March 16, 2020

Via Email to: Bradley.Gilbert@dhcs.ca.gov
Attention: Dr. Bradley Gilbert
Director, Department of Healthcare Services

**Re: Urgent Action To Stabilize Safety Net Services**

Dear Dr. Gilbert,

The California Alliance of Child and Family Services (Alliance) and the California Council of Behavioral Health Agencies (CBHA) applaud the efforts that this Administration and the Department of Healthcare Services (DHCS) are undertaking to respond to the COVID-19 crisis. This crisis has long reaching impacts, and our organizations would like to provide solutions for stabilizing and sustaining the infrastructure that serves the most vulnerable in California. Together, our associations represent over 200 nonprofit community-based organizations serving individuals and families across the lifespan in public behavioral health, child welfare, juvenile justice and education systems throughout California. As an essential part of the health and well-being of these individuals, our collective members provide a critical safety net to incredibly vulnerable Californians. As a direct result of the public health emergency caused by COVID-19, many nonprofit providers of behavioral health services for children, adolescents, adults and older adults will experience significant service disruptions that will impact cash flow and threaten the safety net of services for our clients. We are working to support these non-profit providers to keep their doors open to the most vulnerable Californians. We are worried that absent a strong statement of support from the State, there could be long term catastrophic consequences on these providers that are the infrastructure serving our most vulnerable population. Our number one goal is to ensure providers are able to keep safety net services open and available for clients.

*There is an immediate and urgent need for increased contracting flexibility* to meet the changing landscape across the state, while maximizing Federal Financial Participation (FFP) in federally funded behavioral health services. California and its counties have a great deal of flexibility that must be immediately leveraged to mitigate the impact of these disruptions on the imminent and future viability of the behavioral health system in California.

The Alliance and CBHA members are resolute in continuing to provide the critical services for their clients and their respective communities. We strongly believe that if we partner with state and county departments, we will be successful in mitigating the impact of COVID-19.

Below, we have outlined several steps that will allow providers to continue offering essential services unabated. In developing DHCS' 1135 Waiver request, we believe that DHCS can utilize the following sections from Sec. 1135. [42 U.S.C. 1320b–5] to address current barriers to getting timely behavioral health supports to the state's most vulnerable individuals during this national emergency:

"(1) that sufficient health care items and services are available to meet the needs of individuals in such area enrolled in the programs under titles XVIII, XIX, and XXI; and

(2) that health care providers (as defined in subsection (g)(2)) that furnish such items and services in good faith, but that are unable to comply with one or more requirements described in subsection (b), may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse."

While we do not believe that DHCS must use the waiver to implement these suggestions, they are certainly supported by the language in 1135.

**Proposed Solutions:**

1. **Fully fund contract allocations for providers**: It is important to ensure that providers are able to maximize their contracts and that counties continue to draw down the full amount of FFP possible for services provided. The solutions below take into account the ability to continue leveraging FFP by complying with federal Medicaid law. Additionally, the pending Families First Coronavirus Response Act would increase the FMAP for Medicaid (MediCal) services by 6.2% during the emergency period, assisting with any necessary rate increases to ensure stability.

    a. **Fund contracts based on actual costs during pro-rated period:** Counties can request that providers invoice monthly for a pro-rated monthly amount of their contract, while documenting the actual cost of services for the provider (e.g. personnel, facilities,

operations costs, etc.). San Francisco County issued a policy on March 11, 2020 stating: "*Suppliers with Fee-for-Service contracts (i.e., primarily DPH suppliers with contracts with services billed based on units actually provided) should invoice for the month by calculating 1/12th of the contracted units of service, and should be prepared to offer documentation of specific services that were expected but unable to be delivered. For Medi-Cal covered services, DPH will ensure that the cost report settlement process appropriately accounts for the actual cost of services, and DPH expects all units of service to continue to be entered into AVATAR unless notified separately by DPH."*

This solution could also be implemented by averaging the actual cost of service provision for a period of "regular" activity (e.g. during the school year) and using that average as the basis for the pro-rated contract amount for billing. Billing based on actual cost of services is in compliance with federal requirements for drawing down FFP, which is the most important consideration for counties in managing this unprecedented financial time.

In some cases, if a provider is funded for actual costs, it could also result in costs over and above the current contract maximum amount. We suggest that DHCS provide strong guidance to counties that there be an allowance for providers to be reimbursed regardless of contract cap if clear documentation regarding service provision, outreach and client engagement is documented.

b. **Grant fluctuation in billing rates to allow for contract maximization:** Another option is for DHCS to direct counties to allow providers to bill at higher rates for services provided during this time when units of services provided are likely to be lower than anticipated. This solution similarly would allow counties to continue drawing down FFP by meeting all federal Medicaid requirements related to billable services. The allowance for higher rates based on monthly or quarterly costs would be used to help providers maximize their contracts, would be helpful to counties and the State by maximizing FFP, with the understanding that flexible rates would be used to address service unit shortfalls and providers would not exceed existing contract allocations. One scenario might be to use "floating rates" that are based on the provider's costs and units of service and calculated monthly or quarterly.

c. **Flexibility to shift funds between existing contracts/reporting units to reflect changing service needs:** As providers see a spike in the utilization of crisis response programs and community-based programs, and a corresponding decrease in school-based services and other less acute services, DHCS and counties must allow for flexibility to respond to the shifting landscape of need. In counties where a provider holds multiple behavioral health contracts across different reporting units, contract managers could

explore the opportunity to shift staff and resources from under-utilized contracts into over-extended contracts. While this type of flexibility must necessarily be approached on a case-by-case basis, it is critical to be nimble and responsive during this uncertain and unpredictable time for our communities. We are seeking DHCS' direction to counties to provide maximum flexibility within contracts to best meet communities and client's needs, removing the current payment caps on individual programs, supporting sustained funding.

For some counties (e.g., LA) in which contracts have integrated funding (e.g., MHSA, other local funding), this suggestion may be too complicated, but other methods of allowing maximum flexibility within a provider's total contract/s amount is the critical issue to ensuring that services can be delivered and FFP maximized.

2. **All forms of client contact must be deemed equivalent**: We applaud DHCS' leadership in moving quickly to provide guidance on providing all services via telehealth and phone. This guidance resolved any discrepancies across counties regarding the ability to provide services remotely, which was a concern prior to IN 20-009 being released.

3. **Expansion of outreach and collateral services**: Providers must be allowed to do whatever is necessary to locate and engage clients and the important caregivers/family members of clients. Many contracts place a cap on, or do not include, these indirect services, which will be even more critical and important throughout the pandemic. These outreach and collateral services must be included in the array of services providers can deliver and claim to reflect the shifting reality of the service landscape during a period of social distancing and quarantine.

We stand ready to work with DHCS and our county partners to ensure the populations we serve continue to have access to critical behavioral health services. We appreciate the opportunity to share our proposed solutions and look forward to continued dialogue about how we can best assist the Administration as it aims to ensure health for all Californians.

Respectfully,

Christine Stoner-Mertz, LCSW
Chief Executive Officer
California Alliance of Child and Family Services

Paul Curtis
Executive Director
California Council of Community Behavioral Health Agencies

CC: Kelly Pfeifer, Department of Health Care Services
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