**Pediatrics Supporting Parents (PSP) Technical Assistance (TA)**
**Analysis of New Medi-Cal Family Therapy Guidance and Dyadic Integrated Care Models Currently Implemented in California**

## Introduction

When it comes to a child's health and development, perhaps the most critical stage of life is the first 1,000 days, when brain development is proceeding at an unprecedented pace and the nurturing relationship between the child and parent/caregiver – the dyad – is essential. Just as a young child's healthy physical, cognitive, and social and emotional development can set her on the path to school readiness, a challenging social environment – such as a lack of adequate food or housing, financial insecurity, exposure to environmental hazards or violence, or a caregiver's depression or other behavioral health concern – can place serious roadblocks in her way. Striking inequities, that are often the result of entrenched institutional racism, can have enduring, detrimental consequences, especially for children in communities of color. Still, a strong bond between infant and parent/caregiver, as well as family and community supports, help to build resilience, which is key to mitigating the effects of adverse conditions.

Parents looking for guidance on child development issues and for reassurance on their own vital role, most often turn to their child's pediatric care provider at routine well-child visits. The central goal for well-child visits is *prevention* – to identify any health or developmental concerns and intervene right away before potential problems can become more serious and difficult to address. Access to the preventive care that all children need depends in large measure on having health insurance. For 64 percent of California's children under age five, Medi-Cal provides that health insurance, with care delivered predominantly through managed care plans under contract with the California Department of Health Care Services (DHCS) to provide most covered benefits and services.[1]

The comprehensive benefit package available to children with Medi-Cal coverage – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – was designed with prevention as a core feature. Yet, solely focusing on the child, especially the youngest beneficiaries, fails to recognize the critical interplay between healthy child development and strong early foundational relationships. To remedy this problem, there is a growing interest in dyadic care models that leverage the well-child visit to deliver appropriate preventive, integrated (physical and behavioral health) care. In California, these models work (or can work) in tandem with a robust infrastructure of community services, built with the support of First 5 County Commissions, to help ensure families get the assistance they need to obtain social supports and services. Efforts to connect these elements – evidence-based dyadic care models, a community services infrastructure, and Medi-Cal financed managed care plans – can advance an improved standard of care for young children and their families.

## Towards Raising the Standard of Pediatric Primary Care in California

This is a pivotal moment for California. A confluence of urgency and opportunity has created the possibility for accelerating profoundly needed change in the way preventive care is delivered to the youngest children.

- **Imperatives Revealed.** A report released in March 2019 by the California State Auditor concluded that millions of children enrolled in Medi-Cal are not receiving the preventive services to which they are entitled.[2] According to the audit, the utilization rate of preventive services by California's children in

[1] Analysis of July 2019 Medi-Cal enrollment data U.S. Census Bureau estimates of California children ages 0-5. See CHHS Open Data and U.S. Census Bureau.
[2] California State Auditor. DHCS: Millions of Children in Medi-Cal are Not Receiving Preventive Health Services. March 2019. Available here.

Medi-Cal has been consistently below 50 percent—nearly 10 percentage points below the national average – ranking the state 40th in the country. The report called for DHCS to provide more effective guidance and oversight of health plans, as well as to take specific steps to improve performance. The problems highlighted in the audit are exacerbated by California's bifurcated system, which separates physical and behavioral health in ways that are antithetical to a "whole child" approach, undermining the established importance of supporting and strengthening the parent/child bond.

Then, in the midst of sorting out these problems and possible solutions, California and the nation were hit with two crises running in parallel: the COVID-19 public health emergency and the devastating economic crisis. These simultaneous precipitating factors have not only compounded the stress on families and communities, but also have sharpened the focus more than ever on how disjointed systems leave children and families with inadequate, inequitable care.

- **Opportunities to Pursue New Directions.** Under the leadership of Governor Newsom, a team of early childhood experts, advocates, and parents have been tapped to create a Master Plan for Early Learning and Care that is expected to pave the way for directing public investments that could shift the life-course for California's young children and their families.[3] Given the deepening understanding of how health and social factors influence child development, there is an opportunity to ensure the Master Plan makes these connections. In addition, there is an important opening for DHCS to exercise its authority to take action on the Auditor's report: the state is preparing for the reprocurement of Medi-Cal managed care contracts and can use this opportunity to strengthen and support improvements to pediatric care delivery in a way that sets high expectations and clarifies the obligations of health plans to deliver all covered services to Medi-Cal beneficiaries. In fact, DHCS has signaled that a focus of the Medi-Cal reprocurement will be on children's services, including those that "support social and emotional development and address adverse childhood experiences (ACEs)."[4]

Against the compelling backdrop of the current environment, California is taking a leading step forward, demonstrating how Medi-Cal support for evidence-based dyadic care models can broaden and improve the delivery of pediatric preventive care. In June 2020, DHCS issued Medi-Cal Bulletin 537, *Family Therapy is a Medi-Cal Benefit*, which clarifies that, "Family therapy is reimbursable for treatment of mental health conditions in children and adults. *Family therapy is also reimbursable for prevention of mental health conditions in children with specified risk factors.*" (*Emphasis added.*) The guidance, effective retroactively to January 1, 2020, clarifies the availability of family therapy to child beneficiaries under age 21 and lays out how eligible Medi-Cal providers can bill for rendering that service.[5] Since the release of the guidance, DHCS representatives have engaged in a productive dialogue with experienced pediatric behavioral healthcare practitioners and advocates interested in fostering a greater understanding of clinical best practice in early childhood mental health and achieving parity between physical and behavioral healthcare for the youngest children. Historically, without a formal diagnosis, reimbursement for delivering benefits such as family therapy has been prohibited or visits have been limited. Such restrictions run counter to the idea that *prevention* is the hallmark of pediatric care for infants and children. Now that a formal diagnosis is no longer required for children with at least one risk factor for developing a mental health disorder,

[3] California Health & Human Services Agency. Master Plan for Early Learning and Care. Available here.
[4] DHCS. RFI #20-001, Managed Care Plans. September 2020. Available here.
[5] DHCS. Medi-Cal Bulletin 537, Psychological Services: Family Therapy is a Medi-Cal Benefit. June 2020. Available here. (The guidance itself, available under the same link, was updated September 2020.)

conversations are turning to the need for making additional billing codes available and addressing workforce issues. Pursuing these and other important changes are bringing California closer to supporting dyadic integrated care models as a defining element in the standard of pediatric primary care.

## How Can Universal Dyadic Care Models Leverage Medi-Cal and the Existing Early Childhood Infrastructure?

The First 5 Center for Children's Policy, in partnership with First 5 Los Angeles, requested that the PSP TA team (including Manatt Health and Donna Cohen Ross, Advisor to the Center for the Study of Social Policy) review and analyze two leading dyadic care models – HealthySteps[6] and DULCE[7] – currently supported, in large measure, by First 5 County Commissions and private philanthropy. Prompted by the release of the Medi-Cal family therapy benefit guidance,[8] the analysis seeks to assess the extent to which the services provided by HealthySteps and DULCE can be covered under Medi-Cal, and to pinpoint critical aspects of these models that may remain outside Medi-Cal coverage.

In the clinical sites where HealthySteps and DULCE operate, they are offered *universally* to all babies and their caregivers. Considering that traditional pediatric primary care aims to deliver the preventive services that *all* children need, both HealthySteps and DULCE add value by offering a wider range of preventive services – specifically, behavioral health services -- to all children. Finally, HealthySteps and DULCE are distinct from other dyadic care models – such as Parent-Child Interaction Therapy (PCIT), Centering Parenting, and Incredible Years – since they embed into the care team licensed professionals or trained "family specialists" (similar to community health workers) to support families during and between well-child visits. These individuals help families navigate the system of community supports to which they or their children may be referred as a result of well-visit screenings and surveillance. This early childhood infrastructure, built over time by First 5 County Commissions and their partners, encompasses service and navigation networks that can help families gain access to needed services.

**The analysis presented in Table A (below) finds that there is close alignment between the services provided by HealthySteps and DULCE and an array of Medi-Cal covered services, including child health and developmental screenings and the family therapy benefit.** This finding underscores the potential for expanding preventive services envisioned by these two evidence-based models and others, which currently rely largely on funding from First 5 County Commissions and private philanthropy, and as a result, maintain only a modest footprint in California to date.[9] A notable aspect of HealthySteps and DULCE is that they both help extend the reach of the clinical care team by offering the added support of trusted family specialists, peer navigators, and other non-licensed professionals, generally referred to as "community health workers," to help ensure that families are able to connect to the services they and their young children need for optimal health and well-being. Table A also points to strategies that may be used to support the critical contributions of these and other care team members (such as legal assistance partners) either using Medi-Cal directly or by leveraging Medi-Cal Managed Care options. The broader the overlap between Medi-Cal covered services and the dyadic care models, the greater the opportunities to provide valuable preventive services for young children throughout

[6] Zero To Three. HealthySteps. Available here.
[7] First 5 Los Angeles. Project DULCE. Available here.
[8] DHCS. Medi-Cal Update: Psychological Services. September 2020. Available here.
[9] Across California, HealthySteps serves about 30,000 children annually in 15 sites and DULCE serves approximately 120-140 families annually at each of its 7 sites. More than half of the children served by HealthySteps and virtually all children served by DULCE are covered under Medi-Cal. (Data provided by HealthySteps and the Center for the Study of Social Policy.)

California. New and previously available billing opportunities – including for allowable administrative expenditures to cover some start-up and training costs – can help incentivize uptake of underutilized dyadic care models.

| TABLE A: Comparison of Medi-Cal Coverage of Leading Dyadic Integrated Care Models: Family Therapy Benefit and Other Medi-Cal Covered Services | | | |
|---|---|---|---|
| **Medi-Cal Covered Services** | **HealthySteps** | **DULCE** | **Comments & Outstanding Issues** |
| **FAMILY THERAPY BENEFIT:** Interventions must be composed of at least two family members and must be evidence-based, or incorporate evidence-based components | | | |
| **Eligibility:** Medi-Cal beneficiaries under 21 years of age | Children<br>Birth to 2yrs | Children<br>Birth to 6 mos; with site discretion on continuing to 12 or 18 mos | **Comment:** Children are eligible to be enrolled in DULCE and HealthySteps if they receive services in the clinics in which those models operate, not based on risk factors or other eligibility criteria.<br><br>A Medi-Cal provider can bill for a covered service delivered to a Medi-Cal beneficiary. In the case of the family therapy benefit, the child must be enrolled in Medi-Cal; the parent/caregiver does not have to be Medi-Cal eligible. However, if the parent/caregiver *is* eligible for Medi-Cal, coverage for more intensive services may be available, if needed by the adult. |
| **Risk Factors:**[10] To qualify for family therapy,<br><br>• Child has at least one of the following risk factors:<br>- Separation from a parent/guardian due to incarceration or immigration<br>- Death of a parent/guardian<br>- Foster home placement<br>- Food insecurity, housing instability<br>- Exposure to domestic violence or other traumatic events | *See Comments* | *See Comments* | **Comment:** Both HealthySteps and DULCE conduct screenings that are able to identify many, if not most, of these risk factors.<br><br>**Comment:** According to the September 2020 Medi-Cal family therapy guidance, a child beneficiary under age 21 is eligible for family therapy if the child has *at least one of the risk factors* for mental health disorders listed. If the child does not have one of the risk factors noted, the child may receive up to five sessions of a combination of individual or family therapy before a mental health diagnosis is required. The guidance clarifies that the five-session cap |

[10] In addition to these risk factors, DHCS guidance also establishes that a child is eligible for family therapy if "[t]he child has a diagnosis of a mental health condition as defined by DSM or as defined by the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5)." Notably, lack of a formal diagnosis will not preclude access to family therapy, or create a barrier to reimbursement for eligible Medi-Cal providers.

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| - Maltreatment<br>- Severe and persistent bullying<br>- Experience of discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences or disability | | | on family therapy (without a diagnosis) does not apply to child beneficiaries who have at least one of the risk factors. |
| • *OR*, child has a parent/guardian with one of the risk factors below:<br>- Serious illness or disability<br>- History of incarceration<br>- Depression or other mood disorder<br>- PTSD or other anxiety disorder<br>- Psychotic disorder under treatment<br>- Substance use disorder<br>- History of intimate partner or interpersonal violence<br>- Is a teen parent<br><br>• *OR,* the medical provider suspects a mental health disorder and has referred the beneficiary under age 21 for evaluation | *See Comments* | *See Comments* | **Outstanding Issue:** While the list of risk factors is long (and includes a catch-all factor: "the medical provider suspects a mental health disorder and has referred the beneficiary under age 21 for evaluation"), two issues merit consideration:<br>1. Should the list be expanded to include additional risk factors -- such as a caregiver's death or serious illness, or job loss, due to COVID 19, or separation due to military deployment of a caregiver?<br>2. Rather than assessing each individual (or dyad) for risk factors, could a community-based indicator (i.e., counties in which greater than an agreed upon critical percentage of young children have 1-3 ACEs) be applied instead? Such data exist from Kids Count (2016), although more recent data – and a way to track over time -- would be helpful. There are a number of examples of how other public benefit programs use "community eligibility" approaches.[11] |
| **Eligible Providers:**<br>- Psychologist<br>- Licensed Clinical Social Worker (LCSW)<br>- Licensed Professional Clinical Counselor (LPCC) | HealthySteps Specialists are frequently social workers with mental | DULCE Behavioral Health Providers are mostly MFTs and LCSWs and | **Outstanding Issue:** The family therapy benefit guidance identifies healthcare providers eligible to deliver such services, most of whom are licensed or have other professional credentials. Both HealthySteps and DULCE rely on non-licensed practitioners, or individuals trained in disciplines not usually eligible for Medicaid |

[11] For example, the U.S. Department of Agriculture's National School Lunch Program uses Community Eligibility Provision (CEP) to all enrolled students in a low-income, high-poverty school or district, without collecting household applications to enroll in the program. Schools eligible to participate have at least 40 percent of the student population previously identified to receive free school meals without the use of household applications, such as SNAP and/or TANF certified homes. More information available at USDA CEP.

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| - Marriage and Family Therapist (MFT)<br><br>Under a Supervising Clinician:<br>- Marriage and Family Therapist intern<br>- Registered Associate Clinical Social Workers<br>- Psychology Assistants | health training, psychologists, early childhood educators, and/or nurses with experience in early childhood development | provide clinical oversight and supervise Family Specialists; in some cases, they are also the administrative supervisor | reimbursement (i.e., early childhood educators), in addition to licensed providers, to offer essential support to children, families and the care team.<br><br>California could amend its Medicaid State Plan to adopt the federal option to cover preventive services recommended by a physician or licensed health care provider and delivered by a non-licensed health care practitioner. Expanding the care team in this manner has numerous advantages, especially when more families with young children are experiencing the extra stressors related to current public health and financial crises.[12,13] |
| **Place of Service:**<br>- Office<br>- Home<br>- Outpatient hospital<br>- Community mental health center<br>- Comprehensive rehab facility<br>- State or local public health clinic<br>- Rural health clinic | - Pediatric care clinics<br>- Hospital outpatient clinics<br>- FQHCs | - Pediatric care clinics<br>- Hospital outpatient clinics<br>- FQHCs | **Comment:** Given current circumstances, many states, including California, are allowing greater flexibility around the use of telehealth.<br>- Healthy Steps and DULCE are generally at clinic sites located in neighborhoods serving families with limited resources and eligible for Medi-Cal.<br><br>**Outstanding Issue:** The COVID-19 public health emergency has generated considerable interest in how telemedicine can be used as a tool to ensure children remain connected with their pediatric care providers and continue to have access to the full range of preventive services they need. In fact, some pediatric care providers are finding that under some circumstances, the ability to choose a video or phone visit improves the delivery of care and can solidify the trusting relationships among patients, parents and providers. Conducting an |

[12] 42 CFR § 440.130(c).Available here.
[13] CMS. CMCS Informational Bulletin: Update on Preventive Services Initiatives. November 2013. Available here.

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| | | | analysis to ensure that California's guidance on telehealth is leveraging all relevant opportunities and is implementing best practices for young children and their parents/caregivers is timely and important. |
| Inpatient Family Therapy: Only for infants hospitalized in a neonatal intensive care unit; may be billed to mother's ID for the month of birth and following month only. | *Healthy Steps sites may work with families with infants in the NICU* | Some DULCE sites work with families with infants in the NICU | |
| **Billing:** Billed to child's or adult's ID | Child most likely covered by Medi-Cal | Child most likely covered by Medi-Cal | **Comment:** Under some circumstances (i.e., NICU) adult's ID might be billed. |
| **Additional Medi-Cal Covered Services:** | | | |
| **SCREENINGS** | | | |
| Perinatal depression screening | Yes | Yes | **Comment**: California recommends maternal depression screening as part of the well-child visit using validated screening tools, and pays providers based on the result of the screen, with a larger payment for a positive screen, since follow-up referral and coordination can be intensive:<br>- HCPCS G8431 (positive): $29.68<br>- HCPCS G8510 (negative): $10.70 |
| Developmental screening | Yes | No (Unless clinic extends DULCE to 12 or 18 mos) | **Comment**: Medi-Cal supplemental payment $59.90 (above well visit rate). |

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| | | | DULCE generally does not conduct developmental screening since child participants are birth to 6 months, too young to screen. |
| ACEs/SDOH screening | Yes | Yes | **Comment:** Medi-Cal supplemental payment $29 (above well visit rate); with use of PEARLS tool/ACEs Aware Grants.<br><br>**Comment:** Training for providers on conducting ACEs and SDOH screenings should include discussion of the family therapy benefit, noting specifically, that identification of any concerns can qualify a young child and parent/caregiver for this critical service. Conversely, outreach and education on the value of the family therapy benefit – and the dyadic care models – can elevate the need for the screening services that are underutilized. |
| Lead exposure/toxicity screening | Yes | No | **Comment**: AAP guidance calls for lead screening of children between 12 and 24 months of age. Again, in general, DULCE participants are too young. |
| **CARE COORDINATION** | | | |
| Care Coordination/Navigation (Closed Loop Referral) | Yes | Yes | **Comment:** Medi-Cal managed care plans are required to ensure the provision of medical case management services to all plan members. These are services provided by the primary care provider in collaboration with the plan that includes member and family education, coordination of services, and referral to other agencies and community resources.[14,15]<br><br>While Medi-Cal managed care plans are obligated to provide care coordination, it is unclear whether there are metrics available to understand and track performance. However, given the serious findings of the California State Auditor's report on the number of |

[14] DHCS., Medi-Cal Two-Plan Non-CCI Boilerplate Contract, Exhibit A, Attachment 11. Available here.
[15] DHCS. All-Plan Letter 18-007. Available here.

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| | | | children in Medi-Cal missing out on preventive services, there is a compelling need to take affirmative steps to improve performance. For example, according to the audit, "A federal law requires DHCS to annually inform families of children who have not used EPSDT services of the benefits of preventive health care, and DHCS relies on the plans to do so. However, none of the plans we spoke with perform this outreach. [16] There are several opportunities to work with health plans to leverage existing infrastructure, including interventions like Help Me Grow and Medical-Legal Partnership, in some cases.[17,18,19] |

## Dyadic Care Models Routinely Deliver Additional Services that Could be Covered by Medi-Cal

Medi-Cal-covered physical and behavioral health services – EPSDT screenings, risk assessments, family therapy – closely align with the services that evidence-based dyadic care models, such as HealthySteps and DULCE, routinely deliver. Despite the broad overlap, however, some key gaps in Medi-Cal coverage remain. For example, while HealthySteps and DULCE generally employ licensed providers eligible to deliver and bill for the family therapy benefit, both models also rely upon non-licensed practitioners, or individuals trained in disciplines not generally eligible for Medi-Cal reimbursement. These individuals, generally referred to as Community Health Workers (CHWs) – but often known as family specialists, peer navigators, or promotoras – play a vital role as members of the extended care team. In addition to the direct support they offer to parents/caregivers of very young children, they also may be best able to provide "care coordination" services required of Medicaid managed care plans.

There are several routes to Medi-Cal coverage for the critical support CHWs provide. Under a Medicaid State Plan Amendment (SPA) DHCS could adopt the option to allow preventive services recommended by physicians or other licensed practitioners to be provided by practitioners other than physicians or other licensed practitioners.[20] A complementary or alternative pathway through MCO contract requirements is also possible, for example, requiring that care

[16] California State Auditor. DHCS: Millions of Children in Medi-Cal are Not Receiving Preventive Health Services. March 2019. Available here.
[17] Help Me Grow National Center. Available here.
[18] Manatt Health. Tapping into Medicaid Financing Streams: Strategies for Medical Legal Partnerships. May 2019. Available here.
[19] Medical Legal Partnership. Issue Brief Two: Financing Medical Legal Partnerships: View from the Field. April 2019. Available here.
[20] See notes 13 and 14.

coordination to include screening for health-related social needs and connecting beneficiaries to community resources and specifying that the care coordination be delivered in part by community health workers.[21]

## Implementation and Promotion

To optimize take-up of the Medi-Cal family therapy benefit, it will be crucial to conduct outreach and education for Medi-Cal managed care organizations, providers, and beneficiaries' families, and to train providers on the proper use of billing codes and the procedures to ensure reimbursement. (See Table B) Under federal regulations, states are responsible for informing health plans and beneficiaries about new covered benefits, and health plans are responsible for informing providers and beneficiaries.[22] However, elevating awareness and effective implementation may be most successful when a range of organizations with deep local commitments and broad reach are involved. First 5 County Commissions, and provider organizations, such as local chapters of the American Academy of Pediatrics (AAP) and Primary Care Associations, as well as family-led organizations and advocacy groups, all have a stake in the successful delivery of Medi-Cal benefits.

Strategies for assuring robust implementation of the policies and procedures set forth in the DHCS guidance on the family therapy benefit can be drawn from the 2016 federal Medicaid guidance on coverage of maternal depression screening and treatment. Whether the focus is on a new policy, payment procedure or other change, the federal guidance notes that, "states and managed care plans use a variety of approaches to promote a new benefit among providers, including:

- Posting information on provider websites and publishing information in provider newsletters.
- Delivering provider trainings to promote the use of [the new benefit]and proper billing codes.
- Conducting in-person visits to clinics to train providers on how to implement [the new benefit], help practices modify clinic flow, and discuss referral strategies.
- Offering practitioners continuing medical education (CME) credits for participation.

States that elect to cover a new service utilizing a managed care delivery system must ensure that the service is appropriately reflected in the managed care plans' contract and can include performance standards to ensure that the service is widely performed. Activities designed to promote use of a new benefit among Medicaid providers and to train them on how to incorporate the new benefit into the EPSDT well-child visit are generally eligible for Medicaid administrative matching funds." [23]

[21] New Mexico requires their Medicaid MCOs to engage a minimum of three percent of the MCOs' total enrollment with CHWs who are either employed or contracted with the MCO or community health representatives/organizations to provide care coordination; health education outreach; informal counseling; community support services; social supports; advocacy; and translation services. MCO contract available here.

[22] 42 CFR § 438.10. Available here.

[23] CMS. CMCS Informational Bulletin: Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children. May 2016. Available here.

Minnesota's Department of Health coordinated extensive provider training and outreach to ensure healthcare providers accessed the state's new maternal depression screening benefit reimbursable under the child's Medicaid ID. The Department designed, published, and promoted a resource page for providers, including proposed work flows for pediatric primary care providers implementing the maternal depression screening in well-child checks; clinical guidelines; scripts and appropriate language to use when discussing results with the mother in a pediatric setting; and how to document the mother's screening results in a child's medical chart.[24] In addition, the Department updated the Minnesota's Child and Teen Checkups Provider Manual (the State's well-child visit requirements) to include the provider resources for maternal depression screening, as well as payment and reimbursement policies and protocols.[25]

In California, Medi-Cal is jointly administered at the state and county levels. DHCS has used its authority to promote the uptake of new policies and procedures, most recently via ACEs Aware grants to eligible local entities and providers.[26] In addition, Local Government Agencies (LGAs) participating in the County-based Medi-Cal Administrative Activities (CMAA) program are eligible to receive federal reimbursement for a portion of the costs of performing certain administrative activities. LGAs may also contract with private community-based organizations to perform CMAA activities.[27]

| TABLE B: Implementation & Promotion of Medi-Cal Covered Benefits | | | | | |
|---|---|---|---|---|---|
| **Task** | **Responsible Entity** | | | | |
| | **DHCS** | **Medi-Cal Health Plans** | **Medi-Cal Providers & Provider Associations** | **First 5 County Commissions** | **Family/Beneficiary Organizations** |
| Announce and promote family therapy through an All-Plan Letter that elevates the importance of the benefit and clarifies MCO responsibility to pay appropriate claims. The All-Plan Letter can encourage health plans to support provider and beneficiary education | ✓ | | | | |
| Provide outreach, education, and training for pediatric providers on the value of family therapy, how to determine eligibility, billing codes, reimbursement protocols, etc. | ✓ | ✓ | ✓ | ✓ | |
| Conduct outreach to Medi-Cal beneficiaries to inform on the availability of family therapy and how it can help | ✓ | ✓ | | ✓ | ✓ |

[24] Minnesota Department of Health. Perinatal Mental Health – Information for Health Professionals. Available here.
[25] Minnesota Department of Human Services. Child and Teen Checkups Provider Manual. October 2019. Available here.
[26] ACEs Aware. ACEs Aware Grants. June 2020. Available here.
[27] DHCS. County-Based Medi-Cal Administrative Activities Program Description. November 2019. Available here.

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| Establish partnerships to share the importance of family therapy and how to ask for help | | | | ✓ | ✓ |

## Conclusion

The close alignment of Medi-Cal covered services with the services evidence-based dyadic care models such as HealthySteps and DULCE routinely deliver to young children and their parents/caregivers presents new opportunities to extend preventive care as envisioned by these and similar models throughout California. Taking affirmative steps to address remaining gaps in covered services (such as coverage for services delivered by Community Health Workers), as well as efforts to optimize utilization of key services, makes such opportunities even more feasible to adopt and sustain. Medi-Cal managed care plans and First 5 County Commissions can strengthen partnerships to help sustain dyadic care models, as well as leverage the existing early childhood community-based service network, to ensure young children and their families have access to the services and supports they need.

One opportunity to support dyadic treatments and models such as HealthySteps and DULCE is in the upcoming Medi-Cal managed care contract reprocurement Request for Information (RFI) released September 1, 2020 with public comment available through October 1, 2020.[28] The RFI will inform DHCS's development of the Request for Proposal (RFP) expected to be released in early 2021, with the newly procured contract expected to be implemented in January 2024.[29]

[28] DHCS. Request for Information: #20-001: Managed Care Plans. August 2020. Available here.
[29] DHCS. Medi-Cal Managed Care Request for Proposal Schedule by Model Type. February 2020. Available here.