Medi-Cal 101: The Financing Foundation

Webinar Series: The Path to Funding Racially Just, Relationship-Centered Schools

Training 1 | October 4, 2022
DRINKING FROM A FIRE HYDRANT

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California Children's Trust

60 MINUTES TO COVER...

• Medi-Cal as a Tool for Equity & Justice in Schools
• The Social and Emotional Health of Children in California: Striking Increases in Utilization and Acuity
• California’s Medicaid Program in Context
• How Medicaid Works and What It Means for Schools: The 7 Essential Medi-Cal Payors and The Need To Know Them All.
• A Framework for Solutions
• What’s Next and Where to Begin
THE SOCIAL AND EMOTIONAL HEALTH OF CHILDREN IN CALIFORNIA:

Striking Increases In Utilization And Acuity

How did we get here?
THERE IS A CRISIS IN YOUNG PEOPLE’S MENTAL HEALTH
Consider the facts before COVID-19:

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
Many receive the wrong services at the wrong time…in restrictive or punitive settings

81% of children on medicaid are children of color.

The suicide rate for black children, ages 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 dramatically over-represented.

Creating racially just, relationship-centered schools a reality isn’t simply a matter of tweaking access or programs…

It requires acknowledgment of how racism and poverty impact the social and emotional health of children
Beginning in April 2020, the proportion of children’s mental health-related ED visits among all pediatric ED visits increased and remained elevated through October.

Compared with 2019, the proportion of mental health related visits for children aged 5 to 11 and 12 to 17 years increased approximately 24% and 31% respectively.

One in four young adults between the ages of 18 and 24 say they’ve considered suicide because of the pandemic, according to new CDC data that paints a big picture of the nation's mental health during the crisis.
Half of all lifetime mental illness begins by age 14

Average delay between onset of symptoms and intervention is 10 years

Adolescents Ages 12-18

37% of students with mental illness age 14 and older quit school.

This is the highest dropout rate of any disability group.

National Institute of Mental Health. Mental Health by the Numbers. 2015.
THE MEDICAL MODEL ISN’T THE ANSWER

- Approximately 75% of mental illness manifests between the ages of 10 and 24. Since adolescents have the lowest rate of primary care utilization of any demographic group, it makes early warning signs difficult to detect.

- Provider shortages at the PCP and mental health practitioner level compound the challenge.

- Diagnosis-driven models are only appropriate for some children. Early identification and intervention is essential to any recovery framework.

How did we get here?

We have no common framework for defining and understanding behavioral health among and between public systems and clinical care providers.

Our public systems are deeply fragmented and under-resourced. Commercial payers have not effectively partnered with child-serving systems.

A lack of clarity over whether youth mental health care is an essential benefit or a public utility prevents commercial payers from fully engaging.

Our definition of medical necessity is outdated and inconsistent with emerging trends and evidence regarding the impact of trauma and adversity on social and emotional health.

The field is young. Many clinical modalities with widespread application are less than 20 years old.
WE HAVE EVOLVED TO BETTER MODELS

Where We Were

WAVE 1
Psychoanalysis

WAVE 2
Behavior Modification

WAVE 3
Humanistic/Experiential Psychotherapy

WAVE 4
Cognitive Psychotherapy

WE ARE HERE
Racial Justice and Social Capital Building Strategies in Emerging Delivery Models: Resisting Pathology

- Redefining Medical Necessity
- Expanding Eligible Providers
- Relationship-Centered Community Schools
- Peer Support
- Indigenous and Spiritual Practice Integration
- Family Resource Models
- Community Defined Practices
- Telepsychiatry
- Social Models
SCHOOLS CAN (and must) BE ESSENTIAL ACTORS IN OUR RESPONSE:

Schools are and have been ground zero for the youth mental health crisis, and our collective failure to support them has contributed to the marginalization of black and brown children (80% of children on Medi-Cal are children of color.) Medi-Cal covers more than half of all children in California but MCPs have struggled to invest strategically or effectively in Children's Behavioral Health. As a result, children make up 42% of enrollees but only 14% of all expenditures.

The Health Care System Needs Schools: Children ages 8-18 have the lowest rate of primary care utilization of any demographic in Medi-Cal—and 75% of mental illness manifests in adolescence. Not only are schools essential actors in a reformed mental health system that overtly addresses healing, justice, and structural racism, but they are also essential service settings for children with clinical needs.

The Finances Align: Schools have what the publicly funded Medicaid system needs: 1) Access to kids 2) Braided funding opportunities, and 3) Consensus on Framework (MTSS) and Mechanism (COST)
WHAT IS MEDI-CAL?
WHAT IS MEDI-CAL

• **California’s version of Medicaid.** The program is administered by the Department of Health Care Services (DHCS).

• **A federal entitlement program** that provides free or low-cost medical services—including mental health services—for low-income children and adults

• **Federally funded** but is primarily administered at the county level
SCHOOLS: WHO IS ELIGIBLE FOR MEDI-CAL?

1. All children living in families that make **less than 266% Federal Poverty Level** (approx $74,000 for a family of 4) are eligible for Medi-Cal.

2. **Most children who qualify for Free & Reduced Lunch** also qualify for Medi-Cal.

3. **Eligible students under the age of 26** qualify for Medi-Cal regardless of immigration status.
MEDI-CAL BY THE NUMBERS

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

BEHAVIORAL HEALTH: $12 BILLION

Total Californians: 39 Million

MEDI-CAL COVERED: 13 MILLION

*Current budget estimates show a 25% increase in Medi-Cal enrollees due to COVID-19
Almost 6 out of 10 children are covered by Medi-Cal. They are served by county administered Specialty Mental Health Plans (MHPs) and Medi-Cal Managed Care Plans (MCPs)

- **Total California Children**: 10 Million
- **COMMERCIALLY INSURED**: 4 MILLION
- **MEDI-CAL COVERED**: 6 MILLION
- **MCP Total Served Annually**: 90,000 Kids
- **MHP Total Served Annually**: 152,409 Kids

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AND ALTHOUGH ELIGIBILITY FOR MENTAL HEALTH SERVICES HAS INCREASED...

6 million of California's 10 million children are now covered by Medi-Cal and the EPSDT entitlement (a 30% increase over last five years)

Everyone under 26 living in a family that makes less than 266% FPL qualifies for Medi-Cal

CALIFORNIA IS GROUND ZERO FOR INCOME INEQUALITY:

7 OUT 10 CHILDREN BORN INTO POVERTY WILL NEVER GET OUT
ACCESS REMAINS LIMITED

Less than 5% get access to any care

Only 3% are in ongoing care
DRAMATIC UNDER-INVESTMENT IN CHILDREN

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 all expenditures.

California ranks 44th in the nation of in access to care for children.

California operates the largest MediCaid Program in the nation—April 2019 Audit exposed significant underperformance under the EPSDT Mandate and Bright Futures Guidelines.
HOW CAN MEDI-CAL HELP CALIFORNIA CENTER SCHOOLS IN THE MENTAL HEALTH CRISIS
A SNAPSHOT OF CALIFORNIA’S CHILDREN

Most children are in Public Schools

- 9M Youth in California
- 50% Hispanic or Latino
- 6.2M Enrolled in Public Schools

Many experience the impact of poverty

- 21% Children receiving public assistance
- 1 in 4 Children in low-income working households

The majority of children live in Hispanic/Latinx households

Source: Multiple sources as stated in this infographic from the Judicial Council of California, https://www.courts.ca.gov/documents/mhys_infographics__published_62022.pdf
WHY MEDI-CAL IS IMPORTANT TO SCHOOLS

Medi-Cal is an untapped resource - especially in California.

- Nationally, Medicaid is the third largest federal funding source in schools after Title 1 and IDEA. Each year, schools across the country bill for $13-$14 billion dollars in Medicaid.

The majority of students in CA are Medi-Cal eligible.

- 6 out of 10 kids are covered by Medi-Cal (and growing).

Medi-Cal can help fund mental health services in schools.
EXAMPLES OF WHAT MEDI-CAL PAYS FOR IN STUDENT MENTAL HEALTH SERVICES

Direct Services
• Mental health assessments
• Therapy
• Counseling
• Targeted case management
• Crisis intervention

Administrative Activities
• Outreach and enrollment
• Program planning
• Transportation
• Care coordination
• Referral

Good News
• Diagnosis is no longer required for certain groups of students
• Recent changes have made it easier for students to qualify for support from a licensed therapist
• There are increased efforts to grow the number of providers that represent the cultural diversity of our state
Certified Public Expenditure (CPE) = A state’s use of public funds spent by other government entities (state or county) to claim federal reimbursement for Medicaid services.

Federal Financial Participation (FFP) = The Federal share of Medicaid dollars – GUARANTEED match without limit or cap
HOW TO CAPTURE MEDI-CAL FUNDS

Numerous state, county, and local funds can qualify for this “non-federal match.” It is critical for districts to think creatively about what counts as a match.

<table>
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<tr>
<th>Potential “non-federal” funding sources include</th>
<th>Federal funding that DOES NOT qualify as a match includes</th>
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<tbody>
<tr>
<td>• Local Control Funding Formula (LCFF)</td>
<td>• ESSER I, II, III</td>
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<td>• State special education funding</td>
<td>• Title I</td>
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<td>• After School Education and Safety (ASES) funds</td>
<td>• Title II Part A</td>
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<td>• Community Schools Partnership Program (CSPP) grants</td>
<td>• Title III</td>
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<tr>
<td>• Expanding Learning Opportunity Program (ELOP) funds</td>
<td>• IDEA</td>
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<td>• Local parcel taxes</td>
<td>• 21st Century Learning Center</td>
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<td>• First 5 Commission funds</td>
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<td>• Mental Health Services Act grants</td>
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<td>• County General Fund dollars</td>
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THE MEDICAID MAP: WHO PAYS FOR FEDERALLY ENTITLED SERVICES TO CHILDREN AND FAMILIES

Federal Government
Distributed through Federal departments with funding authorized by Congress (FFP/Match)

State of CA
Acting as pass-through, enhancer, or reconciler of funding—sometimes providing it, sometimes certifying (CPE)

Managed Care Plans (MCP)
County Mental Health Dept. (MHP)
School Districts (BOP/MAA)
Community Health Centers (FQHC)
Dept. of Health
Public Hospital
Regional Center
WHO ARE THE MOST IMPORTANT PAYORS FOR SCHOOLS?

Federal Government
Distributed through Federal departments with funding authorized by Congress (FFP/Match)

State of CA
Acting as pass-through, enhancer, or reconciler of funding—sometimes providing it, sometimes certifying (CPE)

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“BIG THREE” PAYORS IN SCHOOLS
IMPORTANT PAYORS FOR SCHOOLS: Managed Care Organizations (MCOs)
The Sleeping Giants for Schools

- Managed Care Organizations = Managed Care Plans = Health Plans
- Every county has at least one health plan serving children in Medi-Cal.
- Licensed public and private health plans contracted by the state.
- Historically, MCPs have not invested in schools.
- In 2021, the state created the School Behavioral Health Incentive Program (SBHIP) to help MCPs partner with schools.

Example: School districts can partner with local Managed Care health plans to explore co-location of services onsite and/or a contract with a community-based provider.
IMPORTANT PAYORS FOR SCHOOLS: Mental Health Plans (MHPs)

- **County Mental Health Plans (MHP) = County Behavioral Health Departments**
  - Federally designated health plans that manage the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mental health benefit for children.
  - Control Prop 63/MHSA funds which can be used as a non-federal match (CPE).
  - Explore creative financing strategies with local MHPs to generate federal matching funds.

**Example:** County MHPs can contract with a CBO to locate and staff mental health services at a school sites. The CBO takes care of Medi-Cal billing and hiring staff.
IMPORTANT PAYORS FOR SCHOOLS: LEA BOP/SMAA

SCHOOL DISTRICTS

- Bill Medi-Cal directly through the LEA Medi-Cal Billing Options Program (LEA BOP) and School-Based Medi-Cal Administrative Activities (SMAA).
- Since 2020 school districts can bill Medi-Cal for allowable expenditures in general education (not just IEPs)—opens opportunities to bill for additional students and services.
- CDE has stepped up outreach and technical assistance efforts to help districts increase BOP and SMAA revenues.
- Review if any recently hired staff funded by the State’s Community School or Expanded Learning programs are eligible Medi-Cal providers and administering activities billable under LEA BOP/SMAA.

Example: School districts currently participating in LEA BOP or SMAA can partner with their Medi-Cal billing vendor to conduct an “Opportunity Analysis” and see where there is potential to grow revenue.
IMPORTANT PAYORS FOR SCHOOLS: Federally Qualified Health Centers (FQHCs)

- Community Health Center = Federally Qualified Health Center (FQHC)
- A FQHC provides comprehensive health services (preventative, dental, mental health, etc.) to underserved populations on a sliding fee scale.
- A FQHC has its own federal reimbursement designation and access to a supplemental payment—referred to as the wrap payment—that can be used to pay for services in schools.

Example: School districts can partner with a FQHC to co-locate services at a school site such as a school-based health center at a middle or high school.
A FRAMEWORK FOR SOLUTION: WHERE WE ARE HEADED
WE HAVE A ONCE-IN-A-GENERATION OPPORTUNITY TO ADDRESS THE CRISIS

Public opinion and policymaker agendas are aligned

- **Political Will:** New administration has a stated focus on children’s well-being and has expressed interest and willingness to engage.

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

- **Emerging Consensus and Consciousness:** Of the impact of adversity, structural racism, and the pandemic on the social and emotional health of children.

**TO TAKE ADVANTAGE OF THIS MOMENT IN TIME WE MUST:**

- Embrace the critical need to reform our financing and delivery models in schools so that they are healing and relationship centered.

- Adopt a concurrent but aligned paradigm shift across child serving systems, with particular focus on the role of Medi-Cal in schools.
THIS IS THE TRUST’S FRAMEWORK FOR SOLUTIONS

Expand Access and Participation
- Shifting agency (who does the work) and power (who gets paid to do it) in child serving systems
- Expand who is eligible, who can provide care, what is provided, and the agency of the beneficiary

Maximize Funding
- Increase state and county spending, and fully claim the federal match

Equity + Justice
- Increase transparency and accountability

Reinvent Systems
- Reinvent systems
- Maximize funding
- Shifting agency and power in child serving systems
- Expand who is eligible, who can provide care, what is provided, and the agency of the beneficiary
- Increase transparency and accountability
MORE TO COME…

UNPRECEDENTED INVESTMENT IN SCHOOLS AND SYSTEMS

FUNDING OPPORTUNITIES FOR SOCIAL, EMOTIONAL AND MENTAL HEALTH IN SCHOOLS AND SYSTEMS

CYBHI

- Managed Care Plans ($400 million)
- Competitive Grants Program ($550 million)
- MHSA SSA funding ($250 million)
- Workforce including BH Coaches ($800 million)
- BH Virtual Platform: ($750 million)
- Expanding Evidence Based Programs ($429 million)
- DYADIC Benefit

CA Budget Act ESSER

- Community School Partnership Grant Program ($4 billion+)
- Expanded Learning Opportunity Grant Program ($4 billion)
- Mindfulness ($75 Million); Peer to Peer Demonstration ($10 million)
- Investments in Counselor/Social Worker pipeline
- Educator Effectiveness Grant ($1.5 billion)
- HCSB/Special Ed/Other….($1.5 billion)
- Universal TK ($176 million)
- ESSER 1, II, III ($23.4 billion)

CalAIM/Waiver Renewals

CalAIM: $4.5 billion ($3.1 billion in 22-23 year)
- Enhanced Case Management
- Community Supports
- Population Health Management
- Universal Eligibility for System Involved Children
FINANCING IS MESSY....BUT WE HAVE CONSENSUS ON THE MODEL AND MECHANISM
Pyramid of Interventions

Tier 3
Longer-Term Intensive Interventions

Tier 2
Short-Term Targeted Interventions

Tier 1
School-Wide Interventions

Coordination of Services Team (COST)
A proven strategy for coordinating learning supports and resources for students

✔ Students with needs get appropriate services
✔ System of student support is well coordinated

Source: Centers for Disease Control and Prevention
FIVE ACTIONS SCHOOL LEADERS CAN TAKE NOW:

Commit to social, emotional, and mental health as a district priority: Identify activities (immediate, short, longterm) that can be done to address the youth mental health crisis which has only grown more stark during the current pandemic.

Identify your key collaborators: Connect with your thought partners and potential agency collaborators. If applicable, determine who will provide the services and who will do the billing.

Prepare financial scenarios: Determine your Medi-Cal eligible student population. Identify the costs you are incurring that can be claimed from direct and administrative services. Estimate the new and/or additional Medi-Cal revenue that could be generated.

Design your partnership: Develop the new, enhanced, or expanded services to be financed with the new and/or additional Medi-Cal revenue. Convene a working group to apply the step-by-step process outlined in the next section.

Execute your strategy: Bill Medi-Cal for services and ensure revenue is reinvested to support students’ social and emotional well-being.

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<td>October 11, 2-3:30 am</td>
<td>October 18, 2-3:30 am</td>
<td>October 25, 2-3:30 am</td>
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<td><strong>Sustaining Change: How to Finance Long-Term Student Health and Well-Being</strong></td>
<td><strong>Essential Components for Change: Applying MTSS and COST for Student Health and Well-Being</strong></td>
<td><strong>California’s Historic Investment in Students: Creating Racially Just, Relationship Centered Schools</strong></td>
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OFFICE HOURS WITH CALIFORNIA CHILDREN’S TRUST

Do you have a specific question related to Medi-Cal or funding mental health in schools that you would like discuss further? Want to learn more about how this information can apply to your school district? Bring your questions and join Alex Briscoe in Office Hours this fall:

October 13, 2022 10 am - 12 pm
November 10, 2022 1 - 3 pm
November 29, 2022 1 - 3 pm

Email aimee@cachildrenstrust.org
Please share your feedback on today’s webinar in a short survey.
You can access the survey by:
• Scanning this QR code ➡️
• Or visiting this website:
  https://ucsf.co1.qualtrics.com/jfe/form/SV_dhhduaGZ3nCM1Vk

(the link will also be pasted in the chat)
Thank You!

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