County Behavioral Health SB 89 Emergency Relief Fund Proposal

Problem Statement

The viability of California's public behavioral health delivery system is contingent upon the ability of providers – both county-operated as well as contracted providers, to bill for services. In the short two-week period since efforts to self-quarantine and mitigate the impacts of the COVID-19 pandemic started, county behavioral health systems and their contracted providers have already begun to experience fiscal impacts which threaten the viability and sustainability of the public behavioral health system at the very moment when we anticipate demand for public behavioral health services to skyrocket.

In the weeks and months ahead, as individuals experience the individual and collective trauma associated with this unprecedented global pandemic, the need for behavioral health services – both mental health and substance use disorder services, will increase. Many millions of Californians will be hit with devastating life changes associated with the pandemic – from life-threatening illness, to the death of loved ones, to job loss, and effects of prolonged isolation. Increases in anxiety, depression, and ultimately substance use disorders and suicide rates, will be felt across populations while at the same time, the economic devastation associated with the virus will also result in many millions more Californians qualifying for public behavioral health services under Medi-Cal.

Among one survey of county contracted behavioral health providers, 58% reported a decrease in service provision since the quarantining efforts were implemented. Among this cohort, approximately 33% reported that they had clients who were too sick to engage in treatment. Over 30% of survey respondents are considering massive staff layoffs or furloughs without immediate relief via emergency funding.

While DHCS has worked valiantly to identify and support the need to migrate as many services to telehealth as possible, this is a significant shift in culture and practice which will take time, as well as an investment of resources to effectuate. In the first week of telehealth offerings, approximately 20% of surveyed contracted providers reported that existing clients refused the offer of telehealth services. The underlying reasons for the refusals are unknown at this point, but if we have the opportunity to stabilize our provider networks, we can learn and innovate over the course of the upcoming weeks. Many of our services are grounded in psychosocial models of care which can be challenging to migrate to tech-based platforms. Whole lines of service delivery have been significantly disrupted, such as group therapy sessions. Perhaps most at risk are those substance use residential treatment providers with clients and/or staff in isolation due to illness. These providers are unable to bill for services, and their counties cannot draw from otherwise flexible funding sources, such as the Mental Health Services Act funds, to offset those losses.

Anecdotally, we know that the vast majority of our existing client base are individuals who qualify for Medi-Cal; as such, many of our clients are struggling to address the immediate basic needs for food,

shelter, and safety. While many of our behavioral health teams are at the same time adjusting to assist with these needs, individuals and families focus on their basic survival is taking precedence to making the leap to telehealth counseling or recovery services.

Counties as a whole are documenting extreme losses as well, which threaten our ability to sustain minimum service levels, given that county behavioral health is limited to cost in terms of reimbursement, and therefore have little to no margins. An analysis[1] of one of our mid-sized counties found a 42% reduction in county staff productivity since March 14th, and a 68% reduction in services by contracted providers. Due to the short amount of time that has elapsed and the evolving nature of this crisis, additional analysis of the impact to our broader system is forthcoming.

While county behavioral health and their contracted providers appreciate that there are many funding priorities before the administration for consideration, we would argue that the ability to address the mental health and substance use disorder needs of Californians should be among the state's top health and safety priorities.

While other sectors of the health care delivery system are heavily impacted, all of our systems will ultimately rely on our public behavioral health system to address the immediate crisis and long recovery that will be required. The public behavioral health system is as vital to our health and wealth as a state as it supports our workplaces, schools, courts, hospitals, and social services safety net.

The impending loss of significant portions of our provider capacity would be devastating and ill-timed. Unlike with other licensed professionals, much of our system is supported by paraprofessionals that would leave the profession and likely not return. Furthermore, without immediate relief funding, we estimate that many county behavioral health systems will be unable to bill for enough services to bring in the requisite Medicaid Federal Financial Participation (FFP) to support the sustainability of this crisis through to the end of the Spring. The crisis for county behavioral health and their contracted providers is now and requires swift action.

Proposal and Funding Criteria

Under this proposal, funds would be reserved for COVID-19 response and mitigation. Counties would use these funds to pay for immediate COVID-19 emergency response activities not otherwise fundable through existing county behavioral health resources, such as: the stabilization of our delivery system (e.g. stabilization of contractors who are unable to bill for services) and making necessary investments to adjust to the safe delivery of services in the context of COVID-19. Our goal would be to ensure continued access to behavioral health services through the county behavioral health safety net. While it is important to ensure maximum flexibility in the use of funds, as the state has with the homelessness funding allocated under SB 89, our groups hoped to provide some specific examples of the intended use of these funds:

- Capital investments in building up additional surge capacity;

[1] This county analyzed average service delivery levels from July 1, 2019-February 21, 2020 as baseline in production, then compared these service rates to the period of March 14-March 22, 2020.

- Investments to support the migration to phone-based and telehealth services, including the purchase of equipment, training, or service plans, end-to-end for clients and/or providers;
- Investments supporting the shift to more field and home-based services and fewer facility-based services, as appropriate;
- Contract enhancements for those contractors who agree to render services, unless and until the client(s) or worker(s) are in isolation due to suspected or tested COVID-19 illness;
- Payment of shift differentials to retain staff who agree to continue to provide essential services unless and until isolation measures are necessary to mitigate the impacts of COVID-19;
- Efforts to provide for the safety and wellbeing of clients and/or workers via Personal Protective Equipment or sanitization.

Distribution Formula

Our proposal would allocate funds to each county behavioral health plan as well as our two city operated plans and distribute funding based on the Mental Health Services Act distribution formula. The behavioral health plans would then allocate funding pursuant to the flexible COVID-19 funding criteria.