

COVID-19 and Demands for Racial Justice Underscore the Urgent Need to Advance CalAIM's Children's Behavioral Health Reform Effort

Our nation is experiencing the rage, grief, fear, and uncertainty of the compounding crises of a global pandemic, economic recession, and response to deeply rooted racial injustice in this country, all of which creates trauma for youth and demands leadership and swift action to strengthen the systems foundational to their healing.

While the public narrative has painted COVID-19 as a shared common trauma, the reality is that the pandemic is disproportionately affecting already marginalized communities. Jevon Wilkes, Executive Director for the California Coalition for Youth (CCY), points to the ever-widening disparities across our communities as “COVID-19 leverages structural racism to prey on the vulnerabilities of the people that our public policy consistently undermines—poor people, people of color and people with pre-existing conditions.”¹ Youth and families of color, already facing far greater challenges and systemic barriers to health and wellbeing before this crisis, are disproportionately hurt in this turbulent time. CCY's statewide youth crisis line alone has seen a 227% increase in calls from youth ages 12 to 24 as compared to 2019. These disparities—and the continued systematic racism and violence perpetrated against communities of color—are at the heart of the protests and anger gripping our country today.

COVID-19 has not only more clearly illuminated but also compounded these disparities, and in the context of a children's mental health crisis that existed prior to the onset of the global pandemic. In the decade before COVID-19, children and youth (ages 5-19) experienced a 52% increase in mental health hospitalizations.² Suicide is the second leading cause of death among young people ages 15 to 24, according to a 2017 study from the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Also, the CDC released 1991-2017 High School Youth Risk Behavior Survey Data that reported that one in six high school students stated they seriously considered ending their lives and more than one in 12 reported attempting suicide.

With the onset of COVID-19, school closures and shelter-in-place orders have disconnected children and families from some of their best and most accessible supports: education, food, social networks, and access to care. Children are suffering, and now is not the time to stop working toward a system that can meet their needs. California Surgeon General Dr. Nadine Burke Harris has stated that because of this pandemic, “we're going to see increased stress-related cognitive impairment and diseases” and probably increased toxic stress among young people. Experts say that when kids return to schools, the demand for mental health care will be greater than the available services, as the effects of the coronavirus disruptions cut across socioeconomic status, affecting all children throughout California.

¹ Chronicle for Social Change. “The Pandemic You Know, and the One You Don't: Vulnerable Youth in the Crisis.” April 30, 2020. Available at: <https://chronicleofsocialchange.org/child-welfare-2/pandemic-you-know-one-you-dont-vulnerable-youth-in-the-crisis/42962>

² Kidsdata: “Hospitalizations for Mental Health Issues, by Age Group. Available at: <https://www.kidsdata.org/topic/715/mental-health-hospitalizations/trend#fmt=2342&loc=2&tf=5,108&ch=1066&pdist=7>

The California Children’s Trust (CCT) and the California Alliance of Child and Family Services (CACFS) are among the many stakeholders who participated in the state’s CalAIM process over the past six months. Through CalAIM, the state signaled its intention to initiate structural reforms to the behavioral health sector to better serve vulnerable California residents. An astonishing amount of progress was made in a remarkably short time.

As COVID-19 continues to change our world, not to mention our state budget, we understand the timelines for implementing the sweeping changes to the Medi-Cal program proposed have also changed. However, **we urge the Administration, the Health and Human Services Agency, and Department of Healthcare Services leadership to continue to advance these key reform efforts, many of which can be acted on—in whole or in part—without a federal waiver.**

The great risk as we enter a period of economic recession is that we will pause on urgently needed system improvements, and in fact lose ground and witness a deterioration of our system of care. We cannot afford to lose ground as our Medi-Cal enrollment skyrockets and our public safety net is called upon to serve greater and greater numbers of Californians.

Even before the pandemic, the majority of children in California were enrolled in Medi-Cal, and the proportion was growing fast. According to the CalEQRO Performance Outcomes System, between 2010 and 2018, enrollment increased by 30%.³ Covered California has reported a 41% increase in enrollment across coverage offerings through April 1 due to the initial impacts of the pandemic. The current unprecedented job losses will undoubtedly result in more and more low-income families enrolling in Medi-Cal. The Children’s Trust projects a 25% increase in enrollment by fall 2020, bringing the total to 70% of the state’s children.

The recommendations outlined below can be accomplished through state plan amendments or through technical assistance, guidance, and incentives to county departments from the state. The CCT and CACFS remain ready partners in advancing all solutions to improve outcomes for children and youth in California.

Broaden the Definition of Medical Necessity for Children and Youth

We applaud the state’s commitment to modifying the eligibility criteria for Medi-Cal specialty mental health services in alignment with the EPSDT federal entitlement and reflecting the inherent limitations of a diagnosis-driven system for children. **We must shift from a diagnosis-driven system to an approach that responds to a child’s level of impairment and reflects an understanding of the impact of trauma and the social determinants of health on long-term health and mental health outcomes.**

Our comprehensive recommendations are included in [this letter to DHCS](#) from March 6, 2020, and includes the recommendation for standardized and simplified screening and assessment tools, presumptive eligibility for foster youth, and the elimination of delivery system screenings for children and youth. Many of these changes can be enacted through a State Plan Amendment and do not require a federal waiver to advance.

Maximize Federal Investment in Medi-Cal

The payment reform components of CalAIM would create unparalleled opportunity to maximize federal revenue and increase access to services for Medi-Cal beneficiaries. We recognize that the proposed move to an Intergovernmental Transfer (IGT)-based funding model may not be possible without a formal waiver process at this time, but there are still many mechanisms available to counties and the state that can be pursued in the absence of a waiver.

The CalAIM process facilitated a broader understanding of the self-imposed limitations of the Certified Public Expenditure (CPE) process across public system stakeholders. We must capitalize on that more nuanced understanding to advance several opportunities to maximize federal investment even without a shift to IGT:

- » Identify un-leveraged sources of eligible CPE across the child-serving systems, including social services, education, developmental services, and juvenile justice. The behavioral health needs of children often span multiple systems—the CPE for Federal Financial Participation (FFP) should as well. The Administration should convene state agency leadership and key partners in a process to identify unmatched sources of state and local revenue that can be used to draw down

³ DHCS MHS Performance Dashboard Archived Reports. Available at: <https://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx>

additional FFP in the provision of services.

- » Advocate for increased Federal Medical Assistance Percentages (FMAP) for the duration of the crisis and through the coming recession to facilitate cost savings for counties and the state while simultaneously incentivizing counties to invest in—not cut—behavioral health services for young people. The federal government has already approved a 6.2% increase in FMAP, but there is precedent for more robust investment. For example, the Affordable Care Act increased FMAP to 100% to encourage states to expand Medicaid coverage. As with ACA, the percentage can be gradually reduced over five years, to 90%, where we recommend it be permanently fixed. In addition to funding immediate response, this investment will develop sustainable system infrastructure and facilitate innovation.

Our comprehensive recommendations regarding payment reform are included in [this letter to DHCS](#) from March 6, 2020.

Eliminate Medi-Cal Administrative Inefficiencies to Save Money and Increase Access

CACFS and CCT also saw CalAIM as an opportunity to streamline the plethora of administrative barriers that restrict access to services. **Most importantly, we advocated throughout CalAIM for DHCS to create a set of statewide documentation forms and requirements that are standardized across all counties. In the absence of clear guidance and limited audit exposure from DHCS, our state now has 57 sets of requirements for SMHS documentation, a system which burdens mental health workers serving children in multiple counties.** This fragmented system creates a myriad of barriers to care, and many of the opportunities to simplify and streamline administrative inefficiencies are well within the purview of the state to implement without federal approval or authorization.

We also urge the Administration to consider a centralized credentialing process at the State (instead of at the MHP level) for providers. This has been done in Ohio, which also has a county-based mental health delivery system. The intention and benefit of state-level credentialing is to streamline the process and create efficiencies (and reduce administrative costs) so providers are not completing a credentialing application process with each county. In our current system, the same individual can provide certain types of mental health services in one county, but not in a neighboring county. This causes unnecessary service inequities and disruptions for children and families, and is the very definition of bureaucracy driving service access and quality.

No one questions the impact of the pandemic on the most vulnerable among us. We can and should use the unprecedented experience of COVID-19 to make reforms that will invest in the social and emotional health of our children. As they return to school, let us ensure every school is healing centered, and every child has access to dramatically expanded behavioral health supports, including clinical resources. Let us make sure low-income children have what they need to survive and thrive in a post-COVID world. As we seek to heal our nation, let us begin with our children, carefully cultivating their resilience and the positive wisdom and intelligence that is their birthright.

These recommendations reflect only a small portion of the comprehensive recommendations submitted by CCT and CACFS throughout the CalAIM process. The full list of submitted documents can be accessed here: [Medical Necessity \(March 6, 2020\)](#), [Medical Necessity and No Wrong Door \(Jan 3, 2020\)](#), [Payment Reform \(March 6, 2020\)](#), [Payment Reform \(December 23, 2019\)](#), [Behavioral Health Integration \(February 21, 2020\)](#).