California Community Mental Health Funding

Evolution and Policy Implications

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Major CA Historical Fiscal/Policy Milestones

- 1969: Community Mental Health Services Act, Deinstitutionalization, Short/Doyle Act
- 1991: Realignment 1991
- 1993: Medi-Cal Rehabilitation Option
- 1995-97: Medi-Cal Specialty Mental Health Consolidation
- 2004: Prop. 63 – Mental Health Services Act
- 2008: Federal Mental Health Parity
- 2009-10 Federal Health Care Reform/CA 1115 Waiver
- 2011: AB 100/MHSA Changes
- 2011: Realignment 2011/Public Safety Realignment

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Community Mental Health Services Act/Deinstitutionalization (1969)

* The California Community Mental Health Services Act 1969 was a national model of mental health legislation that "deinstitutionalized" mental health services, serving people with mental disabilities in the community rather than in state hospitals.

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Short-Doyle Act (1969)

* The Short-Doyle Act was the funding mechanism intended to build the community mental health system. Legislative intent language called for funding to shift from state hospitals to community programs.

* However, the state failed to distribute the full savings achieved through the closures of state hospitals to the community mental health system.

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No Entitlement for Mental Health Services

- Unlike services to persons with developmental disabilities, ***the mental health system was never conceived as an "entitlement."***
- Mental health services were to be provided ***"to the extent resources are available."***
- This essential difference built rationing of services into the framework of mental health service delivery…

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Community Mental Health System in Crisis

1970-1990

- Beginning with an inadequate funding base, state allocations to counties were severely diminished due to inflation throughout the 1970s and 80s.
- In 1990, California faced a $15 billion state budget shortfall which would certainly have resulted in even more drastic cuts to mental health.
- Community mental health programs were already near collapse and overwhelmed with unmet need. This crisis propelled the enactment of "Realignment."

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Realignment
(1991)

- "Realignment" was enacted in 1991 with passage of the Bronzan-McCorquodale Act.
- *It represented a major shift of authority from the state to counties for mental health programs.*
- Realignment 1991 created a new dedicated revenue source for counties.
- Instead of community mental health being funded by the State General Fund (and thus subject to the annual state budget process), new "Realigned" revenues would flow directly to counties.

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Realignment 1991 Funding Sources

- Realignment included two dedicated revenue streams:
  - ½ cent increase in state sales tax
  - State Vehicle License Fee (VLF)

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Mental Health Programs Realigned from the State to Counties

- All community-based mental health services
- State hospital services for civil commitments
- Mental health services for those in "Institutions for Mental Disease (IMDs)," which provide long-term psychiatric nursing facility care

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Benefits of 1991 Realignment

- Realignment has generally provided counties with many advantages, including:
  - A stable funding source for programs, which made a long-term investment in mental health infrastructure financially practical.
  - The ability to use funds to reduce high-cost restrictive placements, and to serve clients appropriately in the community.
  - Greater fiscal flexibility, discretion and control, including the ability to "roll-over" funds from one year to the next, enabling long-term planning and multi-year funding of projects.
  - Emphasis on a clear mission and defined target populations.

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Public Health and Social Services Were also Realigned in 1991

* Although it was initially begun as an effort to reform mental health financing, public health programs and some social services (such as In-Home Supportive Services and Foster Care) were also added to the Realignment mix.
* Because the social services programs were "entitlement" programs, they were given priority for any "growth" in Realignment revenues.
* ***Over time, this structure contributed to many of the shortcomings of 1991 Realignment for mental health– revenues dedicated to mental health did not keep pace with community needs.***

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Realignment Funds Distributed by Formula[1]

* Annually, Realignment revenues were[1] distributed to counties on a monthly basis until each county received funds equal to the previous year's total.

[1] Realignment 2011 has made changes to 1991 distribution amounts and methodologies that will be explained later under 2011 Realignment.

* Funds received above that amount were placed into growth accounts: Sales Tax and VLF.
* Realignment "growth" funds were distributed annually, and ***the first claim on the Sales Tax Growth Account went to caseload-driven social services entitlement programs (IHSS and child welfare).***
* Any remaining growth from the Sales Tax Account and all VLF growth were then distributed according to a formula developed in statute.

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Realignment Formula Flawed – Insufficient Growth for Mental Health

- ***Under Realignment 1991, mental health received no Sales Tax growth since FY 2005/06.***
- *In Fiscal Years 2007/08, 2008/09 and 2009/10, mental health did not even make the prior year's base.*
- ***FY 2009/10 and FY 2010/11, Mental Health Sales Tax revenues approximated the original baseline amounts from FY 1991/92.***
- FY 2010/11 VLF revenues were approximately the same as FY 2003/04 amounts.

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Realignment Mental Health Growth Insufficient

- Mental Health Sales Tax revenues declined:
  - Down 13% in FY 2008/09
  - Down 4% in FY 2009/10
  - Unchanged in FY 2010/11
- Mental Health VLF revenues declined:
  - Down 8% in FY 2008/09
  - Down 7% in FY 2009/10
  - Unchanged in FY 2010/11
- Overall decline in FY 2009/10 total Mental Health Realignment of approximately 5%.

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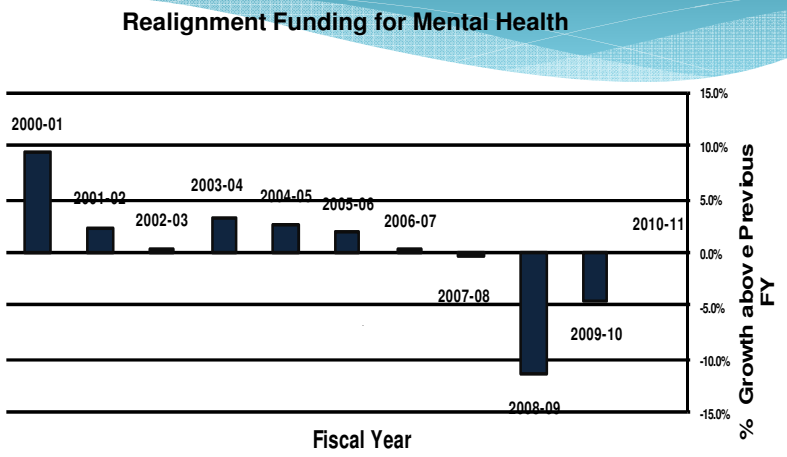
Realignment Growth for MH: Fiscal Year 2000/01 to 2010/11



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Medi-Cal Mental Health Services

Understanding the changes in California's Mental Health Medi-Cal program since Realignment, and the interaction of Medi-Cal revenues with Realignment, is critical to analyzing the current structure and status of public mental health services in California…

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Medi-Cal Mental Health Services History in California

* The Fee-for-Service "clinic option" Medi-Cal program originally consisted of "physical" health care benefits, with mental health treatment making up only a small part of the program.
* Mental health services were limited to treatment provided by physicians (psychiatrists), psychologists, hospitals, and nursing facilities, and were reimbursed through the Fee-For-Service Medi-Cal system (FFS/MC).

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Medi-Cal Mental Health Services

* Short-Doyle/Medi-Cal (SD/MC) started as a pilot project in 1971, and counties were able to obtain FFP to match their own funding to provide certain mental health services to Medi-Cal eligible individuals.
* The SD/MC program offered a broader range of mental health services than those provided by the original FFS Medi-Cal program.

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Medi-Cal Rehabilitation Option
(1993)

* A CA Medicaid State Plan Amendment in 1993 added more services under the federal Medicaid "Rehab Option" to the scope of benefits, including:
  * Community based (non-clinic) services
  * Expanded service provider types
  * Additional service types
  * Expanded acute care model to include long term community care model

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Medi-Cal EPSDT
(1995)

* Early and Periodic Screening, Diagnosis and Treatment (EPSDT) represents an expansion of services resulting from a successful class action lawsuit against the state.
* The state's settlement agreement resulted in increased state responsibility for funding for Medi-Cal specialty mental health services for full scope Medi-Cal beneficiaries under age 21.

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Medi-Cal Specialty Mental Health Consolidation (1995-1997)

* From 1995 through 1998, the state consolidated Fee-for- Service and Short-Doyle programs into one "carved out" specialty mental health managed care program, under a Medicaid 1915(b) "Freedom of Choice" waiver.
* Counties were given the "right of first refusal" for taking on this new responsibility of managing specialty mental health care.
* Under this system, all Medi-Cal beneficiaries must receive their specialty mental health services through the county Mental Health Plan (MHP).

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Medi-Cal Consolidation

* General mental health care needs for Medi-Cal beneficiaries remain under the responsibility of non-specialty fee-for-service providers and Medi-Cal Managed Care plans.
* DHCS fee-for-service is still responsible for all pharmaceutical costs for specialty mental health MHP beneficiaries.

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Medi-Cal Consolidation

* Upon consolidation, the state DHCS transferred the funds it had been spending under the FFS system for inpatient psychiatric and outpatient physician and psychologist services to county Mental Health Plans (MHPs).
* It was assumed (by counties) that MHPs would receive additional funds yearly beyond the base allocation for increases in Medi-Cal beneficiary caseloads, and for COLAs.
* ***Any costs beyond that allocation were to come from county 1991 Realignment revenues.***

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Medi-Cal Consolidation

* In other words, the risk for this entitlement program shifted from the state to the counties…

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Impact of Medi-Cal on Realignment Funds

* After Medi-Cal Consolidation, administrative requirements by DMH grew dramatically.
* Counties have not received COLAs for the Medi-Cal program since 2000.
* The FY 2011/12 Managed Care Allocation is approximately **the same amount** as the FY 2000/01 Managed Care Allocation.

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EPSDT and Medi-Cal Consolidation

* County MHPs were originally reimbursed the entire non-federal expenditure for all EPSDT eligible services in excess of expenditures made in the baseline year (FY94/95), adjusted for inflation.
* However, in FY01/02, county MHPs became responsible to fund 10% of the growth in the state/local match above FY01/02 cost-settled amounts of state/local match.

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Federal Medi-Cal Changes Since Consolidation

* CMS determined that county mental health plans are managed care prepaid inpatient health plans (PIHP)
* CMS determined that the counties are responsible for certifying the required public expenditure (CPE)
* CMS required the state to update the fiscal and coverage provisions of the 1915 (b) waiver and state plan amendments
* CMS required changes to the cost report to meet government accounting requirements
* AB 1297 (sponsored by CMHDA) required the replacement of the Statewide Maximum Allowance (SMA) with a federal UPL in FY 12/13

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Medi-Cal Reimbursement Under Consolidation Now

* County MHPs are reimbursed a percentage of their actual expenditures based on the Federal Medical Assistance Percentage (FMAP)
* County MHPs are reimbursed an interim amount throughout the fiscal year based on approved Medi-Cal services and interim billing rates
* County MHPs and the State reconcile the interim amounts to actual expenditures through the year end cost report settlement process
* The State audits the cost reports to determine final Medi-Cal entitlement

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Medi-Cal Specialty Mental Health

* Federal Medicaid dollars (FFP) currently constitute the largest revenue source for county mental health programs.

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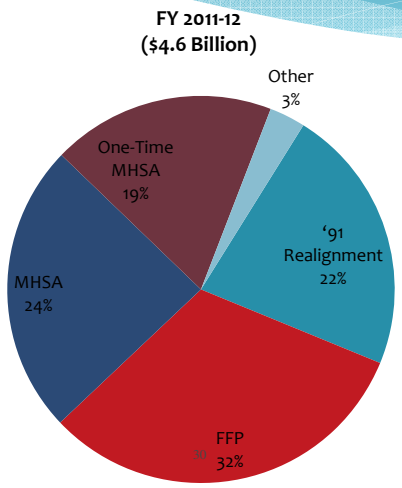
Current Community Mental Health Funding Sources



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Proposition 63
The Mental Health Services Act (MHSA) (2004)

- Proposition 63 – a California voters' ballot initiative
- Passed by majority vote on November 2, 2004
- Became effective as statute -- the Mental Health Services Act (MHSA) -- on January 1, 2005

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MHSA: What Is it?

- 1% tax on personal income in excess of $1M
- Purpose is to reduce the long-term adverse impact of untreated mental illness
- Intent is to ***expand*** mental health services
  - Recovery/wellness
  - Stakeholder involvement
  - Focus on un-served and underserved
  - Focus on effective services and cost-effective expenditures

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MHSA Is Community-Driven

"The most important change that the MHSA brought forward is to bring the voice of the person receiving services and the families – across ethnicity – to the center of the conversation rather than at the margins of the conversation." (Dr. Marvin J. Southard, Los Angeles County Mental Health Director)

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MHSA: AB 100
(2011)

* Facing another major budget deficit in FY 2011-12, the Governor proposed and the Legislature adopted AB 100, which fundamentally changed the landscape of the MHSA – in both positive and not so positive ways…

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MHSA/AB 100

- **Not so positive:**
  - *Diverted $862 million on a one-time basis from the MHS Fund to backfill SGF obligations for EPSDT, Medi-Cal managed care and Educationally-Related Mental Health Services (formerly AB 3632).*
- **Positive:**
  - Eliminated State approval of MHSA Plans (thus eliminating significant state-level bureaucracy)
  - Created continuous MHSA appropriation to counties
  - Changed accounting from cash to accrual (thus eliminating big cash reserves at the State)
  - Maintained community-driven local stakeholder process

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AB 100 Changes to State Role in MHSA Administration

- Reduced the state administrative funds reserved for DMH, MHSOAC, California Mental Health Planning Council and other state agencies from five percent (5%) to three and half percent (3.5%) (the difference goes to counties for services).
- Deleted requirement that DMH and the MHSOAC annually review and approve county plans and updates.
- Deleted requirement that a county annually update the 3-year plan, but updates are still required.
- Specified that the "state," instead of DMH specifically, will administer the Mental Health Services Fund (MHSF), and issue regulations.

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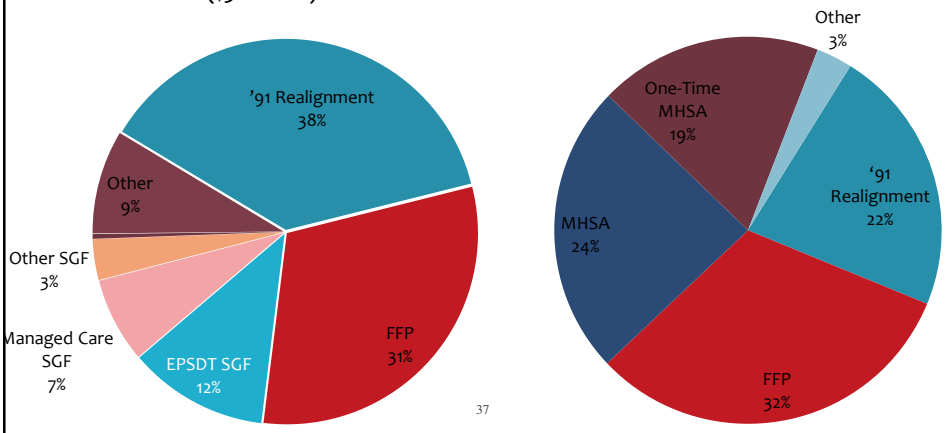
The MHSA is a Significant Source, While State General Funds Have Been Eliminated

FY 2004-05 ($3.1 Billion) **vs.** FY 2011-12 ($4.6 Billion)



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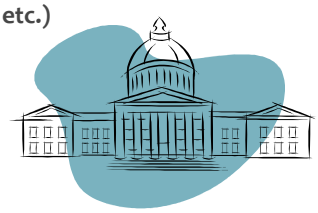
Federal Mental Health Parity (2008)

- MH & SU services must be provided at parity with general healthcare services, including in these areas:
  - **Coverage restrictions (copayments, deductibles, etc.)**
  - **Lifetime limits/costs**
  - **Treatment limits (number of visits/days covered)**
- Parity applies to:
  - **Large Employers**
  - **Medicaid**
  - **Health Insurance Exchanges for Individual and Small Group Policies**



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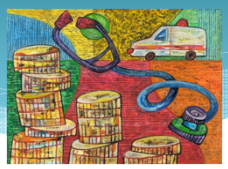
Health Care Reform
Federal Affordable Care Act (2009)



* Employers with 50+ employees will be fined if they don't offer health insurance. Small companies that offer coverage can receive tax credits.
* Medicaid expansion in 2014 will be 100% federally funded to cover single adults up to 133 % of federal poverty
  * $14,404 individual income, $29,326 family of four income.
  * An estimated 16 million new people nationally, at least one-fifth of whom are likely to have mental illness and/or substance use disorder service needs.
* The Congressional Budget Office estimates almost one-quarter of Americans who lack health insurance today will be covered under Medicaid over the next 10 years.

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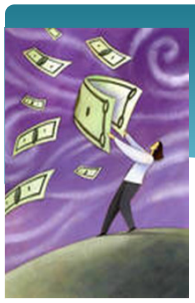

California's 1115(b) Waiver: A Bridge to Health Reform

* California has received approval for a new 5-year Medicaid waiver (2010-2015) as a "bridge to federal reform"
* If savings are achieved and milestones met, it could bring as much as $10 billion in new federal funds.

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1115(b) Waiver
Low Income Health Program (LIHP)

* County option to participate
* Counties provide match to expand coverage to individuals up to 133% of federal poverty before 2014
* Receive 50% federal matching dollars.
* Counties may set their own eligibility levels up to 133%.

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1115(b) Waiver
Low Income Health Program (LIHP)

Low Income Health Program (LIHP) – two components:

1. Medicaid Coverage Expansion (MCE)
   - Up to 133% FPL
   - Mental Health Minimum Benefit Required
   - FFP not capped
   - May be CPE or capitated
2. Health Care Coverage Initiative (HCCI)
   - 134% to 200% FPL
   - Mental Health Minimum Benefit Not Required
   - FFP is capped – county will get an allocation
   - Financed through Inter-Governmental Transfer (IGT)

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Minimum MH Benefits in 1115(b) Waiver

- **For MCE enrollees (under 133% of FPL), each participating county must provide the following minimum package of mental health benefits:**
  - Up to 10 days/year acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric health facility.
  - Psychiatric pharmaceuticals.
  - Up to 12 outpatient encounters/year, including assessment, individual/group therapy, crisis intervention, medication support and assessment. If a medically necessary need to extend treatment to an enrollee exists, the plan can optionally expand the service(s).
  - Substance Use Services are **Optional** in MCEs.

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Bottom Line:

- Realignment 1991, which never fully funded mental health needs, was intended to grow over time. That growth did not occur as expected.
- Under Realignment 1991, counties were using an increasing amount of Realignment funding as Medi-Cal match, leaving little, if any, for indigent services.
- MHSA helped significantly, but cannot fill all the gaps and continues to be a major budget target.
- Time for another MAJOR Policy Shift – Realignment 2011!

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Lead up to Realignment 2011

- **$25.4 Billion Budget Problem**
  - $8.2 Billion deficit for FY 2010-11
  - $17.2 Billion deficit for FY 2011-12

Why the continued deficit?

1. Various one-time budget solutions used in previous years
2. Not enough federal funding obtained as hoped
3. Continued weak economy
4. Previous program cuts did not create enough savings

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Realignment 2011

- Pressured by continuing deficits, Governor Brown proposed realigning many public safety and health and human services programs from the state to counties.
- He wanted to move responsibility for these services so that they could be more efficiently managed and provided at a level that was "closer to the people."
- The plan was to create a *new, dedicated, constitutionally protected* revenue source for counties that was approved by voters by ballot initiative.

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No Constitutional Protection -- Yet

* Unfortunately, the plan that the Legislature ultimately adopted did not include support for a ballot initiative. The Governor remains committed to ongoing funding and to achieving Constitutional protection.

* He has filed a ballot initiative with the Secretary of State that includes Constitutional protections for counties, and hopes to qualify it for the November 2012 ballot.

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Realignment 2011
2011-12 Funding Structure

* Several FY 2011-12 budget trailer bills included components of realignment financing, recognizing that additional work to refine the financing structure will take place this year.

* The primary vehicle for the 2011 Realignment provisions was AB 118, which transferred the equivalent of $5.559 million of annual state fiscal responsibilities for "public safety programs" to counties.

* This bill also creates the account structure and allocations for some of this funding, and dedicates 1.0625% of existing state sales tax revenue to fund these local costs in FY 2011-12.

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AB 118

- AB 118 establishes a reserve account should revenues come in higher than anticipated, and funds will be allocated from that reserve account to entitlement programs (Foster Care, Drug Medi-Cal, and Adoption Assistance).
- *The bill is silent as to what happens should funds come in lower than expected.*

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"Public Safety" Realignment 2011-12 – What is Included?

- Trial Court Security Account
- Local Community Corrections Account
- Local Law Enforcement Services Account
- **Mental Health Account (1991 Realignment)****
- District Attorney and Public Defender Account
- Juvenile Justice Account, including the following subaccounts:
  - Youthful Offender Block Grant
  - Juvenile Reentry Grant

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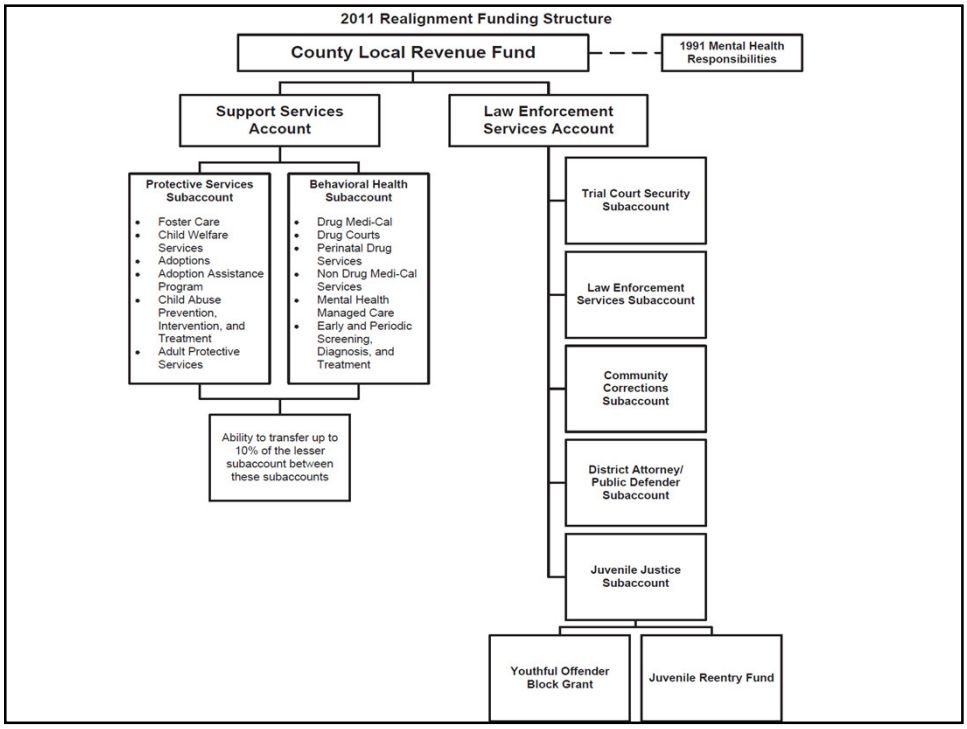
Realignment 2011-12 – What is included?

* **Health and Human Services Account**, including:**
  * Adult Protective Services
  * Foster Care
  * Child Welfare
  * Adoptions Assistance
  * Child Abuse Prevention and Treatment
  * Woman and Children's Residential Treatment Services
  * Drug Court
  * Drug Medi-Cal
  * Reserve Account

**EPSDT and Medi-Cal Specialty Mental Health Managed Care are realigned, but not until 2012-13.



Governor's Budget Proposed Expenditures for 2011 Realignment

(In Millions)

	2011–12	2012–13	2013–14	2014–15
Adult offenders and parolees	$1,587	$858	$1,016	$950
Local public safety grant programs	490	490	490	490
Court security	496	496	496	496
Pre–2011 juvenile justice realignment	95	99	100	101
EPSDT	579	544	544	544
Mental health managed care	184	189	189	189
Drug and alcohol programs	180	180	180	180
Foster care and child welfare services	1,562	1,562	1,562	1,562
Adult Protective Services	55	55	55	55
CalWORKs/mental health transfer	1,105	1,164	1,164	1,164
Unallocated revenue growth	—	180	444	989
Totals	**$6,332**	**$5,816**	**$6,240**	**$6,720**

EPSDT = Early and Periodic Screening, Diagnosis, and Treatment program.

Source: Legislative Analysts Office (LAO)

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Realignment Funding for Mental Health**

	2011-12	2012-13 (Forward)
EPSDT	0 (AB 100)	$629 million
Medi-Cal MH Managed Care	0 (AB 100)	$183.7 million
1991 Community MH Realignment	$1.083 billion	$1.119 billion

- Since AB 100 is providing MHSF in 2011-12, Medi-Cal Specialty Mental Health is not realigned until 2012-13.
- Only the funding source for 1991 community mental health realignment is changing. Funds will be deposited monthly. ***The 2011-12 amount is 5.9% higher than would be anticipated without the 2011 Public Safety Realignment.***

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New Proposed FY 12-13 Baseline Allocations for Realigned Mental Health Programs

- In total, reduced by $34.9 M in new figures.
- Critical to determine adequacy of baseline figures.
- EPSDT impacted by Katie A. and Healthy Families proposal.

	2011-12		2012-13		2013-14		2014-15	
	Original Figures	**New Figures**	Original Figures	**New Figures**	Original Figures	**New Figures**	Original Figures	**New Figures**
Mental Health Managed Care	-	-	$183.7	**$188.8**	$183.7	**$188.8**	$183.7	**$188.8**
EPSDT	-	-	$629	**$544**	$629	**$544**	$629	**$544**
1991 MH Responsibilities	$1,083.6	**$1,104.8**	$1,119.4	**$1,164.4**	$1,119.4	**$1,164.4**	$1,119.4	**$1,164.4**

Public Safety Realignment (AB 109)

- **While AB 118 provides the funding structure, AB 109 specifies the operative provisions of "Public Safety" realignment.**
- Under AB 109, certain offenders are being held under local rather than state custody. They include:
  - 1) Non-violent offenders;
  - 2) Non-serious offenders; and
  - 3) Non-sex offenders.

Mental Health/AOD Directors Critical to Success of AB 109

* AB 109 created an "Executive Committee" from the "Community Corrections Partnership (CCP)" members, and includes a representative from either the county department of social services, mental health, or alcohol and substance abuse programs, as appointed by the County Board of Supervisors.
* MH/AOD Services are an essential ingredient to the success of "Public Safety" realignment, if we are to finally break the cycle of incarceration.
* To the extent possible, using AB 109 public safety realignment funds to match Medi-Cal services for parolees who can be enrolled under the LIHP should be a win-win for public safety and counties in general.

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Key Issues for Realignment of Medi-Cal Specialty Mental Health

1) Medi-Cal Specialty Mental Health MHP Contract: Right of First Refusal, Mandates Issues
2) Revenue Growth Proposal Issues for Behavioral Health Subaccount
3) Base Realignment Funding Issues for Behavioral Health Subaccount
4) Structure and Risk of Behavioral Health Subaccount (including Drug Medi-Cal)

Current "Knowns" about Community MH Financing

* 2011 Realignment of MH Managed Care and EPSDT will start in FY 12/13
* AB 1297 requires the replacement of the SMAs with a CMS approved UPL protocol
* The county is responsible for the Medi-Cal "full funds" expenditure required under the federal CPE requirements
* The county will be required to contract with DHCS under the provisions of the 1915 (b) waiver as a managed care prepaid inpatient health plan (PIHP)
* The county will be responsible for the Medi-Cal coverage and expenditure obligations specified in the waiver, SPAs and the MHP Contract
* The 1991 realignment provisions for the transferred MH programs will remain in place

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Current Unknowns for Community MH Financing

* What the FY 12/13 and beyond base and growth will be for Health and Human Services Subaccounts.
* The amount of the monthly transfers to be made by the state to each county's account for 2011 realignment and MHSA in FY 12/13
* Whether there will be Constitutional mandate protections and remedies available to the county for the entitlement programs transferred
* The impact of the tax revenue volatility on base and growth
* The ultimate impact of Katie A and Emily Q on EPSDT cost on a county by county and statewide basis
* The impact of the transfer of the Healthy Families Program to Medi-Cal

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Discussion Questions: Realignment 2011

- Now that the state's role has significantly diminished, and counties' has increased, how do counties collectively manage both intra-county issues (such as funding distributions) and external relations: state, stakeholders, CSAC, etc.?
- How can counties ensure that they have sufficient funds to meet Medi-Cal entitlement obligations for EPSDT, Medi-Cal Managed Care, and Drug Medi-Cal with so many other realigned programs competing for funding?
- How can the LIHP programs be used to leverage federal funds for parolees returning to our communities?
- **Other questions for local MH/AOD leaders?**

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Discussion Questions /Health Care Reform

- How will HCR, Parity and the 1115 Waiver impact our capacity as providers of mental health and substance use service providers?
- How will administration, contracting, and reimbursement of services change through the 1115 waiver and HCR?
- How will MH/SU advocates ensure that sufficient resources, providers and progressive models of service remain available for the populations that we serve?
- How will we develop our competencies as mental health providers working in primary care settings?

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Our/your Future: How can you provide leadership in these major policy areas?

- Realignment 2011, including full risk for Medi-Cal behavioral health services
- Federal Health Care Reform
- Federal Mental Health Parity
- Community Corrections – continued shift from state to counties
- Elimination of DMH/ADP

It is clear that counties will need to be the leaders, with the full engagement of stakeholders in their communities, in the development of behavioral health policy in California.

Are you ready??

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