-children-mental-health-disorders-are-not-treated>.
- 6** See Stacy Hodgkinson, Leandra Godoy, Lee Savio Beers & Amy Lewin, *Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting*, 139 *Pediatrics* 1 (2017), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5192088/#B5> (citing S.H. Kataoka, L. Zhang & K.B. Wells, *Unmet need for mental health care among US children: variation by ethnicity and insurance status*, 159 *Am. J. Psychiatry* 9, 1548-1555 (2002); C.D. Santiago, S. Kaltman & J. Miranda, *Poverty and mental health: how do low-income adults and children fare in psychotherapy?*, 69 *J. Clin. Psychol.* 2, 115-126 (2013)).
- 7** Discussions regarding mental health use a variety of terms to describe mental health "problems" (for example, mental health issues, mental health conditions, mental illness, and mental disorder) and mental health generally (for example, mental wellness, mental well-being, and social, emotional, and mental health). This range of language reflects several factors, including an effort to distinguish between diagnosed illnesses and other mental health needs, a growing recognition that "mental health is more than just the absence of mental health disorders or disabilities" and exists on a spectrum, and an increasing awareness of how the language we use to describe mental health can unintentionally reinforce harmful stigma. World Health Organization, *Mental health: Strengthening our response* (2018), <https://www.who.int/news-room/factsheets/detail/mental-health-strengthening-our-response>. In this paper, we will do our best to use terminology that is accurate, precise, and non-stigmatizing, but we acknowledge that this language is imperfect.
- 8** See Centers for Disease Control and Prevention, *Preventing Adverse Childhood Experiences*, <https://www.cdc.gov/violenceprevention/aces/fastfact.html>.
- 9** See World Health Organization & Calouste Gulbenkian Foundation, *Social Determinants of Mental Health* (2014), available for download at https://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/ ("Certain population subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, interrelated with gender. Disadvantage starts before birth and accumulates throughout life.")
- 10** American Academy of Pediatrics Section on Adolescent Health, Council on Community Pediatrics, *Poverty and Child Health in the United States*, *Pediatrics* 137 (4) e20160339 (2016), available at <https://pediatrics.aappublications.org/content/137/4/e20160339#ref-16> (citing Ratcliffe C, McKernan SM, *Childhood poverty persistence: facts and consequences*, Urban Institute Brief (June 2010)).
- 11** *Id.*
- 12** Maria Trent, Danielle G. Dooley, & Jacqueline Dougé, American Academy of Pediatrics Section on Adolescent Health, Council on Community Pediatrics and Committee on Adolescence, *The Impact of Racism on Child and Adolescent Health*, *Pediatrics* 144 (2) e20191765 (2019), available at <https://pediatrics.aappublications.org/content/144/2/e20191765>.
- 13** See Daniel Wood, *As Pandemic Deaths Add Up, Racial Disparities Persist—And In Some Cases Worsen*, NPR (Sept. 23, 2020), available at <https://www.npr.org/sections/health-shots/2020/09/23/914427907/as-pandemic-deaths-add-up-racial-disparities-persist-and-in-some-cases-worsen> ("African Americans continue to get infected and die from COVID-19 at rates more than 1.5 times their share of the population.")
- 14** Centers for Disease Control and Prevention, *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24-30, 2020*, *Weekly* 69(32), 1049-1057 (August 14, 2020), available at <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>. This is on top of already-growing mental health needs for young adults ages 18 to 24. A recent study found that between 2014 and 2018, the percentage of young adults with "serious psychological distress" increased from 11.3% to 23%. D. Imelda Padilla-Frausto, Firooz Kabir, Blance Wright, Safa

Salem, Ann Crawford-Roberts & Hin Wing Tse, UCLA Center for Health Policy Research, *Serious Psychological Distress on the Rise Among Adults in California*, 4 (2020), available at <https://healthpolicy.ucla.edu/publications/Documents/PDF/2020/SPD-policybrief-sep2020.pdf>.

15 Centers for Disease Control and Prevention, *Mental Health—Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic—United States, January 1–October 17, 2020*, Weekly 69(45), 1675–1680 (Nov. 13, 2020), available at https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm?s_cid=mm6945a3_w (“Beginning in April 2020, the proportion of children’s mental health-related ED visits among all pediatric ED visits increased and remained elevated through October. Compared with 2019, the proportion of mental health-related visits for children aged 5–11 and 12–17 years increased approximately 24% and 31%, respectively.”)

16 Anya Kamenetz, *The Pandemic Has Researchers Worried About Teen Suicide*, NPR (Sept. 10, 2020), available at https://www.npr.org/2020/09/10/911117577/the-pandemic-has-researchers-worried-about-teen-suicide?utm_medium=RSS&utm_campaign=news.

17 See, e.g. Mental Health America, *Children’s Mental Health*, available at <https://www.mhanational.org/issues/childrens-mental-health>; Centers for Medicare and Medicaid Services, *CMCS Informational Bulletin: Prevention and Early Identification of Mental Health and Substance Use Conditions*, 2–3 (March 27, 2013), available at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-03-27-2013.pdf> (noting that “[n]umerous organizations in the medical community have issued clinical guidelines calling for early identification and screening for mental illness and substance use disorders,” and highlighting recommendations from the American Academy of Pediatrics, the American Medical Association, the Surgeon General, and the United States Preventive Services Task Force, among others).

18 See National Alliance on Mental Illness, *Mental Health by the Numbers*, available at <https://www.nami.org/learn-more/mental-health-by-the-numbers>.

19 American Academy of Child & Adolescent Psychiatry, et al., *Improving Lives, Avoiding Tragedies*, available at https://www.aacap.org/App_Themes/AACAP/docs/Advocacy/policy_resources/Children’s_Mental_Health_Fact_Sheet_FINAL.pdf (referring to an estimate by the Institute of Medicine).

20 See e.g., Laura Wherry, Genevieve Kenny & Benjamin Sommers, *The Role of Public Health Insurance in Reducing Child Poverty*, 16 Acad. Pediatr. 3 Suppl, S98–S104 (2016), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5034870/> (“Expansions in public health insurance for low-income children and adults are associated with reduced out-of-pocket medical spending, increased financial stability, and improved material well-being for families. When out-of-pocket medical expenses are taken into account in

defining the poverty rate, Medicaid plays a significant role in decreasing poverty for many children and families. In addition, public health insurance programs connect families to other social supports such as food assistance programs that also help reduce poverty... Exposure to Medicaid and CHIP during childhood has been linked to decreased mortality and fewer chronic health conditions, better educational attainment, and less reliance on government support later in life.”).

21 See Dep’t of Health Care Servs., *Medi-Cal Monthly Eligible Fast Facts: Characteristics of the Medi-Cal population as captured by the Medi-Cal Eligibility Data System (MEDS)* (Sept. 2020), 7, available at <https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast-Facts-June2020.pdf> (indicating that there are 5,237,964 “Medi-Cal certified Eligibles” ages 0–20 as of June 2020).

22 California State Auditor, *Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services*, 1, 13 (2019), available at <https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf>.

23 Commonwealth Fund, *2020 Scorecard on State Health System Performance, California: Ranking Highlights* (2020), available at <https://2020scorecard.commonwealthfund.org/files/California.pdf>.

24 See 42 U.S.C. § 1396 et seq.

25 See Medicaid and CHIP Payment and Access Commission, *State Plan*, <https://www.macpac.gov/subtopic/state-plan/>.

26 Sara Rosenbaum et al., George Washington University School of Public Health and Health Services Department of Health Policy, *Policy Brief: National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT* (April 2005), available at <https://cachildrenstrust.org/wp-content/uploads/2020/03/History-of-EPSDT.pdf>.

27 See Omnibus Budget Reconciliation Act of 1989, Pub.L. 101–239, § 6403 (codified in part and as amended at 42 U.S.C. § 1396d(r)); H.R.Rep. No. 101–386, at 453 (1989) (Conf. Rep.), reprinted in 1989 U.S.C.C.A.N. 3018, 3056. See also 135 Cong. Rec. S13, 233–34 (Oct. 12, 1989); 135 Cong. Rec. s. 6899 (daily ed. June 19, 1989) (statement of Sen. Chafee).

28 President Lyndon B. Johnson, *Welfare of Children*, H.R. Doc. No. 54, 90th Cong., 1st Sess. (1967), 113 Cong. Rec. 2883 (Feb. 8, 1967).

29 Centers for Medicare and Medicaid Services, *EPSDT—A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*, 1 (2014) [hereinafter CMS, *EPSDT Guide*], available at https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf.

30 *Elkoff v. Rodgers*, 443 F. Supp.2d 1173, 1178 (D. Ariz. 2006) (citing H.R. 3299, 101st Cong. § 4213 (1989)). See also *Rosie D. v. Romney*, 410 F.Supp. 2d 18, 25 (D. Mass. 2006) (“As broad as the overall Medicaid umbrella is generally, the

initiatives aimed at children are far more expansive.”)

31 CMS, *EPSDT Guide*, at 36.

32 For information about the Centers for Medicare & Medicaid Services (CMS), see <https://www.cms.gov/>.

33 Centers for Medicare & Medicaid Services, *Early and Periodic Screening, Diagnostic, and Treatment*, available at <https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html>.

34 CMS, *EPSDT Guide*, at 1.

35 See 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

36 For an overview of EPSDT, see Jane Perkins, National Health Law Program, *EPSDT Is Essential* (2017), available for download at <https://healthlaw.org/resource/epsdt-is-essential/>.

37 42 U.S.C. § 1396d(r)(1)(B).

38 42 U.S.C. § 1396d(r)(1)(A).

39 42 C.F.R § 441.56(b)(2).

40 42 CFR § 441.58.

41 CMS, *EPSDT Guide*, at 4.

42 Hagan J.F., Shaw J.S., & Duncan P.M., eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics (2020), available at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf. For more information regarding Bright Futures, see <https://brightfutures.aap.org/Pages/default.aspx>.

43 *Id.* at n.13.

44 *Id.* at 1.

45 Centers for Medicare and Medicaid Services, *State Medicaid Manual*, § 5123.2E, available for download at <https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927>.

46 CMS, *EPSDT Guide*, at 5.

47 *Id.*

48 *Id.*

49 42 U.S.C. § 1396d(r)(5).

50 42 U.S.C. § 1396d(a).

51 42 U.S.C. § 1396d(a)(13). See also 42 C.F.R. § 440.130(d) (“Rehabilitative services,’ except as otherwise provided under this subpart, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.”).

52 42 C.F.R § 440.130(c).

53 CMS, *EPSDT Guide*, at 10-11.

54 *Id.* at 11-12. For a discussion of how the Medicaid EPSDT benefit and the ADA integration mandate, together, require states to ensure that mental health services are provided in integrated home- and community-based settings, see J. Lav & K. Lewis, *Children’s Mental Health Services: The Right to Community-Based Care* (2018), available for download at <https://healthlaw.org/resource/childrens-mental-health-services-the-right-to-community-based-care/>.

55 J. Lav & K. Lewis, *Children’s Mental Health Services: The Right to Community-Based Care*, 16-18 (2018), available for download at <https://healthlaw.org/resource/childrens-mental-health-services-the-right-to-community-based-care/>.

56 *Id.* at 17 (citing Ctr. for Health Care Strategies, *Medicaid Financing for Family and Youth Peer Support: A Scan of State Programs* (2012), available at <https://www.chcs.org/media/Family-Youth-Peer-Support-Matrix-reformatted-070714.pdf> (noting that numerous states cover family and youth peer supports, via state plan amendments and waivers)).

57 42 U.S.C. § 1396d(a)(19); 42 U.S.C. § 1396n(g)(2).

58 42 U.S.C. § 1396n(g)(2).

59 See *K.G. by and through Garrido v. Dudek*, 2012 WL 13168029, *5 (S.D. Fla. 2012) (“Although the EPSDT statutory provisions use the terms ‘necessary’ and ‘medical necessity,’ federal law does not define either term.... Instead, federal law grants states the authority to set reasonable standards for the terms ‘necessary’ and ‘medical necessity.’”) (citing 42 U.S.C. § 1396a(a)(17) (requiring the state plan to “include reasonable standards ... for determining ... the extent of medical assistance under the plan which are consistent with the objectives of [the Medicaid Act]”); 42 C.F.R. § 440.230(d) (2011) (allowing the state agency to “place appropriate limits on a service based on such criteria as medical necessity”); *Rush v. Parham*, 625 F.2d 1150, 1154-55 (5th Cir. 1980) (holding that “a state may adopt a definition of medical necessity that places reasonable limits on a physician’s discretion” and finding that “the Medicaid statutes and regulations permit a state to define medical necessity in a way tailored to the requirements of its own Medicaid program”).

60 Amy Clary & Barbara Wirth, *National Academy for State Health Policy, State Strategies for Defining Medical Necessity for Children and Youth with Special Health Care Needs*, 2 (2015), available at <https://www.nashp.org/wp-content/uploads/2015/10/EPSDT.pdf>.

61 See, e.g., *Ekloff v. Rodgers*, 443 F.Supp.2d 1173, 1180 (D. Ariz. 2006).

62 *Rosie D. v. Romney*, 410 F.Supp.2d 18, 26 (D. Mass. 2006) (citing *Collins*, 349 F.3d at 375 (holding that if a competent medical service provider determines that a specific type

of care or service is medically necessary, state may not substitute a different service that it deems equivalent); *Rosie D.*, 310 F.3d at 232; *John B. v. Menke*, 176 F.Supp.2d 786, 800 (M.D. Tenn.2001) (noting that a state “is bound by federal law to provide ‘medically necessary’ EPSDT services”). See also *Mj v. District of Columbia*, 401 F.Supp.3d 1, 14-15 (D.D.C. 2019) (“Courts construing EPSDT requirements have ruled that so long as a competent medical provider finds specific care to be ‘medically necessary’ to improve or ameliorate a child’s condition, the Medicaid statute requires a participating state to cover it”) (citing *Collins v. Hamilton*, 349 F.3d 371, 375-76 (7th Cir. 2003) (holding that if a competent medical service provider determines a specific type of care or service is medically necessary, a state may not substitute a different service that it deems comparable)).

63 CMS, *EPSDT Guide*, at 23.

64 *Id.* at 24.

65 *Id.* at 23.

66 *Id.*

67 *Id.* at 30. See also J. Perkins & R. Agrawal, *Protecting Rights of Children with Medical Complexity in an Era of Spending Reduction*, 141 *Pediatrics* S242, S246 (2018) [hereinafter Perkins & Agrawal, *Protecting Rights of Children with Medical Complexity in an Era of Spending Reduction*] (“As Medicaid beneficiaries are increasingly moved from fee-for-service to managed care, accountable care organizations, and other risk-based payment structures, it is important to note that Medicaid beneficiaries entitled to EPSDT retain the rights to receive all medically necessary services... Whether management is delegated to a third party, the state Medicaid agency remains responsible for ensuring that EPSDT is provided as the law intends.”)

68 42 U.S.C. § 1396a(43)(A)-(C). For an example of a court discussing the active, not passive, nature of states’ EPSDT obligation, see e.g. *Tinsley v. Faust* (411 F. Supp. 3d 462, 474 (D. Ariz. 2019)) (“Arizona may not simply shrug indifferently when children do not request help, but instead must affirmatively determine what obstacles lie between the children and the ‘help that is available,’ and then mitigate those obstacles.”).

69 42 C.F.R. § 441.56(a).

70 *Id.*

71 *Id.*

72 *Id.*; CMS, State Medicaid Manual §§ 5121.A, 5121.C; CMS, *EPSDT Guide*, at 17.

73 J. Perkins & R. Agrawal, *Protecting Rights of Children with Medical Complexity in an Era of Spending Reduction*, at S245.

74 See also *B.K. by next friend Tinsley v. Snyder*, 922 F.3d 957, 974 (9th Cir. 2019) (citing *Katie A.*, *ex rel. Ludin v. Los Angeles Cty.*, 481 F.3d 1150, 1159 (9th Cir. 2007)). A state plan must specify a single state agency established or designated “to administer or supervise the administration of the [Medicaid

state] plan.” 42 U.S.C. §1396a(a)(5). That agency must have legal authority to “[a]dminister or supervise the administration of the plan” and “[m]ake rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.” 42 C.F.R. § 431.10(b). For an agency to qualify as the Medicaid single state agency, it must not delegate its “authority to supervise the plan or issue policies, rules, and regulations on program matters” to anyone other than its own officials. 42 C.F.R. § 431.10(e). In addition, the authority of the Medicaid single state agency must not be impaired. This means that other offices or agencies performing services for the Medicaid single state agency may review rules, regulations, or decisions from the Medicaid single state agency. However, these offices must not have the authority to change or disapprove any administrative decision of the Medicaid single state agency, or otherwise substitute their judgment for that of the Medicaid single state agency with respect to the applications of policies, rules, and regulations issued by the Medicaid agency. In California, the Medicaid single state agency is DHCS.

75 42 U.S.C. § 1396a(43)(D). Regarding the obligation to take a proactive approach, see, e.g. *Katie A.*, 481 F.3d at 1158–59 (collecting cases); *Rosie D.*, 410 F. Supp. 2d 18, 26 (D. Mass. 2006); *Tinsley v. Faust*, 411 F. Supp. 3d 462, 473 (D. Ariz. 2019).

76 Cal. Welf. & Inst. Code § 14100.1. See also Dep’t of Health Care Services, *Medi-Cal Coverage for EPSDT*, available at <https://www.dhcs.ca.gov/services/medi-cal/Documents/Medi-Cal-Coverage-for-EPSDT.pdf>

77 See Cal. Welf. & Inst. Code § 14132(v) regarding inclusion of EPSDT in California’s Medicaid program, consistent with federal law.

78 *TL v. Belshe*, No. CV-S-93-1782 LKKPAN (E.D. Cal. 1995) (settlement) (requiring the state to issue regulations to ensure coverage for EPSDT treatment services for children that are not included in the state’s Medicaid plan for adult recipients).

79 *Emily Q. v. Bonta*, 208 F. Supp. 2d 1078 (C.D. Cal. 2001) (permanent injunction) (requiring therapeutic behavioral services (TBS) for class of children, including: (1) adequate notice about TBS, (2) TBS certification, (3) immediate assessment of all class members, (4) transitional TBS, (5) compensatory TBS as a form of equitable relief, and (6) monitoring of counties’ provision of TBS).

80 *Katie A. v. Bonta*. For more information about *Katie A.*, see <https://youthlaw.org/case/katie-a-v-bonta/> and <https://healthlaw.org/resource/katie-a-v-los-angeles-county-central-district-of-california-western-division/>

81 See Dep’t of Health Care Servs., *Documentation and Billing Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), & Therapeutic Foster Care (TFC)*, available at https://www.dhcs.ca.gov/services/MH/Pages/Manuals_And_Guides.aspx Dep’t of Health Care

Servs., *Court Documentation: Katie A. Settlement Agreement Implementation*, https://www.dhcs.ca.gov/services/MH/Pages/Court_Documentation.aspx (“While the Katie A. settlement only concerned children and youth in foster care, or at imminent risk of placement in foster care, membership in the Katie A. class or subclass is no longer a requirement for receiving medically necessary Intensive Care Coordination (ICC), IHBS, and Therapeutic Foster Care (TFC). Therefore, a child or youth need not have an open child welfare services case to be considered for receipt of ICC, IHBS, or TFC.”)

82 See California Assembly and Senate Health Committees, *Informational Hearing: The Medi-Cal Mental Health Delivery System, Background*, 2-3 (Feb. 26, 2019) [hereinafter *Informational Hearing: The Medi-Cal Mental Health Delivery System*], available at <https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/Final%20February%2026%20Medi-Cal%20Mental%20Health%20Background%202.pdf>.

83 States may seek changes to their Medicaid programs through amendments to their state Medicaid plans (called State Plan Amendments, or SPAs). For additional information on SPAs, see Medicaid.gov, *Medicaid State Plan Amendments*, <https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html>. States may also make changes to their Medicaid program by seeking an exemption or waiver from certain statutory requirements. These changes are subject to federal approval. For example, Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary likely to assist in promoting the objectives of the Medicaid program. See Medicaid.gov, *About Section 1115 Demonstrations*, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html>. Alternatively, 1915(b) waivers are used to restrict enrollees’ freedom of choice (under Section 1902(a)(23)) to mandate enrollment in a restricted network, enroll traditionally exempt individuals in managed care, or limit choice to a single mandated plan. See Medicaid and CHIP Payment and Access Commission (MACPAC), *1915(b) waivers*, <https://www.macpac.gov/subtopic/1915b-waivers>; Benjamin Finder, MACPAC, *The Role of Section 1915(b) Waivers in Medicaid Managed Care*, <https://www.macpac.gov/wp-content/uploads/2017/03/The-Role-of-1915b-in-Medicaid-Managed-Care.pdf>; Medicaid.gov, *Managed Care Authorities*, <https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html>. For information about California’s Medicaid waivers, see Dep’t of Health Care Servs., *Medi-Cal Waivers*, <https://www.dhcs.ca.gov/services/Pages/medi-calwaivers.aspx>.

84 See 42 U.S.C. § 1396a(a)(23).

85 *Informational Hearing: The Medi-Cal Mental Health Delivery System*, at 3. For information about California’s Section 1115 Medicaid Waiver, see Dep’t of Healthcare Servs., *Medi-Cal 2020 Demonstration*, <https://www.dhcs.ca.gov/>

[provgovpart/Pages/medi-cal-2020-waiver.aspx](https://www.dhcs.ca.gov/services/Pages/medi-cal-2020-waiver.aspx). For information about California’s Section 1915(b) waiver, see Dep’t of Healthcare Servs., *Medi-Cal Specialty Mental Health Services*, https://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx. A list of county mental health plans can be found at: <https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx>.

86 Cal. Code Regs., tit. 9, § 1810.247. “EPSDT supplemental specialty mental health services” is a California-specific term defined in a web of cross-referenced state regulations, some of which are outdated. See Cal. Code Regs., tit. 9, § 1810.215 (defining EPSDT “supplemental specialty mental health services” as “mental health related diagnostic services and treatment, other than physical health care, available under the Medi-Cal program only to persons under 21 years of age pursuant to Title 42, Section 1396d(r), United States Code, that have been determined by the Department to meet the criteria of Title 22, Section 51340(e)(3) or (f); and that are not otherwise covered by this Chapter as specialty mental health services”).

87 See Dep’t of Health Care Servs., All Plan Letter 17-018, 10 (Oct. 27, 2017) [hereinafter APL 17-018], available at <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-018.pdf>. For descriptions of ICC, ICBS, TFC, and TBS, see Dep’t of Health Care Servs., *Mental Health & Substance Use Disorder Services (MHSUDS) Info. Notice 18-043* (2018) [hereinafter *MHSUDS Info. Notice 18-043*], Enclosure 1, *Mental Health Plan Beneficiary Handbook Specialty Mental Health Services*, 35-38, available at https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN_18-043_Beneficiary_Handbook/MHP_Beneficiary_Handbook.pdf; Dep’t Health Care Servs., *Specialty Mental Health Services for Children and Youth*, https://www.dhcs.ca.gov/services/MH/Pages/Specialty_Mental_Health_Services.aspx.

88 Section 1915(b) Waiver Proposal For MCO, PIHP, PAHP, PCCM Programs And FFS Selective Contracting Programs, 2015-2020, Version June 10, 2015, 21-23 [hereinafter 1915(b) Waiver], available at <https://www.dhcs.ca.gov/services/MH/Documents/1915-b-SMHS-Waiver.pdf>. See also Dep’t Health Care Servs., *Behavioral Health Info. Notice No. 20-043* (2020), available at <https://www.dhcs.ca.gov/Documents/BHIN-20-043-2020-International-Classification-of-Diseases-ICD-10-Included-Code-Sets-Update.pdf>, for the most recent annual update on International Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes “applicable to inpatient and outpatient specialty mental health services (SMHS),” including “the addition of a code that may be used during the assessment period prior to diagnosis, coverage of several mental health diagnoses caused or influenced by substance use, and coverage of autism spectrum disorder.”

89 *Id.* at 23.

90 *Id.* at 23-24.

91 *Id.* at 24 (“Treatment for the health care conditions of Medi-Cal beneficiaries who do not meet the medical necessity criteria for specialty mental health services (for example, excluded diagnoses, mental health conditions resulting in mid to moderate impairment of mental, emotional or behavioral functioning as well as all non-mental health medical conditions and services) is not covered under the waiver program. Services for these ‘excluded’ conditions may be provided through other California Medi-Cal programs—primarily the Medi-Cal Managed Care Plans (MCPs) or the Fee-for-Service Medi-Cal (FFS/MC) program.”)

92 See, e.g., APL 17-018 and Cal. Dep’t Health Care Servs., MHSUDS Info. Notice 16-061 (Dec. 9, 2016) [hereinafter MHSUDS Info. Notice 16-061], available at https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS_16-061.pdf, which distinguish between “mild to moderate” and “significant” impairment in adults.

93 See MHSUDS Info. Notice 16-061 at 3-4 (“DHCS recognizes that the medical necessity criteria for impairment and intervention for Medi-Cal SMHS differ between children and adults. For children and youth, under EPSDT, the ‘impairment’ criteria component of SMHS medical necessity is less stringent than it is for adults, therefore children with low levels of impairment may meet medical necessity criteria for SMHS (Cal. Code Regs., tit. 9 § 1830.205 and § 1830.210), whereas adults must have a significant level of impairment. To receive SMHS, Medi-Cal children and youth must have a covered diagnosis and meet the following criteria: (1) Have a condition that would not be responsive to physical health care based on treatment; and (2) The services are necessary to correct or ameliorate a mental illness and condition discovered by a screening conducted by the MCP, the Child Health and Disability Prevention Program, or any qualified provider operating within the scope of his or her practice, as defined by state law regardless of whether or not that provider is a Medi-Cal provider.”) The same language can be found in APL 17-018, at page 2.

94 1915(b) Waiver at 24.

95 *Id.* at 40.

96 *Id.*

97 See Cal. Code Regs., tit. 22, §§ 51340(d)-(e), 51340.1, 51003, 51303; Cal. Code Regs., tit. 9, §§ 1830.205, 1830.210.

98 42 U.S.C. § 1396d(r); Cal. Welf. & Inst. Code §§ 14132(v), 14059.5 (medical necessity standard enacted through Senate Bill No. 1287, Chapter 855 (2017-18) [hereinafter SB 1287], available at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1287.)

99 *Id.*

100 Cal. Welf. & Inst. Code § 14059.5, available at http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14059.5.&lawCode=WIC.

101 *Id.*; SB 1287.

102 Generally speaking, capitated systems are those in which the entity receives a fixed amount of money per patient per unit of time for health care services. Managed care systems used capitation as a way to control costs. See Patrick Alguire, *Understanding Capitation*, American College of Physicians, available at <https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/guidance/understanding-capitation#:~:text=Capitation%20payments%20are%20used%20by,to%20control%20health%20care%20costs.&text=Capitation%20is%20a%20fixed%20amount,delivery%20of%20health%20care%20services>.

103 Abbi Coursole, et al., National Health Law Program, *An Advocate’s Guide to Medi-Cal Services*, Ch. 1, p. 6 (2020) [hereinafter NHeLP, *An Advocate’s Guide to Medi-Cal Services*], available for download at <https://healthlaw.org/resource/an-advocates-guide-to-medi-cal-services/>.

104 See Dep’t of Health Care Servs., All Plan Letter 19-010 (Aug. 14, 2019) [hereinafter APL 19-010], available at <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-010.pdf>.

105 APL 19-010 at 3-4. For more information about the Bright Futures periodicity schedule, see <https://brightfutures.aap.org/states-and-communities/Pages/California.aspx> and <https://www.dhcs.ca.gov/services/chdp/Pages/Periodicity.aspx>.

106 Dep’t of Healthcare Servs., *Staying Healthy Assessment*, <https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx>. As part of “ACEs Aware,” a new initiative launched by California Surgeon General Dr. Nadine Burke-Harris, Governor Gavin Newsom, and DHCS, DHCS now reimburses Medi-Cal providers for conducting annual screenings for Adverse Childhood Experiences (ACEs) for children and adults with full-scope Medi-Cal. See ACEs Aware, <https://www.acesaware.org/about-aces-aware/aces-aware/>. This includes Medi-Cal Managed Care network providers as well as fee-for-service providers. See ACEs Aware: *Medi-Cal Certification and Payment*, 4, available at <https://www.acesaware.org/wp-content/uploads/2020/05/Provider-Toolkit-Medi-Cal-Certification-and-Payment.pdf>.

107 See Welf. & Inst. Code § 14132.03; California, State Plan Amendment # 13-035 (2014), <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-13-035.pdf>; NHeLP, *An Advocate’s Guide to Medi-Cal Services*, ch. 3, p. 7 (citing 42 U.S.C. §§1396a(k)(1), 1396u-7(b)(5); Michelle Lilienfeld, Nat’l Health Law Prog., *Alternative Benefit Plans for the Medicaid Expansion Population* (2014), <https://healthlaw.org/resource/alternativebenefit-plans-for-the-medicaid-expansion-population/>).

108 See Dep’t of Healthcare Servs., All Plan Letter 18-015, 2 (Sept. 19, 2018) [hereinafter APL 18-015], available at <https://www.dhcs.ca.gov/formsandpubs/Documents/>

[MMCDAPLsandPolicyLetters/APL2018/APL18-015.pdf](https://www.dhcs.ca.gov/PolicyLetters/APL2018/APL18-015.pdf); APL 17-018 at 4.

109 APL 18-015 at 2. See also Medi-Cal Managed Care Boilerplate contracts, available at <https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx> (e.g., see 2-plan Non-CCI Boilerplate contract, Exhibit A, Attachment 20, para. 4).

110 All Plan Letters, or APLs, are used by the Department of Health Care Services to inform contractors of “information or interpretation of changes in policy or procedure at the Federal or State levels” and provide “instruction... on how to implement these changes on an operational basis.” See Dep’t of Health Care Services, *Medi-Cal Managed Care Letters*, <https://www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx>.

111 APL 19-010 at 5.

112 APL 17-018 at 7. Note that the current boilerplate MCP contracts are available at <https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>.

113 APL 19-010 at 7-10.

114 *Id.* at 7-9.

115 Dep’t of Healthcare Servs., All Plan Letter 14-017, 3 (Dec. 12, 2014) [hereinafter APL 14-017], available at <https://www.dhcs.ca.gov/services/Documents/MDS/2014%20DAPLs/APL%2014-017.pdf>.

116 See 22 C.C.R. §§ 51184(g)-(h), 51340(f)(1), 51340(k); 9 C.C.R. § 1810.249. See also 42 C.F.R. § 441.18, 440.169.

117 See APL 19-010 at 7; Dep’t of Health Care Servs., *Medi-Cal Managed Care Boilerplate Contracts, Two Plan Non-CCI Boilerplate*, Exhibit A, Attachment 11, Item 3 (Targeted Case Management Services), available at <https://www.dhcs.ca.gov/provgovpart/Documents/2-Plan-Non-CCI-Boilerplate-Final-Rule-Amendment.pdf>.

118 APL 19-010 at 7; Dep’t of Health Care Servs., *Medi-Cal Managed Care Boilerplate Contracts, Two Plan Non-CCI Boilerplate*, Exhibit A, Attachment 11, Item 3 (Targeted Case Management Services), available at <https://www.dhcs.ca.gov/provgovpart/Documents/2-Plan-Non-CCI-Boilerplate-Final-Rule-Amendment.pdf>.

119 APL 19-010 at 7; Dep’t of Health Care Servs., *Medi-Cal Managed Care Boilerplate Contracts, Two Plan Non-CCI Boilerplate*, Exhibit A, Attachment 11, Item 3 (Targeted Case Management Services), available at <https://www.dhcs.ca.gov/provgovpart/Documents/2-Plan-Non-CCI-Boilerplate-Final-Rule-Amendment.pdf>.

120 APL 19-010 at 6.

121 *Id.* at 7-8.

122 *Id.* at 8.

123 *Id.* at 5-6.

124 APL 17-018 at 6.

125 NHeLP, *An Advocate’s Guide to Medi-Cal Services*, ch. 1, pp. 5-6 (internal citations omitted).

126 Cal. Welf. & Inst. Code § 14093.09.

127 Aurrera Health Group, Dep’t of Health Care Servs., Dep’t of Soc. Servs., & Office of the Governor, *Children and Youth in Foster Care: Background and Current Landscape*, 5 (Aug. 2020), available at <https://www.dhcs.ca.gov/provgovpart/Documents/Children-and-Youth-in-Foster-Care-Landscape-Overview.pdf>.

128 See APL 17-018.

129 See Dep’t of Health Care Servs., *CHDP Program Overview*, <https://www.dhcs.ca.gov/services/chdp/Pages/ProgramOverview.aspx>; Cal. Health & Safety Code § 124025.

130 NHeLP, *An Advocate’s Guide to Medi-Cal Services*, at ch. 8, p. 6 (internal citations omitted).

131 For a discussion of Medicaid financing for services provided through education systems, for example, see Medicaid and CHIP Payment and Access Commission, *Issue Brief: Medicaid in Schools* (2018), available at <https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf>. See also California Children’s Trust & Breaking Barriers, *Practical Guide for Financing Social, Emotional, and Mental Health in Schools* (2020), available at <https://cchildrenstrust.org/wp-content/uploads/2020/08/cct-practicalguide-final-v2.pdf>.

132 *Informational Hearing: The Medi-Cal Mental Health Delivery System*, at 8.

133 *Id.* (internal citations omitted); Ltr. from CMS to Dep’t of Health Care Servs. regarding SMHS CPE Protocol (Oct. 5, 2016), available at https://www.dhcs.ca.gov/services/MH/Documents/CMSLetter_10.5.2016_CPETechCorrection.pdf (“The State makes interim payments of [FFP] to the MHPs based upon expenditures submitted by the [MHPs]. For services provided by a privately operated contract provider, the MHP pays the provider before submitting a claim to the State for the payment of FFP. When submitting a claim for FFP for services provided by a county-operated or contract provider, the MHP is required to certify that it has made expenditures on which the claim for FFP is based, that the expenditures are no greater than the actual cost of providing services, and that the expenditures meet all federal and State requirements for claiming FFP.”)

134 *Informational Hearing: The Medi-Cal Mental Health Delivery System*, at 8. For a more detailed discussion of realignment, see Legislative Analyst’s Office, *2011 Realignment: Addressing Issues to Promote Its Long-Term Success*, August 17, 2011, available at https://lao.ca.gov/reports/2011/stadm/realignment/realignment_081911.aspx.

135 *Informational Hearing: The Medi-Cal Mental Health Delivery System*, at 8 (citing Section 30025 of the Government Code, as amended by SB 1020 (Committee on Budget and

Fiscal Review, Chapter 40, Statutes of 2012)).

136 *Informational Hearing: The Medi-Cal Mental Health Delivery System*, at 8 (citing California Constitution, Article 13, Section 35, subdivision (c), paragraph (4), and DHCS November 2018 Medi-Cal Estimate, Base Policy Change Number 61)..

137 Cal. Assembly & Senate Health Committees, *Informational Hearing: Improving the Medi-Cal Mental Health Delivery System, Background*, 14 (2019) [hereinafter *Informational Hearing: Improving the Medi-Cal Mental Health Delivery System*], available at <https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/Final%20March%205%20DMC%202%20Background.pdf>.

138 California State Auditor, *Dep't of Healthcare Servs.: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Servs.*, Report No. 2018-111, *Statewide Preventive Care Utilization Rates*, available at <http://www.auditor.ca.gov/reports/2018-111/supplementalgraphics.html>. For the full report, see <https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf>.

139 *Id.*

140 *Informational Hearing: Improving the Medi-Cal Mental Health Delivery System*, at 7 (referencing data from the DHCS Medi-Cal Statewide Aggregate Specialty Mental Health Services Performance Dashboard). For additional information on SMHS penetration rates, including county-level data, see California Children's Trust, *California Children and Youth Services Dashboard* (2020), available at <https://cchildrenstrust.org/wp-content/uploads/2020/03/California-Children-and-Youth-Services-Dashboard.pdf>.

141 See Dep't of Health Care Servs., *Managed Care Performance Monitoring Dashboard Report*, 18-20 (June 2019), <https://www.dhcs.ca.gov/services/Documents/MMCD/Jan9-2020Release.pdf>.

142 *Id.* at 19. (This data does not reflect services that may have been provided through fee-for-service Medi-Cal.)

143 *Id.*

144 See Dep't of Health Care Servs., *Youth Under 21 Receiving Psychosocial Services Statewide by Fiscal Year as of 5/1/2019*, 2 (2019), https://www.dhcs.ca.gov/services/MH/Documents/20190501_EPSDT_Psychosocial_Utilization-ADA_youth.pdf; Dep't of Health Care Servs., *Youth Under 21 Receiving Psychosocial Services Statewide by Fiscal Year as of 5/1/2019*, 2 (2019), https://www.dhcs.ca.gov/services/MH/Documents/20190501_EPSDT_Psychosocial_Utilization_youth.pdf. (This data does not reflect services that may have been provided through fee-for-service Medi-Cal.)

145 See Dep't of Health Care Servs., *Performance Outcomes System, Demographics Report: Unique Count of Children and Youth Receiving SMHS by Fiscal Year, Statewide as of February 12, 2019*, 3, 7, <https://www.dhcs.ca.gov/services/MH/>

[Documents/00-20190304-Statewide-SUP-Final.pdf](https://www.dhcs.ca.gov/services/MH/Documents/00-20190304-Statewide-SUP-Final.pdf) (listing "unique count receiving SMHS" for FY 2017-18 as 267,088, and listing annual penetration rates for one or more SMHS visit as 4.3% for FY 2014-15, 4.1% for FY 15-16, 4.1% for FY 16-17, and 4.4% for FY 17-18). Another potential data source for more in-depth analysis is the CMS Transformed Medicaid Statistical Information System (T-MSIS), which contains state specific Medicaid data. See Medicaid.gov, *Transformed Medicaid Statistical Information System (T-MSIS)*, available at <https://www.medicare.gov/medicaid/data-systems/macbis/transformed-medicare-statistical-information-system-t-msis/index.html> (stating that the T-MSIS data set includes Medicaid and CHIP beneficiary and provider enrollment, service utilization, claims and managed care data, and expenditure data).

146 Kimberly Lewis, et al., National Health Law Program, *Navigating the Challenges of Medi-Cal's Mental Health Services in California: An Examination of Care Coordination, Referrals and Dispute Resolution*, 9 (2018) [hereinafter NHeLP, *Navigating the Challenges of Medi-Cal's Mental Health Services in California*], available for download at <https://healthlaw.org/resource/navigating-the-challenges-of-medi-cals-mental-health-services-in-california-an-examination-of-care-coordination-referrals-and-dispute-resolution/>.

147 For detailed analysis, see NHeLP, *Navigating the Challenges of Medi-Cal's Mental Health Services in California: An Examination of Care Coordination, Referrals and Dispute Resolution*.

148 *Informational Hearing: Improving the Medi-Cal Mental Health Delivery System* at 3.

149 Letter from Mark Ghaly & Richard Figueroa regarding CalAIM Initiative Proposals, 1 (Oct. 28, 2019), available at https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf.

150 Dep't of Health Care Servs., *California Advancing and Innovating Medi-Cal (CalAIM) Proposal*, 74-76 (2019) [hereinafter CalAIM proposal], available at https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf.

151 *Id.* at 78.

152 Letter from Mark Ghaly & Richard Figueroa regarding CalAIM Initiative Proposals, 2 (Oct. 28, 2019), available at https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf.

153 Dep't of Health Care Servs., *California Advancing and Innovating Medi-Cal: Important Update on the Covid-19 Pandemic*, <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx>.

154 Dep't of Health Care Servs., *Trauma Screenings and Trauma-Informed Care Provider Trainings*, available at <https://www.dhcs.ca.gov/provgovpart/Pages/TraumaCare.aspx>.

155 ACEs Aware, *The Science of ACEs and Toxic Stress*,

<https://www.acesaware.org/treat/the-science-of-aces-toxic-stress> (citing Centers for Disease Control and Prevention, *Leading Causes of Death by Age Group, United States—2017* (2017), available at <https://www.cdc.gov/injury/images/lc-charts/leading-causes-of-death-by-age-group-2017-1100w850h.jpg>; MT Merrick MT, DC Ford, KA Ports, & AS Guinn, *Prevalence of adverse childhood experiences from the 2011-2014 Behavioral Risk Factor Surveillance System in 23 states*, 172 *JAMA Pediatrics* 11, 1038-44 (2018), available at <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2702204>). For a discussion of the impact of ACEs and trauma on children's education and learning, see Nicole Tuchinda, *The Imperative for Trauma-Responsive Special Education*, *New York Univ. Law Rev.* 95(3) (2020), available at <https://www.nyulawreview.org/wp-content/uploads/2020/06/NYULawReview-Volume-95-Issue-3-Tuchinda.pdf>.

156 Vanessa Sacks & David Murphy, *Child Trends, The prevalence of adverse childhood experiences, nationally, by state, and by race or ethnicity* (Feb. 20, 2018) (“Children of different races and ethnicities do not experience ACEs equally. Nationally, 61 percent of black non-Hispanic children and 51 percent of Hispanic children have experienced at least one ACE, compared with 40 percent of white non-Hispanic children and only 23 percent of Asian non-Hispanic children.”) See also Natalie Slopen, Jack Shoonkoff, Michelle Albert, Hirokazu Yoshikawa, Aryana Jacobs, Rebecca Stoltz & David Williams, *Racial Disparities in Child Adversity in the U.S.: Interactions with Family Immigration History and Income*, 50 *Am. J. Prev. Med.* 1 (2016), 47-56, available at <https://scholar.harvard.edu/files/davidwilliams/files/child-adversity.pdf> (“Across all groups, black and Hispanic children were exposed to more adversities compared with white children, and income disparities in exposure were larger than racial/ethnic disparities.”).

157 See Dep’t Health Care Servs., *Trauma Screenings and Trauma-Informed Care Provider Trainings*, available at: <https://www.dhcs.ca.gov/provgovpart/Pages/TraumaCare.aspx>; *Early and Periodic Screening, Diagnosis, and Treatment Program: trauma screening*, Assembly Bill No. 340, Chapter 700 (2017-18) [hereinafter AB 340], available at https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB340.

158 See Dep’t Health Care Servs., *Trauma Screenings and Trauma-Informed Care Provider Trainings*, available at: <https://www.dhcs.ca.gov/provgovpart/Pages/TraumaCare.aspx>.

159 ACEs Aware, “*Becoming ACEs Aware in California*” *Provider Training: September Data Update* (Oct. 15, 2020), available at <https://www.acesaware.org/wp-content/uploads/2020/10/ACEs-Aware-Provider-Training-Data-Report-10-15-20.pdf>.

160 See Joint Letter from George Sheldon, Acting Assistant Secretary, Administration for Children and Families, Marylyn Tavenner, Administrator, Centers for Medicare and Medicaid Services & Pamela Hyde, Administrator, Substance

Abuse and Mental Health Services Administration to State Directors (July 11, 2013), 2, 3, available at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf> (“Medicaid is an important source of reimbursement for services and support to children and youth who have experienced complex trauma and have behavioral health needs requiring treatment”) (“Many of these children will demonstrate complex symptoms and/or behaviors that may not map directly to the [DSM] or the International Classification of Diseases (ICD). For example, there is currently no DSM diagnosis that adequately captures the range of child trauma effects. Many children who have experienced complex trauma will not meet the criteria for a diagnosis of [PTSD]. Yet, trauma-related symptoms are identifiable, can be clinically significant and can be addressed with appropriate interventions. For these children, appropriate screening, assessment and referral to evidence-based practices are clearly indicated.”). See also CMS, *EPSDT Guide*, 12 (“CMS has issued detailed guidance encouraging states to include screening, assessments, and treatments focusing on children who have been victims of complex trauma. EPSDT can be a crucial tool in addressing the profound needs of this population, including children who are involved in the child welfare system.”)

161 See Joint Letter from George Sheldon, Acting Assistant Secretary, Administration for Children and Families, Marylyn Tavenner, Administrator, Centers for Medicare and Medicaid Services & Pamela Hyde, Administrator, Substance Abuse and Mental Health Services Administration to State Directors (July 11, 2013), 4, available at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf> (“Achieving well-being among children and youth who have experienced complex trauma requires tools and practices to identify service needs, an array of effective interventions to meet those needs, and periodic data on outcomes to track whether interventions are effective in helping young people.”)

162 Elements of a youth- and family-centered approach include valuing youth and family voice in care planning and implementation, considering the youth and family's cultural and linguistic needs, offering assistance to help address challenges the family is experiencing, and recognizing the youth and family's strengths and progress as well as their needs. See, e.g., Child Welfare Information Gateway, *Family-Centered Approach to Working with Families*, available at <https://www.childwelfare.gov/topics/famcentered/caseworkpractice/working/> (resources regarding family-centered approaches in the child welfare context); SAMHSA, *Person- and Family-centered Care and Peer Support*, available at <https://www.samhsa.gov/section-223/care-coordination/person-family-centered> (discussing person-centered or “patient-centered” and family-centered care).

163 See, e.g. APL 19-010 at 7-9.

164 For a more in-depth discussion of issues related to care coordination, see NHeLP, *Navigating the Challenges of Medi-*

Cal's Mental Health Services in California: An Examination of Care Coordination, Referrals and Dispute Resolution.

165 For more details on the type of data that should be shared between plans, see, e.g., *Medi-Cal: mental health services*, Assembly Bill No. 1175 (Wood), vetoed by the Governor on Oct. 13, 2019, available at https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB1175.

166 See Dep't of Health Care Servs., *Medi-Cal Managed Care Boilerplate Contracts, Two Plan Non-CCI Boilerplate*, Exhibit A, Attachment 10, Scope of Services, available at <https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>.

167 Cal. Welf. & Inst. Code § 14197; Dep't of Health Care Servs., All Plan Letter 20-003, Network Certification Requirements, Attachment A (Network Adequacy Standards) (February 27, 2020), available at <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-003.pdf>, <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-003AttA.pdf>.

168 42 C.F.R. § 441.56(a).

169 *Id.*

170 CMS, *EPSDT Guide*, at 17 (citing 42 C.F.R. § 441.56(a); Centers for Medicare and Medicaid Services, *State Medicaid Manual*, § 5121.A, 5121.C, available for download at <https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927>.

171 CMS, *EPSDT Guide*, at 17 (citing 42 U.S.C. § 2000d (Title VI of the Civil Rights Act); 42 U.S.C. § 18116 (Affordable Care Act § 1557); Centers for Medicare and Medicaid Servs., Letter to State Medicaid Directors regarding policy guidance on Medicaid for persons with limited English proficiency (Aug. 31, 2000), available at <https://downloads.cms.gov/cmssgov/archived-downloads/SMDL/downloads/smd083100.pdf>).

172 See Dep't of Health Care Servs., *My Medi-Cal: How to Get the Health Care You Need*, available at <https://www.dhcs.ca.gov/Documents/myMediCal.pdf>.

173 See 42 C.F.R. § 438.10 (federal regulations require provision of enrollee handbooks). See also Dep't Health Care Servs., MHSUDS Info. Notice 18-043 (2018), Enclosure 1, *Mental Health Plan Beneficiary Handbook Specialty Mental Health Services*, 35-38, available at https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN_18-043_Beneficiary_Handbook/MHP_Beneficiary_Handbook.pdf.

174 See, e.g. Karina Wagnerman, *Racial and Ethnic Disparities Persist in Mental Health Care for Children*, Georgetown University Health Policy Institute, Center for Children and Families (2016), available at <https://ccf.georgetown.edu/2016/10/14/racial-and-ethnic-disparities-persist-in->

[mental-health-care-for-children/](#) (describing studies finding lower mental health care access rates, and increased barriers to access, for African American and Hispanic children).

175 See Dept. of Health Care Servs., MHSUDS Information Notice 18-059, https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN_18-059_Continuity_of_Care/MHSUDS_Information_Notece_18-059_Continuity_of_Care.pdf

176 42 U.S.C. § 1396d(r)(5).

177 *Id.*

178 Centers for Medicare and Medicaid Services, *State Medicaid Manual*, § 5124, available for download at <https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927>.

179 *Id.* at § 5123.2. See also Joint Letter from George Sheldon, Acting Assistant Secretary, Administration for Children and Families, Marylyn Tavenner, Administrator, Centers for Medicare and Medicaid Services & Pamela Hyde, Administrator, Substance Abuse and Mental Health Services Administration to State Directors (July 11, 2013), 3, available at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf> (noting that “[m]any of these children will demonstrate complex symptoms and/or behaviors that may not map directly to the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). For example, there is currently no DSM diagnosis that adequately captures the range of child trauma effects. Many children who have experienced complex trauma will not meet the criteria for a diagnosis of [PTSD]. Yet, trauma-related symptoms are identifiable, can be clinically significant and can be addressed with appropriate interventions. For these children, appropriate screening, assessment and referral to evidence-based practices are clearly indicated.”)

180 See SB 1287. SB 1287 made clear that the Medi-Cal medical necessity standard for children and youth under age 21 is the standard stated in federal law (42 USC § 1396d(r)(5)). It also required DHCS and its contractors to “update any model evidence of coverage documents, beneficiary handbooks, and related material to ensure the medical necessity standard for coverage for individuals under 21 years of age is accurately reflected in all materials,” as well as to “implement, interpret, and make specific these provisions” through all-county letters or similar instructions until regulations are revised or adopted by July 1, 2022.



California
Children's
Trust

