

# The California Children's Trust Initiative: Financing New Approaches to Achieve Child Well-Being

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There is striking evidence of a growing crisis in the health and well-being of California's children. As detailed in *The California Children's Trust Initiative: Reimagining Child Well-Being*<sup>1</sup>, nearly all children and youth in California are vulnerable to, or already experiencing, social, emotional, mental, and developmental stressors and impairments. Yet paradoxically most children are not receiving any supports, including services covered by their health insurance. This is true for children in California at every developmental stage.

## **Children Under Age Six**

For California's children under age six, 1 in 4 is at risk for developmental, behavioral or social delays<sup>2</sup>. Yet less than 1 in 3 receive timely screenings. This places California 43rd in the nation for infant and toddler developmental screenings.<sup>3</sup>

## **School-aged Children**

For school-aged children, school readiness and achievement are critical drivers of child well-being and mobility. Yet, data from 2017 demonstrates that 40 percent of third graders are not reading at grade level, a critical indicator of future academic outcomes. More specifically, approximately 50 percent of California's Black and Latinx third graders are not reading at grade level, which exponentially increases their risk of dropping out of high school.<sup>4</sup>

## **California's Adolescents**

For California's adolescents and transitional age youth, high rates of depression and substance abuse have contributed to increasing inpatient visits for suicide, suicidal ideation, and self-injury. This has contributed to a 50 percent increase in hospitalizations for mental health related concerns for kids in California from 2007-2015.<sup>5</sup> Despite this increase, 66 percent of adolescents who reported a major depressive episode in the past year did not receive any treatment.<sup>6</sup>

Whether measured by risk, symptoms, utilization, or cost, California is underserving its children and youth's social, emotional, mental and developmental health needs. This is despite the fact that almost all children in California have an insurance plan with a mental health benefit.

**This brief outlines fiscal opportunities to initiate and invest in a fundamental re-imagining of how public child-serving systems approach and support children's social, emotional, mental, and developmental health in California.**

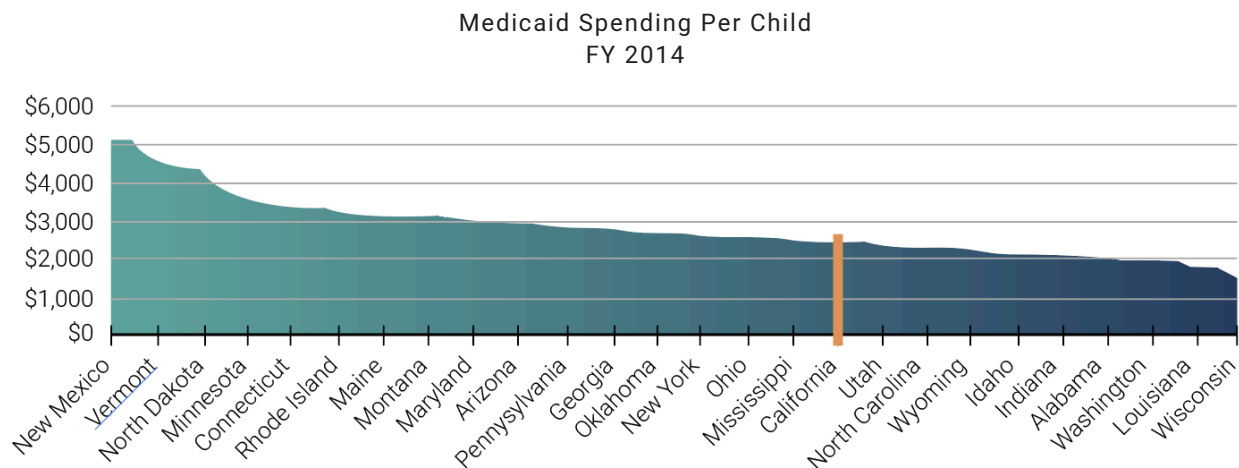
***While this brief focuses on the financial choices and opportunities for California, simply adding capacity and resources to the existing system is not an adequate solution. California needs a holistic and prevention-oriented system of care that reaches children where they are, and provides the right services and supports, at the right time, across all child-serving systems. This will be the subject of an upcoming publication.***

## Why is Medi-Cal the Foundation of Child-Serving Supports in California?

### A majority of California children have Medicaid (called Medi-Cal in California).

Approximately 6.1 million children, nearly 60 percent of all kids in California, are enrolled in Medi-Cal.<sup>7</sup> This reflects a large number of children who live in or near poverty in our state, but also signals a major opportunity to serve over half of California's children through one publicly-funded system.

Unfortunately, California does not have a history of strong and sustained behavioral health investments in children and their families. In 2014, health spending per full-benefit child enrollee in California was \$2,500, ranked in the bottom third of all states.<sup>8</sup>



**For children, the importance of Medi-Cal is magnified since the federal law governing the program includes specific benefit requirements for covering children and youth under the age of 21 through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate.** This federal mandate states that because children experience unique developmental and behavioral changes, states should have the ability to cover a wider range of supports and services for them, under a broad definition of “medical necessity.”<sup>9</sup> However, until recently,<sup>10</sup> California state law included a confusing definition of medical necessity that resulted in more restrictive applications of the broad federal standard. As a result, many California children have not been deemed eligible to receive crucial services.

**EPSDT is a federal entitlement.** Every child covered under Medi-Cal has the opportunity to access services from multiple state and county agencies that are tasked with meeting the social, emotional, mental, and developmental needs of children and youth. Each state agency has different infrastructure and rules guiding what it can pay for, different definitions and measurements for child well-being, and difficulties sharing information—resulting in a lack of accountability to each other and to the children and families they serve. Further complicating the picture is that for children and families to receive services, multiple local departments across each of California's 58 counties must interpret, administer, and coordinate the funds and programs with all of these state agencies. This structure creates an unnecessarily confusing and burdensome process for families trying to navigate services and manage their

child's specific needs.

**When Medi-Cal falls short of its promise, kids, families, and communities lose.** To date, California has failed to ensure widespread access through the EPSDT entitlement despite its generous financing and eligibility rules. While EPSDT services are federally entitled to all 6 million children in California's Medicaid program, less than 5 percent<sup>11</sup> are receiving any specialty mental health services; many get the wrong service, obtain services late or get treatment in a restrictive, punitive, or high acuity setting; and most children receive no services at all. California has not taken full advantage of flexibility and funding opportunities in Medi-Cal and the EPSDT entitlement represents a critical opportunity to get it right for the state's children and families.

### **How Does Medicaid Financing Work?**

Medicaid is a federal cost sharing program, dependent on state and county administration and funding to generate federal matching dollars. In California, much of the responsibility for seeking federal matching funds for mental health services devolves to counties. Current practices among counties are plagued by a difficult administrative burden and the uneven and fragmented sources of non-federal dollars counties receive.

Specifically, the federal government guarantees matching funds for certain Medi-Cal expenditures by providing at least \$1 in federal funds for every \$1 in state spending on the program. For some services or populations, the federal government provides a higher matching rate, such as for children in Medi-Cal who are eligible for the Children's Health Insurance Program (CHIP). Additionally, California has flexibility in determining the sources of state and local funding for the non-federal share of Medicaid spending. This open-ended financing structure allows federal funds to go to states based on costs and needs. If medical costs rise, more individuals enroll due to an economic downturn, or there is a natural disaster (like the recent Camp Fire<sup>12</sup>), Medicaid can respond and federal payments automatically adjust to reflect the additional costs of the program.

In the following section we have outlined some key federal and state opportunities that will allow California to approach care for children differently, while leveraging Medi-Cal to maximize revenue.

## **Federal Opportunities for Innovation and Programmatic Change**

Historically, there has been a tradition of bi-partisan agreement on children's health coverage, and recent legislation and programs have continued to signal the federal government's commitment to children's health. Some of these efforts offer opportunities for innovation, integration, and new models of care and coordination to support children's social and emotional health. Opportunities that California should explore further or consider include:

**1915(b) and 1115(a) Waiver Renewal Opportunities:**<sup>13</sup> Traditionally, federal waivers have been used to include health care treatments that are usually not covered by Medi-Cal and to waive certain provisions of Medicaid law to give states greater flexibility. In recent years, some states have begun using federal waivers to expand the role of traditional health care by funding services that address social determinants of health. For example, CMS approved North Carolina's 1115 Waiver, authorizing the state to run a pilot program coordinating organizations to provide non-medical care like housing supports, legal assistance, meal delivery, and transportation assistance for victims of domestic and other violence.<sup>14</sup> Section 1115(a) of the Social Security Act gives states the ability to plan, negotiate, and implement experimental, pilot or demonstration projects that promote the objectives of Medicaid and CHIP. Section 1915(b) of the Social Security Act gives states the ability to restrict enrollee's freedom of choice. California uses its Section 1915(b) waiver to implement its specialty mental health services program through local mental health plans. In November 2018, CMS sent a letter to state Medicaid directors specifically encouraging states to pursue waivers that targeted children with serious emotional disturbance (SED)<sup>15</sup>. This type of Medicaid reimbursement mechanism is known as an Intergovernmental Transfer (IGT) model.

In California, both Section 1115(a) and 1915(b) waivers were approved for a five-year term in 2015 and are up for renewal in 2020. This impending negotiation provides an opportunity for the state to revisit and restructure the financing and delivery system of behavioral health services.

**Enhanced Federal Matching Funds Available for Data Sharing:**<sup>16</sup> In a recent letter, CMS reminded states of existing opportunities to better coordinate care, such as improving data-sharing capabilities between schools, hospitals, primary care providers, criminal justice, and specialized mental health providers. Not only can states draw down a higher match for improving their data sharing, CMS encourages it, noting that the ability to share data across agencies "can help improve access to treatment." California must improve data sharing in order to ease administrative burdens and improve services and outcomes.

**The Social Impact Partnerships to Pay for Results Act (SIPPRA):**<sup>17</sup> SIPPRA is a new federal program that funds "social impact partnerships." SIPPRA will provide federal dollars for health-related projects, including, but not limited to: improving birth outcomes and early childhood health and development among low-income families and individuals; reducing rates of asthma and diabetes; improving the health and well-being of those with mental, emotional, and behavioral health needs; and improving the educational outcomes of special-needs or low-income children. Although the deadline has passed for 2019 funding, SIPPRA could be an important model for California's efforts going forward.

**Integrated Care for Kids (InCK) Model:**<sup>18</sup> The Centers for Medicare and Medicaid Services (CMS) announced a funding opportunity to test interventions focused on fighting the opioid crisis. InCK is a child-centered model to be delivered through local service systems while using state payment models to fund services. The model will offer states and local providers support to address prevention and intervention supports through a framework of child-centered care integration across behavioral, physical, and other child providers. Although the deadline has passed for 2019 funding, InCK could be an important model for California's efforts going forward.

## Opportunities to Better Leverage State and Federal Funds

Through the opportunities referenced above, federal policymakers have signaled their desire to redesign and restructure supports and services to support children’s social and emotional health in Medicaid. Numerous opportunities exist with known revenues to reimagine California’s support for children and to secure the resources necessary to dramatically expand the nature and scope of services.

California must examine every possible mechanism to simplify and improve claiming models and practices—something that California did when it transformed its physical health payment models from fee-for-service to managed care in the late 1990’s. It is critical to recognize the essential role non-federal dollars play in the Medicaid program for children—particularly under the EPSDT entitlement. If the state and counties identify allowable non-federal dollars, and claim them appropriately, this could draw down significant new federal dollars.

## How Can We Access More Federal Funds?

**Counties can increase their ability to claim federal funds for specialty mental health services:** Unlike the majority of physical health services provided under traditional managed care, county Mental Health Plans (MHPs) are not paid on a capitated basis.<sup>19</sup> Instead, MHPs must pay providers for care at the time of service using local or state dollars. After submitting required documentation to the state, counties then receive the federal match on an interim basis throughout the year.<sup>20</sup> This process requires county MHPs to have enough revenue available to incur the full cost of a service prior to receiving federal reimbursement. This Medicaid reimbursement mechanism is known as a Certified Public Expenditure (CPE) model.

### Mechanisms for Claiming Medicaid Dollars<sup>21</sup>

**Certified Public Expenditure (CPE):** CPE is a statutorily recognized Medicaid financing approach by which a governmental entity, including a provider (e.g., county hospital, local education agency), incurs an expenditure eligible for federal match. The Department of Health Care Services (DHCS) certifies that the funds expended are public funds used to support the full cost of providing the Medicaid-covered service or the Medicaid program administrative activity. Based on this certification, the state then claims federal funds. In other words, counties must spend money first, and then be reimbursed by the federal matching funds.

**Intergovernmental Transfer (IGT):** An IGT is a transaction whereby local public dollars are pooled and used as the non-federal share of a matching program that pulls down federal financial participation. IGTs are commonly used by counties to contribute to the non-federal share for certain governmental providers (e.g., community mental health centers, hospitals) located in those counties. IGTs may also be contributed to directly by governmental providers themselves, such as hospitals operated by state or local government. IGTs can be used to contribute to CPEs that the state then certifies to claim federal funds.

**2011 Realignment funding is a primary source of county revenue used for EPSDT federal match:** As part of the 2011–12 budget plan and in response to the state budget crisis, Governor Brown and the Legislature enacted a major shift, or “realignment,” of fiscal and programmatic responsibility for designated public safety and health and human services programs to counties, with key provisions codified in the state Constitution when voters passed Proposition 30 in 2012. Realigned programs are funded by a dedicated portion of vehicle license fees and state sales tax revenues, and allocated to counties based on a formula. Counties receive 2011 Realignment funds for EPSDT through the Behavioral Health Subaccount, as well as the Behavioral Health Services Growth Special Account.

The impact of 2011 Realignment on children’s behavioral health services is obscured by the lack of publicly available data on how realignment funds are used, as well as several concurrent policy changes, such as the implementation of the Affordable Care Act (ACA). DHCS has clarified that EPSDT is a federal entitlement and that Subaccount allocations are not intended to result in caps to services. Given that service engagement rates for specialty mental health services have stagnated at just above 3 percent<sup>22</sup> over the past four fiscal years, despite more than \$800 million in Growth Special Account Fund and Behavioral Health Subaccount allocations to counties between FY 12-13 and FY 17-18,<sup>23</sup> it is clear that more oversight is needed to understand how funds are used, and to hold counties accountable for providing and measuring the effectiveness of entitlement services.

**There is a need to increase capacity to claim for administrative activities related to behavioral health:** Due to the complexity of documentation and rules of the claiming process,<sup>24</sup> there is variability in counties’ ability to receive federal matching funds for the administration of services. For example, in 2016-2017, MHPs claimed a total of \$28 million of behavioral health administrative activities, also known as Behavioral Health MAA. Alameda County, which represents only 5 percent of the state’s Medi-Cal managed care population,<sup>25</sup> claimed \$17.3 million, while Los Angeles County, with almost 30 percent of the state’s Medi-Cal managed care population, only claimed \$2.7 million<sup>26</sup>.

**The state can better leverage expenditures to claim federal funds:** There are a number of additional current Medi-Cal programs and activities for which California should gain federal matching funds. These include funding models through Managed Care Organizations, Local Education Agencies (LEAs), Federally Qualified Health Centers (FQHCs), and Local Government Agency (LGA) claiming programs.

For example, through the School-based Medi-Cal Administrative Activities (SMAA) program, school districts can be reimbursed for coordinating services from outside providers like translation services. Similarly, through the LEA Medi-Cal Billing Option Program, school districts can be reimbursed for health care services provided by either district employees or outside providers. The majority of the students receiving both SMAA and LEA services are eligible for Medi-Cal. The services provided are eligible for Medi-Cal federal matching funds, but California school districts have reported a hesitancy to bill for these services due to administrative burden and increased financial risk. California ranks 28<sup>th</sup> in the country for the estimated percent of children with a serious emotional disturbance, but ranks 43<sup>rd</sup> for Medicaid spending per student on school-based physical and mental health services, illustrating the state’s inability to fully realize the benefit of Medicaid.<sup>27</sup>

Working with counties to standardize and improve their claiming practices can generate significant new revenue in the form of technical assistance and guidance from DHCS,

from regional collaborations, or from new models of reimbursement tied to enrollees, like capitation or case rate models.

## How Can We Apply More State Funding to the Well-being of California's Children?

There are a number of potential sources of state funds that can serve as new, non-federal sources for an expansion of Medicaid funded services and supports.

**Mental Health Services Act (MHSA) (Proposition 63) can be used to better coordinate care:** MHSA continues to be a pillar of support for mental health services for children and youth. Statewide, MHSA generated more than \$2 billion in FY 2017-18,<sup>28</sup> and these funds should be used as a source of non-federal share. Recently, DHCS and the Mental Health Services Oversight and Accountability Commission have been criticized because many counties have struggled to spend down their MHSA dollars. In 2018, it was reported that counties had built up approximately \$230 million in unused funds.<sup>29</sup> There are many ways to utilize MHSA funds to redesign, improve and expand behavioral health supports for children. Recommendations about how to use those funds to benefit youth can also be found in Children Now's Leveraging MHSA Funding to Coordinate Care for Children.<sup>30</sup>

**Proposition 64 is available to support youth:** In 2016, voters approved Proposition 64, which legalized the use of cannabis for nonmedical purposes by adults age 21 and over. Proposition 64 taxed the purchase of cannabis and directed its revenues for various purposes. After allocating the dollars on specific revenues, Proposition 64 requires 60 percent of the remaining funds be dedicated to the Youth Education, Prevention, Early Intervention and Treatment Account. Funds will be allocated to DHCS to support youth programs, including the substance use disorder education, prevention, and treatment program.<sup>31</sup> Recent reports show that more than a year after implementation, funding to youth programs is not yet flowing.<sup>32</sup>

**Mental Health Plan (MHP) financing reforms can be explored:** California should explore alternative payment models for county mental health plans, targeting how plans receive dollars from the state and federal government and how they provide and procure services at the local level. By creating greater alignment between MHP service delivery and reimbursement with managed care organizations, the state can begin to explore different ways to ease the burden on plans and providers focusing on both aspects of payment reform—how plans get paid and what they pay for. New financing models could include capitated payments or the merging of county MHPs with traditional managed care plans, particularly in underserved regions struggling with the administrative burden and complexity of Medicaid administration and financing. Using waivers to implement creative financing models in California, known as Intergovernmental Transfers (see page 6), California could pilot new payment models between local jurisdictions and the state, or between providers and plans. Similar to what the state has pursued in Whole Person Care and in Health Homes, California can apply proven Medicaid financing strategies to the crisis of youth mental health in California.



**Increased State General Funds are available:** California’s economic security has increased substantially over the last few years. The general fund boasts a strong discretionary reserve of \$9.1 billion<sup>33</sup>, a surplus the state has the ability to use to increase spending on key programs if it chooses.

## The Opportunity to Fund a New Future

California has a unique opportunity to fund a more robust and responsive network of child-serving agencies and organizations to address the growing social, emotional, mental, and developmental health needs of our children. The urgency to meet these needs demands new resources that can make a new future possible. The federal government has signaled that it is willing to support substantive change to the way states provide for the well-being of children, and California has the wherewithal to restructure and increase funding across child-serving systems. California can create an equitable, holistic, coordinated system that meets the individual needs of children by leveraging Medi-Cal’s ability to reduce poverty by providing health insurance, its unique promise to children through the EPSDT benefit, and its capacity to provide services across child-serving systems.

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The California Children’s Trust was established to transform the administration, delivery and financing of our child-serving systems to ensure that they are equity-driven and accountable for improved child health outcomes. We are a statewide initiative that seeks to improve child well-being through policy and systems reform.

Learn more at [www.cachildrenstrust.org](http://www.cachildrenstrust.org)



Children Now is on a mission to build power for kids. The organization conducts non-partisan research, policy development, and advocacy reflecting a whole-child approach to improving the lives of kids, especially kids of color and kids living in poverty, from prenatal through age 26.

Learn more at [www.childrennow.org](http://www.childrennow.org)

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