Little Hoover Commission – CBHDA Testimony
May 13, 2021

Commissioners:

My name is Michelle Doty Cabrera, and I am the Executive Director of the County Behavioral Health Director's Association of California. We represent the county behavioral health executives who administer Medi-Cal and safety net services for serious mental health conditions and substance use disorders (SUDs) in all 58 counties in California.

As discussed in your initial hearing, and today, children and youth throughout the nation, including California, are suffering. And, as you know, the pandemic experience has been especially hard on children and youth. During the pandemic, several of our counties reported the numbers of children and youth in acute mental health crisis shot up – two and sometimes three-fold. We have children as young as eight years old who have been hospitalized due to suicidal ideation. And, as the physical health risks wane with our extensive vaccination rollout and warmer weather, our behavioral health directors report that, consistent with historic trends with youth crisis and the school calendar, the transition back to in-person learning has resulted in a new surge of children and youth in crisis. The issue of children's mental health and substance use disorder needs is not an easy or straightforward one. When it comes to behavioral health, children are not simply little adults. Clinically, emotionally, and in terms of treatment – children and youth are different and require different resources and approaches.

For example, as The Children's Trust reported in their testimony last hearing, most children do not spend a lot of time at the doctor's office – for any reason – after the age of four or five. Identifying serious emotional disturbance in children can be a complex issue, particularly when children are non-verbal, not safe at home, or when normal, healthy developmental shifts may look at a lot like symptoms of a mental disorder. Children and youth are also often reliant on the adults in their life to seek care on their behalf, and not all primary care clinicians screen for behavioral health conditions or have the specialized education and training to accurately identify and diagnose behavioral health conditions in children – all of which can delay necessary care.

And, while not all children who experience trauma have a mental illness, we know that children who have experienced significant levels of trauma should be provided with extra support, including behavioral health supports, to mitigate the potential for anxiety, depression and PTSD which can result from these experiences, as Ms. Francis from Children Now suggested in her testimony.

Finally, we heard in the last hearing and today that policymakers, providers, and advocates desperately want consistency in how services in California are delivered, financed and reported.

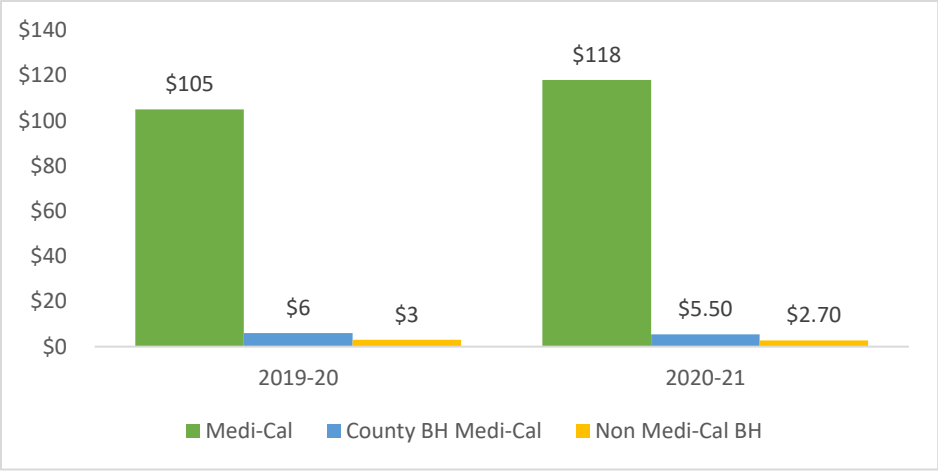
County behavioral health directors agree with the idea that we need more transparency and state-level accountability metrics surrounding the public behavioral health system, and it is important to understand that so much of the variation we experience in behavioral health is baked in as a matter of policy – from the federal level on down. In fact, it is federal and state-level policies have in large part created this inconsistency through categorical, grants-based and inadequate funding for behavioral health services.

Take, for example, the experience of the pandemic. DHCS reported in their February Stakeholder Advisory Committee meeting that Medi-Cal services were down in 2020 across all service lines, including all emergency department visits and hospitalizations. The only services that were up in 2020? Mental health services, and that growth was overwhelmingly driven by the county behavioral health system.

Despite this spike in demand driven by the individual and collective traumas of the pandemic and social reckoning with our country's persistent systemic racism, because policymakers understood the pandemic as primarily a medical and public health emergency hitting hospitals and skilled nursing facilities, the needs of the public behavioral health system were all too often not prioritized. This is not to say that we did not have committed behavioral health champions within the state. Without a doubt, the Newsom Administration's commitment to our behavioral health safety net is clear. What it means however, is that, when key decisions were made in the last year around emergency resources, behavioral health was often left behind in terms of our allocation of resources and attention. And because behavioral health cuts across so many different domains, it is often difficult for those overlapping systems to remember to center and prioritize behavioral health alongside the other, competing interests. Yet, behavioral health recovery will be an urgent imperative in our state's overall recovery from this pandemic.

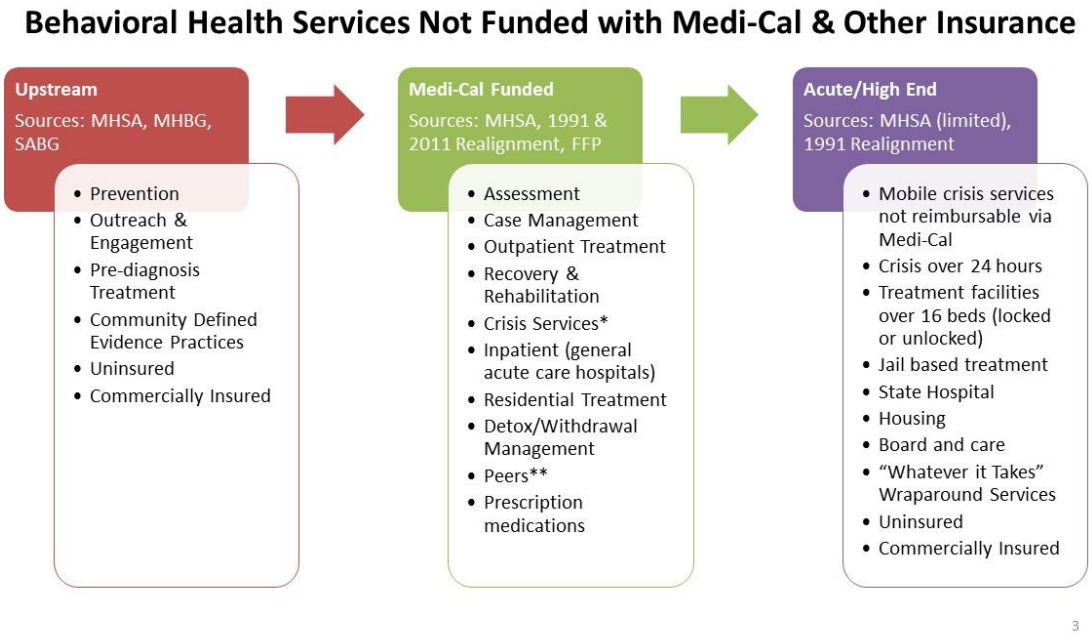
My point is that the challenges holding us back as a state are systemic. Take for example, Dr. Insel's highlight that California spends more on mental health than any state. I would absolutely hope so. Our population is far greater than that of most other states. However, on a per capita basis, what we spend on mental health is only slightly above the national average. And when it comes to Medi-Cal as a whole, we spend nowhere near as much on our county behavioral health safety net as we do elsewhere in Medi-Cal. This fiscal year, our state will spend approximately $115 billion on Medi-Cal as a whole (including physical health and the mild-to-moderate mental health benefit), in comparison to approximately $5.5 billion for specialty behavioral health services – including adults with serious mental illness, children's behavioral health needs under ESPDT, and all substance use disorder spending as seen in this chart developed with data reported as part of our state budget:

Medi-Cal Overall vs. County Behavioral Health Safety Net
(Figures listed are in billions)



Outside of Medi-Cal reimbursement, counties use the remaining $2.5-$3 billion in non-Medi-Cal funding to support a whole array of safety net services that are not reimbursable through Medi-Cal, either due to state or

federal Medicaid rules, or because the insurance model falls short of meeting the comprehensive needs of individuals who require behavioral health care as you can see here:

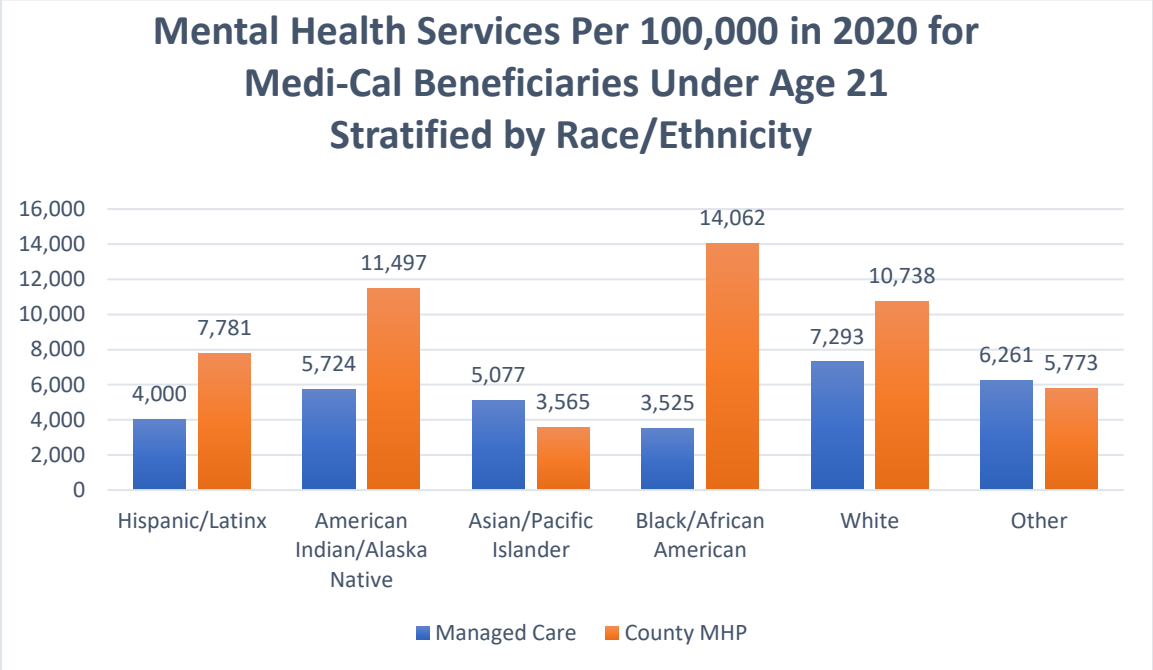


Take for example, prevention, outreach, and engagement. These services are not covered through insurance payers, including Medi-Cal, and yet they are essential when it comes to identifying and bringing people into behavioral health treatment. A lack of insight about one's mental health or SUD condition can be one of the indicators that a person is in need of specialty behavioral health services. Effective outreach and engagement can take months or years of relationship building for individuals who are reluctant to engage in recovery. Counties know that if they can identify clients earlier in the onset of their illness, they stand a much better shot at mitigating the possibility that an individual with a serious emotional disturbance or serious mental illness will experience the devastating losses in education, employment and community connections that too often leave our clients at risk for homelessness, justice involvement, and involuntary treatment.

The limitations of Medi-Cal funding are also the reason why we believe looking solely through the lens of Medi-Cal expenditures is misleading when trying to understand the whole of our behavioral health safety net. What we can, and do, claim against Medi-Cal is just one piece of the story. Counties are all too often forced to compete, nationally, and in-state, for grants – whether through the Substance Abuse and Mental Health Services Administration (SAMHSA) at the federal level, or the Mental Health Services Act (MHSA) and California Health Facilities Financing Authority (CHFFA) at the state level – baking in the variation in the quality and availability of services from one jurisdiction to another. This variability is of our own making and illustrates why it is impossible to tell a complete story through Medi-Cal resources alone, and, frankly, why insurance models will always fall short of meeting the intersectional and layered biopsychosocial needs of individuals who could benefit from specialty behavioral health services.

Another area where significant improvement will be needed is on issues of disparities. If you look at the data of children and youth served in Medi-Cal, across both specialty mental health services delivered by counties and non-specialty services delivered by the Managed Care Plans, stratified by race and ethnicity, we see some alarming trends that must be addressed if we are to achieve equity and eliminate disparities in access to

culturally congruent care. Specifically, for beneficiaries under age 21 the following charts from DHCS preliminary data demonstrate the visits per 100,000 by Medi-Cal plan type in 2020:



You will see in these data that while both plans underserve Latinx and API children and youth, relative to the overall population in Medi-Cal, the Managed Care Plans have managed to serve more white children than any other group within Medi-Cal, and white children and youth are served at the third highest rate for county mental health plans, despite their proportionally much smaller numbers in enrollment. Counties have invested time and effort into improving the rate at which they are serving Latinx populations within California, for example, given that they are by far the largest group of Medi-Cal beneficiaries. Those efforts have paid off and we've seen rates for Latinx children and youth increasing. Currently, counties serve these children at twice the rate of the Managed Care Plans but both plan types need to do more. Conversely, the disproportionately high rates at which county plans serve Black children point to a strong likelihood of disproportionality which needs to be addressed across multiple systems. Understanding racial and ethnic disparities is complex, but these numbers raise important questions for the state about how the state intends to ensure that these disparities do not persist as we seek to expand services to children through various proposed reforms.

These limitations do not mean that the state cannot and should not do more to maximize our use of county behavioral health plans in Medi-Cal. Counties are proud of the partnership we have had with the state in crafting the behavioral health proposals contained in CalAIM. Over the last two years CBHDA has lobbied the state to enact necessary changes to modernize our system as, historically, counites have struggled under unnecessary and overly cumbersome regulatory requirements which drive up administrative expenses and limit access to care. In particular, we believe that the changes we've sought to children's medical necessity criteria – which will remove the requirement for a child to have a diagnosis prior to treatment, will significantly expand access to specialty behavioral health services in Medi-Cal. This change, combined with the payment reform initiative, will help to streamline and simplify our documentation requirements, relieving provider administrative burden, and helping with workforce recruitment and retention. We will be the forty-nineth state in the nation to bring

certified peer support specialists into our Medicaid program. These are only a few examples of the transformative proposals contained within CalAIM for county behavioral health, many which county behavioral health directors asked the state to advance, and which we strongly support. It is our hope that with CalAIM, more of our services will move from the non-Medi-Cal side of the ledger to the Medi-Cal side and give policymakers a better understanding of the breadth and scope of services we provide while bringing in additional federal matching funds.

Among those services which counties have creatively structured as a combination of Medi-Cal and non-Medi-Cal allowable services are our school-based behavioral health services.

California's schools have responsibility for providing something called "Educationally Related Mental Health Services" or ERMHS. These ERMHS are all about supporting student learning when a mental health condition is impeding a student's ability to learn. Schools provide these services through distinct provider types, and within a defined scope of practice. While essential to supporting learners, we have to be clear that the roles and responsibilities of ERMHS providers are distinct from that of the public behavioral health safety net. Schools have the vital role of ensuring all students receive a high-quality education and the public behavioral health delivery system works to provide behavioral health services to California's low-income residents in need of services. The providers working in each system reflect these distinct responsibilities.

As you know by now, county behavioral health plans are responsible for providing specialty behavioral health services to all children in Medi-Cal, consistent with the EPSDT entitlement. Counties understood early on that they could not rely on mental health and substance use disorder referrals from the health care delivery system as the sole way of reaching children and youth in need. Given the fact that over half of all children in California public schools qualify for Medi-Cal, counties realized that schools are a perfect place for county behavioral health to identify and outreach to children and youth with behavioral health needs. County Behavioral Health agencies have partnered over decades with their local education systems to ensure the provision of prevention and treatment services on school campuses. However, laying the initial groundwork for those partnerships was slow, given the lack of additional resources to invest in these partnerships. Investments and interest in these partnerships has been accelerated in recent years through MHSA funding earmarked by the Legislature. And proposals in this year's budget.

Because there is limited statewide information on the various partnerships that have been developed across counties and schools, in January 2021, CBHDA developed a membership survey to help our association identify the quantity and models for school-based partnerships throughout the state. CBHDA received responses from 97% of our membership for this survey and found that 85% of county behavioral health departments are providing Medi-Cal Specialty Mental Health Services (SMHS) on school campuses today. Among the survey respondents, just over a third (33%) indicated that they cover 80-100% of school campuses within their counties. Given that there are close to a thousand school districts across California, across 58 Offices of Education, this degree of collaboration is no small feat.

Another key distinction is that, while education services are a broad public entitlement, behavioral health services are not. So, one of the significant barriers counties have faced in developing these partnerships is that schools rightfully do not want to offer school-based behavioral health services on campus where half the student population or more may be excluded. We found that 65% of counties provide services to non-Medi-Cal beneficiaries and county MHSA funds are the main source of funding for these services. Only about 15% of respondents indicated that they are successful in recouping reimbursement from private commercial insurance for these purposes. As a result, counties provide significant subsidies when providing school-based services to offset costs for youth that have private insurance.

Overall, the three main funding streams that counties utilize to provide behavioral health services on school campuses are Medi-Cal, MHSA and County Realignment funds. Around 16% of respondents indicated that their education partners also contribute education LCAP funds to support county behavioral health services on school sites.

In the delivery of services, counties typically use a combination of county employees and contracted providers to provide SMH. We also found that 55% of County Behavioral Health Departments provide SUD treatment on school campuses with a majority of these services delivered by county employees, as opposed to contracted providers. SUD services are so important in addressing youth mental health needs because youth have higher rates of co-occurring mental health and SUD needs than adults. Find your youth interested in drugs and alcohol, and you are more likely to find your youth with mental health needs as well.

There are four (4) core service delivery models and partnerships that have been developed in these county/school partnerships (although it should be noted that 33% of respondents indicated other ways to blend funding streams). The most common model is for school staff to provide ERMHS as prescribed by AB 114, and County Behavioral Health Departments operate in parallel on the school site to provide specialty behavioral health services. In this model, school staff refer students to the county provider for on-site specialty services, as needed. For example, you may have a student who performs very well in school, and therefore would not qualify for ERMHS, but who nonetheless has significant behavioral health needs. That student would be referred to the county behavioral health team. Conversely, the student who is receiving ERMHS services to support their learning may require additional behavioral health services and supports beyond the services that can be delivered through ERMHS.

The second most common model reported enables schools to contract directly with County Behavioral Health Departments to provide ***both*** ERMHS and specialty behavioral health services. Under this model, schools retain financial responsibility for ERMHS services delivered through the county providers.

Although not as common, we do have service delivery models where the county behavioral health agency will contract directly with licensed, and in some cases unlicensed school staff. With appropriate county behavioral health training and oversight, the counties are able to authorize these school-based providers to provide Medi-Cal SMH services at schools, in addition to fulfilling their ERMHS responsibilities. In all our discussion of partnership models, to date, we are not aware of any models where Medi-Cal managed care plans are providing non-specialty mental health services to children on school campuses. In addition, counites are spending scarce public resources to attempt to link high-needs privately insured students to the insufficient care they have access to through commercial insurers.

Some of the key barriers identified in our membership survey that inhibit the expansion of school based behavioral health services include: limited available space on campuses to provide confidential and appropriate services to students; inadequate funding to subsidize care for commercially insured students; hesitation on the part of schools to pull students away from instructional time; and varied perspectives from one school district to another on the value of more comprehensively addressing students' behavioral health needs on school campuses. I must note, as well, that during the past year, it was at times challenging to rely solely on our school-based partnerships in serving children and youth. As children went home for virtual learning, referrals to services from schools plummeted – and in some cases, campuses were reticent to allow our providers on campus. Our clinicians also found that telehealth has serious limitations. We are, of course, all aware that the digital divide presents a huge barrier for low-income and rural communities, but there are other issues fairly specific to the application of telehealth modalities for children and youth. While many kids in this generation are adept at using tech for school or fun, clinicians found that youth are at times less tolerant of telehealth modalities for behavioral health treatment, or that the treatment was not as effective – particularly for more

acute needs. For children in homes that lack private spaces to engage in telehealth, or where children may not feel safe engaging in telehealth, we encountered some very real limitations that will mean that we need to view telehealth as another tool in the toolbox, but not a replacement for traditional in-person forms of treatment.

According to national data from the CDC, from this March through October 2020, the share of mental health-related hospital emergency department visits rose 24% for children ages 5 to 11 and 31% among adolescents ages 12 to 17, when compared to the same period in 2019. As children return to schools, their ability to access comprehensive behavioral health services will be more critical than ever.

Based on the extensive experience of county behavioral health in providing Medi-Cal EPSDT and school-based services, and in arranging and delivering crisis services to children and youth, we would ask the commission to consider the following recommendations:

1. **CalAIM Reforms.** The state's CalAIM reforms promise to ensure, not only that more children and youth have access to specialty behavioral health services, but that policymakers can more accurately capture county behavioral health investments in children and youth under the EPSDT/Medi-Cal reimbursement framework. Counties are spending too many of our MHSA dollars on serving children and youth without the federal matching funds we should be drawing down through Medicaid due to our state, not federal, payment rules. CalAIM will ensure that California's counties no longer have to leave federal money on the table for allowable Medi-Cal services, increase access to care, and free up MHSA funds to pay for more of those things which are under no circumstances reimbursable through Medicaid, like prevention. In addition, we hope to move away from decades-worth of byzantine payment rules and fiscal audit liabilities, which make it unduly challenging for clients, providers, and policymakers. A new day is coming.
2. **Expanded School-Based Partnerships.** The Governor's January budget proposed a significant investment of $400 million in incentive payments which would be driven by the Managed Care plans to expand school-based partnerships between MCPs, County Behavioral Health plans, and schools. We believe that because of our experience in school-based work, and our expanded scope of services – which is more comprehensive than that of school-based mental health programs, or MCPs, and the ability to leverage funding outside of insurance and pick up those commercially insured kids, the smartest way to approach expanded school-based partnerships is by continuing to invest directly in county behavioral health, including, but not limited to direct investment in the county/school partnerships funded through OAC grants. We will note, also, that this massive infusion must be done strategically so that we are not simply shifting scarce workforce and provider resources from one space and moving it to another. Instead, we want to expand capacity and add to what is already there, which is another reason it will be critical to ensure this effort is carefully coordinated with county behavioral health. To address the issue of the almost half of students with commercial insurance, CBHDA is co-sponsoring AB 552 (Quirk-Silva) to create a framework for counties to more readily serve these children.
3. **Statewide Transparency & Accountability.** CBHDA is co-sponsoring AB 686 (Arambula) with the California Pan-Ethnic Health Network and CBHA, modeled after similar outcomes accountability legislation implemented for child welfare and CalWORKs programs. Counties today have numerous layers of state oversight and send hundreds of pages of reports to the state on an annual basis, in keeping with state and federal reporting requirements. The issue is that the state is not consolidating these reports or looking across the state at a defined set of statewide outcome indicators. This bill would set up a process to develop the outcomes, and also evaluate disparities across the state. Pulling up to the state-level across county behavioral health programs is important since, for example, one of our important state oversight entities, the MHSA OAC reports on the MHSA funded programs, but lacks the Medi-Cal, SUD, or clinical expertise to adequately reflect program outcomes in the aggregate.

4. **Infrastructure Investment.** The Governor's January budget included a significant allocation of $750 million in one-time funds to support the build out of community-based county behavioral health infrastructure. This funding is intended to address systemic gaps which result from the fact that counties have not been reimbursed in a way that allows them to capture revenues above cost. We believe this one-time infusion of capital investments must be kept flexible as needs and gaps are variable throughout the state and meeting those needs will require different approaches in rural verses urban regions, for example.
5. **Statewide Workforce Strategy.** Currently, CBHDA is working with researchers, providers, and our members to develop a forward-looking ten-year workforce strategy. Even without the increased demand for services resulting from the pandemic, and the expansion of Medi-Cal reimbursable services, our state faced an acute workforce shortages. We face unique challenges trying to recruit and retain staff to rural communities and need to be much more intentional about diversifying our workforce. We look forward to bringing forward specific policy recommendations in the future to speak to this urgent and important policy priority for the state.
6. **Address Overall Underfunding of Public Behavioral Health Safety Net.** County behavioral health would argue that the root of our issues is not realignment itself. We need to recall that part of the impetus for realignment is that it serves as a way to protect funding for health and human services programs in light of the Prop 98 education funding guarantee. What makes it untenable for counties is that dedicated funds are agnostic to fluctuating population and service growth, the degree to which certain population needs are reimbursable through insurance, and each pot of funding comes with its own unique restrictions and requirements. We need to come to the understanding, as well, that the comprehensive BH needs of Californians cannot be met through a pure insurance model, and that individuals with SMI and SUD needs often face bias and discrimination when trying to access any number of services, whether housing, health care, education, employment or others. Overall behavioral health funding levels must be monitored and addressed by policymakers to ensure that entitlements like EPSDT, along with broad unfunded mandates like the Bronzan-McCorquodale Act, and community needs like crisis and SUD services are all sufficiently funded.

Thank you for the opportunity to address the Commission on this timely topic. We appreciate the interest of the Commissioners and thorough work of the staff to explore how we can better understand the impacts of the pandemic on children and youth, and your consideration of our recommendations for how to improve the state's response to the youth behavioral health crisis. The past year has been challenging for everyone, and our children and youth have suffered more than most. While we can't always control the biological or environmental factors which will result in increased behavioral health needs, we saw in 2020 that the large-scale and rapid system changes required to respond to those needs are possible. As we turn the corner on hospital ICU surges, we need to put the same intensity of resource investment and energy into responding to the ongoing youth behavioral health crisis at hand.