# SUSTAINING AND GROWING BEHAVIORAL HEALTH SERVICES AT SCHOOL-BASED HEALTH CENTERS

CALIFORNIA SCHOOL-BASED HEALTH ALLIANCE

Putting Health Care Where Kids Are

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# INTRODUCTION

The current moment is a critical one for child and adolescent mental health. Well before COVID-19 turned school and family life upside down in March 2020, young people in California were already experiencing a mental health crisis. Rates of suicide and self-harm had risen sharply, especially among the youngest teens. Increases in depression and anxiety were rising as well, and a heightened awareness about the impact of childhood trauma increased social sensitivity to adverse experiences, including the impact of racism and toxic stress. And of course, the COVID pandemic amplified many of these concerns as students lost access to routines, peers, trusted adults, and various sources of engagement, pride and normalcy. Families struggled to support their children but many faced additional crises such as job loss, death, homelessness, and abuse. As with so many health and social problems, these problems were and remain more concentrated among families with low incomes and people of color, where resources are less available and historic events have driven deep inequalities.

It is well documented that the majority of California youth with mental health needs do not receive any mental health care, and that those who do almost exclusively receive it in a school setting. School mental health services are wide and varied across the 10,000 California K-12 schools, and as funding for public education in California continues to lag far behind other states, the availability of trained school personnel to support student mental health is nowhere near the levels needed.

One important source of mental health care for children and adolescents arrives through the state's 293 school-based health centers (SBHCs). SBHCs provide access to care for 280,000 students annually and two thirds of centers offer mental health services such as individual and group counseling that is tailored to the needs of students and integrated with their primary care. Among those reached are those who experience mental health conditions or disorders as well as a much larger number who face concerns related to social determinants of health, trauma or adverse childhood experiences (ACES), substance misuse/abuse, and various other risk behaviors. The screening that leads to a mental health referral in SBHCs often comes from a trusted medical provider, health educator or peer.

A majority of SBHCs in California are operated by federally-qualified health centers (FQHCs). It is beyond the scope of this document to explain to those not familiar with FQHCs, but this national model of care provides major advances in offering integrated primary care and behavioral health services for students. It also offers a financing stream that can be sustainable when operated well, and when a significant portion of students at a given school site are Medi-Cal eligible or enrolled.

And yet, systems of financing are not well suited to the SBHC delivery system model or to early intervention for youth mental health services more broadly. SBHCs are small and operate in the often challenging and sometimes ambiguous space between the health and education sectors. It is exceptionally difficult for SBHCs to fund the full cost of providing a comprehensive spectrum of high-quality, age-appropriate mental services through Medi-Cal reimbursement alone. Some of these challenges are inherent to the system design, while some result from a lack of widespread information, knowledge and experience.

This guide is an attempt to address the latter category and to help ensure that all SBHCs run by FQHCs in California have the tools they need to maximize the reimbursement to which they are entitled in providing critically needed mental health care to eligible students. It is oriented toward those FQHCs that operate or want to operate SBHCs in California.

In the wake of the 2020-21 COVID pandemic California announced a plan to make major investments in school mental health through a variety of strategies. We applaud this investment and also believe many more investments and reforms will be needed to meet the mental health needs of California youth, and also to take full advantage of the SBHC model, which has nearly unlimited potential if well-resourced, supported and leveraged.

CSHA believes that the future should include at least 500 SBHCs in the K-12 schools with the greatest needs, and that in those schools there should be at least as many mental health as medical providers, well trained and supported, culturally synchronous, and there to serve children, families, school staff and the entire school ecosystem. They will provide a broad range of education, consultation, screening and treatment. And they will be compensated for this work through Medi-Cal and other funding streams.

## Audience

The School Based Health Center Billing Guide is intended primarily for those working in or with Federally Qualified Health Centers (FQHCs). This includes executive leaders, operational and billing managers, and mental health clinicians and case managers who are providing and/or overseeing behavioral health services in California SBHCs - including those who hope to provide these services in the future.

## Limitations

This guide does not include broad information on how school districts might benefit from behavioral health billing strategies such as the Alameda County Smart Financing for School-Based Behavioral Health and the California Children's Trust Practical Guide for Financing Social, Emotional and Mental Health in Schools offers[12]. Nor does it include general Medi-Cal billing guidance for SBHCs such as CSHA's Third Party Billing for School Based Health Centers[3]. CSHA also offers this Student Mental Health Implementation Guide directed toward LEAs and county health departments seeking to incorporate mental health into school planning[4].

## Acknowledgments

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And finally, a special thanks to Oakland Opportunity Fund, an initiative of The San Francisco Foundation, for their generous funding to make this guide a possibility.

**We hope you will find this guide useful. Please share any feedback at info@schoolhealthcenters.org.**
*Thank you!*

*Tracy Mendez*
**Executive Director, California School-Based Health Alliance**

*June 2021*

[1] https://achealthyschools.org/wp-content/uploads/2020/04/123_Smart_Finance_Practices_for_SBBH.pdf

[2] https://cachildrenstrust.org/wp-content/uploads/2020/08/practicalguide.pdf

[3] http://cshca-wpengine.netdna-ssl.com/wp-content/uploads/2011/07/Billing-Manual.pdf

[4] https://cshca-wpengine.netdna-ssl.com/wp-content/uploads/2021/02/CA-SMH-Implementation-Guide.pdf

# ADDRESSING THE BEHAVIORAL HEALTH NEEDS OF CHILDREN AND ADOLESCENTS

School-Based Health Centers (SBHCs) in California provide access to care for 280,000 youth annually. The values and mission of SBHCs includes a commitment to providing access to behavioral health care to address child and adolescent mental health conditions, social determinants of health, and adverse childhood experiences.

Current trends in health outcomes in the United States expose an underlying concern about existing models of medical and traditional mental health care and their ability to treat the real causes and conditions that are driving today's greatest health challenges for children and adolescents. Research demonstrates that traditional medical care does not have the greatest impact on children and adolescent health outcomes, but instead a combination of individual health behaviors, mental health supports (both prevention and treatment) and addressing of social determinants of health. Environmental factors are also known to have a great impact on health, and there is a positive correlation between health outcomes and protective factors which include having safe and supportive relationships.

Even before the COVID pandemic, 41% of adults and children enrolled in Medi-Cal had a mental health diagnosis, and 17% had a substance use disorder[5] . Half of all mental health conditions start at age 14 and most cases are undetected and untreated. Globally, depression is one of the leading causes of illness and disability among adolescents, and suicide is the third leading cause of death among 15-19 year-olds. As of 2017, behavioral health conditions were the leading cause of disability and disease nationwide[6] . Despite the overwhelming prevalence and impact of behavioral health conditions, only 1 in 3 people with serious mental illness, 1 in 10 with substance use disorders and 1 in 20 with mild to moderate behavioral health conditions are able to obtain help for these conditions[7]. Due to systemic racism and oppression, communities of color experience increased mental health problems, have worse treatment outcomes, and more difficulty with accessing services than non-minorities[8] . Half of all low-income Californians say they do not have sufficient access to behavioral health services[9].

This is also true for youth. Based on diagnostic interview data from National Comorbidity Survey Adolescent Supplement, an estimated 49.5% of adolescents had any mental disorder. Of adolescents with any mental disorder, an estimated 22.2% had severe impairment according to DSM-V criteria .

Many had care and routines disrupted during 2020. More than two thirds of parents who sought help since the start of the pandemic said they had witnessed a decline in their child's emotional well-being (72%), behavior (68%), and physical health due to decreased activities/exercise (68%) . This massive decline in childrens' wellbeing since

March 2020 is important to consider as children physically go back to school. What they have been through this past year will not be "fixed" overnight, simply by returning to in-person learning. Behavioral health services will be more important now than ever to support them in this new time of adjustment. This is also a time of opportunity to further normalize, destigmatize, and elevate the importance of behavioral health.

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[5] California Department of Health Care Services, California Mental Health and Substance Use System Needs Assessment

[6] World Health Organization, Depression and Other Common Mental Disorders

[7] California Department of Health Care Services, California Mental Health and Substance Use System Needs Assessment

[8] National Conference of State Legislatures, The Costs and Consequences of Disparities in Behavioral Health Care

[9] California Health Care Foundation, Low-Income Californians and Health Care

[10] World Health Organization, Adolescent Mental Health Fact Sheet

[11] National Institute of Mental Illness Prevalence Rates

[12] The Child Mind Institute 2020 Children's Mental Health Report: Telehealth in an Increasingly Virtual World

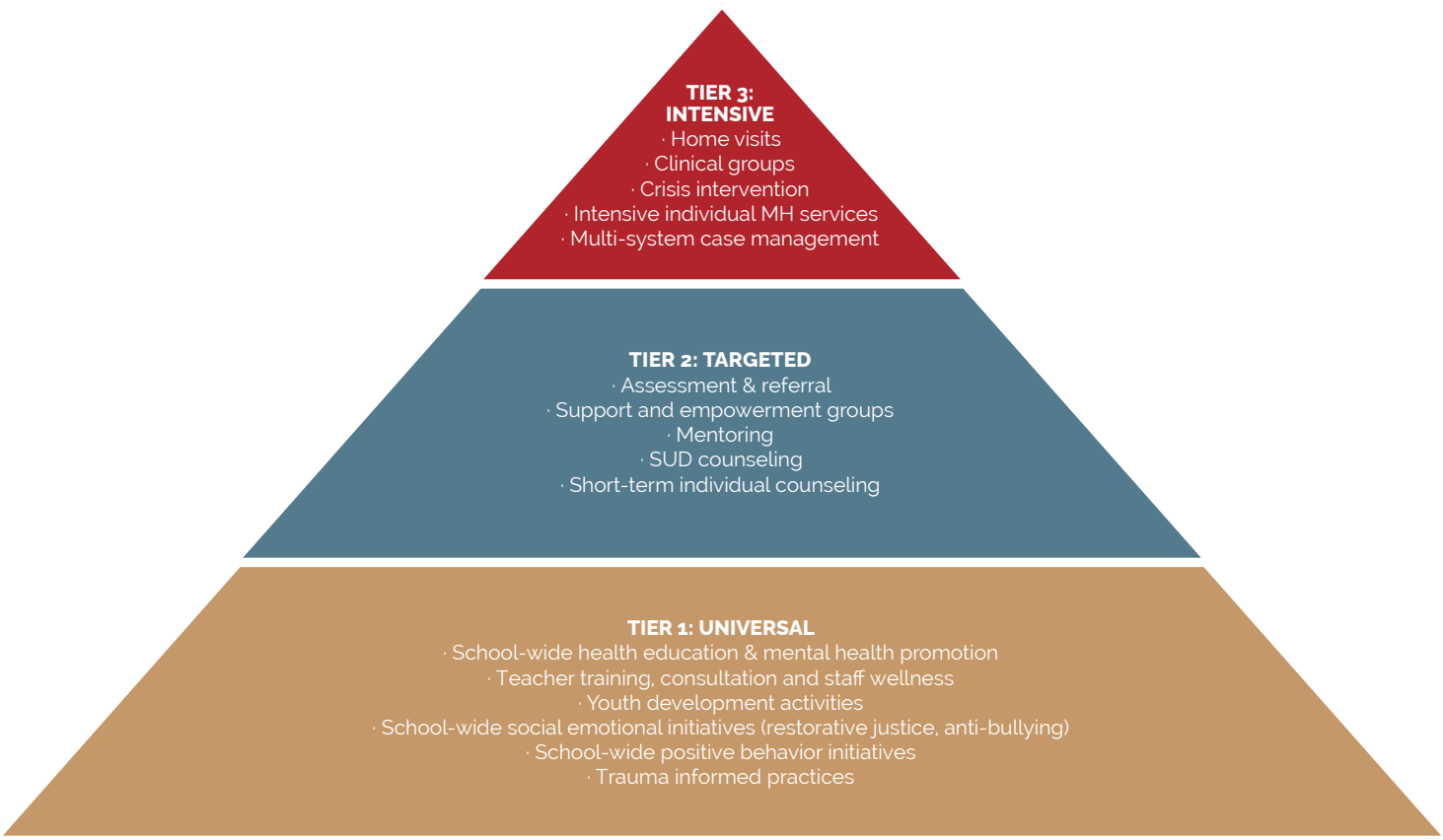
# THE IDEAL MODEL FOR BEHAVIORAL HEALTH SERVICES IN SBHCS

SBHCs can provide behavioral health services in a variety of ways, and all of them add value in addressing unmet mental health needs. This section highlights the models and features that CSHA believes are most effective to provide this care.

## Comprehensive School Mental Health

Comprehensive school mental health systems provide support and promotion of mental health for all students on campus. They weave together school culture interventions with services for students utilizing providers and programs across the school in partnership with community providers including FQHCs and SBHCs.

Many comprehensive school mental health systems use a tiered approach to implement services and programs. The tiers usually range from universal programs and services for all students aimed at a positive school climate and mental health education, and gradually become more targeted and intensive for students needing more individual support. One well-known model is the Multi-Tiered System of Support (MTSS), pictured here.



School mental health personnel such as School Psychologists, School Social Workers and School Counselors[13] are essential in this comprehensive system. When SBHC mental health staff coordinate and integrate their services with school personnel, students can access a number of different complementary services and school communities are able to address their unique needs with the most appropriate level and type of supports. For example, school staff implement a schoolwide social-emotional learning curriculum and offer brief counseling, whereas SBHC staff may provide screening for emotional concerns and substance abuse, while providing more intensive individual and group therapy. Both these groups can then link students who need ongoing wraparound care to community-based providers with whom they are well connected. The California School Based Health Alliance **fact sheet** describes the most common district and community mental health provider types and services[14].

An example of a Tier 1 intervention is this program through **Camarena Health** which advocates for all students to have a better understanding of behavioral health and how it impacts their overall health and well-being. At Madera South High School, Camarena is training peer leaders and the on-campus SBHC to promote mental health access and reduce mental health stigma.

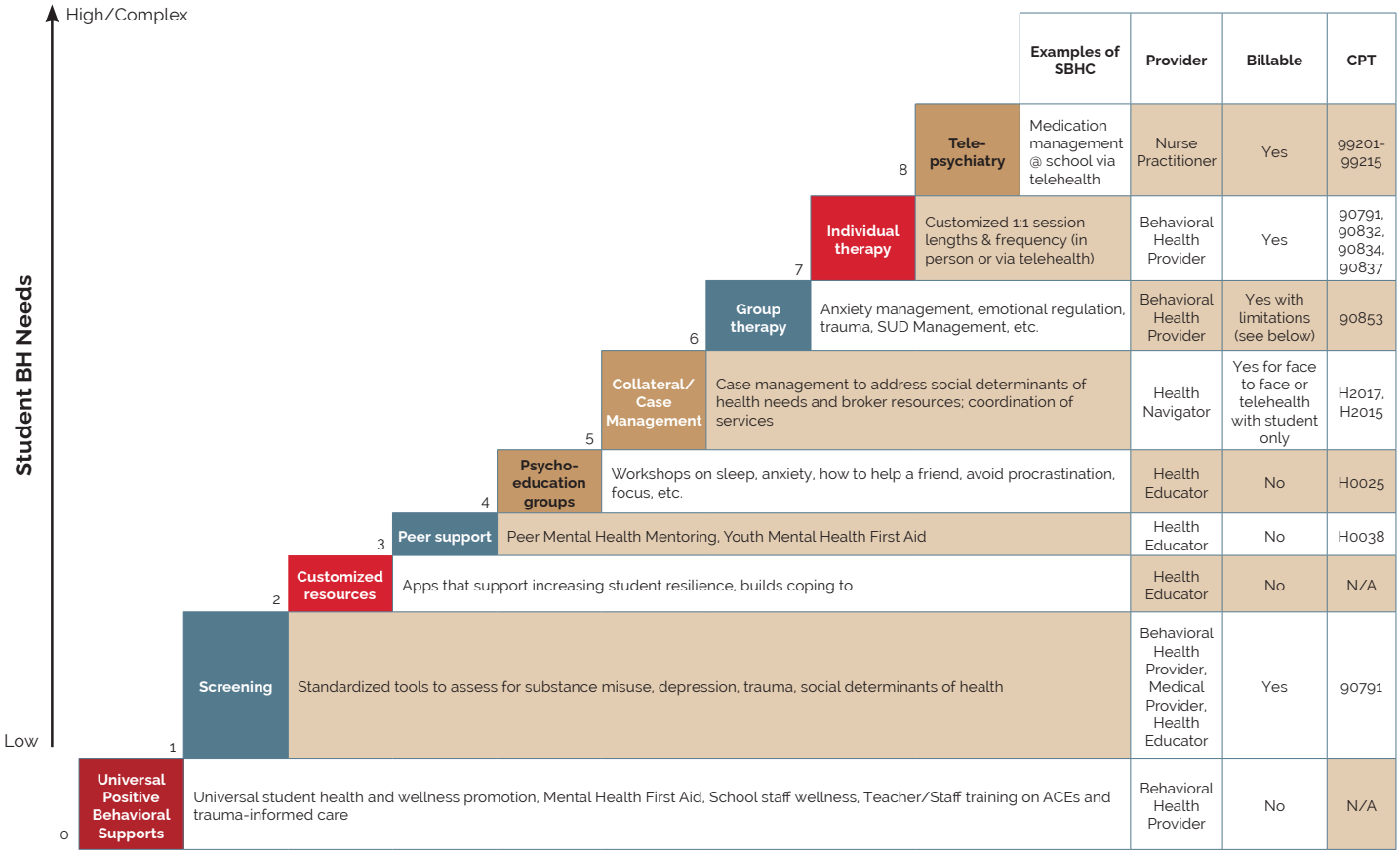
An example of a Tier 2 intervention is services provided at the **James Morehouse Project** (JMP), the SBHC at El Cerrito High School in Contra Costa County. The JMP provides a safe place for crisis support, check-ins, weekly individual counseling, and group counseling for anxiety, grief and loss. These services were transitioned to texting and telehealth visits during the COVID pandemic to maintain a trusted lifeline to students facing isolation, trauma and other struggles. Read more **here** from one of the mental health interns at the JMP.

[13] Some school districts have additional personnel or have arrangements with other agencies such as County-employed Clinical Case Managers. Coordination of roles and services with all different provider types is critical to effective school mental health.

[14] **California School Based Health Alliance, Providers & Personnel for School Mental Health**

[15] **Mental Health Commission of Canada, Backgrounder: Stepped Care 2.0 Demonstration Project**

Below is a model that illustrates behavioral health services ranging from universal to more intensive mental health services and an example of who can provide those services within a comprehensive school mental health system. This "Stepped Care Model" is a framework that has been successfully implemented in Canada and elsewhere[15]. Increasingly, colleges in the United States are adopting it as a model for addressing rising demand for behavioral health services.[16]




| | | Examples of SBHC | Provider | Billable | CPT |
|---|---|---|---|---|---|
| 8 | **Tele-psychiatry** | Medication management @ school via telehealth | Nurse Practitioner | Yes | 99201-99215 |
| 7 | **Individual therapy** | Customized 1:1 session lengths & frequency (in person or via telehealth) | Behavioral Health Provider | Yes | 90791, 90832, 90834, 90837 |
| 6 | **Group therapy** | Anxiety management, emotional regulation, trauma, SUD Management, etc. | Behavioral Health Provider | Yes with limitations (see below) | 90853 |
| 5 | **Collateral/ Case Management** | Case management to address social determinants of health needs and broker resources; coordination of services | Health Navigator | Yes for face to face or telehealth with student only | H2017, H2015 |
| 4 | **Psycho-education groups** | Workshops on sleep, anxiety, how to help a friend, avoid procrastination, focus, etc. | Health Educator | No | H0025 |
| 3 | **Peer support** | Peer Mental Health Mentoring, Youth Mental Health First Aid | Health Educator | No | H0038 |
| 2 | **Customized resources** | Apps that support increasing student resilience, builds coping to | Health Educator | No | N/A |
| 1 | **Screening** | Standardized tools to assess for substance misuse, depression, trauma, social determinants of health | Behavioral Health Provider, Medical Provider, Health Educator | Yes | 90791 |
| 0 | **Universal Positive Behavioral Supports** | Universal student health and wellness promotion, Mental Health First Aid, School staff wellness, Teacher/Staff training on ACEs and trauma-informed care | Behavioral Health Provider | No | N/A |

[16] Cornish, P. A., Berry, G., Benton, S., Barros-Gomes, P., Johnson, D., Ginsburg, R., Whelan, B., Fawcett, E., & Romano, V. (2017). Meeting the mental health needs of today's college student: Reinventing services through Stepped Care 2.0. Psychological Services, 14(4), 428–442.

## Integrated Behavioral Health

There are many different definitions of integrated behavioral health (IBH) and even more definitions of "integrated care". The Agency for Healthcare Research and Quality (AHRQ). AHRQ defines IBH as:

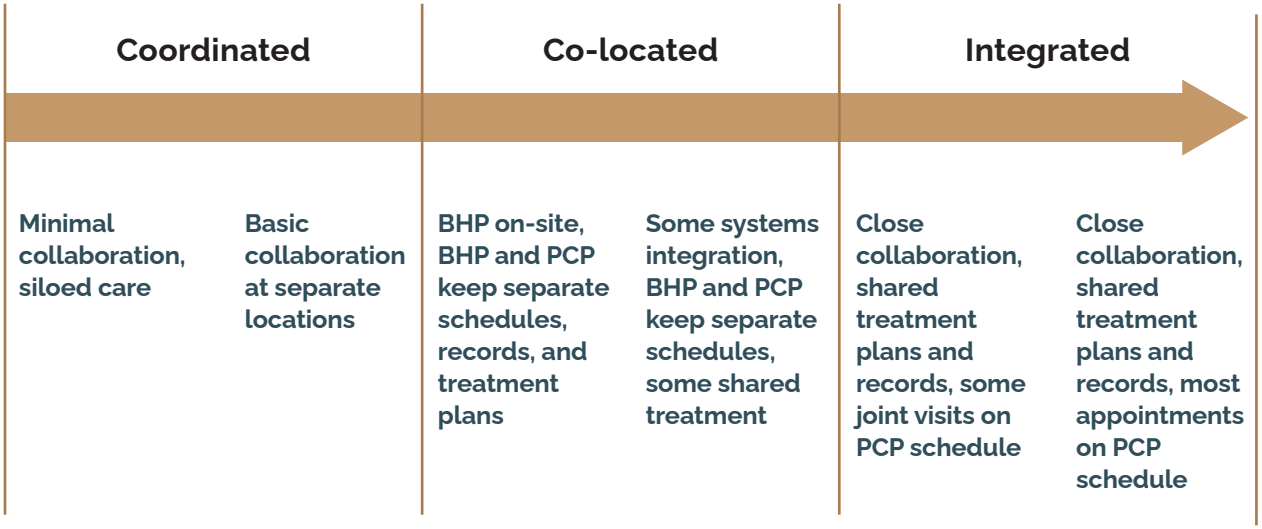
"The care a patient[17] experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population."

Optimally, IBH services means more than just offering brief counseling and therapy in conjunction with, or on the same site as, primary healthcare. It should address more than the co-occurring physical and behavioral health illnesses that influence and compound one another. IBH also includes addressing relationships, safety, social determinants of health, substance use disorder risk, and economic and racial disparities, all of which have profound impacts on one's overall wellbeing. When all these different, but intertwined, domains are considered and responded to with skillful intervention, youth's overall health outcomes improve. As their overall health and wellbeing improve, so does their ability to perform in school - socially, emotionally, and academically. As they flourish in school, they have the foundation and space to develop into healthy and accomplished adults, who will then contribute to their own families, communities and society.

[17] This guide uses the terms "patient" and "client" interchangeably to describe a student or other young person who is receiving physical or behavioral health services in an SBHC. We understand that the term "patient" can be perceived negatively by some communities and that some BH practitioners prefer not to use this term because of its associations with a problem- or deficit-focused hierarchical medical model. The term patient is widely used by FQHCs and the FQHC infrastructure so SBHCs operated by FQHCs are likely to be familiar with this nomenclature. Sites should use the term that is most acceptable to students and the local and school community when communicating with these groups. One FQHC and its SBHCs have adopted the term "member" to be more empowering, collaborative and strengths-based.

There are levels of integration that may be implemented over time.

## Levels of Integration




This vision requires meaningful and intentional partnership between schools and health care providers. Ideally, SBHCs work together with a variety of school personnel and other service providers to focus on prevention and early intervention, teacher support and training, school climate, mental health stigma reduction, and family supports. It is only through this process that schools and SBHCs will be able to achieve a cultural transformation that truly addresses student mental health.

## SBHC-School Integration

Integrating SBHC behavioral health services into the school is key to both clinical and financial success. A deep dive into SBHC-school integration is beyond the scope of this guide, but some best practices and linked resources include:

| Best Practices in School-SBHC Integration | Tools and Resources |
|---|---|
| Participate in Coordination of Services Team (COST) or other equivalent meetings/process; use this process to determine the best provider and service fit for students based on clinical need, insurance, language and other considerations | Alameda County Coordination of Services Team Toolkit |
| SBHC clinicians cross-train school staff in behavioral health topics such as Youth Mental Health First Aid, Trauma Informed Practices, Depression and Anxiety Awareness and Skills, Crisis Intervention and Response, Self-Care for Staff, ACEs, Toxic Stress and Resilience, How to Support Student Resilience, etc. | |
| SBHC staff (including but not limited to BH clinician) attend school staff meetings and professional development, as well as Back-to-School nights and other family-centered events. | |
| Include SBHC outreach in school registration events and include parent consent forms for clinic services in school registration packets to ensure high access and participation rates. | |
| Support school culture and climate (MTSS Tier 1) and help to shift the school to a more trauma-informed approach. | California School Based Health Alliance School-Wide Interventions |
| Support school staff wellness. | California School Based Health Alliance Staff Wellness |
| Support school-wide clinical crisis response for significant events impacting the school community. | School Mental Health Crisis Leadership |
| Collaborate with specialty mental health and other behavioral health providers on campus | California Guide for Sharing Student Health and Education Information |
| Have a clear understanding of the laws that inform information sharing in collaborations between service providing agencies and school districts. | |
| Ensure that there is a robust Memorandum of Understanding between the school district and SBHC lead agency. | |

An excellent overall resource for SBHC-School Integration Assessment from the LA Trust for Children's Health can be found in Appendix A.

## Common Interventions and Evidence-Based Practices Used in Integrated Settings

The most common therapeutic interventions used in primary care settings are Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Dialectical Behavioral Therapy and various trauma-focused interventions such as Trauma-Focused CBT and Eye Movement Desensitization and Reprocessing (EMDR). There are several different youth-specific and population-specific evidence-based programs and curriculum that fall under each of these domains, all of which have overlap in their recommendations and approaches. Common modalities include short-term solution-focused approaches, one on one therapy, and group therapy.

## Minor Consent and Confidentiality

Recent changes in California law allows minors aged 12 and over to consent to their own mental health care counseling if a mental health professional deems them mature enough to participate intelligently in treatment.

It is generally best practice to engage a minor's parent or guardian whenever it is safe to do so.

Sharing information with other health care providers, educators and others is complex and governed by different laws.

These topics are beyond the scope of this guide but much more information about minor consent laws, confidentiality and information sharing can be found here:

**https://www.schoolhealthcenters.org/resources/sbhc-operations/student-records-consent-and-confidentiality/**

# FINANCIAL MODELING FOR BEHAVIORAL HEALTH SERVICES

## Medi-Cal Billing as the Financial Backbone

For 45 years, Federally-Qualified Health Centers (FQHCs) have served people in primary care settings with high healthcare needs and low economic resources, many of whom have Medicaid (Medi-Cal) or are uninsured.

Licensed Social Workers and Licensed Psychologists have been covered (billable) providers at FQHC's for decades. The integration of behavioral health services in FQHC's in California started in 2004, with a handful of early adopters; by 2010, over 70% of FQHCs had some level of IBH. In 2010, the Affordable Care Act (ACA) expanded Medicaid coverage which resulted in lowering barriers to access for care for a wider range of income levels and included a broader menu of covered services. Then in 2014, mental health services for mild or moderate mental illness were added to California's Medi-Cal managed care contracts[18]. Also, in 2015, behavioral health therapy for beneficiaries with autism or autism spectrum disorder was added as a Medi-Cal-covered benefit and started being covered by managed care plans in 2016[19]. All of these factors have contributed to the advancement of IBH in almost all FQHC's in California.

Medi-Cal reimbursement for eligible visits is the revenue backbone for FQHCs. Medi-Cal visits provided by allowable providers are paid at an enhanced fee-for-service rate called the Prospective Payment System (PPS) rate. PPS rates vary by organization and clinic location and are based on a historical scope of services and cost-based rate. PPS rates differ widely, ranging in California from $60 to $900 with a majority of PPS rates falling between $130-300 per visit. This rate applies to services such as medical, dental, behavioral health, nutrition and optometry and is the same for all visits, regardless of length of visit.

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[18] More comprehensive "specialty mental health" services for children and adults with serious mental health conditions continue to be carved out and provided through contracts with county mental health plans. This is sometimes referred to as a "bifurcation" of the Medi-Cal mental health system (or even a trifurcation when the system of care for substance abuse treatment is considered). It should also be noted that, historically, many of the mental health services provided within schools by outside community organizations have been funded through these specialty mental health contracts, often focused on students with Special Education needs, and often referred to as "EPSDT" services.

[19] **KKF, Medi-Cal Managed Care: An Overview and Key Issues**

FQHCs have long histories of successfully sustaining and growing health care services with Medi-Cal PPS billing as the foundational revenue source, which also facilitates the ability to provide care to uninsured patients or for services that cannot be reimbursed.

In California, most schools with SBHCs have at least 70% of students who qualify for Medi-Cal. Therefore, At most SBHC sites, a large number of the behavioral health visits will be billable at Medi-Cal rates. This section lists the major source of Medi-Cal reimbursement that children and adolescents qualify for, as well as a few other sources.

## Mild-to-Moderate Behavioral Health Medi-Cal Benefit

In 2014, when mild to moderate mental health conditions were added to managed care contracts, FQHCs began to take varied approaches with how they manage in-house mental health care and referrals to higher levels of care when needed. A few have moved in the direction of including specialty mental health services; some have established collaborative solutions like embedding county mental health staff on site; and some use a referral approach to link patients with county care. SBHCs most commonly use a collaborative, team-based approach with county therapists and other specialists.

When FQHCs provide medically necessary covered services, including mental health services for those with mild-to-moderate mental health needs, they are eligible for PPS payment.

**Covered Providers**

Only certain FQHC providers are eligible for PPS reimbursement when seeing Medi-Cal patients. These providers are:

1. Physicians, Physician Assistants and Nurse Practitioners
2. Dentists
3. Optometrists
4. Licensed Clinical Social Workers
5. Associate Social Workers*
6. Licensed Clinical Psychologists
7. Licensed Marriage Family Therapists**

***Information about Associate Social Workers**

Associate Social Workers (ASWs) are Social Workers who have received their Master's degree in Social Work (MSW), have completed two years of internship while obtaining the MSW degree, and are registered with the Board of Behavioral Sciences, but are not yet Licensed Clinical Social Workers.

As of May 2020, DHCS has allowed ASWs registered with the Board of Behavioral Sciences to bill for visits at the same PPS rate as licensed clinicians (See Appendix B). Behavioral Health billing vendors like Beacon have been credentialing Associate level clinicians since that change. While it is unknown whether this change will be sustained post-pandemic, many FQHCs have maximized access for behavioral health services hiring ASWs during this time. More information about ASW visits can be found on page 49 below.

****Information about Marriage and Family Therapists (MFTs)**

Until recently, services provided by MFTs within FQHCs were not eligible for reimbursement under an FQHC's PPS rate structure. Starting in 2018, MFTs became approved as billable FQHC providers in California. The Department of Health Care Services (DHCS) is expected to release guidance soon that contains guidelines for licensed FQHC sites to submit a mandatory change in scope of services request (CSOSR) that is required when billing for MFTs.

If they have not done so already, FQHCs should evaluate whether it would be beneficial to submit a CSOSR to allow them to receive PPS reimbursement for MFT visits at their SBHC or other sites. In general, this may be worthwhile if MFTs do or may constitute a sizable proportion of total visits, and assuming the site's overall cost per visit has not declined since PPS rate-setting or the last change in scope. Please see Appendix C for some factors to consider when evaluating whether to submit a scope change.

## Eligible Diagnoses and Procedures

In most cases the Electronic Health Record (EHR) will automatically populate Medi-Cal claims based on the clinician's charting. Behavioral health providers should work with their IT and billing colleagues to ensure that this is happening correctly, that diagnoses are ordered in the right way, and that any additional codes or modifiers to support this process are included.

Denials on claims are rare for behavioral health visits. Generally, as long as the diagnosis, the intervention, the response to treatment, and the plan are documented (see "Documentation", below), the claim will be paid. There are various charting templates and models that offer structure to ensure these domains are included.

All Medi-Cal claims must include at least one valid diagnosis (ICD-10) and procedure (CPT) code. The diagnosis code must be appropriate for the treatment which is identified by the CPT code(s).[20]

[20] One exception is for the newly approved family therapy codes, addressed on the following page.

F codes make up the majority of mental health ICD-10 codes, which are divided into the following categories:

- **F00–F09** — organic, including symptomatic, mental disorders
- **F10–F19** — mental and behavioral disorders due to psychoactive substance abuse
- **F20–F29** — schizophrenia, schizotypal, and delusional disorders
- **F30–F39** — mood disorders, depression, and bipolar disorders
- **F40–F49** — neurotic, anxiety, stress-related, and somatoform disorders
- **F50–F59** — behavioral syndromes associated with physiological disturbances and physical factors
- **F60–F69** — disorders of adult personality and behaviors
- **F70–F79** — intellectual disabilities
- **F80–F89** — pervasive and specific developmental disorders
- **F90–F98** — behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- **F99** — unspecified mental disorder

The most common mental health concerns among adolescents are Anxiety Disorders, Mood Disorders and Behavioral Disorders. Common ICD-10 codes for adolescents include the following:

| | |
|---|---|
| F32.0 Major depressive disorder, single episode, mild | F31.9 Bipolar disorder, unspecified |
| F32.1 Major depressive disorder, single episode, mild | F41.0 Panic disorder [episodic paroxysmal anxiety] without agoraphobia |
| F32.1 Major depressive disorder, single episode, moderate | F42 Obsessive-compulsive disorder |
| F32.8 Other depressive episodes | F43.10 Post traumatic stress disorder, unspecified |
| F33.1 Major depressive disorder, recurrent, moderate | F43.11 Post traumatic stress disorder, acute |
| F39 Unspecified mood [affective] disorder | F43.12 Post traumatic stress disorder, chronic |
| F90.0 Attention-deficit hyperactivity disorder, predominantly inattentive type | F43.23 Adjustment disorder with mixed anxiety and depressed mood |

| | |
|---|---|
| F90.1 Attention-deficit hyperactivity disorder, predominantly hyperactive type | F 10.1 Alcohol abuse, uncomplicated |
| F90.2 Attention-deficit hyperactivity disorder, combined type | F11.10 Opioid abuse, uncomplicated |
| F90.9 Attention-deficit hyperactivity disorder, unspecified type | F 12.1 Cannabis abuse, uncomplicated |
| F41.1 Generalized anxiety disorder | Z65.9 (no dx, more than 5 risk factors present) *page 44 for more information*<br><br>Family therapy is now a reimbursable Medi-Cal service, even when the identified child does not meet a mental health diagnosis. See **this** Family Therapy Benefit Information for more information. |
| F41.8 Other specified anxiety disorders | F99 (no dx, less than 5 risk factors present) Family therapy is now a reimbursable Medi-Cal service, even when the identified child does not meet a mental health diagnosis. See this Family Therapy Benefit Information and page 39 of this guide for more information. |
| F41.9 Anxiety disorder, unspecified | See page 25 for additional codes associated with Minor Consent Medi-Cal |

**The most common behavioral health CPT codes are:**

| | |
|---|---|
| 90791 – Psychiatric Diagnostic Evaluation | 90846 – Family or couple psychotherapy, without the patient present |
| 90792 – Psychiatric Diagnostic Evaluation with medical services | 90847 – Family or couple psychotherapy, with the patient present |
| 90832 – Psychotherapy, 30 minutes (16-37 minutes) | 90853 – Group Psychotherapy (not family) |
| 90834 – Psychotherapy, 45 minutes (38-52 minutes) | 90839 – Psychotherapy for crisis, 60 minutes (30-74 minutes) |
| 90837 – Psychotherapy, 60 minutes (53 minutes and over) | |

## Medi-Cal Managed Care

Most children and adolescents receiving Medi-Cal in California are enrolled in managed care plans. These managed care plans differ by county and include commercial plans like Anthem Blue Cross as well as "Local Initiatives'' such as LA Care or the Partnership HealthPlan of California[21]. All Medi-Cal managed care beneficiaries select or are assigned to a Primary Care Provider (PCP) which can be a private physician or physician group, community health center, County health clinic, Kaiser Permanente, or other arrangement. Although some SBHCs act as official managed care PCPs, many are not able to provide the full continuity during the week or the year required to fulfill this role, even if they are the primary place that young people receive medical care. FQHCs typically act as Medi-Cal managed care PCPs for hundreds or thousands of Medi-Cal members.

In a basic FQHC scenario, a covered provider provides an eligible service to an enrolled member. The FQHC then sends two claims:

- One claim is sent to the health plan or its behavioral health plan administrator such as is Beacon Health Options) which remits a fee-for-service payment or denies the claim requesting further information or challenging the eligibility.
- A second claim called a Code 18 "wraparound" payment is then sent to the state Medi-Cal office, and the state pays that claim. The Code 18 wraparound amount is intended to represent, on average, the difference between what the health plan or Beacon pays and that clinic's PPS rate. (Each clinic has both an assigned PPS rate and a Code 18 wraparound rate.) Through this two-part reimbursement process, FQHCs are intended to be "made whole" for their full PPS rates, to which they are entitled by federal law. Then, through a final process called reconciliation, after the end of each fiscal year FQHCs report all their Medi-Cal revenue and FQHC eligible visits for each licensed site (including related intermittent sites) and are "trued up" to the total by either being paid for any under-compensated visits or, in some cases, owing money that was received in excess back to the state. There is often a long lag time to receive payments owed so most FQHCs attempt to adjust their wraparound rates periodically to avoid large end-of-year adjustments.

It is important to note that FQHCs and their SBHCs can be reimbursed for care provided by covered providers even if the patient is assigned to another PCP. Please see Appendix D for a letter from the California Department of Health Care Services clarifying that FQHCs can still receive their full Medi-Cal PPS rate when they provide an eligible visit to a Medi-Cal beneficiary that is "out of network."

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[21] A complete list of Medi-Cal managed care plans by county can be found at https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx

## Fee-For-Service Medi-Cal

Some children and youth are NOT enrolled in managed care or are in a transition between managed care plans. This might include young people enrolled in the CHDP Gateway Medi-Cal program, foster youth in some counties, the Minor Consent Medi-Cal program described below, and other less common situations. When treating these Medi-Cal members, the process is simpler and only involves sending one claim for the full PPS rate to Medi-Cal. It should be noted, however, that some aid codes do not include behavioral health services and therefore these claims might be denied. An example of this is Presumptive Eligibility for Pregnant Women, which covers a narrow scope of services related to prenatal and postpartum care and does not include mental health treatment.

## Treating Substance Use Disorders

Treatment for Substance Use Disorders (SUD) is generally contracted through County Mental Health Plans similar to specialty mental health. However, the most recent changes in the DSM-5 indicate SUD as a spectrum disorder. Because quantity of use, frequency of use, protective and risk factors, as well as behavioral issues are all domains of treatment, intervening in primary care and SBHC settings is important and can help ensure early intervention while supporting appropriate referrals to county contracted service providers as needed.

SUD interventions are most effective when they occur in real time rather than on a referral basis. Motivational Interviewing, the most common evidence-based-practice aligned with treating SUD centers on empathic communication, respect and eliciting of the patient's goals and values, avoiding argumentation and responding to the patient's readiness to change. Clinicians skilled in providing interventions that address both mental health and SUD conditions or risk factors are ideal providers in SBHCs, so youth are able to access care for both in the same setting. Interventions in SBHCs should also include referrals to community SUD programs such as self-help groups and family support, and when there are acute or severe presentations, referrals to inpatient, residential or intensive outpatient care is recommended.

The privacy law that guides policies and procedures for information exchange about SUD care is called 42-CFR Part 2. It protects the privacy of patients receiving SUD care and requires express patient consent for information exchange. The guidelines state that 42-CFR Part 2's definition of a "program" in a general medical setting are as follows:

- The providers work in an identified unit within the health center that holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment OR
- The primary function of the providers is alcohol or drug abuse diagnosis, treatment or referral for treatment, and they are identified as providers of such services

Otherwise, the patient record security policies must meet the standards of 42-CFR Part 2[22] .

Strategies to ensure early and real-time SUD interventions using strategies such as Motivational Interviewing are billable and include the following:

- Behavioral health clinicians may provide and bill Medi-Cal for assessments and interventions for SUD in combination with mental health as long as the SUD interventions are not "primary". The mental health condition as the primary focus of treatment may be indicated as such in the claim and in the treatment note.
- SBHCs can contract with county Mental Health Plans to provide SUD treatment through Drug Medi-Cal Organized Delivery System.
- Grant funding to expand SUD services is often available from the Substance Abuse and Mental Health Services Administration (SAMHSA) and/or HRSA and commonly used as revenue sources for this service.

### Screening Brief Intervention and Referral to Treatment (SBIRT)

SBIRT is a model that encourages mental health and substance use disorder screening as a routine, preventive service in healthcare. Since 2015, FQHCs have been encouraged to implement and maintain this service for patients 12 and older.

Research indicates that screening and acknowledgment of these results by a medical provider is in and of itself an intervention correlated with positive health outcomes. In addition, this regular practice is an effective vehicle for behavioral health clinicians and medical providers to collaborate on interventions to address mental health problems and substance abuse. With both mental health and SUD, if the screen indicates a need for an intervention, one can occur in real time from either a medical or a behavioral health member of the team. "Warm hand-offs" to behavioral health clinicians are common when SBIRT indicates a need for this support.

**While there is no specific revenue source for conducting SBIRT in FQHCs, the proactive identification of behavioral health needs early and consistently is a strategy to be responsive to patients and to increase the number of patients who engage in behavioral health services.**

In many clinics, the behavioral health team is highly involved in SBIRT implementation as empathic care principles and motivational interviewing skills are known to improve effective care delivery.

[22] SAMHSA 42 CFR Part 2 Revised Rule

More information on SBIRT can be found at:

**https://www.schoolhealthcenters.org/resources/student-impact/substance-use/**

**https://aspe.hhs.gov/report/implementation-barriers-and-facilitators-screening-brief-intervention-referral-and-treatment-sbirt-federally-qualified-health-centers-fqhcs**

**https://www.ncbi.nlm.nih.gov/books/NBK424859/**

## Minor-Consent Medi-Cal

In California, individuals under 21 years old may apply for a special confidential program called Minor Consent Medi-Cal without parent or guardian consent or knowledge. In addition to family planning, sexual assault and pregnancy-related services, this program covers some outpatient mental health and substance abuse services which will be the focus of this section.

### Eligibility

Children and youth ages 12-20 can be covered for outpatient mental health, drug and alcohol abuse treatment and counseling if certain conditions are met. To qualify for these services a minor must be unmarried and considered living in the home of a parent or guardian. The program allows the minor to qualify based on only the minor's income and property and NOT the parent or guardian's; thus, most adolescents qualify. (Proof of income may be required for any income the minor has.) There is no residency or citizenship requirement, but foster care youth and other minors under the care of public agencies are not eligible for this program. However, minors that have family coverage through private or commercial health insurance plans CAN be eligible if other criteria are met.

Minors are only eligible for outpatient mental health treatment and counseling through the program if a mental health professional[23] attests that the minor is mature enough to participate intelligently in the mental health treatment or counseling AND that the minor is either:

(a) In danger of causing serious physical or mental harm to themselves or others without mental health treatment or counseling; OR

(b) An alleged victim of incest or child abuse.

These criteria are left to the judgment of the mental health clinician based on their clinical assessment as documented in the patient chart. Many SBHCs find that a significant number of students seeking mental health services meet one of these criteria.

[23] For the purposes of this requirement, mental health professionals include licensed MFTs, LCSWs, licensed educational psychologists, credentialed school psychologists, clinical psychologists, licensed psychologists, and psychiatrists.

Some SBHCs allow students 1-2 visits with a BH provider to assess whether the student meets the criteria outlined above for Minor-Consent Medi-Cal services. This information can be sensitive and the provider may need time to develop rapport with the student in order for them to feel comfortable with disclosure.

### Covered Services

Minor Consent Medi-Cal recipients do not have full-scope Medi-Cal benefits and instead have access to a narrow scope of services with the specific scope dependent on the aid code assigned. The relevant aid codes are:

| | |
|---|---|
| **Aid Code 7M** | Recipient limited to services related to Sexually Transmitted Diseases, sexual assault, **drug and alcohol abuse,** and family planning with or without a Share of Cost.[24] |
| **Aid Code 7P** | Recipient limited to services related to Sexually Transmitted Diseases, sexual assault, **drug and alcohol abuse,** family planning, and **outpatient mental health** with or without a Share of Cost. |

SBHCs can provide services to someone enrolled in these aid codes based on the following ICD-10-CM diagnosis codes:

| Code | | Description |
|---|---|---|
| **F01.50 through F90.0** | - | Mental health and drug dependence |
| Z13.89 | - | Screening for depression (not isolated) or alcoholism |
| Z65.8 | - | Alcoholism |
| Z71.41 | - | Alcohol abuse counseling and surveillance or alcoholic |

There are no limitations on the number of visits, but visits must be "medically necessary" as with all Medi-Cal services. For SBHCs run by FQHCs to be reimbursed for services provided under Minor Consent Medi-Cal, the provider must be an eligible FQHC provider type as described on page 17.In order for providers to avoid contacting parents or guardians, the clinician must document that it would be disadvantageous to the minor to have their parents or guardians involved.

[24] A Share of Cost is like a deductible but is VERY unusual in the Minor Consent program.

### How to Apply and Recertify

The application process includes the minor completing Form MC 210, MC 4026 (Request for Eligibility Limited Services) and, when applying for mental health treatment or counseling, a written statement from the mental health professional which states that the child needs mental health treatment or counseling, the estimated length of time treatment will be needed (up to 6 or 12 months) and that the minor meets the criteria shown above. Minor consent applicants are not required to provide their Social Security number.

This process can be supported by SBHC staff and/or a county eligibility worker. SBHC staff can help students apply for Minor Consent Medi-Cal in connection with their local Social Services Agency. Often, counties will outstation eligibility workers to FQHCs, SBHCs or other sites to support these and other Medi-Cal or public benefit applications. In other cases, a young person may need to physically go to the Social Services Agency to apply. During the COVID-19 Public Health Emergency, most counties accepted applications and returned eligibility information via phone or email; this flexibility is expected to become permanent beyond the pandemic.

A county eligibility worker must process the application and then issues a Medi-Cal card. If the SBHC address is listed on the application, the card will be delivered to the clinic and the clinic can hold the card for the patient. The card contains the BIC number, issue date and other information needed to submit claims. Typically, eligibility is granted retroactively to the first day of the month when the application was completed (e.g., application completed May 15 will have an Issue Date of 5/1/21).

In general, Minor Consent Medi-Cal eligibility is issued on a month-to-month basis, with a new Form 4026 submitted each month that services are needed; however, based on a statement from the mental health professional the MC 4026 can be waived based on the treatment plan indicated. During the COVID pandemic, eligibility was automatically continued and no Medi-Cal coverage has been terminated.

After a full year, minors generally need to complete a Form MC 210 RV if they continue to need services.

### Reimbursement Rates

FQHC-run SBHCs should receive their full PPS rate directly from the state for eligible visits provided by an eligible provider to minors enrolled in this program. There is no capitation or managed care component for this program.

### Summary

The Minor Consent Medi-Cal program represents a promising source of revenue for certain student patients, including those whose families have commercial health insurance coverage. SBHCs should establish how it works in their county and relationships with their Social Services Agency.

Because this program is more complex than some others, it is helpful for SBHCs to maintain some internal expertise and a tracking system to support re-certifications as needed.

**For more information**

SBHCs should contact their local Social Services Agency or see if their **local clinic consortium** is able to help.

## Commercial (Private) Insurance

All comprehensive insurance plans approved under the Affordable Care Act provide coverage and reimbursement for some behavioral health services. Most pay for a broader range of licensed BH clinicians, including LMFTs and sometimes licensed professional counselors (LPCs) or others. Clinics must generally have contracts with the insurance plans, and individual BH clinicians must be credentialed with those plans. Reimbursement rates and coverages vary but no private insurance plans will pay rates higher than the average PPS rate for behavioral health services. SBHCs with a high penetration of private insurance might want to pursue contracting with the most common insurance plans. In general, this should be viewed as a complementary and not central financing strategy.

Kaiser Permanente, the largest provider of commercial coverage for Californians, generally does not reimburse non-Kaiser providers for care provided to their members, and specifically does not reimburse for school-based mental health care.[25] In some very specific instances Kaiser members may be able to receive authorization to see an outside behavioral health provider, but the process to secure this authorization is beyond the scope of this guide. SBHCs serving a large percentage of students with Kaiser coverage might want to apply to their local Kaiser Community Benefits funding instead and should consider Minor Consent Medi-Cal as a billing strategy for those students who qualify.

## Assessing BH Costs and Revenue

Similar to any business planning, it is important to understand and project the costs and revenues associated with the SBHC's behavioral health services. It is reasonable to think that an established SBHC with the right staffing and a good volume of Medi-Cal enrollment should be able to cover behavioral health program costs, including some overhead, with Medi-Cal reimbursement.

[25] Note that if a student has Kaiser coverage through Medi-Cal, and an eligible FQHC provider delivers care to this child, they will not receive any payment from Kaiser directly but ARE eligible to receive the wraparound payment from the state, and this visit is eligible for full PPS payment through the end-of-year reconciliation process described on page 20.

**Cost Estimates**

Below are the average base salaries for various behavioral health clinicians in California FQHCs over the last 3 years. More detailed information from the California Association of Primary Care's 2020 Compensation and Benefits Survey can be found **here.**

| Position | 2020 Average Base Salary | 2020 Average Base salary with benefits at 26% | Cost of added clinical supervision (minimum 4 hours/ month) | 2020 Average Base Salary with fringe benefits, supervision costs and 15% overhead |
|---|---|---|---|---|
| Associate Clinical Social Worker (ASW) | $60,427 | $76,138 | $2,600 | $90,158 |
| Licensed Clinical Social Worker (LCSW) | $85,687 | $107,965 | N/A | $124,160 |
| Licensed Clinical Psychologist (Ph.D.) | $111,689 | $140,728 | N/A | $161,837 |

If the SBHC employs a full-time LCSW at the 2020 average salary with a benefit rate of 26%, the total cost for that year-round position is approximately $108,000. If the SBHC is open only during the school year, then that employee may work only 10 months at the SBHC. There may be some small equipment or supply costs, and most SBHCs do not pay rent or other space costs. Most FQHCs charge the SBHC unit for some indirect administrative overhead to cover the "home office" costs for human resources, payroll, IT front office and other shared expenses. This yields a total cost for behavioral health services of $124,160 per clinician.

**Revenue Estimates**

One way to calculate monthly BH revenue is as follows:

> 17 days a month (average days of work due to holidays, sick-time, and vacation time) x number of average visits x PPS rate

**For example:**

- 4 Medi-Cal visits a day by a qualified provider at $170 PPS =$680
- $680 x17 work days/month = $11,560  per month x10 = **$115,600 a year**

As this illustration shows, a well-constructed behavioral health program can come close to covering its costs with fairly modest visit expectations of the BH clinician. With the addition of 1 more visit a day, cost neutrality or profitability is possible.  This is not to say it's easy! We all know that sustaining even four Medi-Cal visits per day in a sometimes chaotic school environment can be a challenge. The Common Challenges and Solutions section below addresses many common challenges in obtaining and sustaining this kind of volume.

# PROVIDER CREDENTIALING AND DOCUMENTATION

## Provider Credentialing

Only a few Medi-Cal managed care plans administer their own behavioral health benefits; most contract with a third-party mental health plan like Beacon. Sites should learn whether the health plan is "the payer" or subcontracts with Beacon or another third-party payer. In either case, behavioral health clinicians need to be credentialed with that plan prior to submitting claims. This process can take 6-12 weeks. BH clinicians should be credentialed with all of the same health plans that medical providers are credentialed with, ensuring any patient that sees a medical provider at the SBHC site can also see a BH clinician.

## Documentation

In integrated settings, all documentation for behavioral health services, including substance use disorders, should be included within one shared electronic health record. This means no firewalls, "confidential" tab or other markers separating medical team documentation and behavioral health documentation.

Quality documentation is important in any setting for multiple reasons:

1. **For the patient** - Accurate, high-quality documentation can help support students' eligibility and qualifications for 504 or IEP plans, disability and as evidence for mandated treatment, such as cases involving child protective services or the judicial system. Systems such as "Open Notes" are also being used to make treatment information more accessible to clients and to increase their participation in their own care. It is therefore important for the provider to be transparent and collaborate with the student around sensitive information that could be included in their notes, such as the results of any ACEs screening.
2. **For the treating clinician** - To assist them in remembering relevant disclosures and diagnostic formulations between visits. Additionally, for some clinicians, the process of writing and making decisions about the language and the wording of the documentation assists them in formulating clinical impressions and thoughts about treatment.
3. **For the treatment team** – To enhance collaboration within multidisciplinary teams and help other team members support and communicate about treatment goals.
4. **For the payer** - To justify services and reimbursement.

Beyond this, there are some important differences in how documentation is approached in traditional behavioral health settings like a private clinician practice or specialty mental health clinic and how it is approached in integrated behavioral health settings like FQHCs. In integrated settings:

**Less time is spent on documentation, in general.** In integrated settings, the vast majority of a clinician's time is spent on patients, not documentation. Generally speaking, no more than 10-15 minutes is spent on documentation for each patient seen.

**Documentation is focused where the patient is focused.** Documentation requirements do not set the agenda for the visit. Instead, the patient's needs and preferences should shape what is discussed; documentation follows. This is particularly important for youth, when engagement, trust and connection must succeed in the first session. This may seem commonsensical; however, in many other behavioral health settings, the need to follow standardized assessments or document the use of certain interventions often drives the session's content.

**Documentation is more general when it comes to trauma and other sensitive subjects.** Shared electronic health records are a cornerstone of operational and clinical integration. When records are separated with confidential tabs or electronic firewalls, it is a barrier to collaborative whole-person care, both practically and philosophically. There are exceptions to this when circumstances require additional privacy within the chart to prevent release to parent/guardian. In both cases, because records are shared, behavioral health documentation in integrated settings is typically more general, brief and treatment-focused than documentation in traditional behavioral health settings. As an example: "childhood trauma is endorsed; sexual abuse by grandfather" is a sufficient note to put in the EHR, as opposed to a paragraph detailing the abuse's frequency or severity. Documentation should only consist of that which is medically necessary for the health team to know and what is relevant to support treatment planning.

## Documentation Basics

**Blue = good clinical practice**

**Red = mandatory for payers**

**Presenting problem:** What the patient says they are there for.

Example: *"Patient reports they are here because the school nurse referred them, states they are unsure why" or "patient is with mom, who states presenting problem is concern about depression and restrictive eating."*

**Diagnosis**

Example: Adjustment Disorder; Depression NOS (should be selected from a pick list built in to EHR)

**Symptoms to Support Diagnosis**

Example: *"Patient reports depressed mood, short term memory and concentration impairment, anhedonia and insomnia for the last 8 months."*

**Mental Status Exam:** Commonly used on the first visit and in a structured cadence from that point forward. This assessment intervention may be replaced with other regular screens like PHQ and should only be used if questions are non-duplicative.

**Worsening or improvement in presenting problem and/or diagnostic symptoms since last visit:** This is where to reference progress toward goals. More information below.>

Example: *"Patient reports improvement in mood and decrease in anxiety over past 2 weeks."*

**Assessment:** Assessment of the presenting problem; assessment of diagnostic cluster; assessment of patient strengths, beliefs, preferences; family history, SUD/trauma, etc. Assessment is ongoing, not a one-time event; the first visit should always include treatment, with concurrent assessment.

**Intervention:** What the BH clinician  does in the session.

Example: *"Intervened to build rapport, elicit patient beliefs about their depression, elicit patient preferences about treatment, past history with counseling; intervened to give patient basic feelings management information re: identification and expression of feelings; explored patient's early childhood history, including family patterns and impact on current functioning."*

**Patient strengths:**

Examples: *"Patient reports strong bond with father"* or *"Patient has a history of seeking help"* or *"Patient reports a strong support system including regular school attendance and close friends"* or *"Patient reports strong faith and cultural traditions"* or *"Patient has a history of health changes including successful management of Type 1 diabetes and no longer using cannabis socially."*

**Functional impairment:** Symptoms should be rated as mild, moderate or severe based on how they impair functioning in areas such as school, family, relationships, work, activities, etc.

**Patient goals for course of therapy:** It is important clinically, to focus us on eliciting from patients what they want to accomplish with a course of therapy - in other words, how they, and we, will know if therapy is helpful.

**Plan:** This includes both patient goals before the next visit, and also the clinician's recommendations and/or referrals before the next visit.

Example: *"Patient states she will increase assertive communication with her boyfriend; is going to try leaving her phone off after 11 to get more sleep; will continue to connect with best friend and aunt for support. Follow up appointment in 2 weeks."*

# MODELS OF CARE AND THE RELATIONSHIP TO FINANCIAL SUSTAINABILITY

Various approaches to providing behavioral health care in schools each have positive aspects and drawbacks. Generally, the more siloed and traditional mental health models are associated with low productivity, high documentation burden and fiscal challenges. Integrated behavioral health, when modeled on primary care, has higher visit volume, but often misses the mark on quality and human-centered approaches. Integrated models are most successful when they balance access, productivity, patient/provider experience, clinical outcomes and cost-effectiveness. The table below summarizes some key aspects of these different approaches.

| | Ideal IBH models | Traditional mental health models | Overly medicalized BH models |
|---|---|---|---|
| **Volume of daily visits** | Between 5-9 visits a day | Low productivity (3 or fewer visits a day)<br>Visits are 50-90 minutes long with 10-20 minute breaks between | Over 9 visits a day on average |
| **Time spent on documentation** | 10 minutes per patient on average | High documentation burden; often hours a day | Minimal and sometimes inadequate documentation |
| **Which clients are referred out for specialty care** | Majority of patients are treated in house; some referrals out for very complex needs | No referrals out | High percentage of patients referred out for BH care |
| **Focus of treatment** | Relationship-based care with a focus on quality outcomes | Relationship-based care | More transactional care |

| | | | |
|---|---|---|---|
| **Office space** | Office space is flexible and diverse. It includes comfortable seating, therapeutic toys, games and art supplies and allows for adequate space for multiple people to be in the room if needed. Behavioral health staff are physically located nearby, either in offices or in space designated for them with medical providers | Office space is siloed and emphasizes privacy over accessibility | Office space might be cold and clinical and visits may be conducted in medical exam rooms |
| **Purpose of documentation** | Documentation is primarily used for billing purposes, and to communicate broad patient needs, goals, and progress with medical teams | Documentation guidelines are rooted in privacy over ease of team communication | Documentation may be limited to screenings and structured models, limiting clinical autonomy |

## BH Staffing Ratios

Staffing ratios for SBHCs should be determined by a needs assessment and ideally a team-based care approach where roles and responsibilities are clearly defined. A common practice by SBHCs is under-staffing or inconsistently staffing behavioral health, with BH clinicians working fewer than 3 days a week at the site or working a complicated combination of half days. This results in youth, families, medical teams and the school staff having to remember when behavioral health is available and when it's not. This results in an "out of sight, out of mind" phenomenon that breeds low engagement.

From an operations perspective, an ideal goal is to have both medical and behavioral health clinicians working as close to full-time as possible and both available during the same time. This promotes easy consistent access for students, trust in school staff, and the potential for consistent revenue generation.

Even if the school population is small and the medical team care is limited, having a behavioral health clinician available consistently will increase referrals, decrease no-shows, and allow "just-in-time" access for students and families. Adolescents in particular don't engage in therapy unless they experience it as supporting them with the needs they have as they arise. In general, the longer they have to wait, the less likely they are to attend a health care visit.

In community FQHCs, it is common to staff 1 FTE behavioral health clinician for every 3-4 FTE medical providers. In SBHCs, the ratio should tilt much more heavily toward behavioral health. Students being seen for medical visits may present behavioral health needs and ideally there are ways for a medical provider to make a warm handoff or introduction to a behavioral health clinician. Because of the social-emotional needs related to child and adolescent development, and their relative physical health, a ratio more like two behavioral health clinicians for every one medical provider may in fact be more appropriate.

## Selecting Ideal BH Providers for SBHCs

The role of behavioral health clinicians in SBHCs covers many domains. Hiring for fit is important to the sustainability of this unique model. Ideally school-based clinicians: love working with youth, are culturally responsive and humble, linguistically congruent with the population served, are experienced in "systems work" with schools and families, and value being on an interdisciplinary team. In the graphic below, the various roles of an SBHC BH clinician are illustrated as a helpful tool when considering a good fit for this position. SBHC clinicians don't necessarily need to fill all these roles; ideally they have experience in several, are excited to learn what they do not already know, and work well with team members who share other qualities listed. More information on hiring BH clinicians for integrated settings can be found here: **https://www.rsourced.com/resources/hiring/.**

*Figure: Roles of a Behavioral Health Clinician*

## Financial Sustainability and Productivity

Productivity can be a difficult subject for behavioral health teams, particularly in fee-for-service settings, such as most FQHCs, because the number of patient visits completed by providers is the main source of revenue and therefore drives many decisions made by business leaders. They may express concern that too narrow a focus on productivity will endanger quality, documentation, and/or relationship-based care. Thanks to years of experience, trial and error, we can now offer these general guidelines:

1. Avoid the binary framing of mission vs. money or clinical quality vs. productivity. In fact, maintaining a reasonable productivity standard improves access to care for more patients, which is core to the mission of most FQHCs and SBHCs. Particularly during a behavioral health workforce shortage and growing mental health need, it is essential to use the valuable time and expertise of behavioral health clinicians well.
2. Productivity expectations involve clinical decisions and should be established by a Behavioral Health Director, ideally one who continues to be in practice in a similar setting. While consultation with the entire leadership team and CFO should always occur, the BH Director should ultimately drive and endorse productivity standards.
3. Commit to financial sustainability. "No money, no mission" is a common refrain in safety net settings. All leaders in integrated environments need to be committed to the financial health and sustainability of the organization and its programs. For Behavioral Health Directors, this need is amplified, as behavioral health services are always combatting a misconception that they are "auxiliary" services that should be grant funded because they are not self-sustaining. Behavioral health services in all types of primary care settings can in fact be profitable and the Behavioral Health Director can elicit the confidence of other leaders by actively committing to making behavioral health services cost-neutral or better.
4. Use data to inform decision making. In order to review costs and revenues, organizations should regularly run financial reports. The reports should include appropriate expenses and reimbursements, as well as the productivity of behavioral health providers. This data should be transparent and shared with relevant stakeholders and those who can influence improvements.
5. Embrace a team-based care culture so that behavioral health clinicians can be supported to provide billable visits while other members of the team offer outreach, coordination, administrative support for consents and other documents, patient follow-up, data entry, and/or referral linkages.

### Specific Recommendations for Productivity Expectations

Most primary care organizations with integrated behavioral health services have set productivity expectations that range between 6-9 patients a day (or about 100 visits a month). In SBHCs generally, it is very difficult for even full-time provider staff to see patients 8 hours a day, 40 hours a week. Schools are frequently impacted by holidays, breaks and other closures, crises and lockdowns, student testing, professional development days, and a host of other planned and unplanned interruptions to a "normal" clinical schedule. In addition, SBHC BH clinicians often play a more complicated and collaborative role than those working in outpatient community-based settings. Their role should include liaising with school staff, participating in coordination of service meetings, offering some "Tier 1" interventions, training school staff, attending IEPs, and supporting youth development and other core SBHC activities.

For all these reasons, SBHC leaders should expect much lower productivity from SBHC BH clinicians, in the range of 4-5 a day or 20-25 a week for a full-time clinician. Completing fewer visits limits access to care, and if clinicians feel overwhelmed with this type of volume, it is important to explore with them what is preventing higher productivity. Some common barriers to productivity are addressed below.

Having a productivity range can be helpful. Provider temperament, preferences, and clinical practice styles vary between all types of providers, including behavioral health providers. Granting providers some autonomy in determining their own pace within an accepted range can help clinicians thrive. The more autonomy an organization provides to employees, the more employees will be apt to affirm autonomy with patients, which is related to client engagement and activation.

### School Schedules

Different SBHCs operate on different yearly schedules. Some are tied closely to the school calendars while others operate independently year-round, much as a community clinic would do. These decisions are influenced by many factors, and in general: SBHCs that serve a broader community tend to be open more hours and months; SBHCs that are in a separate building and/or have an external entrance are more likely to be open more hours and months; and lead agencies other than school districts are more likely to be open year-round. Many FQHC run SBHCs operate year-round and are able to see patients (students and others) even when school is not in session. Some close for the summer and others have reduced summer hours. A best practice for clinical continuity is to ensure after hours care coordination and offer at least some services during the summer and other school breaks - if not onsite at the SBHC, then at another local clinic or via telehealth. SBHC staff and providers may work a 10-month schedule (as with school district employees), have reduced hours during summer breaks, be redeployed to the lead agency to cover other employee leaves, or be offered paid or unpaid time off.

### Scheduling Templates

Schedule templates are an important tool to focus BH clinician time. Session lengths vary within IBH settings and sites. Organizations may utilize 30-minute, 45-minute and/or the traditional 50-60 minute sessions, and most allow for a mix of all of these depending on whether a client is new, their acuity, comfort with mental health, and how frequently they are seen. It is important to remember that the average visit length will impact the productivity range of clinicians and that the goal of productivity is to be sitting in front of patients, providing services, for at least 50% of the day for school-based clinicians (and 75% for other clinic settings). Supervisors should work with BH clinicians to increase their comfort with shorter appointments and share research about the value of this approach, since many clinicians are trained in a more traditional model emphasizing one hour as standard practice[26] .

The graphic below shows a BH provider schedule that utilizes varying visit lengths interspersed with time for unbillable but vital activities like outreach, charting, consultations with teachers, and IEP meetings. Scheduling this number of visit slots doesn't mean that they will all be booked or completed. It's helpful to have more slots in the schedule than are expected to fill to help account for several variables that impact productivity targets like cancellations and missed appointments - and to leave room for warm handoffs and walk-ins.

In general, using 30-minute visits alone will allow a total of 32 billable touches per week; using exclusively 60-minute visits shows a total of 23 billable touches per week; and using a varied approach with some 30-minute and some 60-minute visits shows a total of 25 billable touches per week.

[26] EM Consulting, Integrated Behavioral Health Manual, Second Edition

*Figure: Sample schedule: Using a varied approach with some 30-minute and some 60-minute visits shows a total of 25 billable touches per week. During Admin and Outreach Time, warm hand-offs commonly occur.*

| Time | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| 8:30 | Student Visit | Student Visit | Student Visit | Student Visit | Student Check-in |
| 9:00 | Admin & Outreach Time | | Student Visit | | IEP, SST or Collaborative School Site Meeting |
| 9:30 | Student Visit | Admin & Outreach Time | Admin & Outreach Time | Admin & Outreach Time | Admin & Outreach Time |
| 10.00 | | Student Visit | | Student Check-in | Student Visit |
| 10:30 | Admin & Outreach Time | Student Visit | Therapy Group | Staff Meeting | |
| 11:00 | Student Visit | Admin & Outreach Time | | | Admin & Outreach Time |
| 11:30 | Admin & Outreach Time | | Admin & Outreach Time | Clinical Supervision | Student Visit |
| 12:00 | | Student Visit | | Student Visit | |
| 12:30 | | | | | |
| 1:00 | Student Check-in | | Student Visit | | Student Visit |
| 1:30 | IEP, SST or Collaborative School Site Meeting | Admin & Outreach Time | Admin & Outreach Time | Admin & Outreach Time | Admin & Outreach Time |
| 2:00 | | Student Visit | Student Visit | Student Visit | |
| 2:30 | Student Visit | | | Student Visit | Student Visit |
| 3:00 | | Admin & Outreach Time | Admin & Outreach Time | Admin & Outreach Time | Student Visit |
| 3:30 | Admin & Outreach Time | Staff Meeting | Family Visit | | Admin & Outreach Time |
| 4:00 | | | | Family Visit | |
| 4:30 | Open Office Hours | Open Office Hours | Admin & Outreach Time | Admin & Outreach Time | Open Office Hours |
| Number of billable visits | 4 | 5 | 6 | 5 | 5 |

Billable  Non-billable

# COMMON CHALLENGES AND SOLUTIONS

## Unbillable Same Day Visits

Unique to FQHC settings, a barrier to financial sustainability is that FQHCs will not be reimbursed for their PPS rate for a mental health visit and a medical visit and a medical visit that occur on the same day. And yet failing to offer integrated same-day visits can be a real barrier for patients with a combination of physical and emotional needs. Senate Bill 316 (Eggman) is a bill introduced during the 2021-22 California state legislative session that would allow FQHCs and Rural Health Centers to bill Medi-Cal for two visits if a patient is provided mental health services on the same day they receive other medical services. In the meantime, two visits may not be reimbursed.

**Strategies to Address:**

Same day visits are sometimes necessary and often the best way to begin engaging students in therapy. For example, trusted medical providers can utilize a warm hand-off to introduce a student to the behavioral health provider for a brief first visit, and this practice is correlated with a dramatic reduction in no-show rates for behavioral health intakes. And other times, urgent mental health matters need immediate attention. One strategy is to train front office staff, medical assistants, or a behavioral health coordinator to offer skilled interventions where they have access to supervision as needed.

## Unbillable Time

In a fee-for-service structure, one of the biggest challenges is conceptualizing how to manage non- billable time. Because only client-facing non-same day services are eligible for reimbursement, most other activities tend to be implicitly undervalued, and yet these activities are often central to a positive, sustainable model of care.

**Strategies to Address:**

- Try not to use the term "productivity" only with respect to billable visits as this implies that only reimbursed patient care is productive, and this can undercut meaningful touches like front office staff connections, medical assistant interventions, time spent coordinating care, team members consulting with one another, and training and professional development.
- Spend intentional time training the team on roles and responsibilities that complement the fee-for-service structure. In the table below, there are examples of ways to prioritize visits and distribute tasks among other team members. For example, health educators or clinic coordinators - or even youth educators - could conduct outreach regarding behavioral health services instead of the clinician if they understand the services and feel like valued members of the team.

**Table title:** Structuring Roles with Billable and Nonbillable Time in Mind

| | Important for BH clinician to do: | Use other staff[27] to do: |
|---|---|---|
| **Billable** | - Direct services such as screenings, assessments, return visits and group visits for students, family or community members, in person, video or telephone[28], that fall on a different day than a medical appointment<br>- Visits with parents/guardians that are focused on family therapy needs and goals Check page reference for family therapy reference (see page 44 for more information) | N/A |
| **Not billable** | - Same-day visits as needed to engage students<br>- Same-day visits for urgent or crisis needs<br>- 504 and IEP team meetings for students with high behavioral health needs<br>- Consults with medical team<br>- Consults with teachers/school administrators<br>- Behavioral health visits with uninsured youth and families<br>- Charting and documentation<br>- Trainings for school staff that require BH expertise | - BH appointment reminder calls<br>- Follow-up outreach to youth identified with a BH need who have disengaged from care<br>- Outreach to youth generally about their health and well-being<br>- Outreach to teachers and school staff about BH services<br>- Responding to records requests<br>- Follow up calls for missed appointments<br>- Obtaining ADHD assessments from teachers<br>- General teacher trainings about SBHC services<br>- Participating in coordination of services meetings<br>- Conducting routine BH and wellness screenings |

[27] Staffing models vary dramatically across SBHCs. The tasks listed here could conceivably be handled by some combination of: clerk, medical assistant, BH assistant, unlicensed case manager, peer provider, health navigator, health educator, community health worker, clinic coordinator, or other.

[28] Video and telephone visits were included in billable visits during the COVID-19 global health crisis. While there is advocacy to maintain this benefit, it may be revised in the future.

## Low Productivity Due to Limited Population Base

The majority (83%) of SBHCs in California serve community members outside the school population. This means that the opportunity for billable visits exists outside the school day and is not limited to school hours. In these instances, behavioral health visits can often occur outside school hours and on days when school is not in session.

For SBHCs more tied to student and school schedules, achieving 4-5 billable visits per day may be more challenging due to the size of the student population, fewer clinic hours, and all the interruptions such as testing, bell schedules and other commitments. These clinics also have fewer revenue-generating days a year between professional development days, school holidays, breaks and other events.

**Strategies to Address:**

- With permission from the school, SBHCs may consider widening the target population to include graduates, students from other local schools, siblings, or even community members unaffiliated with the school. This decision should be considered carefully with special attention to the impact on confidential adolescent services. Some SBHCs have separate entrances and waiting rooms for community members or differentiated hours for different populations.
- SBHCs can also consider adjusting clinic schedules to ensure that the availability of BH services is a good fit with client and prospective client demand.

## Low Productivity Due to Fit/Match with Provider

Clinicians who are authentically motivated to offer empathic, culturally resonant care, tracking and improving health outcomes with attention to client experience, and taking an active role in how services are coordinated for students across the school campus, are the ideal fit for a SBHC setting.

Clinicians who don't take an active role in outreach, engagement and ensuring access can influence the sustainability of the behavioral health services. They may create rigid barriers to higher productivity, maintain low caseloads, or not collaborate fully with other team members.

The following are common myths and beliefs of some traditional BH clinicians, which can become barriers to a successful integrated SBHC model.  Clinicians that hold these beliefs closely may be a poor fit for a sustainable IBH practice in the SBHC.

**Traditional Belief: More time with each patient is associated with better quality services.**

**Alternative Perspective:** Especially in an integrated setting, shorter visits and flexibility with how schedules are managed can be positive drivers for patients and providers alike. Simple, skilled, empathic care moments are associated with shortened time spent in visits. Focusing on clients' strengths and resilience prevents providers from assuming more time and attention is needed when actually patients might benefit from confidence building that leads to independent resolution of problems. It's often the case that children and adolescents prefer 30-minute visits due to the cadence of their day and their attention span. See page 32 in this guide for more information on alternatives to the "50-minute hour".

**Key Considerations:**

We know high volume, fast pace work is correlated to providers burning out, so the system culture that includes autonomy and flexibility is key.

**Traditional Belief: Documentation takes 40-50% of the shift.**

**Alternative Perspective:** Documentation standards at FQHCs are purposely designed to be less cumbersome than those in specialty mental health to allow clinicians to spend more time addressing the needs of patients. Providers who come from other systems of care might bring those practices with them and may be closed off to learning new ways of thinking about documentation. This may show up as an insistence on a separate informed consent for BH services, an emphasis on including more information than necessary in the notes, and/or an assertion that BH notes need to be kept private from the medical record. All of these practices are rooted in a paradigm that is different from an integrated model and all are associated with a more time-intensive documentation workload.

**Key Considerations:**

Integration requires skills-training on how and what to document and how information is shared on interdisciplinary teams.

**Traditional Belief: The role of the clinician is limited to face-to-face visits.**

**Alternative Perspective:** Ideally, clinicians will take a comprehensive approach to applying several strategies that foster integration:

- Encouraging an open-door, flexible approach to youth, teachers, medical team members, and families
- Playing an active role in access solutions by ensuring there is always an open door for new visits so youth are never placed on a wait list
- Taking ownership and action when there is a cancellation or missed appointment and using that time to meet the needs of other youth
- Committing to billable visit targets with an understanding that fiscal sustainability is connected to meeting the needs of students
- The addition of telehealth visits, allowing clinicians to reach out by phone to those who may be waiting for an appointment

**Key Considerations:**

Leadership embodiment that models this and hiring for fit/match is helpful in fostering this type of cultural milieu.

## Low Productivity Due to Low Referrals

To sustain an ongoing flow of students, an ongoing referral stream is needed. A low volume of referrals may be a result of several factors. Youth may not be aware that they have access to behavioral health care, they may hold fear, stigma or other beliefs about behavioral health that contribute to low engagement, clinicians may not be a cultural fit for the student population, and/or the medical staff and school staff may not understand the service options or may carry their own perceptions and myths about behavioral health that prevent them making appropriate and robust referrals.

**Strategies to Address:**

- School integration is critical to maintaining a steady flow of student referrals. Clinicians and other SBHC staff should attend school staff meetings to explain the services offered, how school staff can refer students, and the benefits of behavioral health services for students. This should happen repeatedly over the course of each school year.

- SBHC staff can also attend school staff meetings and professional development sessions to be more integrated into the school staff community and be seen as part of the team.
- Youth Advisory Boards of students can serve as ambassadors and outreach workers, explaining SBHC services to their peers, and vouching for the confidentiality and accessibility of services.
- Clinicians should avoid jargon and use language and concepts that are accessible to youth and families. Diagnostic jargon is especially problematic and can increase the stigma associated with behavioral health care. For example, the word "stress" is more accessible than "anxiety". SBHC staff should appeal to student and school strengths rather than focusing on pathology concepts.
- Use a variety of outreach modalities. Announcements, presentations, flyers, videos, text blasts and social media presence are all useful ways to connect directly with youth or through school communication to students. Special events are also great ways to spread the word. Many SBHCs host events like wellness fairs or host tours during school registration or Back to School Night. Others make connections with student groups and Gay-Straight Alliances.
- Share examples. Use storytelling to champion examples of how behavioral health care has impacted young people in positive ways. Avoid stories that are overly focused on the clinician or the type of therapy and instead highlight the accessible human centered changes in areas that young people care about. (And always protect client confidentiality!)
- Actively address systemic racism and cultural mismatch. Name the disconnect if it's there and try to ensure that staff faces and voices that resonate with youth and families. Use student advisory structures to influence services, hiring, and outreach materials.
- Encourage "open access" so youth and staff are familiar with coming to see a behavioral health clinician whenever openings pop up.
- Offer regular messaging and workshops that promote human-centered behavioral health care so staff are aligned in an open access framework. One form of stigma is assuming only certain types of people will need or want therapy. Move from that "us and them" thinking to the collective "we".
- Establish robust automated referrals from screening.  Most SBHC use multiple screening tools at new patient visits and yearly intervals. These likely include PHQ-9 (depression), SBIRT (substance use), Pediatric Symptom Checklist (emotional, behavioral, cognitive difficulties), PEARLS (adverse childhood experiences), GAD-7 (anxiety), and others. When referrals to behavioral health are

standing orders for positives on any screening tool and when medical assistants and other staff are empowered to make these referrals, volume increases and youth needs are more apt to be met.

- Other outreach strategies might include regular drop-in hours for teachers to consult about youth, drop-in hours for parents to meet BH clinicians, and ad-hoc consultations with school staff and the medical team. If behavioral health clinicians are completing an average of 4-5 billable visits per day, these other activities happen throughout the week. Varying the day to day work to include outreach and connection to school staff generally supports clinician job satisfaction. (Note that it's important to consider student confidentiality concerns when scheduling school staff meetings/drop-in hours.)

## Low Productivity Due to Missed Appointments

Across care settings, the average missed appointment rate is 30% for behavioral health visits - although most clinics are reporting that this rate fell closer to 10% with the widespread shift to telehealth during the COVID pandemic. It is generally thought this is related to the ease with which patients access the appointments. It is important to consider the many barriers that can lead to missed appointments for both in-person and telehealth appointments. For example, ambivalence is common for many behavioral health clients and especially adolescents. Like adults, teens have competing priorities including peers, classes, tests and other activities. They may become immersed in these activities which can take priority over their BH appointment. Some of this ambivalence, distraction or time management can also be addressed directly in therapy.

Relying on referrals can be problematic - we want to see every child at the well child visit and every parent after a PEARLS screen, for example. But, this can also be done through active outreach to increase referrals.

**Strategies to Address:**

- Many SBHCs are experimenting with text reminders and other electronic methods for prompting higher show rates.
- One of the unique opportunities of being a school-based clinic is having your patient population in the same building or very close by. If a student misses an appointment, an SBHC staff member should be able to call their classroom and ask their teacher to remind them of their appointment (or text their phone directly if they are able to check their phone during class).

- Clinicians may know where to find their patient on campus and can walk to get them if the student is amenable.
- SBHC staff should be able to "juggle" the schedule to give another student that slot and reschedule the missed appointment.
- Change language from "no-show" to "schedule opening" or other similar terminology to indicate that this time is to be used for some other service provision. This re-framing encourages clinicians to be proactive in how they might use that time.
- Use a weekly rather than daily time tracking ratio to encourage more autonomy and increase the likelihood of successfully meeting visit targets. One way to do this is to set weekly billable visit targets and weekly ratios for documentation so that clinicians can flex their time when there are unexpected openings.
- Utilizing telehealth, a student may be available for a phone appointment even if they are not on campus for their in-person visit.

# OTHER FINANCING STRATEGIES

## Utilizing Unlicensed Clinicians (ASWs)

**How This Can Increase Revenue:**

Sustainable staffing models are typically focused on licensed clinicians. As of May 2020, the California Department of Health Care Services (DHCS) has allowed associate level social workers (ASWs) registered with the Board of Behavioral Sciences to bill for visits at the same PPS rate as licensed clinicians. While it is unknown whether this change will be sustained post-pandemic, many FQHCs have maximized access for behavioral health services by hiring ASWs during this time. ASW salaries are typically 30% lower than licensed BH clinicians and therefore they can help support higher net operating income and more support for the SBHC mission. There are significant workforce benefits to hiring ASWs as well, in that the FQHC can provide clinical supervision and professional development throughout their path to licensure and promote the clinician post-licensure, in a "growing our own" model.

In addition, ASW visits may also be covered by commercial (private) insurance plans for those SBHCs that serve these students and submit claims for their care.

**Why This is Good Clinical Practice:**

Using various levels of trained providers is a common practice in healthcare settings. Having a mix of licensed and unlicensed team members can foster a positive culture of learning, supervision, and collaboration. This strategy also increases the pool of viable clinicians that understand the SBHC model and can help support a more diverse and culturally congruent workforce given that licensed clinicians are more likely to be White and English-speaking than the larger pool of unlicensed social workers. Similarly, while it requires more supervision resources, offering an MSW internship program for students working towards their ASW is another effective way to invest in future SBHC behavioral health provider workforce. Many LCSWs find it rewarding to supervise MSW interns for their own professional development.

## Maximizing Telehealth Access

**How This Can Increase Revenue:**

California's recent approval of reimbursement for phone and video behavioral health services provides an important new pathway to achieve financial sustainability for behavioral health services. SBHCs can confidently pursue telehealth for children and youth knowing the service is highly utilized and valued by parents. Giving youth and families choice about how they would like to engage for their visit often decreases

missed appointments and when missed visits do occur, clinicians can utilize this time to call other patients who are at risk or need follow-up, engaging in sessions on the spot when patients indicate a willingness. See Appendix E for additional information.

**Why This is Good Clinical Practice:**

During the COVID pandemic, over half of primary care visits and 60% of behavioral health visits for Medi-Cal patients have been by phone.[29] 90% of all telehealth visits were audio-only telephone visits, dwarfing video visit numbers by far.[30] Data from a 2020 study by the Child Mind Institute[31] found that:

- An overwhelming number of parents sought help for their children via telehealth. Anxiety (40%) and depression (37%) are the most common reasons caregivers sought care for their children, with problem behavior (30%), ADHD (30%) and learning challenges (23%) also common.
- Talk therapy (49%) is the most common service parents have accessed or sought out through telehealth for their child, with psychiatric consultation at 32%.
- Parents in the survey who have used telehealth services for children report strongly positive responses. 86% said their child benefited, 84% said it was a positive experience for their child, 78% said they had seen significant improvement in their child, and 87% said they would recommend it to others.

Youth have also expressed a preference for behavioral health telehealth by attending sessions at a higher rate.

Early data from studying the telehealth transformation in 2020 demonstrated that those who have lower incomes and people of color were more apt to use telephone only visits.[32] Data from the 2020 Children's Mental Health Report: *Telehealth in an Increasingly Virtual World*[33] , shows that tele-mental health care:

- **is equally effective as in-person:** Cognitive Behavioral Therapy (CBT) telehealth treatment for youth has been shown to be as effective — and in some cases even more — as in-person treatment for reducing symptoms of anxiety, depression and obsessive-compulsive disorder (OCD). One 2020 study of trauma-focused

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[29] Uscher-Pines L, Sousa J, Jones M, et al. Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic. JAMA. 2021;325(11):1106–1107.

[30] Mehrotra A, Bhatia RS, Snoswell CL. Paying for Telemedicine After the Pandemic. JAMA. 2021;325(5):431–432.

[31] Child Mind Institute, Children's Mental Health Report

[32] Eberly LA, Kallan MJ, Julien HM, et al. Patient Characteristics Associated With Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic. JAMA Netw Open. 2020;3(12):e2031640.

[33] Child Mind Institute, Telehealth in an Increasingly Virtual World

CBT (TF-CBT) offered to underserved youth via one-on-one videoconferencing found that 88.6% completed the treatment and, of those, 96.8% no longer met criteria for a trauma-related disorder afterward.

- **has lasting results:** One randomized controlled trial of CBT for children ages 8 to 13 with anxiety showed that after treatment, 20% of children in the treatment group no longer met criteria for their primary diagnosis; after three months this number jumped to 50%. Another trial of telephone cognitive behavioral therapy for adolescents with OCD compared to standard clinic-based, face-to-face CBT found that the two treatments were equally effective through 12-month follow-up and had similarly high levels of patient satisfaction.
- **supports eating disorders being treated at home:** Teens with anorexia nervosa who received family-based treatment (FBT) via telehealth showed significant improvement on measures of weight, cognition, mood and self-esteem — both at the end of treatment and at six-month follow-up.
- **enhances ADHD treatment:** A preliminary feasibility study of parent-teen therapy for ADHD via synchronous videoconferencing reported high family satisfaction and reduction in symptoms and challenges around organization, time management and planning, as reported by parents and teachers. Therapists said that the telehealth format actually enhanced treatment for 50% of the families.

## Group Visits

**How This Can Increase Revenue:**

Only one PPS payment is allowed for group visits that include multiple Medi-Cal beneficiaries. BH clinicians can select one person from the group to submit a billing claim for. Scheduling brief checks-in before or after the group with different clients is often clinically warranted, and any visit lasting at least 16 minutes can be submitted for payment as an individual visit. This might include preparing a new member for the group, checking in with a patient who shared something significant after the group, and can help extend the benefit and revenue from groups. These check-ins need to include brief assessments on mood and functioning as well as evidence-based interventions to be billable. If this strategy is implemented, each group can generate several more billable visits in an efficient and powerful use of clinician time.

**Why this is Good Clinical Practice:**

Group therapy has been found to be as effective as individual therapy and in some cases, the peer connection can increase engagement and retention in treatment. Because peers are so critical to adolescent social and self development, group therapy can be especially effective with teens and young adults. It also exerts a normalizing influence on students' view of mental health services generally. Offering groups can be a rewarding practice

for clinicians facing burnout with high individual caseloads. SBHC support staff can help organize and coordinate groups to share responsibilities and foster greater teamwork.

## Leveraging ACEs/PEARLs Payments to Primary Care Providers

**How This Can Increase Revenue:**

In December 2019, California approved a $29 incentive payment for all ACEs and PEARLS screening completed.[34] For those under 18, the recommendation is to screen using the PEARLS yearly. Providers can be paid for one per client per year, and screening is often conducted during primary care visits. This represents a new, additional payment that can go toward sustaining behavioral health services. If an SBHC screens every child and adolescent in the practice every year, even small clinics can generate over $10,000 a year.

If 300 youth are screened with PEARLs in one year, usually during wellness exams, $10,000 in revenue would be generated.

More information can be found on the ACEs Aware website: **https://www.acesaware.org/** and the APL can be found in Appendix F.

**Why This is Good Clinical Practice:**

Screening early and often for adverse childhood experiences is associated with better health outcomes later in life. Without screening, behavioral health clinicians may miss trauma histories, ongoing micro-traumas, and signs and symptoms may go undetected. This can also cause clinicians to treat disorders without understanding their etiology or source. We know that trauma is not only associated with social, emotional and cognitive problems, it is also associated with many negative physical health difficulties. Addressing trauma early allows adults to help youth increase their resilience and protective factors.

[34] Department of Health Care Services, Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services

## New Family Therapy Benefit

**How this Can Increase Revenue:**

Family therapy is now a reimbursable Medi-Cal service, even when the identified child does not meet a mental health diagnosis. See **this** Family Therapy Benefit Information for more information. This benefit allows BH clinicians wider freedom in engaging families for prevention and early intervention services. For example:

- BH clinicians can call families during down time or during missed appointments; virtually any skillful "check-in" that elicits family input and provides psychoeducation is billable.
- BH clinicians can see children and youth alone, then see a child and parent, caregiver or other family member together, and bill two separate sessions if this is clinically appropriate.

**Why this is Good Clinical Practice:**

Involving family in the treatment of youth is key to understanding many dynamics problems comprehensively and is also key to supporting and sustaining improvements and change. If the child or adolescent receives therapy to address their struggles, but those struggles are exacerbated at home, the likelihood that they will be able to benefit from therapy is reduced. Additionally, the health and well-being of families is foundational to healthy communities.

There are times when involving family is not indicated. If the well-being of the youth is not supported, they are at least 12 years old, and able to engage in treatment independently, the treatment plan can include privilege with confidentiality being held between the student and the clinician.

## Guidelines

**Basics:**

- 26-minute minimum time
- CPT code: 90846 for family therapy without patient present
- CPT code: 90847 for family therapy with patient present
- ONLY LCSW can bill at PPS rate; no exceptions for ASW during public health emergency
- Children under the age of 21
- 5 sessions allowable without any risk factors present use: ICD 10 code F99
- More than 5 sessions with documented risk factors use: ICD 10 code Z65.9

**Risk factors for the child include:**

- Separation from a parent/guardian due to incarceration or immigration
- Death of a parent/guardian
- Foster home placement
- Food insecurity, housing instability
- Exposure to domestic violence or traumatic events
- Maltreatment
- Severe or persistent bullying
- Experience of discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences or
- Disability

**OR child has a parent/guardian with one of the risk factors below:**

- Serious illness or disability
- History of incarceration
- Depression or other mood disorder
- PTSD or other anxiety disorder
- Psychotic disorder under treatment
- Substance use disorder
- History of intimate partner or interpersonal violence
- Is a teen parent

**Some examples of evidence-based family therapy are:**

- Child-Parent Psychotherapy (ages 0 thru 5)
- Triple P Positive Parenting Program (ages 0 thru 16)
- Parent Child Interactive Therapy (ages 2 thru 12)

# GOING FORWARD

The need for qualified behavioral health clinicians and paraprofessionals to provide empathic, skilled behavioral health care to children and teens in schools has never been greater. The role of school-based health centers run by FQHCs in this arena is valuable and growing, and a well-constructed program should be able to cover its costs without compromising quality or comprehensiveness. Behavioral health can and should be at the cornerstone of a strong and well-resourced SBHC!

We hope this guide provides some resources and support for those engaged in this critical effort. Please reach out to us if you have any questions or ideas for improvement or future guides. Thank you for your commitment to California youth and keep up the amazing work!

# APPENDICES

## Appendix A: LA Trust School Health Integration Measure Tool

| School Health Integration Measure | | | | | | |
|---|---|---|---|---|---|---|
| | 1. Health authority | Never (0%) | Sometimes (1-33%) | Often (34-66%) | Frequently (67-99%) | Always (100%) |
| 1a. | SBHC contributes subject matter expertise on school wellness policies and health-related programs and services (nutrition, physical activity, safety, discipline) that support student well-being. | | | | | |
| 1b. | SBHC actively promotes campus-wide policies and practices that assure a safe and healthy school environment for all students and staff, including participation in school's crisis prevention and intervention plans. | | | | | |
| | 2. Integrated programming | | | | | |
| 2a. | A specific protocol exists for the SBHC to refer students for academic support in the school. | | | | | |
| 2b. | A specific protocol exists for the school to refer students for health support in the SBHC. | | | | | |
| 2c. | SBHC conducts schoolwide health campaigns or events. | | | | | |
| | 3. Marketing and recruitment | | | | | |
| 3a. | SBHC conducts active outreach in the school or community to inform **students** about the services it provides. | | | | | |
| 3b. | SBHC conducts active outreach in the school or community to inform **school staff** about the services it provides. | | | | | |
| 3c. | SBHC conducts active outreach in the school or community to inform **families** about the services it provides. | | | | | |
| 3d. | SBHC successfully enrolls students in services who are identified in school population screens. | | | | | |
| | 4. Shared outcomes | | | | | |
| 4a. | SBHC and school regularly and actively exchange information about aggregate student well-being and outcomes. | | | | | |
| | 5. Staff Collaboration | | | | | |
| 5a. | SBHC and school staff spend time together collaborating on student support. | | | | | |
| 5b. | SBHC has a formalized understanding of how it collaborates with school administration, teachers, and support staff—school nurses, psychologists, and counselors—to ensure the partnership meets student needs efficiently, effectively, and seamlessly. | | | | | |
| | | | | | | |

# Appendix B: ASW Eligible for Billing

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
*DIRECTOR*

GAVIN NEWSOM
*GOVERNOR*

**Associate Clinical Social Worker and Associate Marriage and Family Therapist Services for Federally Qualified Health Centers and Rural Health Clinics**

**May 20, 2020**

The Department of Health Care Services (DHCS) continues to closely monitor the 2019 Novel Coronavirus (COVID-19) situation and provide updates and guidance to Medi-Cal providers related to amended Medi-Cal services or reimbursement policy. To that end, effective immediately, the following temporary new policy is instituted:

**Temporarily adds the services of Associate Clinical Social Worker (ACSW) and Associate Marriage and Family Therapist (AMFT) at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as a billable visit.**

Note: The Calfornia Board of Behavioral Sciences (BBS) does not consider ACSWs or AMFTs as licensed practitioners. Therefore, licensed behavioral health practitioners must supervise and assume the professional liability of services furnished by the unlicensed ACSW and AMFT practitioners. The licensed practitioner must also comply with supervision requirements established by the BBS.

Pursuant to the federally approved State Plan Amendment (SPA) 20-0024, a FQHC or RHC can be reimbursed at the Prospective Payment System (PPS) rate for a visit between a FQHC or RHC patient and an ACSW or AMFT. The visit may be conducted as a face to face encounter or meet the requirements of a face to visit provided via telehealth.

**Payment for ACSW or AMFT Services**

- ACSW or AMFT services that meet visit criteria and are provided on, or after March 1, 2020 are eligible for reimbursement at the PPS rate.
- Services are billed under the licensed billable behavioral practitioner of the FQHC or RHC.
- These services are billed utilizing existing claiming processes that includes billing managed care plans first, followed by billing DHCS for the PPS rate wrap payment. Note that the services are billed using the appropriate behavioral health billing code set.

Please see the Federally Qualified Health Centers/Rural Health Medi-Cal Provider Manual

This temporary change will remain in effect through the end of the public heatlh emergency including any extensions.

Primary, Rural, and Indian Health Division
1500 Capitol Avenue, MS 8502
P.O. Box 997413, Sacramento, CA 95899-7413
(916) 440-5770 phone, (916) 440-5779 fax
Internet Address: www.dhcs.ca.gov

## Appendix C: FQHC Billing for MFTs

Until recently, services provided by MFTs within FQHCs were not eligible for reimbursement under an FQHC's PPS rate structure. Starting in 2018, MFTs became approved as billable FQHC providers in California. The Department of Health Care Services (DHCS) is expected to release guidance soon that contains guidelines for licensed FQHC sites to submit a mandatory change in scope of services request (CSOSR) that is required when billing for MFTs.

If they have not done so already, FQHCs should evaluate whether it would be beneficial to submit a CSOSR to allow them to receive PPS reimbursement for MFT visits at their SBHC or other sites. In general, this may be worthwhile if MFTs do or may constitute a sizable proportion of total visits, and assuming the site's overall cost per visit has not declined since PPS rate-setting or the last change in scope.

This evaluation is complex and will include many factors, among them:

- If an SBHC is operated as an intermittent site of a host or parent clinic, then the CSOSR needs to be completed and submitted on behalf of the parent/host site and will impact that site and all its intermittent linked sites.
- Similarly, the analysis should be done on behalf of the entire set of services included in the clinic(s) - medical services, behavioral health services, and any other linked services such as dental or ancillary.
- If a clinic submits a change of scope request and DHCS finds that the cost per visit has actually declined, there will not be an opportunity to withdraw the request.
- The scope change request should be based on total costs and visits for the fiscal year, and not some sub-portion.
- DHCS scrutinizes and audits these requests carefully, so expect to have some cost disallowances and possible visit imputations if medical provider visits fall below standard productivity rates. (There are not yet productivity standards for MFTs or other behavioral health providers.) Documentation of all related direct and indirect costs is critical to this process, as is documentation to support PPS visits (e.g., through EHR or other patient records).
- A variety of costs may be adjusted or disallowed in the final calculation - including community services, travel expenses, excess executive compensation, depreciation, lease costs, legal costs, marketing and "excess space." In general, experts recommend not submitting a CSOSR unless the cost per visit has increased by at least 15-20% given possible adjustments and the methodology DHCS uses.

Remember that MFTs can continue to see patients regardless, and be included in total costs of that clinic in any future rate-setting, but their visits are not considered FQHC PPS visits, and claims are not eligible for PPS reimbursement until the clinic completes a CSOSR.

A few additional notes:

- This process is separate from a federal Change in Scope request but should be consistent with the FQHC's federal (HRSA) Scope of Project and Services.
- The CSOSR must be submitted within 150 days after the end of the fiscal year when the FQHC began billing for MFT services.
- Even if an FQHC does not obtain authorization to include MFT visits in its scope, it can bill these claims to Medi-Cal managed care plans and other entities. However, it should be noted that revenue received from Medi-Cal plans will be subject to the reconciliation process and therefore this may not be financially advantageous.

If it appears that submitting a scope change for MFT billing is advantageous to the organization, the process begins with submitting Form DHCS 3096. The entire process typically takes between 6 months and 2 years.

For more information, FQHCs can contact CPCA, WIPFLI or view the DHCS website **here**.

# Appendix D: Billing Out of Network Patients

TOBY DOUGLAS
*DIRECTOR*

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
*GOVERNOR*

June 3, 2013

Ginger Smith, Director
Health Center Operations
California Primary Care Association
1231 I Street, Suite 400
Sacramento, CA 95814

Dear Ms. Smith:

During recent meetings with the California Primary Care Association (CPCA), the issue of "out of network" Medi-Cal managed care beneficiaries receiving services at Federally Qualified Health Centers (FQHCs) was discussed. The discussion centered on the increasing frequency of "out of network" visits at FQHCs relating to Medi-Cal beneficiaries. In these instances, CPCA wants assurance that the visits will be fully reimbursed by the Department of Health Care Services (DHCS) as part of the Code 18, Code 19, and Code 20 reconciliation process.

Our current process is, Audits and Investigations (A&I) counts "out of network" visits as reimbursable at the Prosective Payment Systems (PPS) rate established for each clinic, subject to offset of managed care payments (paid at the managed care plan's out of network rates) received by the clinics. Proof of payment from the managed care plans showing that "out of network" services were billed to and subsequently paid or denied by the managed care plans shall be maintained by the clinics. Further, proof of payment from the managed care plans is subject to review by A&I during the Code 18, Code 19, and Code 20 reconciliation process.

Audits and Investigations
PO Box 997413, MS 2000, Sacramento, CA 95899-7413
Telephone Number (916) 440-7552 – FAX Number (916) 440-7555
Internet Address: www.dhcs.ca.gov

In addition to the above documentation, since Medi-cal beneficiaries in managed care plans are required to be seen by "in network providers" except in emergency or other isolated instances (e.g. on vacation), we ask that clinics document that they reminded the Medi-Cal beneficiary of this situation, and redirect the beneficiary back to an "in network provider" to receive services or have the beneficiary request to change networks.

Sincerely,

Bruce Lim
Deputy Director

cc: Karen Johnson
Chief Deputy Director
Department of Health Care Services
P.O. Box 997413-MS 0000
Sacramento, CA 95899-7413

William L. Alameda
Assistant Deputy Director
Audits and Investigations
P.O. Box 997413-MS 2000
Sacramento, CA 95899-7413

Jeff Sandman, Chief
Financial Audits Branch
P.O. Box 997413
Sacramento, CA 95899-7413

Deborah Ortiz, Vice President
Governmental Affairs
California Primary Care Association
1231 I Street, Suite 400
Sacramento, CA 95814

# Appendix E: Telehealth

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
*DIRECTOR*

GAVIN NEWSOM
*GOVERNOR*

**DATE:** March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS

**SUBJECT:** EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

**PURPOSE:**
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

**REQUIREMENTS:**
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
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State of California—Health and Human Services Agency
Department of Health Care Services

RICHARD FIGUEROA
*ACTING DIRECTOR*

GAVIN NEWSOM
*GOVERNOR*

**DATE:** December 26, 2019

ALL PLAN LETTER 19-018

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

**SUBJECT:** PROPOSITION 56 DIRECTED PAYMENTS FOR ADVERSE CHILDHOOD EXPERIENCES SCREENING SERVICES

**PURPOSE:**
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of standardized Adverse Childhood Experiences (ACEs) screening services for adults (through 64 years of age) and children.

**BACKGROUND:**
On November 8, 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and other tobacco products. Under Proposition 56, a portion of the tobacco tax revenue is allocated to the California Department of Health Care Services (DHCS) for use as the nonfederal share of health care expenditures in accordance with the annual state budget process.

Assembly Bill (AB) 74 (Ting, Chapter 23, Statutes of 2019), Section 2, Item 4620-101-3305 appropriates Proposition 56 funding to support clinically appropriate trauma screenings for children and adults with full-scope Medi-Cal coverage as well as Provider training for trauma screenings, which DHCS is implementing in the form of a directed payment arrangement.[2] On June 30, 2019, DHCS requested approval from the federal Centers for Medicare & Medicaid Services (CMS) for this directed payment arrangement in accordance with Title 42 of the Code of Federal Regulations (CFR), Section 438.6(c)(2).[3] Subject to future budgetary authorization and appropriation by the California Legislature and the necessary federal approvals of the directed payment arrangement, DHCS intends to renew this directed payment arrangement on an annual

[1] This APL does not apply to Prepaid Ambulatory Health Plans or Rady Children's Hospital.
[2] AB 74 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB74.
[3] Part 438 of the CFR can be accessed at: https://www.ecfr.gov/cgi-bin/text-idx?SID=c131f365759360ca3555585f2b6a1b6e&mc=true&node=pt42.4.438&rgn=div5.

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basis for the duration of the program. The requirements of this APL may change if required for CMS approvals applicable to this directed payment arrangement.

AB 340 (Arambula, Chapter 700, Statutes of 2017)[4] required DHCS, in consultation with the California Department of Social Services and others, to convene an advisory working group to update, amend, or develop, if appropriate, tools and protocols for screening children for trauma as defined within the Early and Periodic Screening, Diagnostic, and Treatment benefit. The workgroup reported its findings and recommendations to DHCS and the legislative budget subcommittees on health and human services for consideration.[5]

An ACEs screening evaluates children and adults for trauma that occurred during the first 18 years of life. The ACEs questionnaire[6] for adults (ages 18 years and older) and Pediatric ACEs and Related Life-events Screener (PEARLS) tools for children (ages 0 to 19 years) are both forms of ACEs screening.[7] Both the ACEs questionnaire and the PEARLS tool are acceptable for use for Members aged 18 or 19 years. The ACEs screening portion (Part 1) of the PEARLS tool is also valid for use to conduct ACEs screenings among adults ages 20 years and older. If an alternative version of the ACEs questionnaire for adults is used, it must contain questions on the 10 original categories of ACEs to qualify.[8]

DHCS will provide and/or authorize ACEs-oriented trauma-informed care training for Providers and their ancillary office staff. DHCS must approve or authorize any other trauma-informed care training that is not provided by DHCS. The training will be available in person, including regional convenings, and online. The training will include general training about trauma-informed care, as well as specific training on use of the ACEs questionnaire and PEARLS tool. It will also include training on ACEs Screening Clinical Algorithms to help Providers assess patient risk of toxic stress physiology and how to incorporate ACEs screening results into clinical care and follow-up plans. More information about training is available on https://www.acesaware.org/.

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[4] AB 340 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB340.
[5] The advisory workgroup's findings and recommendations are available at: https://www.dhcs.ca.gov/provgovpart/Documents/AB340Recommendations.pdf.
[6] The ACEs questionnaire was derived from the 1998 ACE study, which can be found at: https://www.ajpmonline.org/article/S0749-3797(98)00017-8/pdf.
[7] The ACEs questionnaire and the PEARLS tool are available at the following link: https://www.acesaware.org/screen/screening-for-adverse-childhood-experiences/.
[8] The 10 original ACE categories are: abuse—physical, emotional, and sexual; neglect—physical and emotional; and household dysfunction—parental incarceration, mental illness, substance dependence, separation or divorce, and intimate partner violence.

DHCS will establish a website for Providers to self-attest to their one-time completion of the state-sponsored trauma-informed care training. DHCS will maintain a list of Providers who have self-attested to their completion of the training. MCPs will have access to the list. Beginning July 1, 2020, Network Providers must attest to completing certified ACEs training on the DHCS website to continue receiving directed payments.

On January 17, 2019, DHCS issued APL 19-001, "Medi-Cal Managed Care Health Plan Guidance on Network Provider Status," which describes how DHCS evaluates Network Provider status and establishes requirements that must be satisfied in order for Network Providers to be eligible for directed payments.[9]

**POLICY:**
Subject to obtaining the necessary federal approvals, DHCS is requiring MCPs, either directly or through their delegated entities and Subcontractors, to comply with a minimum fee schedule of $29.00 for each qualifying ACEs screening service (as defined below) by a Network Provider with dates of service on or after January 1, 2020, in accordance with the CMS-approved preprint, which will be made available on the DHCS Directed Payments Program website upon CMS approval.[10] Network Providers must receive at least the amounts specified in the table below from the MCP, or the MCP's delegated entities and Subcontractors, for each qualifying ACEs screening service.

A qualifying ACEs screening service is one provided by a Network Provider through the use of either the PEARLS tool or a qualifying ACEs questionnaire to a Member enrolled in the MCP who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D). To qualify, the ACEs questionnaire must include questions on the 10 original categories of ACEs.[11] Providers may utilize either an ACEs questionnaire or the PEARLS tool for Members 18 or 19 years of age; the ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adults ages 20 years and older. MCPs are responsible for ensuring that qualifying ACEs screening services are reported to DHCS in encounter data in accordance with APL 14-019, "Encounter Data Submission Requirements," using Healthcare Common Procedure Coding System (HCPCS) codes G9919 or G9920. MCPs are responsible for ensuring that the encounter data reported to DHCS is appropriate for the services being provided, and that HCPCS codes G9919 and G9920

[9] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[10] DHCS' Directed Payments Program website is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.
[11] The 10 original ACE categories are: abuse—physical, emotional, and sexual; neglect—physical and emotional; and household dysfunction—parental incarceration, mental illness, substance dependence, separation or divorce, and intimate partner violence.

are not reported for non-qualifying ACEs screening services or for any other services. Providers must calculate the score for the billing codes using the questions on the 10 original categories of ACEs.

| HCPCS Code | Description | Directed Payment | Notes |
|---|---|---|---|
| G9919 | Screening performed – results positive and provision of recommendations provided | $29.00 | Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk). |
| G9920 | Screening performed – results negative | $29.00 | Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk). |

Providers may screen Members utilizing a qualifying ACEs questionnaire or PEARLS tool as often as deemed appropriate and medically necessary. However, each MCP is only required to make the $29.00 required minimum payment to a particular Network Provider once per year per Member screened by that Provider, for a child Member assessed using the PEARLS tool, and once per lifetime per Member screened by that Provider, for an adult Member (through age 64) assessed using a qualifying ACEs questionnaire.

To be eligible for the directed payment, the Network Provider must meet the following criteria:

1. The Network Provider must utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;
2. The Network Provider must bill using one of the HCPCS codes in the table above based on the screening score from the PEARLS tool or ACEs questionnaire used; and
3. The Network Provider that rendered the screening must be on DHCS' list of Providers that have completed the state-sponsored trauma-informed care training. The training requirement will be waived for dates of service prior to July 1, 2020. However, commencing July 1, 2020, Network Providers must have taken a certified training and self-attested to completing the training to receive the directed payment for ACEs screenings.

Providers must document all of the following: the tool that was used; that the completed screen was reviewed; the results of the screen; the interpretation of results; what was discussed with the Member and/or family; and any appropriate actions taken. This documentation must remain in the Member's medical record and be available upon request.

**Data Reporting**

Starting with the calendar quarter ending June 30, 2020, MCPs must report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to this APL, either directly by the MCP or by the MCP's delegated entities and Subcontractors. Reports must include all directed payments made for dates of service on or after January 1, 2020. MCPs must provide these reports in a format specified by DHCS, which, at a minimum, must include the Health Care Plan code, HCPCS code, service month, payor (i.e. MCP, delegated entity, or Subcontractor), and the Network Provider's National Provider Identifier. DHCS may require additional data as deemed necessary. All reports must be submitted in a consumable file format (i.e. Excel or Comma Separated Values) to the MCP's Managed Care Operations Division (MCOD) Contract Manager.

Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, MCPs must submit an attestation to DHCS stating that no updated information is available. If updated information is available for the quarterly report, MCPs must submit the updated quarterly report in the appropriate file format and include an attestation that the MCP considers the report complete.

MCPs must submit encounter data for HCPCS codes G9919 and G9920, as required by DHCS.

**Payment and Other Financial Provisions**

MCPs must ensure the payments required by this APL are made within 90 calendar days of receiving a clean claim[12] or accepted encounter for a qualifying ACEs screening service, for which the clean claim or accepted encounter is received by the MCP no later than one year after the date of service. MCPs are not required to make the payments described in this APL for clean claims or accepted encounters for qualifying ACEs screening services received by the MCP more than one year after the date of service. These timing requirements may be waived only through an agreement in writing

[12] A "clean claim" is defined in 42 CFR 447.45(b). 42 CFR Part 447 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=605e8561a83bfced0a6ea61f9d7b4e20&mc=true&node=pt42.4.447&rgn=div5.

between the MCP (or the MCP's delegated entities or Subcontractors) and the Network Provider.

As required by the MCP contract for other payments, MCPs must have a formal procedure for the acceptance, acknowledgment, and resolution of Provider grievances related to the processing or non-payment of a directed payment required by this APL. In addition, MCPs must have a process to communicate the requirements of this APL to Network Providers. This communication must, at a minimum, include a description of the minimum requirements for a qualifying screening, how payments will be processed, how to file a grievance, and how to determine who the payor will be.

Subject to obtaining the necessary federal approvals, the projected value of the directed payments will be accounted for in each MCP's actuarially certified, risk-based capitation rates. The portion of capitation payments to the MCP attributable to this directed payment arrangement will be subject to a two-sided risk corridor. DHCS will perform the risk corridor calculation retrospectively and in accordance with the CMS-approved preprint, which will be made available on the DHCS Directed Payments Program website upon CMS approval. The parameters and reporting requirements of the risk corridor calculation will be specified by DHCS in a future revision of this APL or other similar future guidance.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and Subcontractors.

Subject to future budgetary authorization and appropriation by the California Legislature and CMS approval of the directed payment arrangement, DHCS intends to renew this directed payment arrangement on an annual basis in future years. Please note that the requirements of this APL may change if required for CMS approvals applicable to this directed payment arrangement or as required in future budgetary authorization and appropriation by the California Legislature.

If you have any questions regarding this APL, please contact your MCOD Contract Manager and Capitated Rates Development Division Rate Liaison.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

WILL LIGHTBOURNE
*DIRECTOR*

State of California—Health and Human Services Agency
Department of Health Care Services

GAVIN NEWSOM
*GOVERNOR*

DATE: June 24, 2021

Medi-Cal Eligibility Division Information Letter No.: 21-09

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

SUBJECT: CONTINUING TELEPHONIC FLEXIBILITIES FOR THE MINOR CONSENT PROGRAM BEYOND THE COVID-19 PUBLIC HEALTH EMERGENCY

The purpose of this Medi-Cal Eligibility Division Information Letter (MEDIL) is to provide information to counties on ongoing changes being made to the Minor Consent program to allow for telephonic interviews and appointments beyond the flexibilities resulting from the COVID-19 Public Health Emergency (PHE).

BACKGROUND

California Family Code provides that a minor may, without parental consent, receive services related to sexual assault, pregnancy and pregnancy-related services, family planning, sexually transmitted diseases, drug and alcohol abuse, and outpatient mental health treatment and counseling.

Minor consent services are categorized by age as follows:

UNDER AGE 12:

- pregnancy and pregnancy-related care
- family planning services
- sexual assault services

AGE 12 YEARS AND OLDER:

- sexually transmitted diseases treatment
- drug and alcohol abuse treatment/counseling
- mental health outpatient care
- pregnancy and pregnancy-related care
- family planning services
- sexual assault services

Medi-Cal Eligibility Division
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The above-named services which a minor may receive on his/her own are referred to as "'minor consent services."

Prior to the PHE, counties were instructed to only accept Minor Consent applications or renewals from minors in person. However, at the onset of the PHE, DHCS modified this policy and instruction to counties. To prevent and mitigate the effects of the COVID-19 pandemic, counties were instructed to follow guidance provided in ACWDL 19-17 to conduct telephonic interviews/appointments in situations that usually require an applicant or beneficiary to visit the county office for services, including the Minor Consent program. Forms that would usually require a wet signature to be valid, could be completed and signed via telephonic signature for the duration of the PHE.

Given the effectiveness of this change in policy throughout the PHE, DHCS has adopted this change ongoing to allow minors to apply and/or renew eligibility for the Minor Consent program either in-person or by telephone. Counties shall continue to accept applications, renewals, and reported changes in information over the telephone for the Minor Consent program beyond the PHE.

IMPORTANT REMINDER REGARDING CONFIDENTIALITY OF MINOR CONSENT

All minor consent cases are confidential and parents are not to be contacted regarding their child's receipt of the requested services. A minor must apply for minor consent services. Parent(s) may not apply on behalf of their minor child. Whether applying or renewing eligibility for the Minor Consent program in person or over the phone, contact shall ONLY be directed to the minor applying for or renewing services, and the confidentiality requirement shall not be waived under any circumstance. Notices of Action (NOAs) or paper BIC cards shall not be sent to the home address, to preserve the confidentiality of the minor's case.

POLICY NEXT STEPS

DHCS will be updating Medi-Cal Eligibility Procedures Manual, Article 4V, to reflect this modification to the Minor Consent program policy. DHCS will also provide further guidance to counties as needed in a subsequent policy letter.

For additional information on the Minor Consent program, please contact Lucy Hall, by phone at (916) 345-8088 or by email at Lucy.Hall@dhcs.ca.gov.

Original Signed By
Sandra Williams, Chief Medi-Cal Eligibility Division