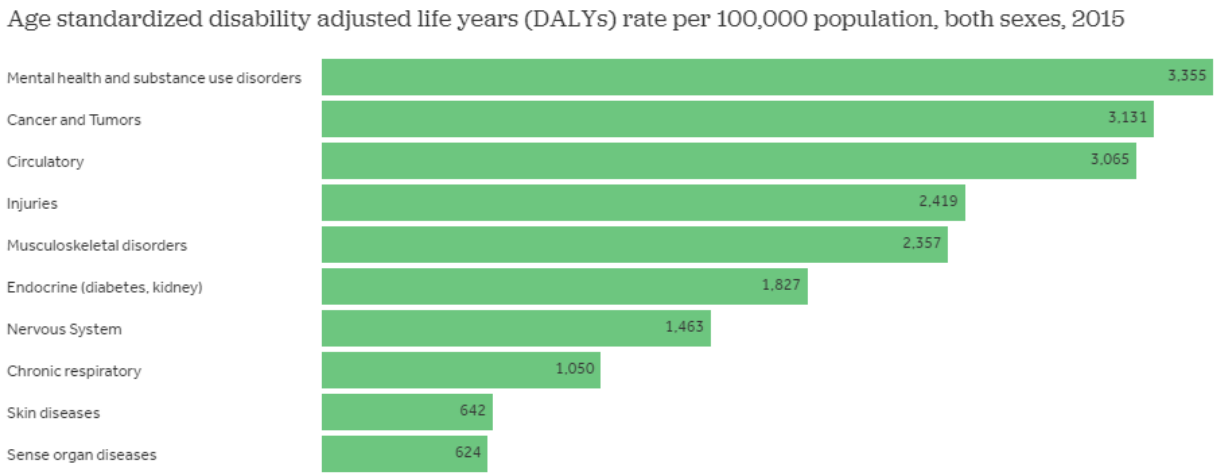
Written Testimony of Alex Briscoe, Principal of California Children's Trust, submitted to the Little Hoover Commission in support of the hearing on Thursday, April 22

In the U.S. today, mental health and substance use disorders are the leading causes of disease burden. According to a study on age-standardized disability-adjusted life years (DALYs) rate per 100,000 population for both sexes in 2015, mental health and substance use disorders ranked highest at 3.4 (source). DALY is a metric that combines the burden of mortality and morbidity (non-fatal health problems) into a single number, for which one DALY can be thought of as one lost year of "healthy" life.



Additionally, among comparable countries, the U.S. has the highest rate of death from mental health and substance abuse disorders (source). Their age-standardized death rate is 12 per 100,000 population, again for both sexes in 2015, which is nearly double that of the countries with the next highest rates.

Anxiety and mood disorders dominate the youth and young adult mental health landscape, with anxiety disorders the most common mental health disorders of childhood and adolescence. Now more than ever, anxiety and depression are on the rise: Nearly one in three adolescents (31.9%) will meet criteria for an anxiety disorder by the age of 18. Yet, different kinds of anxiety affect young people at different times in development. Phobias (19.3%) and separation anxiety (7.6%) affect primarily young children, while social anxiety (9.1%) develops later, as peer relationships become more important. Social, political, and environmental causes are likely implicated in an increase in the number of teens each year who have had a depressive episode, up 37% between 2005 and 2014.

Amidst the mental health crisis, behavioral health stands as the fundamental driver of morbidity for 10- to 24-year-olds (source). Homicide, suicide, and unintentional injury (mostly car-related) are the three leading causes of death for youth ages 10-24. After almost steadily declining between 1986 and 1999, the national suicide rate increased a startling 24% between 1999 and

2014, with a 2% increase per year beginning in 2006. The suicide rate for young women ages 10-14 increased the most in that time, jumping 200% from 0.5 suicides per 100,000 to 1.5 suicides per 100,000. Now, in the past 10 years, suicide has leap-frogged cancer and unintentional injury and become the second leading cause of death for youth and young adults. However, it's not just suicide rates. There have been striking increases in both self-reported need (surveys) and demonstrated acuity (diagnosis and utilization of crisis and inpatient services) over the last 10 years of available data. Overall children's hospitalizations are not increasing. The primary drivers of increases in hospitalizations among youth and young adults are behavioral health conditions.

Still, while major depression rates are increasing annually among youth, access to care is limited (source). Nearly 12% of youth (ages 12-17) report suffering from at least one major depressive episode (MDE) in the past year. Major Depression is marked by significant and pervasive feelings of sadness that are associated with suicidal thoughts and impair a person's ability to concentrate or engage in normal activities. 63.1% of youth across all states with major depression do not receive any mental health treatment. That means that 6 out of 10 young people who have depression and who are most at risk of suicidal thoughts, difficulty in school, and difficulty in relationships with others do not get the treatment needed to support them. Additionally, state-level budget cuts and coverage contraction have presented a challenge for federal programs, such as Medicaid, which have the greatest influence over mental health trends among children.

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 compound the challenge, as do reimbursement models that require a diagnosis to be eligible reimbursement. While diagnosis-driven models are only appropriate for some children, early identification and intervention are essential to any recovery framework.

So how did we get here? First and foremost, There is no common framework for defining and understanding behavioral health among and between public systems and clinical care providers. On top of that, public systems are deeply fragmented and under-resourced. Further, commercial payers have not effectively partnered with child-serving systems so there is a lack of clarity over whether youth mental health care is an essential benefit or a public utility prevents commercial payers from fully engaging. The 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.

Nationally, there has been an 104% increase in inpatient visits for suicide, suicidal ideation, and self-injury for children ages 1-17, and a 151% increase for children ages 10-14. Between 2006 and 2014, there was a 50% increase in mental health hospital days for children. Additionally, the rate of self-reported mental health needs since 2005 has increased by 61%. However, the dim reality is that California ranks low in the country at 43rd for providing

behavioral, social, and development screenings that are key to identifying early signs of challenges.

The price has always been higher for Black and Brown children. They are receiving the wrong series at the wrong time. 81% of children on Medicaid are Black are non-white, the suicide rate for Black children ages 5-12 is two times that of their white peers; 70% of youth in California's juvenile justice system, where youth of color are over-represented, have unmet behavioral health needs. 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.

In response to the pandemic, the crisis is compounding, and disparities are deepening. The collateral damage of COVID-19 entails an exacerbated equity gap as operating outside of school structures decreases access to resources—technology, food, mental health supports, child abuse screening, etc. Additionally, there is a massive disruption to children's routines, which thereby increases anxiety, social isolation, and erosion of social capital. Economic insecurity and isolation are other pandemic consequences resulting in increased risk of intimate partner violence. Lastly, destabilization of the provider network leads to a dramatic disruption in access to care, including behavioral and mental health, and reproductive services. As California Surgeon General Dr. Nadine Burke Harris states, "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."

Moreover, COVID has disrupted access to care for children and youth most notably through school closures. In fact, 66% of the state's 9 million children are in public schools and 40-50% of California youth receive mental health access at or through their school. In addition, social distancing impacts clinical settings in which state and local distancing requirements are limiting access to traditional outpatient settings. Lastly, there is poor coordination between levels of government—a longstanding problem exacerbated by devolution, including 2011 Realignment, and further strained by the rapidly changing landscape created by COVID-19.

Unfortunately, recent studies show these problems are only getting worse. There are never-before-seen levels of depression as nearly a quarter of people in the United States are experiencing symptoms of depression—almost three times the number before the pandemic began. "Interpersonal support is the single best predictor of human resilience. This disaster undermines our single most important protective factor," said George Everly, psychologist at Johns Hopkins University. And youth mental health is being hit hard. In a June CDC study, one in four youth ages 18 to 24 said they had "seriously considered" suicide in the past 30 days—more than twice as high as any other age group. Overall, California is failing on children's mental health and preventive care. According to the Commonwealth Fund 2020 report, our state ranks 48th in the nation for "Children Who Did Not Receive Needed Mental Health Care." Dr. Sandro Galea, Dean of the School of Public Health at Boston University, further expressed, "I

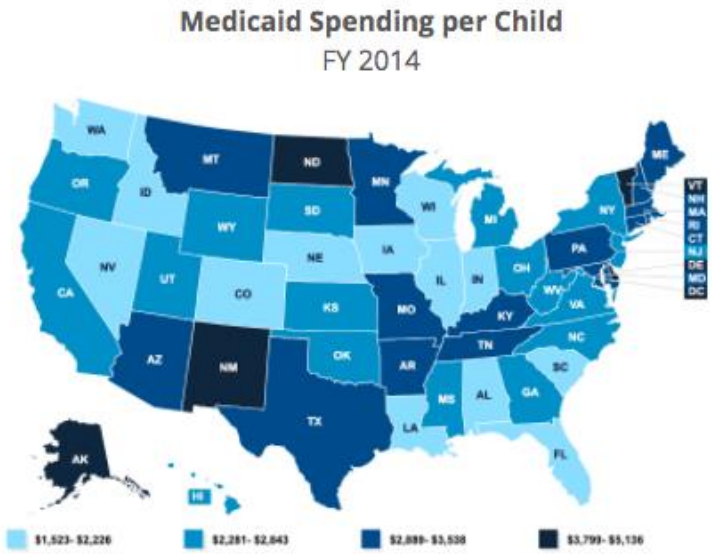
fear the COVID-19 pandemic has paved the way for a pandemic of depression. We must remember that poor mental health is at the heart of poor health."

COVID data illuminates the mental health crisis. 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. Also, compared with 2019, the proportion of mental health-related visits for children ages 5-11 and 12-17 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 bleak picture of the nation's mental health during the crisis.

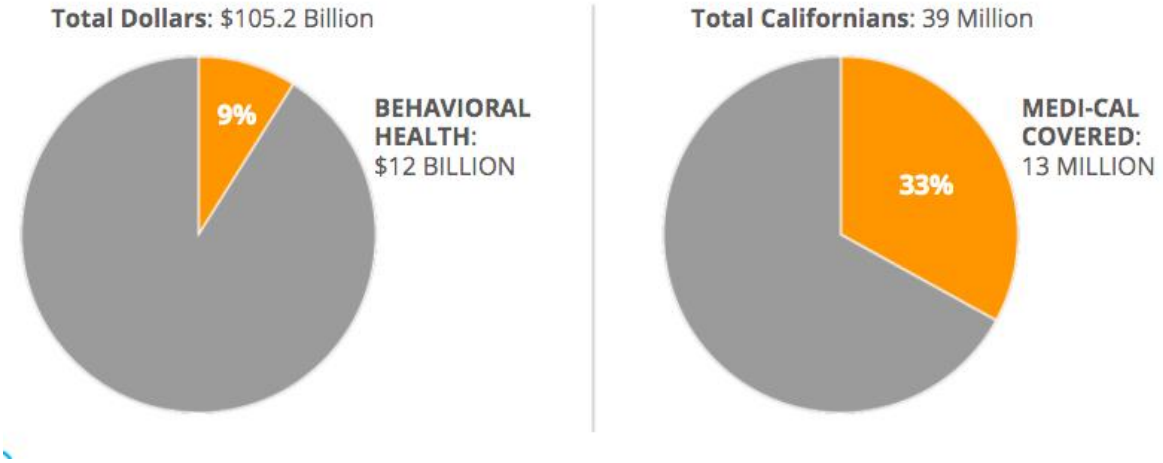
What will California do—as the fifth largest economy in the world—when it sees that twice as many of its children are trying to kill themselves? We must reimagine children's mental health—not simply as a response to pathology, but as a support for healthy development and social justice. And we must fund a dramatic expansion of services and support by leveraging Medicaid and claiming federal matching funds on what we are already spending.

Again, eligibility for mental health services has increased, but access remains limited. Six million of California's 10 million children are covered by Medi-Cal (California's version of Medicaid), and EPSDT entitlement. This is a 33% increase over the last five years, growing rapidly with the economic crisis due to COVID-19. However, less than 5% get access to any care, and only 3% are in ongoing care.

The Children's Trust projects a 20% increase in enrollment by fall 2020, bringing the total to 70% of the state's children relying on Medi-Cal. These problems pertain to a dramatic under-investment. California is in the bottom one-third nationally for health spending at $2,500 per child enrollee, children represent 42% of enrollees but only 14% of expenditures, and California ranks 44th in the nation in access to care for children.



As for the system, one-third of Californians are covered by Medi-Cal, which underinvests in their mental and behavioral health. There are 39 million Californians, but only 33% or 13 million are Medi-Cal covered. California totals a $105.2 billion investment in Medicaid with only 9% of that in behavioral health at just $12 billion—with children historically the most underfunded. The current budget estimates show a 25% increase in Medi-Cal enrollees due to COVID-19.



Looking at the numbers, there are 10 million total children in California, 4 million of whom are commercially insured and approximately 6 million of whom are Medi-Cal covered, which gives a ratio of almost 6 out of 10 children being covered by Medi-Cal. They are served by county-administered Specialty Mental Health Plans (MHPs) and Medi-Cal Managed Care Organizations (MCOs). The total number of kids served annually by MCOs and MHPs amounts to 110,000 and 252,409 kids respectively, which means 96% who are eligible are not accessing. Moreover, children have unique access to federal matching dollars in which Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is an entitlement. All allowable expenditures for eligible populations must be matched.

In order to respond at scale, schools can and must be essential actors, particulary for school age children and adolescents (8-18).

Schools are and have been ground zero for the youth mental health crisis, and our collective failure at supporting them has contributed to the marginalization of Black and Brown children. But it isn't just need that requires we center schools--the health care system needs schools, Children ages 8-18 have the lowest rate of primary care utilization of any demographic in MediCal—and 75% of mental illness manifests before the age of 24.

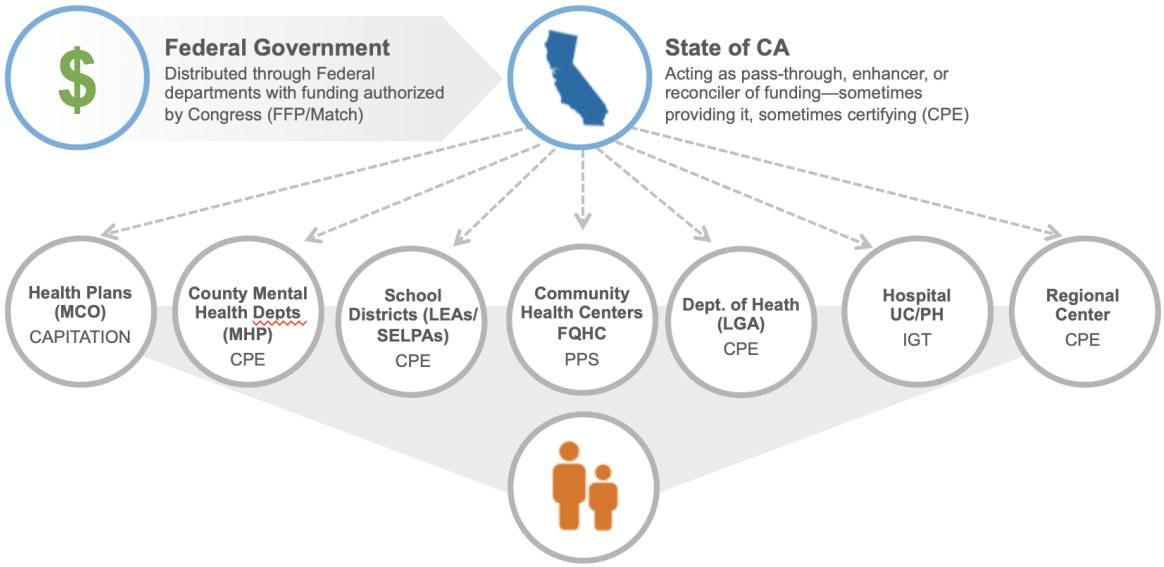
Not only are schools essential actors in a reformed mental health system that overtly addresses healing, justice, and structural racism, but they are also essential service settings for children with clinical needs. Further, the finances align as schools have what the publicly funded Medicaid system needs most: access to kids and essential eligible non-federal dollars to claim against.

The federal match is guaranteed for children in Medicaid—it is a unique and uncapped federal entitlement. Every Medicaid expenditure includes two parts, a Certified Public Expenditure (CPE), defined as public funds spent by other government entities (state or county) and Federal Financial Participation (FFP), the federal share of any Medicaid expenditure. Every Medicaid expenditure includes these two components.

Despite this relatively simple structure California's system is deeply fragmented between payors and levels of government (state and county) and these challenges have left the nation's largest MediCal program ranking among the worst nationally (44th in access to mental health/ 43rd in screening rates).

There are seven different payers that support the social and emotional health of children in California's decentralized system, each with their own rules and cultures. In order to understand the system, you have to follow the federal dollars from the source to the lives and experiences of children. Horizontal (among payors) and vertical fragmentation among levels of government) conspire to diffuse accountability for federally entitled services and supports. This complexity also confounds reform efforts, as any strategy must be applied across an extraordinarily diverse range of structures and actors.

HOW MEDICAID DOLLARS REACH CHILDREN AND FAMILIES



The California Children's Trust is a a coalition-supported initiative to reimagine how California defines, finances, administers, and delivers children's mental health supports and services. With a focus on equity and justice, we frame our approach to state and county finance reform with a clear and open acknowledgement of the ways existing child-serving systems have underserved, excluded, and in some cases harmed populations of children and families. The strategies are centered on equity and justice in which transformed behavioral health systems are not simply financed or administered differently but rather are anchored in new principles that acknowledge structural racism and poverty; are informed by relationships to and with beneficiaries; and are designed as methods for accountability.

There is hope and real progress. DHCS recently approved the new Family Therapy Benefit which provides opportunity to open Z codes and to redefine medical necessity criteria. This is the first time in the history of California's MediCal program that we have removed diagnosis as a pre requisite for treatment. There is no cap on the number of family therapy visits billed with ICD-10 code Z65.9 in place of a mental health diagnosis ICD-10 code.

The state's 1915b waiver application also includes fundamental reforms to the definition of Medical Necessity for specialty menta health services, and, the governor's budget proposes 750 million in new investments to support the social and emotional health of children in schools.

Our call to action is based on policy agenda defined in our Framework for Solutions

Current priorities include a statewide advocacy effort to remove diagnosis as a requirement for treatment, capture Medicaid dollars by claiming against what we are already spending, and center schools as healing and anti-racist centers of support.

Please visit our website for more information www.cachildrenstrust.org, read and share CCT's policies briefs, and join our coalition!

Thank you so much for the commission's interest and engagement on this issue.

The California Children's Trust