California Children's Trust

REIMAGINING CALIFONIA'S MENTAL HEALTH SYSTEM TO ACHIEVE EQUITY AND HEALING FOR CHILDREN AND YOUTH

NASEM Children's Forum Workshop on Youth Mental Health Crisis

MAY 9, 2022

THERE IS A CRISIS IN YOUNG PEOPLE'S MENTAL HEALTH

Consider the facts before COVID-19:

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

Increase in mental health hospital days
for children between 2006 and 2014

Increase in the rate of self-reported mental health needs
since 2005

[2]

California ranks low in the country for providing behavioral, social, and development screenings that are key to identifying early signs of challenges

IMPACT OF COVID: What we feared is coming to pass…

ED VISITS

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

24/31 %

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

25%

One in for 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 nations mental health during the crisis

RADY CHILDREN'S HOSPITAL IN SAN DIEGO:

Between FY2011 and FY2019, annual behavioral health volume has increased

1746%

From 163 visits to 3,009 visits in 8 years

Comparatively, total Emergency Department visits has grown 23% during this same time period

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. Mental health must be reimagined and infused with contextual understanding of the SDOH and ACES.

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.

DRAMATIC UNDER-INVESTMENT IN CHILDREN

California is in the bottom 1/3 nationally for health spending at $2,500 per child enrollee.

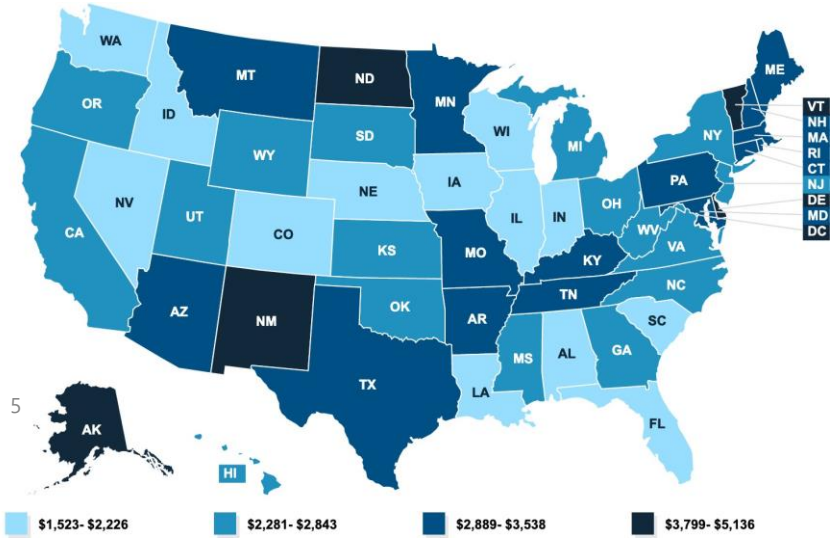
Children represent **42% of enrollees** but only **14% of all expenditures**.

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.

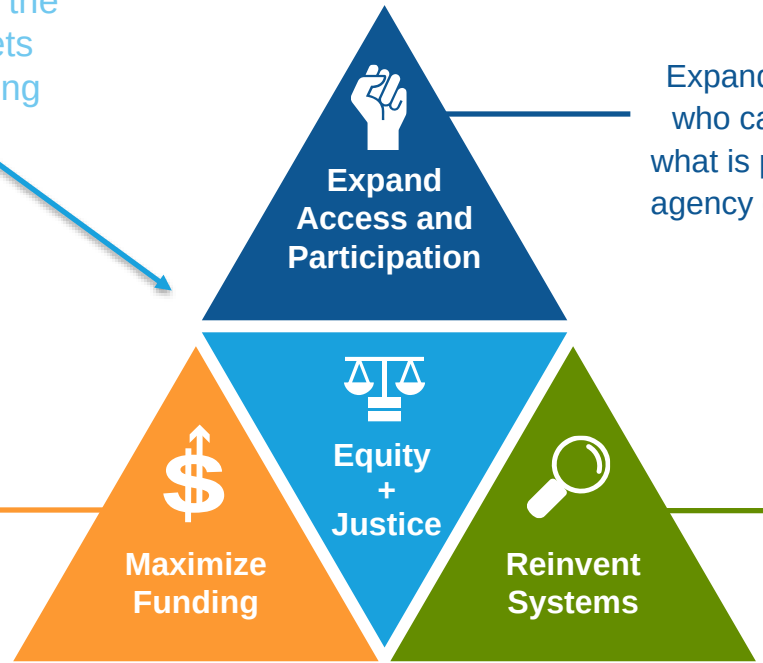
Medicaid Spending per Child

FY 2014



THIS IS THE TRUST'S FRAMEWORK FOR SOLUTIONS

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

Increase state and county spending, and fully claim the federal match

Increase transparency and accountability

OUR CALL TO ACTION

1. **Remove diagnosis** as a requirement for treatment (expand Medical Necessity Criteria in context of EPSDT and ACES)
2. **Capture Medicaid dollars** by claiming against exisitng expenditures in child serving systems.
3. **Center schools** as healing and anti-racist centers of support
4. **Expand Eligible Provider Classes** to address workforce shortages, build culutrally concordant workforce, and honor the widsom and intelligence of lived experience,
5. **Focus on Benefit Design in Managed Care Organizations to develop scaleable reimbursement for Dyadic Models** in Pediatric Primary Care.
6. **Focus on Care Coordination models** to bring culturally concordant non clinicla CBO's into health system networks.
7. **Develop social model, cascading mentorship, and mutual aid** strategies as essential social capital building strategies in Medicaid.

Read and share our policy briefs

cachildrenstrust.org

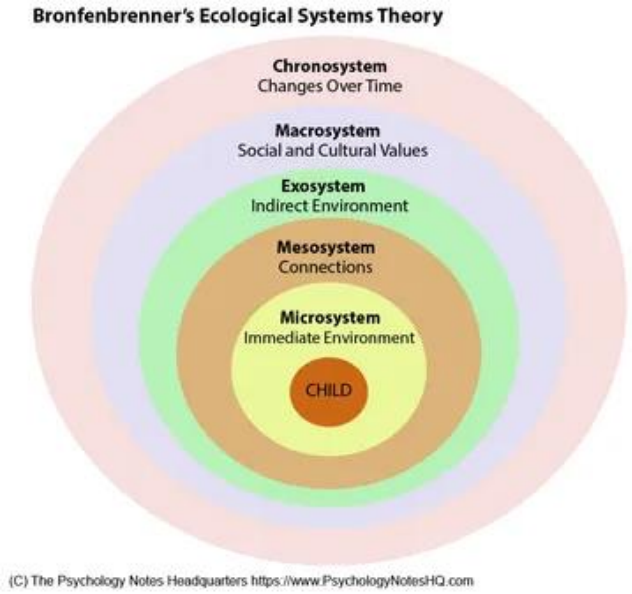
Join our Coalition

@CAChildrenTrust

Sign up for the CCT Newsletter

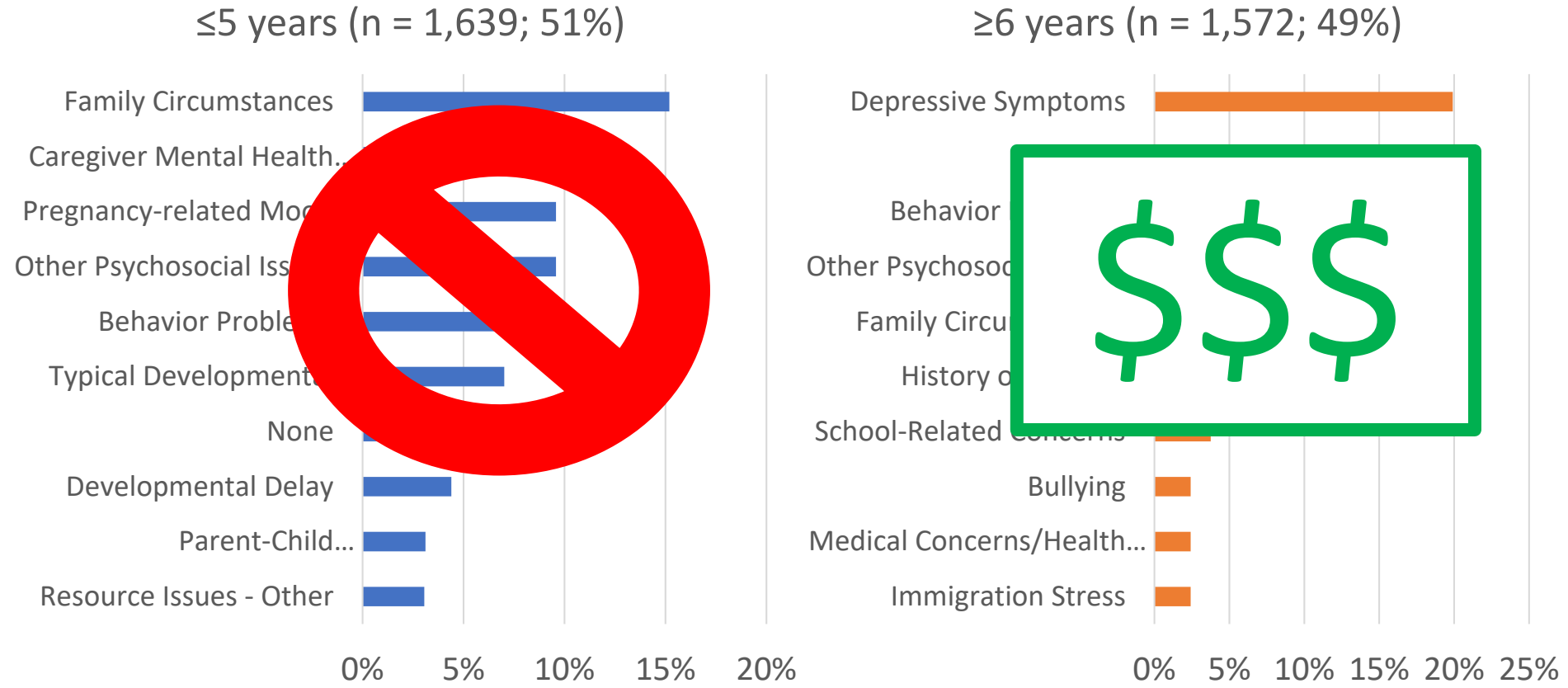
Preventing the Next Youth Mental Health Crisis

The Opportunity of Early Childhood

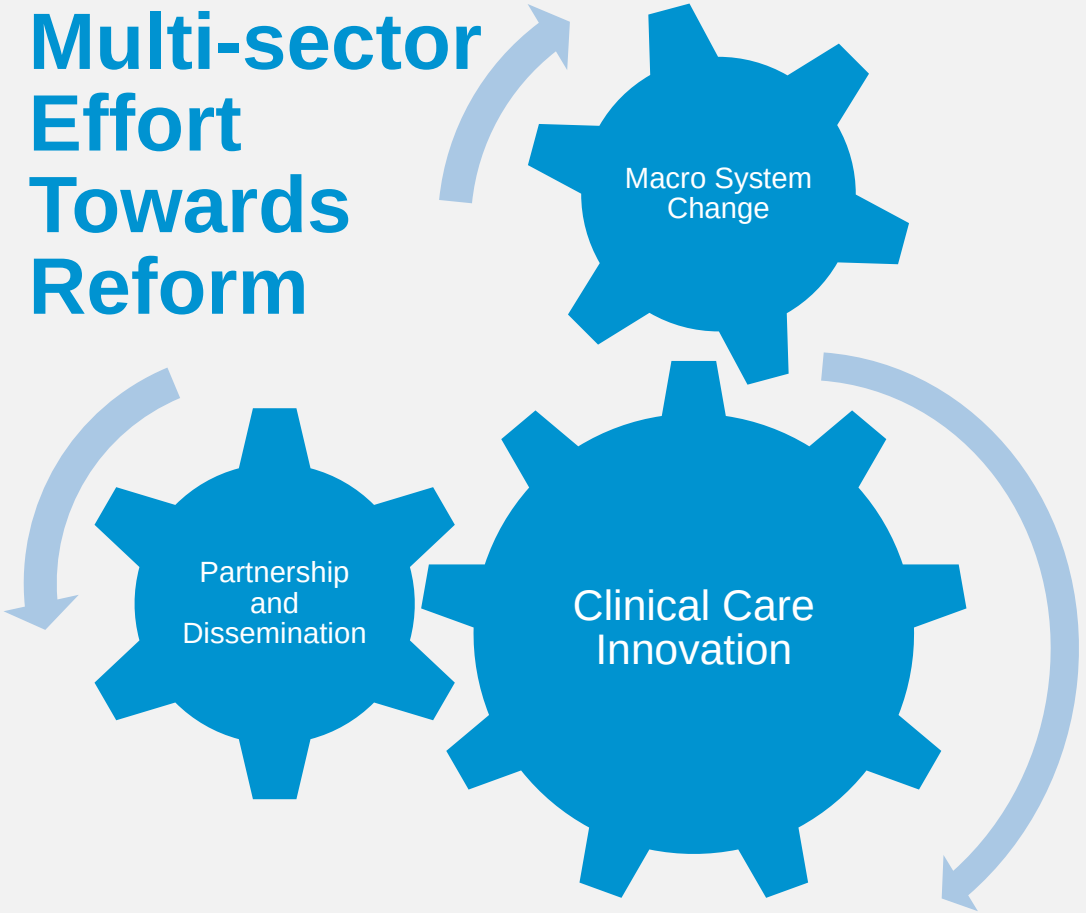


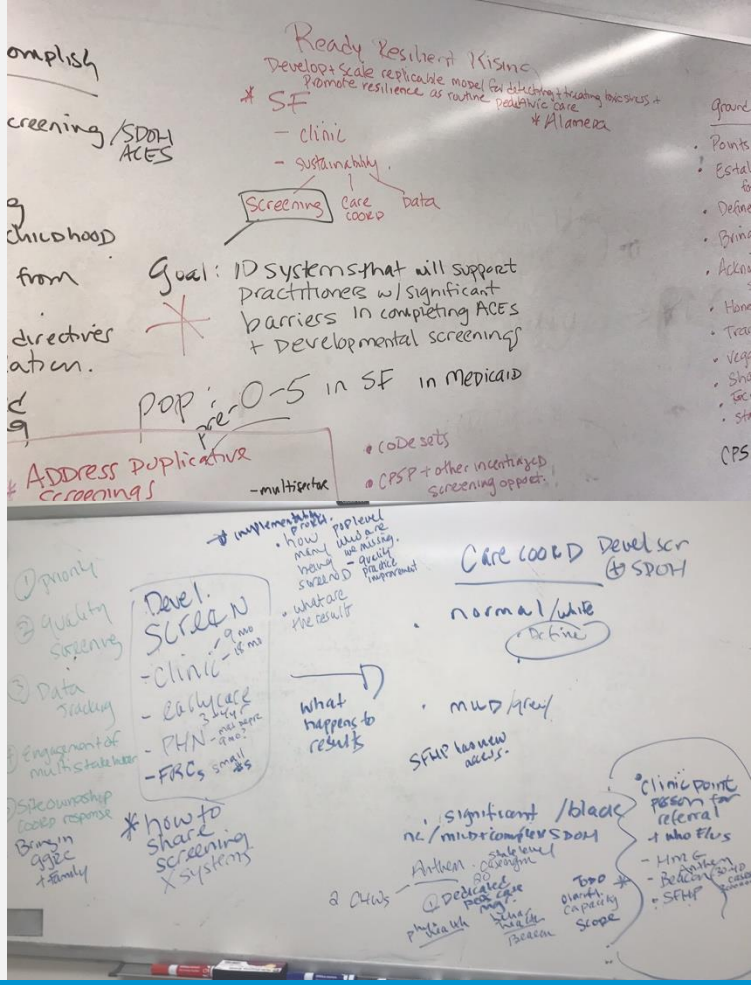
Newborn | 2 Week | 1 month | 2 months | 4 months | 6 months | 9 months | 12 months | 15 months | 18 months | 24 months | 30 months | 3 years

Integrated BH in Pediatrics Presenting Problems



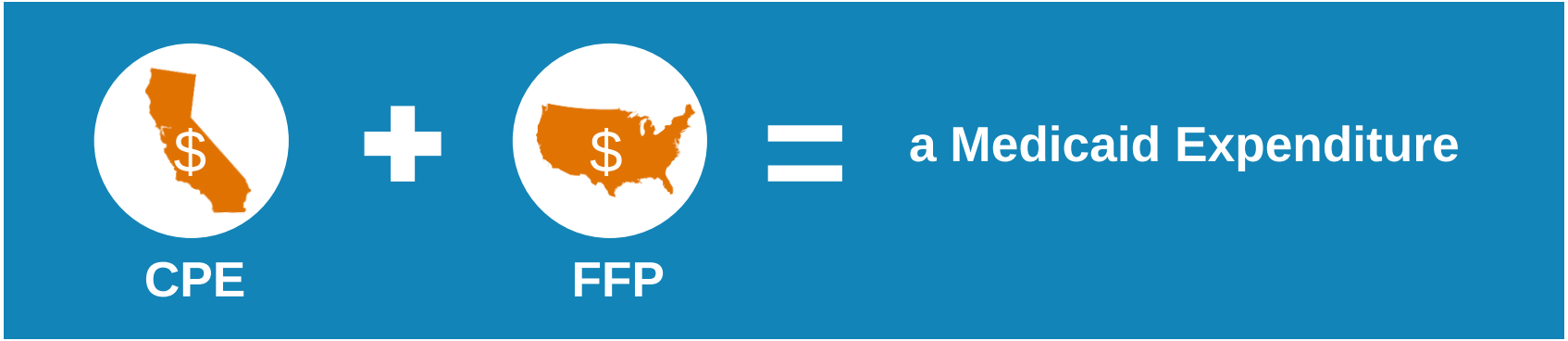
Multi-sector Effort Towards Reform





Dyadic Billing Demonstration Pilot in San Francisco

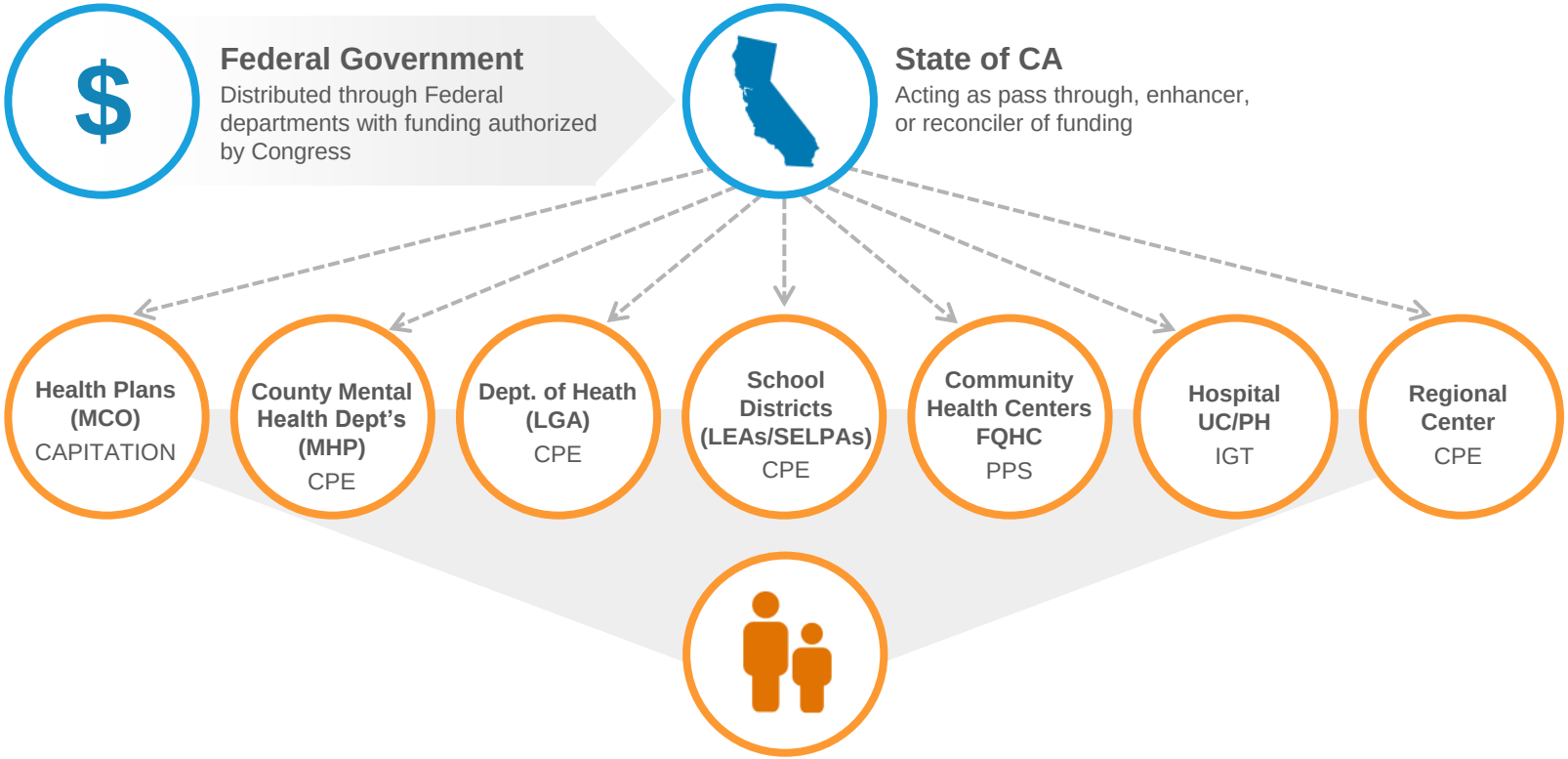
THE FEDERAL MATCH IS GUARANTEED:



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.

FOLLOW MEDICAID DOLLARS TO FIND MONEY LEFT ON THE TABLE



LEVERAGING EPSDT IN MANAGED CARE NEGOTIATIONS

Early Periodic Screening and Diagnostic Treatment (EPSDT)

Applies to those age <21 years on Medi-Cal

Require Medicaid Programs to cover comprehensive screening, diagnosis, treatment and preventive health care services, including behavioral health services, when those services are necessary to "correct or ameliorate any physical or behavioral conditions" or "to prevent disease, disability, and other health conditions or their progression, to prolong life, and to promote physical and mental health and efficiency."

Source: DHCS All Plan Letter. 18-007, March 2, 2018, p. 1-2.

What is the meaning of EPSDT in Distributed Risk Models (Managed Care)?

Dyadic Billing Demonstration Pilot to Pay for Prevention

Babies Don't Go to the Doctor By Themselves:

Innovating a Dyadic Behavioral Health Payment Model to Serve the Youngest Primary Care Patients and Their Families

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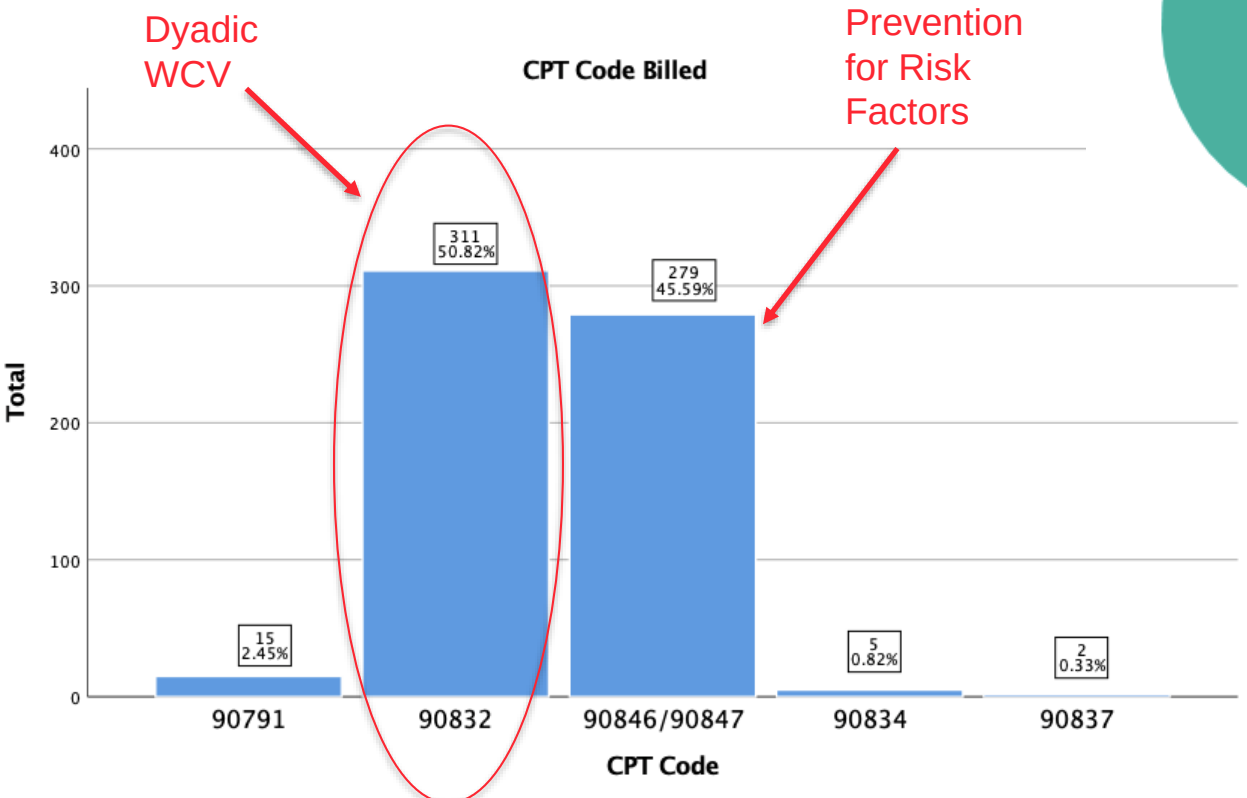
- → A statewide demonstration project to align reimbursement with clinical best practices in early childhood mental health
- → Essential support for proven dyadic models
- → Improving health outcomes for young children and their caregivers
- → Pioneering clinical best practices to inform state-level guidance
- → Demonstrating partnership with safety-net clinical leadership

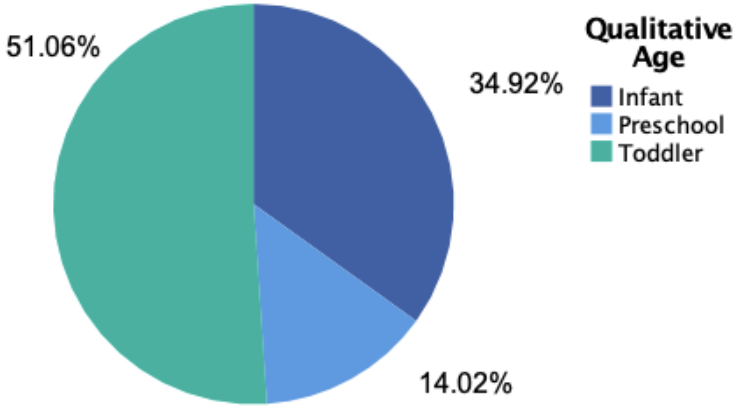
Proposal Summary

The caregiving and family context is the most

Dyadic Billing Demonstration Pilot

First 12 Months of Claims (Birth to 5 yos)





- **> 1,300 Encounters**
- **> 724 Claims**
- **Over half of claims for Infants**
- **Over half of claims for Dyadic BH WCV**

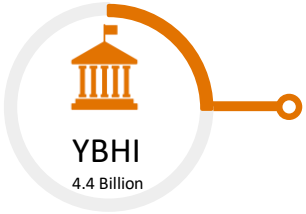
SNAPSHOT:

California Early Childhood Policy Landscape

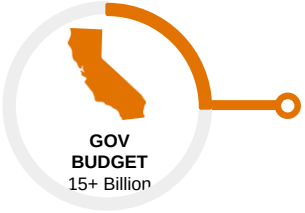
Practice to Policy

UNPRECDENTED INVESTMENT
IS COMING TO SCHOOLS AND SYSTEMS:

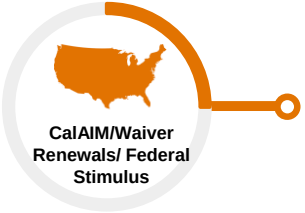
FUNDING OPPORTUNITIES FOR SOCIAL, EMOTIONAL AND MENTAL HEALTH IN SCHOOLS AND SYSTEMS:



- **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



- Expanded Learning Opportunity Grant Program (4.6 Billion)
- ELOP ongoing 1.75 (proposed at 4.4)
- Learning Loss Mitigation (5.3 Billion)
- Community School Partnership Grant Program ($3B)
- Educator Effectiveness Grant (1.5B)
- HCSB/Special Ed/Other....(1.5 Billion))



- ESSER I (CARES Act) - $1.6 billion
- ESSER II (CRRSA Act) - $6.7 billion
- ESSER III (ARP Act) - $15.1 billion

CalAIM:

- Enhanced Case Management
- Community Supports
- Population Health Management
- Universal Eligibility for System Involved Children

REDEFINING MEDICAL NECESSITY:
NEW MEDI-CAL BENEFITS PAY FOR PREVENTION

$800M
Over 5 Years

A FAMILY WELLNESS CHECK: CALIFORNIA INVESTS IN TREATING PARENTS AND CHILDREN TOGETHER

ANALYSIS | BY KAISER HEALTH NEWS | JULY 08, 2021

California is poised to become the first state to pay for "dyadic care," treating parents and children simultaneously.

KEY TAKEAWAYS

THE REMOVAL OF DIAGNOSIS AS A PRE-REQUISITE FOR CARE IN COUNTY MENTAL HEALTH PLANS AND MEDICAL MANAGED CARE

Challenges

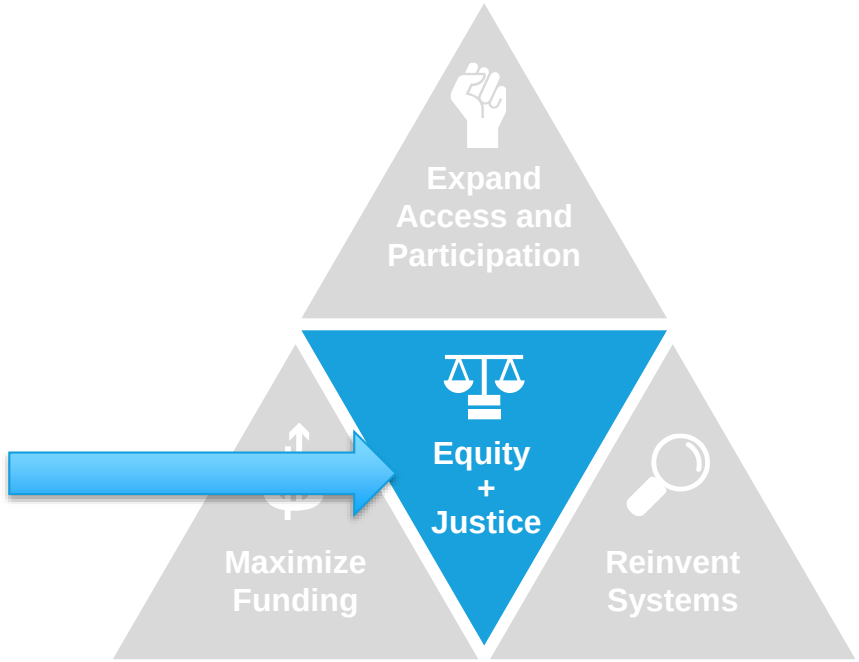
- Provider Class Limitations
- FQHC Same Day Exclusion
- State and Local Implementation
- Health Plan Accountability
- Workforce Recruitment and Retention

THE STRATEGIES ARE CENTERED ON EQUITY + JUSTICE

Transformed behavioral health systems are not simply financed or administered differently, they are:

- Anchored in new principles that acknowledge structural racism and poverty,
- Informed by relationships to and with beneficiaries and
- Designed as methods for accountability.

Equity and Justice must include Shifting Agency (who does the work) Power (who gets paid to do it).



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