



Foster Youth Access to Medi-Cal Specialty Mental Health Services:

A Review of Policies, Procedures, and Beneficiary-Facing Materials in the California Counties with the Largest Foster Care Populations

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Executive Summary

Children and youth involved in child welfare have complex mental health needs, due in part to their compounding experiences with trauma and often inadequate access to appropriate services. In California, the State’s Medicaid program (Medi-Cal) provides a critical safety net for foster children and youth. In Medi-Cal, County Mental Health Plans (MHPs) provide Specialty Mental Health Services (SMHS) to beneficiaries with intensive mental health needs.

This report series examines the extent to which foster children and youth in California have meaningful access to Medi-Cal SMHS. Our research focuses on the policies and practices of the five California counties with the largest foster youth populations: Los Angeles, San Bernardino, Riverside, Fresno, and Orange. Our research is presented in three parts: (1) a review of county policies, procedures, and beneficiary-facing materials; (2) a review of the available data in California and the counties; and (3) results from qualitative research studies in the five counties, including a survey of providers and advocates as well as test calls to each county’s 24/7 mental health access line.

Taken together, this research seeks to provide a multifaceted picture of foster youth access to Medi-Cal SMHS on the ground. Our analyses suggest that many children and youth are not receiving the services they need to address their mental health conditions and to which they are entitled. In our reports, we make a number of recommendations for improving access to SMHS for foster children and youth, including enhancing State oversight of the counties, implementing greater data transparency, and improving education and training for county staff and providers.

This research was made possible in part through the support of the [Conrad N. Hilton Foundation](#).

Table of Contents

Introduction	4
Purpose and Goals.....	4
Methodology	5
Limitations.....	6
 Findings and Analysis.....	 8
1. Specialty Mental Health Services and Access Criteria.....	8
A. Scope of Services.....	8
B. Access Criteria.....	8
C. Screening for EPSDT SMHS.....	10
D. Prior Authorization.....	11
2. Timely Access and 24/7 Access Lines.....	12
3. Provider Choice and Care Coordination.....	13
4. Due Process Rights.....	13
 Conclusion and Recommendations	 15

Introduction

Purpose and Goals

Children and youth in California are experiencing an escalating mental health crisis. This is especially true for youth involved in child welfare, who have unique health care needs due to their complex histories of trauma and often inadequate access to appropriate services prior to entering foster care. Once in care, difficulties with navigating multiple social service and health care delivery systems, and continuity of care disruptions caused by placement instabilities, can serve to further compound barriers to accessing the mental health care services that they need.

Most foster youth are eligible for California's Medicaid program, Medi-Cal, which provides a critical safety net to youth who otherwise cannot access mental health care services. In Medi-Cal, County Mental Health Plans (MHPs) are responsible for providing Specialty Mental Health Services (SMHS) to beneficiaries.¹ SMHS include a variety of mental health services, including crisis services, rehabilitation services, psychotherapy, medication support, case management services, and peer support services.² Medi-Cal beneficiaries under the age of 21 are entitled to additional services under Medicaid's "Early and Periodic Screening, Diagnosis, and Treatment" (EPSDT) benefit, which is sometimes referred to as "Medi-Cal for Kids & Teens" in California.³ For example, in addition to the SMHS that are available to Medi-Cal beneficiaries of all ages, beneficiaries under age 21 are entitled to intensive care coordination (ICC), intensive home based services (IHBS), therapeutic foster care (TFC), and therapeutic behavioral services (TBS) that they need to correct or ameliorate a behavioral health condition.⁴ MHPs must provide beneficiaries up-to-date and accurate information about SMHS, including through a comprehensive MHP Beneficiary Handbook.⁵

Effective January 2022, California updated and expanded the criteria for access to Medi-Cal SMHS, making it easier for foster children and youth to access services.⁶ Notably, under the new SMHS criteria, the State made clear that youth do not need a diagnosis to access care and that "involvement in the child welfare system" is enough, in itself, to access services.⁷ This policy reform was one part of a broader state initiative called California Advancing and Innovating Medi-Cal (CalAIM), which seeks to promote a more equitable,

coordinated, and person-centered approach to health care, including behavioral health care.⁸

This report is one part of a three-part series examining the extent to which foster children and youth in California have access to Medi-Cal SMHS.⁹ The State's expansion of the SMHS access criteria was an important first step. However, state policy reform does not by itself result in meaningful change on the ground. It is important to examine the implementation of this policy change at every level – from the counties to providers to beneficiaries.

As a first step in this research, we examined the counties' written policies, procedures, and beneficiary-facing materials to determine the extent to which they have adopted the expanded SMHS access criteria, as well as other beneficiary legal protections that are critical to ensuring access, into their county-level documents.¹⁰ While the California Department of Health Care Services (DHCS) does conduct and publish oversight reviews of each county MHP to determine their compliance with federal and state law, these reviews are currently only conducted once every three years.¹¹ In consideration that significant mental health policy reform has outpaced DHCS's Triennial Reviews,¹² and in recognition of the urgency¹² of ensuring that children and youth involved in child welfare have access to services as soon as possible, we undertook this independent and more timely review. In this report, we summarize the results of our document review, analyze our findings, and make recommendations for improving access to SMHS for foster youth.

Methodology

For this research, we examined the written policies, procedures, and beneficiary-facing materials in five counties in California: Los Angeles, San Bernardino, Riverside, Fresno, and Orange.¹³ These five counties were selected because they had the largest foster care populations in July 2022.¹⁴

Our research focused on two primary categories of documents:

1. Written policies, procedures, manuals, or other documents concerning information on, availability of, and access to Medi-Cal Specialty Mental Health Services for foster youth and former foster youth; and
2. Beneficiary handbooks, brochures, flyers, notices, letters, or other documents provided to foster youth or former foster youth, or their caregivers or placement providers, concerning access to Medi-Cal Specialty Mental Health Services.

We obtained these written policies, procedures, and beneficiary-facing materials through a review of publicly available documents on each of the counties' websites.¹⁵ Additionally, we sent California Public Records Act (PRA)¹⁶

requests to San Bernardino, Riverside, Fresno, and Orange counties, requesting any and all documents matching the above descriptions. We did not send a PRA request to Los Angeles County because sufficient documentation was publicly available. All documents and materials were obtained in Fall 2022, except for the MHP Beneficiary Handbooks, which underwent an update in March 2023 and were re-reviewed at that time. In total, we reviewed over 600 multi-page documents from the five counties.

Substantively, our research examined the extent to which the counties have implemented relevant federal and state law related to the expanded SMHS access criteria, as well as other beneficiary legal rights and protections important to ensuring SMHS access, into their written policies, procedures, and beneficiary-facing materials. The scope of our review can be categorized into four primary categories: (1) Specialty Mental Health Services and Access Criteria, (2) Timely Access and 24/7 Access Lines, (3) Provider Choice and Care Coordination, and (4) Due Process Rights.

Limitations

Our research had limitations. First, we only had access to the documents that the counties made publicly available online or sent us pursuant to our PRA requests. While we combed through each of the five counties' and their relevant departments' websites, it is possible that we missed documents, particularly those that are not mapped to the website or otherwise linked to. Additionally, while, in theory, the counties were legally required to send us all documents responsive to our PRA (subject to a few narrow exceptions), in practice, there is room for human error in the processing of the request, especially when considering the legally imposed time limits on the counties' responses. We strived to be as clear and comprehensive as possible in our requests, however, the county has some discretion in how they interpreted them and what materials they deemed responsive. Because of this, there is a potential for selection bias.

Second, our document review only captures a point in time. The written county policies, procedures, and beneficiary-facing materials we analyzed were obtained in Fall 2022. Additionally, we analyzed the updated MHP Beneficiary Handbooks, which were published in March 2023. We acknowledge that any further county updates, particularly those outside the scope of the Handbooks, are not captured in this research.

Finally, it is difficult to draw conclusions from a review of written documents and materials. As with state policy reform, county policy reform is only one piece of a broader picture. It does not equate to proper implementation on the ground. It is an indication that the county has knowledge of the State policy

and is moving to implement it, however, it is not evidence, in itself, of meaningful access to SMHS. For this reason, our research was also expanded to a review of available data¹⁷ and qualitative studies, the reports for which have been published in conjunction with this report.¹⁸

Findings and Analysis

1. Specialty Mental Health Services and Access Criteria

A. Scope of Services

By law, county MHPs must cover a defined set of SMHS for all beneficiaries who meet the access criteria, including psychologist and psychiatrist services, medication support, crisis intervention and stabilization, and residential or inpatient services.¹⁹ Additionally, for beneficiaries under age 21, MHPs must provide heightened EPSDT services, which include all services necessary to correct or ameliorate²⁰ a mental health condition, regardless of whether such services are covered under the state's Medicaid plan.²¹ In California, EPSDT has been defined to include intensive care coordination (ICC), intensive home based services (IHBS), therapeutic behavioral services (TBS), and therapeutic foster care (TFC).²²

From our review of county-level documents, Los Angeles, San Bernardino, Riverside, Fresno, and Orange counties have all codified the relevant federal and state law standards with respect to the scope of available SMHS into their written policies and beneficiary-facing materials. Additionally, Los Angeles, San Bernardino, and Riverside counties have released internal guidance documents and/or informational flyers further explaining the scope of EPSDT services and the impact that the *Katie A. Settlement Agreements*²³ had on defining the scope of these services with respect to children and youth who are in foster care or who are at an imminent risk of foster care placement in the State.²⁴ Fresno and Orange counties did not send similarly specific materials pursuant to our PRA request, nor were such materials publicly available at the time of this review.

B. Access Criteria

Effective January 1, 2022, the State established expanded access criteria for SMHS.²⁵ For beneficiaries age 21 or older, it requires MHPs to provide covered SMHS if the beneficiary has a mental health disorder or a suspected one not yet diagnosed, and that condition causes a significant impairment or a reasonable probability of significant deterioration in an important area of life functioning.²⁶ Notably, the State made clear that a diagnosis is not required to access services, even for adult beneficiaries.²⁷

For beneficiaries under age 21, the State requires MHPs to provide all medically necessary SMHS if either of the following criteria are met:

1. The beneficiary has a condition placing them at high risk for a mental health disorder due to trauma evidenced by any of the following: scoring in the high-risk range on a trauma screening tool, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness; or
2. The beneficiary has a mental health disorder, a suspected disorder not yet diagnosed, or has experienced trauma that places them at a risk for of a future mental health condition, based on an assessment by a mental health professional; and the beneficiary has: (a) a significant impairment, (b) a reasonable probability of significant deterioration in an important area of life functioning, (c) a reasonable probability of not progressing developmentally as appropriate, or (d) a need for SMHS, regardless of the presence of impairment, that are not included within the mental health benefits the Med-Cal managed care plan is required to provide.²⁸

The addition of the first access criteria for beneficiaries under age 21 represents a significant step forward in access to mental health care for children and youth in foster care. “Involvement in child welfare”²⁹ is enough, in itself, to presumptively evidence trauma and thus a high risk for a mental health disorder. This means that foster youth and other beneficiaries under age 21 with an open child welfare case meet the access criteria for SMHS and must be assessed by the MHP or network provider to determine what SMHS are necessary.

Unfortunately, our review of the counties’ internal documents and beneficiary-facing materials yielded little evidence that this expanded SMHS access criteria has been adopted. First, with respect to policies and procedures, only one out of the five counties provided or made publicly available documents demonstrating county-level implementation of this policy change. Los Angeles County published a County Bulletin³⁰ twelve days prior to the policy’s implementation, as well as a Frequently Asked Questions document³¹ a couple months later. Both documents describe the new access criteria, with the latter getting into more detail of how the policy will function on the service delivery level. San Bernardino County sent a copy of the State’s sub-regulatory guidance document that detailed the new SMHS access criteria³² in response to our PRA request, which demonstrated that they are aware of the new standards. However, they did not provide any documentation showing incorporation of the criteria into county-level policies. Riverside, Fresno, and Orange counties did not provide via PRA, nor did we discover through research of publicly available materials, any internal policies, procedures, manuals, or other documents that referenced or incorporated the updated SMHS access criteria.

Second, with respect to beneficiary-facing materials, none of the five counties had updated their MHP Beneficiary Handbooks to reflect the expanded SMHS access criteria at the time of our initial review and through mid-March 2023. For well over a year, all five of the Handbooks contained outdated and contradictory SMHS access standards. Most notably, Los Angeles, San Bernardino, Riverside, Fresno, and Orange counties' handbooks all stated that "a diagnosis covered by the MHP" is required for beneficiaries under age 21 to access SMHS.³³ This is inaccurate (for both beneficiaries under and over age 21) and could have deterred children, youth, and young adults from attempting to access care during this time period.

The five counties published updated MHP Beneficiary Handbooks in late March 2023, which did reflect the updated SMHS access criteria.³⁴ While we appreciate that the counties have now brought their handbooks into compliance with the law, the significant time delay was unacceptable. In December 2022, the State published sub-regulatory guidance instructing the counties to update their handbooks to comply with CalAIM initiatives, including the SMHS access criteria, no later than March 12, 2023.³⁵ However, the State's endorsement of a fifteen-month delay in updating the MHP Beneficiary Handbooks to reflect current policy does not absolve the counties of their obligation to comply with federal law governing managed care plans, including the county MHPs, regarding the provision of handbooks containing legally accurate information to beneficiaries.³⁶ The State should not have allowed this lengthy delay, and the counties should not have taken full advantage of it.

When a beneficiary does not have access to current and accurate information regarding their right to access services, it can have a chilling effect on whether or not they attempt to access care. As explored further in our report *Foster Youth Access to Medi-Cal Specialty Mental Health Services: Results from Qualitative Research in the California Counties with the Largest Foster Care Populations*,³⁷ there appears to be a widespread lack of information and misinformation about the SMHS access criteria among mental health and child welfare providers and advocates. Having outdated Beneficiary Handbooks — a resource directly provided to and reasonably relied upon by beneficiaries when navigating their benefits — contributes to this problem and serves to undermine the very goal that this policy change was enacted to address: increasing access to SMHS. Going forward, it is critical to ensure that county policies, procedures, and beneficiary-facing materials are updated in a timely manner.

C. Screening for EPSDT SMHS

County MHPs also have an affirmative responsibility to determine if children and youth who meet the SMHS access criteria need EPSDT covered services such as ICC, IHBS, and/or TFC.³⁸ The State released a Medi-Cal Manual with

guidance intended to assist counties in identifying children and youth who may need ICC, IHBS, and TFC.³⁹ It lists criteria such as having received crisis stabilization or intervention services, having had multiple child welfare placements or mental health hospitalizations within a certain time period, or having been in a institutional setting such as a Short-Term Residential Therapeutic Program (STRTP), as examples of situations that are likely to indicate medical necessity.⁴⁰ The State is clear that this is not an exhaustive list, nor is there any one “correct” assessment for determining an individual’s need for EPSDT services.⁴¹

Effective January 1, 2023, DHCS did release standardized, statewide Adult and Youth Screening Tools, which all MHPs must use to guide referrals of beneficiaries who are not currently receiving services.⁴² However, these screening tools are intended to direct beneficiaries to the correct mental health delivery system(s) (i.e., MHP, which provides SMHS, and/or their Managed Care Plan or Fee-for-Service provider, which provides Non-Specialty Mental Health Services); it does not replace MHP clinical assessments, crisis assessments, or service determinations, including those related to EPSDT services.⁴³

We reviewed the five counties’ written policies, procedures, and beneficiary materials to confirm whether and to what extent their county-level documents reference and incorporate this affirmative responsibility to screen for EPSDT SMHS such as ICC, IHBS, and/or TFC. We found that San Bernardino and Riverside counties have internal policies referencing or explaining implementation of this affirmative duty.⁴⁴ We could not confirm the same in Los Angeles, Fresno, and Orange counties from the materials that we were publicly available or provided via PRA.

D. Prior Authorization

The State has defined specific standards for when MHPs may not and when they must require prior authorization for SMHS. MHPs may not require prior authorization for ICC, crisis intervention and stabilization services, mental health services (including initial clinical assessment), medication support services, peer support services, and targeted case management.⁴⁵ Prior authorization or referral by the MHP is required for IHBS, TBS, TFC, Day Treatment Intensive, and Day Rehabilitation.⁴⁶

Our research yielded unclear results regarding the extent to which the five counties have incorporated the SMHS prior authorization rules into their internal documents and beneficiary-facing materials. The internal policies and procedures available to us did not address it. Further, in Fall 2022, the MHP Beneficiary Handbooks contained incomplete and misleading information regarding prior authorization. All counties made clear that prior authorization is not required for “emergency services,” which, here, would include crisis

intervention and stabilization services and other SMHS that are needed on an emergent basis. There were no additional references to prior authorization. There were, however, separate sections in each of the five handbooks titled “Who Decides Which Services I Will Get?,” which explained the need for “service authorization” for all SMHS. These sections implied that prior authorization was needed for all SMHS, which is inaccurate.⁴⁷

The misleading description of SMHS service authorization was corrected in the March 2023 updates to the counties’ MHP Beneficiary Handbooks. The handbooks now describe prior authorization in greater detail and contain an explicit list of the SMHS services that require it.⁴⁸

2. Timely Access and 24/7 Access Lines

Federal law requires all health plans to make Medicaid services available and accessible to beneficiaries in a timely manner.⁴⁹ In California, all health plans, including county MHPs, must comply with state timely access standards.⁵⁰ MHPs must make SMHS available 24 hours a day, seven days a week, when medically necessary.⁵¹ Additionally, they must make appointments available to beneficiaries within specified timeframes, which vary from within 48 hours to 15 business days depending on the urgency.⁵²

MHPs must also maintain a 24/7 toll-free telephone number, with language capability in all threshold languages spoken by beneficiaries in the county, to facilitate and connect beneficiaries with needed services.⁵³ Trained staff must be available to provide beneficiaries information on how to access SMHS, the access criteria, what services are available, and how the beneficiary can use the grievance, appeal, and fair hearing processes.⁵⁴

Through our research, we found that all five counties have beneficiary-facing materials that correctly incorporate the timely access standards, including the emergent care and appointment timeframe requirements.⁵⁵ Additionally, each county advertises their 24/7 Access Line in their Beneficiary Handbook and four out of the five counties prominently display the Access Line on the homepage of their websites.⁵⁶ Orange County does not include the Access Line on their homepage, but instead only on a subpage with more information about behavioral health services.⁵⁷ Orange County also calls their 24/7 Access Line the “Administrative Services Organization (ASO)” and hosts a separate 24/7 “navigator” line called “OC Links,” which may cause some confusion.⁵⁸ Further, the phone number that Riverside County lists in its own materials differs from the number listed in DHCS resources.⁵⁹ While, upon testing, they both direct to the same call center, the numbers should be made consistent.

Finally, while the counties' policies and beneficiary materials related to timely access and the 24/7 Access Lines establish a helpful baseline, it is not a complete picture. A county policy should set forth, for example, that an urgent appointment must be provided within 48 hours; but, if that is not being met operationally at the service level, then the beneficiary does not have timely access. Likewise, counties can host and advertise a 24/7 Access Line for mental health services, but if the staff member that answers the phone call is not properly trained and does not provide accurate information, then it can function to obstruct access. For this reason, among others, we expanded our research to include a survey of advocates and providers with firsthand knowledge and test calls to the 24/7 Access Lines. Results from those studies are documented in our report *Foster Youth Access to Medi-Cal Specialty Mental Health Services: Results from Qualitative Research in the California Counties with the Largest Foster Care Populations*.⁶⁰

3. Provider Choice and Care Coordination

Federal and state law contain a number of protections to ensure that Medi-Cal beneficiaries have access to providers that meet their unique needs and that there is coordination among their various providers and services. These legal protections are important for all Medi-Cal beneficiaries, but particularly relevant for foster youth and transition age youth, many of whom have complex mental health needs, are navigating multiple health and social service delivery systems, and/or are transitioning from child and youth to adult provider systems.

For this research, we examined the five counties' written policies and procedures and beneficiary-facing materials for compliance with rules related to a beneficiary's right to choose their own SMHS provider;⁶¹ right to change providers;⁶² right to continuity of care when moving to another county or when their established provider is out-of-network,⁶³ and right to coordinated care.⁶⁴ We found that all five counties' written policies and beneficiary-facing materials were consistent with these legal requirements.

The counties' compliance with provider network adequacy requirements was outside the scope of this review. However, an analysis of MHP network certification compliance is included in our report *Foster Youth Access to Medi-Cal Specialty Mental Health Services: A Review of the Data in California and the Counties with the Largest Foster Care Populations*.⁶⁵

4. Due Process Rights

Federal and state law require MHPs to develop and provide beneficiaries a grievance, appeal, and expedited appeal system to resolve any problems or concerns related to the delivery of SMHS.⁶⁶ In addition to the MHP's internal

grievance and appeal system, Medi-Cal beneficiaries may also appeal denials or terminations and reductions of services through the Medi-Cal state fair hearing process.⁶⁷ These rights help protect beneficiaries, including foster youth, from improper service denials and other MHP actions or inactions that may impact their access to SMHS.

We examined the five counties' internal documents and beneficiary-facing materials for compliance with the rules related to the grievance and appeal systems,⁶⁸ as well as the beneficiary's rights to proper notice⁶⁹ and continuation of services pending appeal.⁷⁰ We found that all five counties' written policies, procedures, and beneficiary-facing materials were consistent with these legal requirements.

Conclusion and Recommendations

Our county document review revealed that some California counties have been slow to update their internal policies, procedures, and beneficiary-facing materials to comply with State policy reform that expanded foster youth access to Medi-Cal Specialty Mental Health Services. Of the five counties we reviewed, only one (Los Angeles County) provided or made publicly available documents evidencing implementation of the expanded SMHS access criteria prior to March 2023. Further, for over a year, all five counties continued to distribute MHP Beneficiary Handbooks that contained outdated and misleading information related to the SMHS access criteria and prior authorization, which could have deterred children and youth from attempting to access care. In other substantive areas within the scope of our review, the counties were largely in compliance with relevant federal and state law, as described above.

In light of these findings, we recommend that DHCS increase its oversight of the MHPs and that the counties take steps to ensure that they are more adaptive to future State policy reforms, which will be forthcoming as the CalAIM initiative continues to roll out. Specifically, we recommend the following:

- DHCS should conduct more frequent oversight reviews of the county MHPs. Triennial Reviews do not adequately hold MHPs accountable for compliance with current law and policy. In some instances, the current structure allows MHPs a three-year grace period for legal compliance. These reviews should be made publicly available and corrective actions plans put in place when counties are found to be out-of-compliance with relevant law.
- Counties should be required to keep their internal policies and procedures up to date with relevant federal and state law and policy, and provide copies of those policies and procedures to the State. When there is reform, counties should update their own documents to reflect this change by the time it goes into effect. This will help ensure that beneficiaries realize the benefit of reform and counties adhere to their legal obligations. This may be expected under the MHP contract, however, it is not currently happening.

- Counties should be required to keep their MHP Beneficiary Handbooks and other beneficiary-facing materials up to date with current law and policy. If beneficiaries are not provided with timely and accurate information, then it can inhibit access to the mental health services that individuals are entitled to.
- Counties should be more transparent with their internal policies and procedures. A majority of the counties that we reviewed did not have their policies and procedures publicly available. Instead, we sent PRA requests to counties, a process that may serve as an administrative barrier for many. In order to promote accountability and enable greater self advocacy, counties should be required to publish their policies and procedures on their website in a clear, accessible, and easy to find location.
- Counties should make their beneficiary-facing materials more readily available and user-friendly. The current county websites are difficult to navigate and, in some cases, inaccessible for people with disabilities or limited English proficiency. Additionally, some of their published flyers and resource documents are hard to find and difficult to understand. Counties should ensure that their published materials and online resources are accurate and easily accessible.

Endnotes

- ¹ See CAL. LEGISLATURE, ASSEMBLY & SENATE HEALTH COMMS., *Informational Hearing: The Medi-Cal Mental Health Delivery System: Background* at 2–3 (2019), <https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/Final%20February%2026%20Medi-Cal%20Mental%20Health%20Background%202.pdf>.
- ² See NAT'L HEALTH LAW PROGRAM, *An Advocate's Guide to Medi-Cal Services: Chapter III: Mental Health Services* at 4 (Dec. 2022), <https://healthlaw.org/wp-content/uploads/2023/05/NHeLP-MediServicesGuide-Chapter-3-R3.pdf>.
- ³ See 42 U.S.C. § 1396d(r); CAL. WELF. & INST. CODE §§ 14132(v), 14684(7); see also CAL. DEP'T OF HEALTH CARE SERVS., *Medi-Cal for Kids & Teens*, <https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/home.aspx> (last modified June 20, 2023).
- ⁴ See CAL. DEP'T OF HEALTH CARE SERVS., *Specialty Mental Health Services for Children and Youth*, https://www.dhcs.ca.gov/services/MH/Pages/Specialty_Mental_Health_Services.aspx (last modified Feb. 13, 2023).
- ⁵ Beneficiary Handbooks must provide information about SMHS, including on how to access services, how to contact a designated provider, and how to file a grievance or appeal. The handbook may be distributed in printed copy by mail, via email (with the beneficiary's consent), on the MHP's website, and through other modalities that the beneficiary has reasonable access to. See 42 C.F.R. §§ 438.10, 438.208(b)(1); see also CAL. DEP'T OF HEALTH CARE SERVS., Behavioral Health Information Notice No. 22-060 (Dec. 12, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-060-MHP-and-DMC-ODS-Beneficiary-Handbook-Requirements-and-Templates.pdf>.
- ⁶ See CAL. WELF. & INST. CODE, § 14184.402; CAL. DEP'T OF HEALTH CARE SERVS., Behavioral Health Information Notice No. 21-073 (Dec. 10, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf> [hereinafter BHIN 21-073].
- ⁷ CAL. WELF. & INST. CODE, § 14184.402; CAL. DEP'T OF HEALTH CARE SERVS., BHIN 21-073, *supra* note 6.
- ⁸ See CAL. DEP'T OF HEALTH CARE SERVS., *CaAIM*, <https://www.dhcs.ca.gov/CaAIM> (last modified August 10, 2023).
- ⁹ See also Alexis Robles-Fradet, Abbi Coursolle, & T. Nancy Lam, NAT'L HEALTH LAW PROGRAM, *Foster Youth Access to Medi-Cal Specialty Mental Health Services: A Review of the Data in California and the Counties with the Largest Foster Care Populations* (Sept. 2023), <https://healthlaw.org/wp-content/uploads/2023/09/CA-Foster-Youth-SMHS-Data-Review-Report.pdf>; Carly Myers & T. Nancy Lam, NAT'L HEALTH LAW PROGRAM, *Foster Youth Access to Medi-Cal Specialty Mental Health Services: Results from Qualitative Research in the California Counties with the Largest Foster Care Populations* (Sept. 2023), <https://healthlaw.org/wp-content/uploads/2023/09/CA-Foster-Youth-SMHS-Qualitative-Report.pdf>.

- ¹⁰ For a summary of the legal requirements and beneficiary rights critical to ensuring access to SMHS, see Abbi Coursolle & T. Nancy Lam, NAT'L HEALTH LAW PROGRAM, *Access to Medi-Cal Specialty Mental Health Services: Network Adequacy Requirements and Other Beneficiary Rights* (May 17, 2023), <https://healthlaw.org/resource/access-to-medi-cal-specialty-mental-health-services-network-adequacy-requirements-and-other-beneficiary-rights/>.
- ¹¹ See CAL. DEP'T OF HEALTH CARE SERVS., *Medi-Cal Specialty Mental Health Services Plans of Correction*, https://www.dhcs.ca.gov/services/MH/Pages/County_MHP_POC.aspx (last modified August 24, 2023).
- ¹² At the time of our research, none of DHCS's Triennial Reviews included the Fiscal Year (FY) beginning in January 2022, which is the time period in which significant SMHS policy reform went into effect. See *id.* Los Angeles, San Bernardino, and Riverside counties were last reviewed in FY 2021–2022 (ending in January 2022), Fresno County was last reviewed in FY 2020–2021, and Orange County was last reviewed in FY 2019–2020. *Id.*
- ¹³ The counties are listed in the descending order of their foster care population.
- ¹⁴ See CAL. DEP'T OF SOC. SERVS. & UNIV. OF CAL. BERKELEY, California Child Welfare Indicators Project, *Children in Foster Care*, <https://ccwip.berkeley.edu/childwelfare/reports/PIT/MTMG/r/ab636/s> (last visited Sept. 7, 2023). “Foster care population” is defined here as “all children who have an open child welfare placement episode in the CWS/CMS system.” *Id.*
- ¹⁵ We focused our review of the online materials on the following websites and their sub-pages: LOS ANGELES CNTY., <https://lacounty.gov>; LOS ANGELES CNTY. DEP'T OF MENTAL HEALTH, <https://dmh.lacounty.gov>; LOS ANGELES CNTY. DEP'T OF PUBLIC SOC. SERVS., <https://dpss.lacounty.gov>; SAN BERNARDINO CNTY., <https://main.sbcounty.gov>; SAN BERNARDINO CNTY. DEP'T OF BEHAVIORAL HEALTH, <https://wp.sbcounty.gov/dbh/>; SAN BERNARDINO CNTY. TRANSITIONAL ASSISTANCE DEP'T, <https://wp.sbcounty.gov/tad/>; RIVERSIDE CNTY., <https://rivco.org>; RIVERSIDE CNTY. DEP'T OF MENTAL HEALTH, <https://www.rcdmh.org>; RIVERSIDE CNTY. DEP'T OF PUBLIC SOC. SERVS., <https://rivcodpss.org>; FRESNO CNTY., <https://www.co.fresno.ca.us/>; FRESNO CNTY. DEP'T OF BEHAVIORAL HEALTH, <https://www.co.fresno.ca.us/departments/behavioral-health>; FRESNO CNTY. DEP'T OF SOC. SERVS., <https://www.co.fresno.ca.us/departments/social-services/>; ORANGE CNTY., <https://www.ocgov.com>; ORANGE CNTY. HEALTH CARE AGENCY, <https://www.ochealthinfo.com>; ORANGE CNTY. SOC. SERVS. AGENCY, <https://ssa.ocgov.com>.
- ¹⁶ CAL. GOV. CODE § 6253 *et seq.*; see also CAL. CONSTITUTION, as amended by Prop. 59.
- ¹⁷ Robles-Fradet, Coursolle, & Lam, *supra* note 9.
- ¹⁸ Myers & Lam, *supra* note 9.

- ¹⁹ CAL. CODE REGS. tit. 9, § 1810.247; CAL. DEP'T OF HEALTH CARE SERVS., Behavioral Health Information Notice No. 23-063, Enclosure 1, at 7 (Dec. 19, 2022), <https://www.dhcs.ca.gov/Documents/Enclosure-1-SMHS-Protocol-FY-22-23-7-28-22.pdf> [hereinafter BHIN 23-063]; CAL. DEP'T OF HEALTH CARE SERVS., All Plan Letter 17-018 (Oct. 17, 2017), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-018.pdf>.
- ²⁰ “Correct or ameliorate” has been further defined to include services that sustain, support, improve, or make more tolerable a mental health condition. CAL. DEP'T OF HEALTH CARE SERVS., BHIN 21-073, *supra* note 6; CTRS. FOR MEDICARE & MEDICAID SERVS., *EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014), https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf.
- ²¹ 42 U.S.C. § 1396d(r); CAL. WELF. & INST. CODE § 14184.402(d); CAL. DEP'T OF HEALTH CARE SERVS., BHIN 21-073, *supra* note 6.
- ²² Katie A. v. Bonta, No. 2:02-cv-05662-JAK-FFMx (C.D. Cal) (2020 Settlement Agreement with Los Angeles County available at <https://healthlaw.org/wp-content/uploads/2020/09/1031-Joint-Stip-Re-Class-Action-Settlement.pdf>); CAL. DEP'T OF HEALTH CARE SERVS., Behavioral Health Information Notice No. 21-058, <https://www.dhcs.ca.gov/Documents/BHIN-21-058-Claiming-for-Intensive-Care-Coordination.pdf> [hereinafter BHIN 21-058]; CAL. DEP'T OF HEALTH CARE SERVS. & CAL. DEP'T OF SOC. SERVS., *Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries* (3rd Ed. 2018), https://www.dhcs.ca.gov/Documents/ChildrensMHContentFlaggedForRemoval/Manuals/Medi-Cal_Manual_Third_Edition.pdf [hereinafter Medi-Cal Manual for ICC, IHBS, and TFC].
- ²³ Katie A., No. 2:02-cv-05662-JAK-FFMx (C.D. Cal) (2011 Settlement Agreement with the State available at <https://healthlaw.org/wp-content/uploads/2020/09/KatieASettlementAgreement.pdf>; 2020 Settlement Agreement with Los Angeles County available at <https://healthlaw.org/wp-content/uploads/2020/09/1031-Joint-Stip-Re-Class-Action-Settlement.pdf>).
- ²⁴ Documents on file with the National Health Law Program.
- ²⁵ CAL. DEP'T OF HEALTH CARE SERVS., BHIN 21-073, *supra* note 6.
- ²⁶ CAL. WELF. & INST. CODE § 14184.402(c); CAL. DEP'T OF HEALTH CARE SERVS., BHIN 21-073, *supra* note 6, at 3. “Impairment” is defined as “distress, disability, or dysfunction in social, occupational, or other important activities.” CAL. DEP'T OF HEALTH CARE SERVS., BHIN 21-073, *supra* note 6, at 3.
- ²⁷ *See id.* at 3–5.
- ²⁸ CAL. WELF. & INST. CODE § 14184.402(d); CAL. DEP'T OF HEALTH CARE SERVS., BHIN 21-073, *supra* note 6, at 4–5.

- ²⁹ The State defined “involvement in child welfare” to mean that the beneficiary has an open child welfare services case, is at imminent risk of one but for a prevention plan, or was adopted through the child welfare system. A beneficiary has an open child welfare services case if: “a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance case (pre-placement or post-reunification), including both court-ordered and by voluntary agreement. A child can have involvement in child welfare whether the child remains in the home or is placed out of the home.” CAL. DEP’T OF HEALTH CARE SERVS., BHIN 21-073, *supra* note 6, at 8.
- ³⁰ LOS ANGELES CNTY., Quality Assurance Bulletin No. 21-08 (Dec. 20, 2021), https://file.lacounty.gov/SDSInter/dmh/1117880_QABulletin21-08UpdatedCriteriaToAccessSMHS.pdf.
- ³¹ LOS ANGELES CNTY. DEP’T OF MENTAL HEALTH, Quality Assurance Unit, *New Criteria to Access Specialty Mental Health Services (SMHS) & Medical Necessity Frequently Asked Questions* (Feb. 15, 2022), https://file.lacounty.gov/SDSInter/dmh/1119877_QABulletin21-08FAQs.pdf.
- ³² CAL. DEP’T OF HEALTH CARE SERVS., BHIN 21-073, *supra* note 6.
- ³³ See LOS ANGELES CNTY., MHP Beneficiary Handbook (Jan. 2022), https://file.lacounty.gov/SDSInter/dmh/1102224_MentalHealthPlan-BeneficiaryHandbook.pdf; SAN BERNARDINO CNTY., MHP Beneficiary Handbook (Apr. 2019), https://wp.sbcounty.gov/dbh/wp-content/uploads/2019/04/MHP_Beneficiary_Handbook-4-2019.pdf; RIVERSIDE CNTY., MHP Beneficiary Handbook (2018), <https://www.rcdmh.org/Portals/0/PDF/Substance%20Use/2020/Jan/Beneficiary%20Handbook%202018%20Final%20English.pdf%20Large%20Font.pdf?ver=2020-01-07-080808-513>; FRESNO CNTY., MHP Beneficiary Handbook (Sept. 2019), <https://www.co.fresno.ca.us/home/showpublisheddocument/2575>; ORANGE CNTY., MHP Beneficiary Handbook (2019), <https://www.ochealthinfo.com/sites/hca/files/import/data/files/11995.pdf>.

- ³⁴ See LOS ANGELES CNTY. MHP, Beneficiary Handbook (Mar. 24, 2023), https://file.lacounty.gov/SDSInter/dmh/1139051_Enclosure-1-MHP-Beneficiary-Handbook-English-FINAL2023.pdf (note that Los Angeles County’s Beneficiary Handbook states that it was “published” in 2022, however, it was not available on their website until late March 2023); SAN BERNARDINO CNTY. MHP, Beneficiary Handbook (Mar. 2023), https://www.sbcounty.gov/uploads/DBH/2023/03/SBCDBH_Beneficiary%20Handbook_02.2023_FINAL_v.2.pdf; RIVERSIDE CNTY. MHP, Beneficiary Handbook (Mar. 29, 2023), <https://www.rcdmh.org/Portals/0/PDF/Beneficiary%20Handbooks/Beneficiary%20Handbook%20MH%202023.pdf?ver=2023-03-29-164737-050> (note that Riverside County’s Beneficiary Handbook states that it was “published” in 2022, however, it was not available on their website until late March 2023); FRESNO CNTY. MHP, Beneficiary Handbook (Mar. 2023), <https://www.co.fresno.ca.us/home/showpublisheddocument/72734/638137951343530000>; ORANGE CNTY. MHP, Beneficiary Handbook (Mar. 2023), <https://ochealthinfo.com/sites/healthcare/files/2023-03/MHP%20Beneficiary%20Handbook%20-%20English%20update%203.14.23.pdf>.
- ³⁵ CAL. DEP’T OF HEALTH CARE SERVS., Behavioral Health Information Notice No. 22-060 (Dec. 12, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-060-MHP-and-DMC-ODS-Beneficiary-Handbook-Requirements-and-Templates.pdf> (also requiring the handbooks to reflect new behavioral health documentation requirements and the “No Wrong Door” policy, among other reforms).
- ³⁶ See 42 C.F.R. § 438.10(g).
- ³⁷ Myers & Lam, *supra* note 9.
- ³⁸ CAL. DEP’T OF HEALTH CARE SERVS., BHIN 21-058, *supra* note 22.
- ³⁹ See CAL. DEP’T OF HEALTH CARE SERVS. & CAL. DEP’T OF SOC. SERVS., *Medi-Cal Manual for ICC, IHBS, and TFC*, *supra* note 22, at 9-12.
- ⁴⁰ *Id.*
- ⁴¹ See *id.*; CAL. DEP’T OF HEALTH CARE SERVS., BHIN 21-058, *supra* note 22, at 2-3.
- ⁴² CAL. DEP’T OF HEALTH CARE SERVS., Behavioral Health Information Notice No. 22-065 (Dec. 22, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-065Adult-and-Youth-Screening-and-Transition-of-Care-Tools-for-Medi-Cal-MHS.pdf>.
- ⁴³ *Id.*
- ⁴⁴ These documents were obtained via PRA request and are on file with the National Health Law Program.
- ⁴⁵ CAL. DEP’T OF HEALTH CARE SERVS., Behavioral Health Information Notice No. 22-016 at 7 (Apr. 15, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-016-Authorization-of-Outpatient-Specialty-Mental-Health-Services.pdf> [hereinafter BHIN 22-016]; see also CAL. DEP’T OF HEALTH CARE SERVS., BHIN 21-058, *supra* note 22 (authorization of ICC, IHBS, and TFC).

- ⁴⁶ CAL. DEP'T OF HEALTH CARE SERVS., BHIN 22-016, *supra* note 45, at 8. Expedited authorization decisions are required if the standard timeframe could jeopardize the beneficiary's life, health, or functioning. 42 C.F.R. § 438.210(d)(2)(i).
- ⁴⁷ See LOS ANGELES CNTY., *supra* note 33, at 16, 23; SAN BERNARDINO CNTY., *supra* note 33, at 13, 18; RIVERSIDE CNTY., *supra* note 33, at 18, 28–29; FRESNO CNTY., *supra* note 33, at 18, 25–26; ORANGE CNTY., *supra* note 33, at 17–25.
- ⁴⁸ See LOS ANGELES CNTY., *supra* note 34, at 18–19.; SAN BERNARDINO CNTY., *supra* note 34, at 25–26; RIVERSIDE CNTY., *supra* note 34, at 16; FRESNO CNTY., *supra* note 34, at 26–27; ORANGE CNTY., *supra* note 34, at 18–19.
- ⁴⁹ 42 C.F.R. § 438.206.
- ⁵⁰ See CAL. CODE REGS. tit. 28, § 1300.67.2.2.
- ⁵¹ 42 C.F.R. § 438.206(c)(1)(iii); CAL. CODE REGS. tit. 9, § 1810.405.
- ⁵² Urgent appointments must be provided within 48 hours or, if prior authorization is required, within 96 hours. For non-urgent appointments, MHPs must provide beneficiaries: (i) a non-urgent psychiatric appointment within 15 business days of the request for an appointment; (ii) a non-urgent non-physician mental health appointment within 10 business days of the request for an appointment; and (iii) a non-urgent non-physician mental health follow up appointment within 10 business days of the prior appointment. CAL. WELF. & INST. CODE § 14197(d)(1)(A)–(B) (incorporating requirements in CAL. HEALTH & SAFETY CODE § 1367.03(a)(5)(D)–(F) to apply to all Medi-Cal plans including MHPs); CAL. CODE REGS. tit. 28, § 1300.67.2.2(c)(5)(A)–(B), (D)–(F); CAL. DEP'T OF HEALTH CARE SERVS., Behavioral Health Information Notice No. 21-023 (May 24, 2021) at 26–27, <https://www.dhcs.ca.gov/Documents/BHIN-21-023-2021-Network-Adequacy-Certification-Requirements-for-MHPs-and-DMC-ODS.pdf>.
- ⁵³ CAL. CODE REGS. tit. 9, §§ 1810.405(d), 1810.410(e)(1); see also BHIN 23-063, *supra* note 19, Enclosure 1, at 27–28. “Threshold language” is defined as “a language that has been identified as the primary language... of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.” CAL. CODE REGS. tit. 9, § 1810.410(a).
- ⁵⁴ *Id.* §§ 1810.405(d), 1810.410(e)(1).
- ⁵⁵ See LOS ANGELES CNTY., *supra* note 33, at 16, 23.; SAN BERNARDINO CNTY., *supra* note 33, at 12–13, 17; RIVERSIDE CNTY., *supra* note 33, at 17–18, 27; FRESNO CNTY., *supra* note 33, at 18, 25; ORANGE CNTY., *supra* note 33, at 16–18, 24.
- ⁵⁶ See LOS ANGELES CNTY. DEP'T OF MENTAL HEALTH, <https://dmh.lacounty.gov/> (last visited Sept. 7, 2023) (“Get Help Now” tab); SAN BERNARDINO CNTY. DEP'T OF BEHAVIORAL HEALTH, <https://wp.sbcounty.gov/dbh/> (last visited Sept. 7, 2023); RIVERSIDE CNTY. DEP'T OF MENTAL HEALTH, <https://www.rcdmh.org/> (last visited Sept. 7, 2023); FRESNO CNTY. DEP'T OF BEHAVIORAL HEALTH, <https://www.fresnocountyca.gov/Departments/Behavioral-Health> (last visited Sept. 7, 2023).

- ⁵⁷ See ORANGE CNTY., *Administrative Services Organization*, <https://www.ocohealthinfo.com/about-hca/behavioral-health-services/more-mhrs/administrative-services-organization-aso> (last visited Sept. 7, 2023).
- ⁵⁸ See *id.*; ORANGE CNTY., *OC Links: Where Wellbeing Begins*, <https://www.ocohealthinfo.com/services-programs/mental-health-crisis-recovery/navigation-help-resources/oc-links> (last visited Sept. 7, 2023).
- ⁵⁹ Compare RIVERSIDE CNTY. DEP'T OF MENTAL HEALTH, <https://www.rcdmh.org/> (listing 800-499-3008) (last visited Sept. 7, 2023), with CAL. DEP'T OF HEALTH CARE SERVS., *County Mental Health Plan Information*, <https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx> (listing 800-706-7500) (last visited Sept. 7, 2023).
- ⁶⁰ Myers & Lam, *supra* note 9.
- ⁶¹ 42 C.F.R. § 438.3(l); see also CAL. CODE REGS. tit. 9, § 1830.225(a); BHIN 23-063, *supra* note 19, Enclosure 1, at 13.
- ⁶² See CAL. CODE REGS. tit. 9, § 1830.225(b); BHIN 23-063, *supra* note 19, Enclosure 1, at 13.
- ⁶³ See CAL. DEP'T OF HEALTH CARE SERVS., *Mental Health and Substance Use Disorder Services Information Notice No. 18-059* (Dec. 17, 2018), https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN_18-059_Continuity_of_Care/MHSUDS_Information_Note_18-059_Continuity_of_Care.pdf.
- ⁶⁴ See *id.*; 42 C.F.R. § 438.208(b)(2)(i)-(iv); CAL. WELF. & INST. CODE § 14184.402(f)(1)(D)-(E).
- ⁶⁵ Robles-Fradet, Coursolle, & Lam, *supra* note 9.
- ⁶⁶ 42 C.F.R. §§ 438.228(a), 438.402(a); CAL. CODE REGS. tit. 9, § 1850.205(a)-(b); see also CAL. DEP'T OF HEALTH CARE SERVS., *Mental Health and Substance Use Disorder Services Information Notice No. 18-010E* (March 27, 2018), https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/NOABD%20IN/MHSUDS_IN_18-010_Federal_Grievance_Appeal_System_Requirements.pdf [hereinafter *MHSUDS IN 18-010E*]. For additional detail on federal and state laws related to the grievance, appeal, and fair hearing process, see Coursolle & Lam, *supra* note 10, at 6-8.
- ⁶⁷ CAL. WELF. & INST. CODE § 10950.
- ⁶⁸ See 42 C.F.R. §§ 438.400(b), 438.404(a)-(b); CAL. DEP'T OF HEALTH CARE SERVS., *MHSUDS IN 18-010E*, *supra* note 66.
- ⁶⁹ See 42 C.F.R. §§ 438.228(a), 438.402(a).
- ⁷⁰ See *id.* § 438.420(a)-(c)."