MAXIMIZING MEDICAID FUNDING:
LEVERAGING THE COMMON DENOMINATOR ACROSS ALL CHILD SERVING SYSTEMS TO RE-INVENT BEHAVIORAL HEALTH

Overview and Call-to-Action
May 2020
THERE IS A CRISIS IN CHILDREN’S MENTAL HEALTH
Consider the facts

104% Increase in inpatient visits for suicide, suicidal ideation and self injury for children ages 1-17 years old, and 151% increase for children ages 10-14

50% Increase in mental health hospital days for children between 2006 and 2014

61% Increase in the rate of self-reported mental health needs since 2005

43rd California ranks low in the country for providing behavioral, social and development screenings that are key to identifying early signs of challenges
THE “PRICE” IS HIGHER FOR BLACK AND BROWN CHILDREN
They receive the wrong services at the wrong time

81% of children on medicaid are black or brown.

The suicide rate for black children, aged 5-12 is 2x that of their white peers.

70% of youth in California's juvenile justice system have unmet behavioral health needs, and youth of color are over-represented in the system.

Addressing disproportionality in the mental health system is not just a matter of tweaking access or programs, it is a matter of rooting out racist infrastructure.
AND ALTHOUGH ELIGIBILITY FOR MENTAL HEALTH SERVICES HAS INCREASED

6 million of California's 10 million children are covered by Medi-Cal and EPSDT entitlement (a 33% increase over last five years)

96% of California children are covered by a health plan with a mental health benefit
ACCESS TO MENTAL HEALTH SERVICES, ESPECIALLY FOR VULNERABLE CHILDREN, HAS DECLINED

The access rate (one-time visit), has declined from 4.5% to 4.1%. For ongoing access (more than 5 visits), the rate is down to 3%

Those accessing care, are approaching the system in crisis

There has been a 20% increase in crisis service utilization since 2011
WE HAVE A ONCE-IN-A-GENERATION OPPORTUNITY TO ADDRESS THE CRISIS

Public opinion and policymaker agendas are aligned

- **Political will**: New administration has stated focus on children’s well-being.

- **Community support**: Half (52%) of all Californians say their community does not have enough mental health providers to serve local needs.

To take advantage of this moment in time we must:

- Embrace the critical need to reform our financing strategy, and

- Fundamentally transform how we fund and administer children’s behavioral health services, during a time when

- COVID-19 has created massive holes in local safety net services due to dramatic revenue decreases and budget cuts.
WHAT WILL CALIFORNIA DO— AS THE FIFTH LARGEST ECONOMY IN THE WORLD—WHEN IT SEES THAT TWICE AS MANY OF ITS CHILDREN ARE TRYING TO KILL THEMSELVES?
THIS IS THE TRUST’S FRAMEWORK FOR SOLUTIONS

- Expand Access and Participation: Expand who is eligible, who can provide care, what is provided, and the agency of the beneficiary
- Increase state and county spending, and fully claim the federal match
- Maximize Funding
- Equity + Justice
- Reinvent Systems
- Increase transparency and accountability
BEFORE WE CAN TALK ABOUT SOLUTIONS, WE HAVE TO UNDERSTAND THE SYSTEMS AND THE PROBLEMS
1/3 of Californians are covered by Medi-Cal (California’s version of MEDICAID), which underinvests in their mental and behavioral health. Children are historically the most underfunded.

**Total Dollars:** $105.2 Billion

**Total Californians:** 39 Million

**BEHAVIORAL HEALTH:** $12 BILLION

**MEDI-CAL COVERED:** 13 MILLION

*Current budget estimates show a 25% increase in Medi-Cal enrollees due to COVID-19*
THE SYSTEMS

MEDICAID BY THE NUMBERS - CALIFORNIA’S KIDS

Almost 6 out of 10 children are covered by Medi-Cal. They are served by county administered Specialty Mental Health Plans (MHP) and Medi-Cal Managed Care Organizations (MCO’S)

- Total California Children: 10 Million
- MCO Total Served Annually: 90,000 Kids
- MHP Total Served Annually: 152,409 Kids
- Eligible & Not Accessing: 96%

Commercially Insured: 4 Million
Medi-Cal Covered: 6 Million
EPSDT is an entitlement.
All allowable expenditures for eligible populations must be matched.
THE SYSTEMS

ORIGIN STORY OF EPSDT: THE VIETNAM WAR

• 50% of draftees failed their medical and/or mental health entrance exam for reasons that it was determined could have been addressed in childhood and adolescence.

• These young adults typically came from impoverished families (nearly 50%) and had experienced unrelenting deprivation in health care, education, and employment.

• The report’s findings provided compelling evidence for an underlying tenet of President Johnson’s conclusion that improving the health and well being of the nation’s poor required strategies aimed at ameliorating the effects of social, economic, and health disparities—a foundational finding for the establishment of EPSDT.
Certified Public Expenditure (CPE) = A state’s use of public funds spent by other government entities (in this case, a county) to claim federal reimbursement for Medicaid services.

Federal Financial Participation (FFP) = The Federal share of Medicaid dollars – GUARANTEED
THE SYSTEMS

3 PRIMARY SOURCES OF NON-FEDERAL FUNDS (CPE) ARE ESSENTIAL TO TRANSFORMING THE SYSTEM

Estimated FY 2019-20

- Federal Medicaid Matching Funds (FFP) $3.2B
- Mental Health Services Act (MHSA) $2.3B
- 1991 Realignment Mental Health $1.3B
- 2011 Realignment $1.5B
- State General Funds $304M
- SAPT Block Grant $231M
- Other MH Funds $350M

Sources: CA Governor’s 2020-21 Budget (January 2020); CA State Controller’s Office; and DHCS Medi-Cal Estimates
## THE SYSTEMS

### OVERVIEW OF FUNDING MEDI-CAL MENTAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>MANAGED CARE ORGANIZATIONS (MCO)</th>
<th>$2.5 Billion</th>
<th>$12 Billion</th>
<th>$9.5 Billion</th>
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<tbody>
<tr>
<td></td>
<td>Mild to moderate levels of impairment</td>
<td>A Medi-Cal beneficiary's severity of illness drives the funding source for the mental health services</td>
<td>Significant levels of impairment that meet Title 9 medical necessity criteria</td>
</tr>
<tr>
<td></td>
<td>1) Beneficiary accesses MH services via Medi-Cal FFS or Medi-Cal Managed Care Plan</td>
<td>1) Beneficiary accesses mental health services via County MHP</td>
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<tr>
<td></td>
<td>Medi-Cal FFS Enrollee</td>
<td>2) Provider submits claims for payment to the County MHP</td>
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<td>2) Providers submit claims directly to DHCS.</td>
<td>3) MHP pays 100% of the up-front costs of services at reimbursement rates set by the county for directly operated and contracted services</td>
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<td>Medi-Cal managed Care Plan Enrollee</td>
<td>4) MHP submits Certified Public Expenditures to the DHCS to draw down federal reimbursement for Medi-Cal</td>
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<td>3) DHCS reimburses providers via a fiscal intermediary.</td>
<td>5) DHCS reimburses the MHP costs throughout the year based on the federal matching rate</td>
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<td>4) DHCS seeks reimbursement from CMS.</td>
<td>6) DHCS seeks reimbursement from CMS</td>
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<td>7) Year-end cost reconciliation between DHCS and county MHPs</td>
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**DHCS is responsible for the non-federal share of Medi-Cal through state General Fund revenue.**

**Counties are responsible for the non-federal share of Medi-Cal funding through the following revenue sources:**

- 1991 & 2011 realignment
- MHSA and county general fund

**Mental Health Plans (MHP):**

- DHCS reimburses the MHP costs throughout the year based on the federal matching rate.
MENTAL HEALTH PLANS: 4 WAYS TO CLAIM CERTIFIED PUBLIC EXPENDITURES (CPEs)

- Direct services—including case management
- Utilization review and quality assurance
- Medicaid administrative activities
- Administrative—15% cap on gross expenditures
THE SYSTEMS

MANAGED CARE ORGANIZATIONS: THE SLEEPING GIANT OF CHILDREN’S MENTAL HEALTH

• Funded through capitated payments, per member/per month
• Designed to spread risk across a broad population
• Children represent 42% of enrollees, but only 14% of expenditures

Urgent Questions:
• What’s behind the gap between children enrollees, access and expenditures?
• If plans are being paid, but children are not being served, where is the money going?
• How can MCOs use the money to address the children’s mental health crisis?
THE SYSTEMS

FUNDING MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES

Here’s what you need to know:

1. The federal Centers for Medicare and Medicaid Services (CMS) administers the federal Medicaid programs for people with low incomes and/or disabilities.
2. California operates the largest Medicaid program in the nation, called Medi-Cal.
3. The state Department of Health Care Services (DHCS) administers the Medi-Cal program.
4. Local Mental Health Plans (MHPs) are county-organized and operated entities that contract with DHCS to provide Medi-Cal specialty mental health services.
5. Counties manage non-risk contracts, meaning there is no ceiling on the amount of federal reimbursement they may draw down so long as counties can provide the non-federal share using the various dedicated mental health funding sources.
6. Counties are both administrators and providers of mental health services. Counties vary in the portion of services they provide directly and contract out, but as much as 80% of services are provided via contractors in some counties.
Most state revenue for mental health services flows directly to county-managed accounts. State law dictates how counties must spend these funds, but counties have significant flexibility and local control.

1. **State Collects Dedicated Revenue**
   - MHSA tax on personal income more than $1 million
   - 2011 realignment funds: state sales tax
   - 1991 realignment funds: State sales tax and vehicle license fees

2. **State controller distributes revenue to county accounts according to methodologies outlined in state law**
   - 2011 Realignment Subaccount
   - Mental Health Services Act Account
   - 1991 Realignment Subaccount
   - Local taxes or fee collections

3. **Money deposited into County Subaccounts**
   - Counties must match 1991 realignment mental health funds with a “maintenance of effort” amount of local tax money.

California pays for public mental health services primarily through dedicated revenue sources that are not directly subject to the annual state appropriations process.

Through a unique policy approach known as “realignment,” revenue flows directly from the state to counties through a distribution methodology set in state law.

Counties must use these funds for certain programs and populations. Generally, Medi-Cal beneficiaries have first priority for the funds, as the law only requires that services for uninsured residents be provided “to the extent resources are available.”

If demand and costs exceed the revenue a county receives from the state, the county must use local dollars to cover the difference or some clients’ needs may go unmet. Some counties contribute more local dollars to mental health services than others.
The Problems

Dramatic Under-Investment

- California is in the bottom 1/3 nationally for health spending at $2,500 per child enrollee.

- Children represent 42% of enrollees but only 14% of expenditures.
THE PROBLEMS

CALIFORNIA’S FRAGMENTED, CAUTIOUS AND COMPLEX SYSTEMS

• Fragmented child-serving systems make it difficult to coordinate care and find innovative payment solutions.

• Entrenched cultural differences amongst systems undermine trust and collaboration.

• The structure of the federal reimbursement—provider-county-state-federal—triggers cautious behavior and stymies the entrepreneurial spirit needed to find and follow CPE dollars.

• A uniquely complex and administratively burdened system for claiming specialty mental health services.
THE SOLUTION

MEDICAID IS THE TIE THAT BINDS FRAGMENTED CHILDREN’S SYSTEMS
THE SOLUTION

FOLLOW MEDICAID DOLLARS TO FIND MONEY LEFT ON THE TABLE

Federal Government
Distributed through Federal departments with funding authorized by Congress

State of CA
Acting as pass through, enhancer, or reconciler of funding

Health Plans (MCO) CAPITATION

County Mental Health Dept’s (MHP) CPE
THE SOLUTION

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- Health Plans (MCO) CAPITATION
- County Mental Health Dept’s (MHP) CPE
- Dept. of Heath (LGA) CPE
- School Districts (LEAs/SELPAs) CPE
- Community Health Centers FQHC PPS
- Hospital UC/PH IGT
- Regional Center CPE
FOLLOWING MEDICAID DOLLARS CAN WORK

Persistence. Questioning the culture of entrenched systems. Mutual accountability.

1996
Alameda County
4 School Health Centers

2019
Alameda County
200 School Health Centers

Today
10,000 Children Added Care – Most Through Schools

Nine funding sources bundled to match this funding

- BHCS (EPSDT + match)
- CHSC Discretionary
- MHSA PEI (ongoing)
- MHSA PEI (one time)
- Measure A, CHSC
- BHCS SAPT Block Grant
- EPSDT/ERMHS blend
- School Districts
- Measure Y
WHAT CAN WE DO TO INCREASE STATE AND COUNTY SPENDING, AND FULLY CLAIM THE FEDERAL MATCH

How We Do It

• Transform state and local Medicaid claiming practices.
• Expand the role and participation of managed care organizations.
• Dig deeper into child-serving systems to find eligible share dollars.
• Advocate for increased Federal Medical Assistance Percentages (FMAP).