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Michael Cohen
Director
California Department of Finance
915 L Street
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Dear Director Cohen,

On behalf of the California Alliance of Child and Family Services whose member agencies provide comprehensive behavioral health services to children, youth and their families throughout California, we are submitting our comments and recommendations regarding the Behavioral Health base and growth allocation formulas under 2011 Realignment, focusing on EPSDT Specialty Mental Health Services (SMHS).

Under federal and state law and regulations, the Department of Health Care Services (DHCS) is required to arrange for or provide healthcare services for all Medi-Cal eligible children who need treatment to correct or ameliorate a mental health condition.

The funding formulas established for both the base and the growth must, therefore:

1. Ensure that children are provided mental health treatment required to correct or ameliorate their mental health conditions, as required under Medi-Cal's EPSDT program. The treatment must be delivered in a timely manner and in the necessary scope, duration, and intensity.
2. Ensure that counties and the state are complying with mandatory federal and state Medicaid obligations; and
3. Support critical state policy goals to improve access to appropriate and cost-effective mental health care for all Medi-Cal-eligible children.

California is currently falling short in meeting its obligation to ensure that children across the state receive the mental health services they are entitled to. The following challenges are seen throughout the state:

1) Penetration Rates statewide are far below acceptable levels.

The statewide penetration rate for SMHS for children is far below generally accepted levels of need within the child and youth population, which is estimated in national studies to fall between 10% and 20%.

Statewide penetration rates for access to ANY single SMHS have decreased from 4.6% in fiscal year 2010-11 to 4.4% in 2013-14. Although this appears to be a small decrease, it actually represents tens of thousands of children. When we look at the penetration rates of actual ongoing **services** (defined as 5 or more contacts), rather than just a single contact, the rates are even more concerning: 3.5% in fiscal year 2010-11 to 3.3% in 2013-14.

Counties have argued that this decrease is reflective of a decision by DHCS to have individuals with "mild to moderate" impairments become the responsibility of Medi-Cal Managed Care Plans rather than the County Mental Health Plans. DHCS has been clear, however, that the MHPs continue to be responsible for all "specialty" mental health services. Since EPSDT SMHS is a mandate for all youth with ANY level of impairment due to a qualifying mental health condition, (in other words, children with any level of impairment, including those with "mild to moderate" impairments) all youth with any mental health needs are entitled to specialty mental health services provided by the county mental health plans, regardless of level of severity.

2) **Penetration rates vary significantly from county to county.**

Penetration rates by county range from 4.29% in Fresno County, to 10.57% in Alameda County. (2013 EQRO data).

Where youth live has more to do with their likelihood of accessing specialty mental health services than do their diagnoses and functional impairments. EPSDT SMHS is a federal entitlement and therefore, where youth live should have no bearing on their ability to obtain the entitled services. Counties with lower penetration rates are often those that are more economically depressed, with limited local discretionary funding. This results in cash flow challenges, making it difficult, if not impossible, for them to carry the upfront costs for the expansion of mandated EPSDT specialty mental health services while they wait 18 months or more for reimbursement of the federal share, and for the percentage increase in their 2011 Realignment base allocation.

3) **The number of services provided has decreased for youth who have accessed care.**

The number of services for youth accessing EPSDT SMHS has decreased since the beginning of 2011 Realignment. Recent data from DHCS show that the average SMHS minutes per unique beneficiary have decreased by 173 minutes in the last 4 years. In fiscal year 2010-11 the average number of minutes per year per client was 1,895. That number dropped to 1,722 in fiscal year 2013-14. Minutes in other mental health service codes have dropped as well (including case management, medication support, and Therapeutic Behavioral Services). The only services which have shown an increase in number of units per youth accessing the service are crisis stabilization and inpatient hospitalization.

County contract language has resulted in the "rationing" of services to youth. Although wait lists are illegal under EPSDT, our members experience county Mental Health Plans (MHPs) placing youth on wait lists within the provider organization rather than modify contracts to increase service levels, and/or some MHPs failing to authorize all medically necessary services requested to meet the mental health needs of children and youth. It is difficult to determine the effects of this decrease in the number of services per youth since there is currently no qualitative data available, however, the

documented increase in the use of highly restrictive placements such as psychiatric hospitalizations is evidence that low intensity of services are not currently meeting the needs of youth.

4) **Katie A. implementation has stalled and in some counties, the number of youth receiving these services has not increased even though DHCS has agreed that the services are no longer limited to the Katie A subclass.**

   The Katie A. v Bonta settlement confirmed the EPSDT SMHS entitlement for the class and sub-class of youth. Services developed as part of the negotiation process (ICC and IHBS), were approved by CMS and added to the state mental health plan. Counties were slow to implement the services, and only did so during the final year of court jurisdiction (2014). Additionally, the state received approval on 2/16/16 to add the third "Katie A" service (Therapeutic Foster Care, or TFC) to the fiscal section of the state mental health plan. On February 5th, 2016, DHCS released MHSUDS INFORMATION NOTICE NO.: 16-004. This notice clarified that all eligible EPSDT beneficiaries who meet medical necessity criteria are entitled to receive the specialty mental health services formerly known as "Katie A;" i.e., Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and TFC.

   Counties view these new services as an expansion and consider them unfunded under 2011 Realignment. The newest service, TFC, was approved after the counties had completed their internal budgeting process. The litigation settlement process and CMS approvals confirmed that these services are part of the continuum of entitled services, but the services are not being provided to the vast majority of eligible youth.

5) **There is no comprehensive continuum of crisis care for youth anywhere in the state.**

   A continuum of crisis care exists in the state mental health plan (i.e., intensive home based services, crisis services, crisis stabilization, crisis residential, and inpatient hospitalization), however, no county provides all components to youth, and those counties that provide any of the components do so at a much lower than expected rate. There are multiple examples of effective crisis continua of care in other states, each demonstrating 80% to 95% successful diversion from expensive locked facilities.

   The lack of intensive community based crisis services for youth who are entitled to this service results in an increased need for locked hospitalization services. Youth often experience lengthy emergency department visits due to the lack of "beds" and community based diversion programs. Start up and on-going costs for this level of care prohibit many counties from initiating these needed services. Funding provided through SB 82 targeting crisis services has been limited to the establishment of crisis programs for adults.

6) **Foster youth placed out of county have no access or delayed access to mental health care, and receive less intensive treatment.**

   Data suggest that foster children placed outside their counties of original jurisdiction have greater mental health needs and less access to most types of mental health care. In the 2011 Data Mining Report issued by the California Child Welfare Council, researchers found out-of-county foster children were more likely to have been diagnosed with a serious mental health disorder than those

placed in-county. Despite having greater service needs, out-of-county foster children were 10-15% less likely to receive *any* mental health service than their in-county peers. Among those that did receive services, out-of-county foster children received fewer services and less intensive treatment compared to children placed in-county.

SMHS are provided using a system of county-based Mental Health Plans (MHPs) under contract with DHCS. Each MHP, in turn, contracts with local private mental health service providers (or uses county mental health staff) to deliver services. All foster children are statutorily eligible for full scope Medi-Cal benefits, including EPSDT SMHS when medically necessary. Currently, the MHP of the foster child's county of jurisdiction is responsible for providing or arranging for the provision of SMHS. These county-based MHPs face substantial administrative barriers when services must be provided to foster children placed out-of-county, that is, outside the service area for the MHP's network of providers. These problems include difficulty: 1) finding providers and services in the child's county of residence; 2) contracting for care; 3) getting treatment authorizations; 4) coordinating and monitoring care; and 5) securing adequate reimbursements from responsible parties including federal, state, and local agencies.

7) **The implementation of AB403 – Continuum of Care Reform, will increase access to EPSDT specialty mental health services.**

   AB 403 was signed in to law in October, 2015. The implementation date is January 1, 2017. The initiative requires that the organizations operating FFAs either be certified to provide EPSDT SMHS or arrange for their provision to youth in their care. Similarly, Short Term Residential Therapeutic Programs are required to be certified to provide SMHS to youth in their care who meet medical necessity criteria. Although this population of youth were eligible for EPSDT SMHS prior to the enactment of AB403, many children and youth were not receiving them. Due to the integrated programming called for in the legislation, all children in these programs will be receiving EPSDT specialty mental health services at the duration and intensity necessary to meet their individual needs. County MHPs are not prepared to implement what they consider to be "expanded" services due to funding and budgeting constraints.

8) **The DHCS EPSDT Performance Outcome System (POS) needs to provide timely county-level qualitative and quantitative data to inform the allocation formulae.**

   The POS was mandated by legislation in 2011 and was scheduled to be fully implemented by 2014. As of this date, only limited state level quantitative data is available. No qualitative or county specific data are yet available. Without a reliable, timely data source, there is no way to determine if the SMHS we provide children are effective and efficient.

We believe that the priority in determining the allocation formula must be to make access to SMHS more equitable, both in terms of access to *any* care and access to more intensive treatment. And we believe it is within the discretion of DOF to do this, exercising its authority under AB 1020. While the statute grants very broad latitude to DOF in setting the funding allocation formula, it cannot be so broad as to authorize policies or procedures that undermine the Medicaid mandate for which the funds are designated.

In their August 19, 2011 report on 2011 Realignment, the Legislative Analysist Office (LAO) offered several recommendations to promote the long-term success of realignment; among them 1) develop local funding allocation formulas with eye towards the long term; 2) ensure that local fiscal incentives are aligned with statewide goals; and 3) promote local accountability. The LAO's report states "it is critical for the success of these programs that allocation formulas *not* be based solely on historical allocations. County financial needs for each program are going to change over time based on changes in county population, caseloads, demographics, wealth, cost of living, and other factors. In the future, county allocations should be based on formulas that are responsive to the specific factors that affect the funding needs of each program."

Funding for the entitlement programs have been and should continue to be prioritized under both 1991 and 2011 Realignment. Base and growth allocations for 2011 Realignment funds should be structured so that counties experience fiscal benefits when they successfully and effectively operate the realigned entitlement programs. The state would likely achieve better outcomes by focusing on establishing the right fiscal incentives and accountability mechanisms. The state should emphasize *outcome* measures that are made available to the general public, as is required by the CMS "Special Terms and Conditions" which were attached to the recent 1915(b) waiver extension. In order to ensure that county administrators and state officials can effectively compare program outcomes across counties, the state should ensure the uniformity of any reporting requirements.

Recommendation #1:
Guarantee full and prompt reimbursement of all EPSDT expenditures which exceed the base allocations of each county.

Recommendation #2:
Growth funds should be made available "up-front" as an "incentive pot" to incentivize counties to expand services. However, these funds should be provided in only two to three year blocks to ensure that counties are achieving their agreed upon qualitative and quantitative outcomes.

We agree with the LAO's 2011 report which stated that the allocation formula be used to prioritize meeting the federal mandates of entitlement programs. Precedent has been set for this type of "incentive pot." The report references a method by which growth in 1991 Realignment revenue was dedicated to addressing underlying funding inequities among counties.

"Incentive pots" funded by realignment growth should be developed to address each of the concerns listed above. Counties would submit two-year plans to accomplish one of the statewide goals, much in the way they are currently doing in response to SB 82. Each two to three-year plan should include the evaluation strategy the MHP will use to determine the effectiveness and efficiency of services, as well as the expected increase in the number of services provided and the number of beneficiaries served through the expansion.

MHPs that agree to utilize a state recommended functional assessment tool in assessing, treatment planning, and monitoring individual, program, and system outcomes would be given extra "points" in the evaluation of funding applications. If the evaluation produces positive results after the two-year period, the funding would continue. If the funding was not used for EPSDT SMHS or there is no evidence that the funded expansion of was effective, the funding would be discontinued after the two-year period. MHP requests for funding should be reviewed and prioritized by a committee inclusive of a diverse stakeholder group

including but not limited to: providers, youth and family members, and legal advocates. Priority for the funding of plans should be dedicated to addressing underlying funding inequities among counties.

The goal of the funding would be to accomplish one or more of the following:

- Increased penetration rates
- Increased access to more intensive treatment
- Increased access to services formerly known as "Katie A" services (ICC, IHBS, and TFC)
- Implementation or expansion of a crisis continuum of care (intensive outpatient services, mobile crisis, crisis stabilization, and crisis diversion programs).
- Implementation of the mental health components of the Continuum of Care Reform.

Recommendation #3:
Until a legislative or administrative solution is found, a "pot" of growth allocation funds should be set aside to fund the services provided to youth when they are placed outside of their county of original jurisdiction. MHPs that are providing services to youth who reside in their county but are under the jurisdiction of another county could claim against that "pot" of funds.

In closing, we urge you to provide written clarification to the counties that the State intends to take the steps outlined above:

1. Guarantee full and prompt reimbursement of all EPSDT expenditures which exceed the base allocation of each county;
2. Advance critical statewide policies, including implementation of CCR, development of crisis services, full implementation of *Katie A.* services, and ensuring timely access to EPSDT SHMHs by developing "incentive pots" for up-front funding which require the applying MHP to meet performance standards in order to obtain continued funding.
3. Establish an additional funding "pot" against which MHPs can claim when providing services to foster youth who reside in their county but remain under the jurisdiction of another county. (This "pot" will not be needed after a legislative or administration solution is found to the out-of-county issue.)

We thank you for the opportunity to offer our recommendations on this important issue. By having all key stakeholders involved in developing a solution, it is more likely that a timely and appropriate resolution can be developed.

Thank you for considering these comments.

Sincerely,

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Executive Director

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