# California's Public Mental Health System and the Mental Health Services Act

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# Agenda

- Community Mental Health
  - Policy Context
  - Funding
  - Mental Health Services Act

# Policy Context

# Origins of Community Mental Health

- 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. *Lanterman-Petris-Short (LPS) Act*

# Origins of Community Mental Health

- 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.
    - That didn't happen as envisioned.

# Federal Health Insurance--Medicaid

- Late 60s, Federal government established a state/federal partnership program to provide health insurance for the poor and disabled.
  - Funding for Mental Health was initially provided primarily for emergency rooms and hospitals
- In 1971, pilot program established in California in early 70s, Short-Doyle/Medi-Cal, to obtain federal matching funding for some mental health services provided by counties.
  - Counties provided the required state/local matching funds.

# Community Mental Health System in Crisis

- Beginning with an inadequate funding base,
  - state allocations to counties were severely diminished due to inflation and funding cuts 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 overwhelmed with unmet need.
- This crisis propelled the enactment of Realignment.

# Realignment
# 1991 Bronzan McCorquodale Act

- Funding provided directly to counties primarily from dedicated sales tax
  - Rather than subject to annual budget process for state general fund.
- Priority populations and services specified in statute.
  - Counties could make decisions based on local priorities

# Realignment

State general fund used to provide

- Community mental health funding
  - Short-Doyle funds
  - State categorical/grant funds
  - IMD Funding (Institutions for Mental Disease)
- State hospital funds for civil commitments

TRADED FOR

- Dedicated realignment funding and responsibility for community mental health services "to the extent resources are available"

# Benefits of Realignment

- Realignment has generally provided counties with many advantages, including:
  - The emphasis on a clear mission and defined target populations
    - Focused effort on comprehensive community-based systems of care appropriate to individuals with severe disabilities.
    - Could use funds for community based services rather than high-cost restrictive placements
  - A stable funding source for programs
    - Local long-term investment in mental health infrastructure financially practical.

# SD/MC "Rehab Option" (1993)

- Obtained federal approval to shift from "clinic" to "rehab" option for Medi-Cal
  - Allowed services to be provided outside of clinic setting
  - Broadened type of services
  - Expanded who could provide/direct services
  - Changed to unit of time reimbursement, adding flexibility
  - Note: Counties continue to be responsible for matching funds.

# EPSDT

- Required part of the Medicaid program
  - To ensure regular screening and early access to all needed health/mental health care for children and youth.
- As result of lawsuit, state asked counties to expand Medi-Cal mental health services and agreed to provide additional funds to counties.
- Counties dramatically expanded services over the next 10 years.
  - Amounts of services increased almost ten fold and clients served tripled.

# Medi-Cal Specialty Mental Health Consolidation

- From 1995 through 1998, a major shift in county obligations occurred with regard to the Medi-Cal program.
- County and state Medicaid programs were
  - "Consolidated" into one
  - "Carved out" specialty mental health
  - Counties are responsible for the entitlement with fixed amount of state funding and balance from county revenues.
    - If they choose to be the Mental Health Plan (first right of refusal)
    - Alternative is to have no federal Medi-Cal funds and to lose some of the realignment.

# Impact of Medi-Cal on Realignment Funds

- Initially, counties were able to reduce inpatient hospital costs and could use those savings flexibly
- More recently,
  - Medi-Cal administrative requirements have grown.
  - State funding has not kept up with population growth and increases in health care costs
  - Resulting in increased pressure on realignment to fund these costs.

# Mental Health Services Act

- A voter initiative, Proposition 63, was passed in 2004 creating
  - a new funding source
    - From an increase in person income tax
  - To expand mental health services
    - Based on recovery principles
    - And emphasis on earlier intervention/prevention.

# Mental Health Services Act

- Additional funding for counties is provided
  - Based on three year plan with annual updates
  - Approved by DMH and OAC
  - Included in performance contract

# SUMMARY
# Revenues and Expenditures

# Summary--Estimated County Mental Health Funding FY 04/05

- Federal Financial Participation 36%
- Realignment 33%
- State funding 18%
- County--Required and Discretionary 9%
- Federal Grants 2%
- Patient fees/insurance/Medicare 2%
- TOTAL $3.6 Billion

# Funding by Service Type
## FY 04/05 Cost Report

- Hospital (Mode 05) 9%
- Residential (Mode 05) 9%
- Day Programs (Mode 10) 8%
- Outpatient (Mode 15) 55%
- Outreach, MAA, Support (Modes 45, 55 and 60) 7%
- Administration and UR 11%

# Revenue Sources

# Federal Financial Participation (FFP)

- Medicaid (Medi-Cal) FFP—Title 19 of Social Security Act
  - 50% federal reimbursement for
    - eligible expenditures
    - eligible services
    - eligible individuals
    - eligible providers

# Medi-Cal

- Eligible expenditures
  - Medicare guidelines
  - Limit lower of cost, charges or statewide maximum allowance
- Eligible clients
  - Beneficiaries
  - Not in jail or living in an IMD if under 65 year
  - Documented medical necessity
- Eligible services
  - 25 service functions
  - Documented service provision
- Eligible provider
  - Meet criteria in regulations
    - Organizational providers must be certified
    - Individual/group providers must be licensed/waivered

# Medi-Cal

- Claims payment
  - SD/MC claims
    - Submitted to DMH, then to DHS
    - By County Mental Health Director
    - Interim payment, cost settled up to statewide maximums 2 years after end of fiscal year
  - Inpatient Consolidation
    - Submitted by hospital to EDS
    - Matched with Treatment Authorization Request (TAR) submitted by county to authorize services to individuals.
- Matching funds provided by county

# Realignment

- % of Sales Tax and Vehicle License Fees
  - Stable funding source
    - Growth has been limited
  - Broad discretion regarding use for mental health
  - Money provided directly to the counties (not through state DMH)
  - 10% shift allowable
    - Into or out of mental health
    - Annual determination
    - Public hearing required
- Total $1.3B

# Mental Health Services Act

- Payments
  - Quarterly payments one month in advance
  - Pursuant to contract
    - Which is based on approved Three-year Program and Expenditure Plan
- Mental Health Services Fund
  - Payments and associated interest must be maintained in a designated fund

# Patient Fees/Insurance

- Sliding Fee Scale required
  - Uniform Method for Determining Ability to Pay (UMDAP)
- Medicare (Title 18 of Social Security Act)
  - Federal program
    - No state involvement in program
  - Primary payer before Medi-Cal

# Mental Health Services Act (MHSA)

# Historical Perspective

- Proposition 63– a California voters' ballot initiative
  - Grassroots support to get signatures to bring it to ballot
- Passed by majority vote on November 2, 2004.
- Became effective as statute, Mental Health Services Act (MHSA) on January 1, 2005

# Summary of Context (from Ballot)

- "Almost 40 years ago, California emptied its mental hospitals, promising to fully fund community mental health services. That promise is still unfulfilled."
- Many not receiving needed treatment
  - Results in children failing school and adults on street or in jail.
- The LAO concludes that Prop 63 could save millions annually by reducing expenses for medical care, homeless shelters and law enforcement.
- Opposition—mentally ill need help, this is a dangerously volatile income source, doubtful of projected savings.

# MHSA Content

- 1% tax on personal income in excess of $1M
- Expand mental health services
  - Recovery/wellness
  - Stakeholder involvement
  - Focus on unserved and underserved
- 6 components
  - Community Program Planning, Community Services and Supports, Education and Training (Workforce), Capital/Technology, Prevention/Early Intervention, Innovation

# Goals

- System Transformation
  - Create state-of-the-art, culturally competent system that promotes wellness/recovery/resiliency where
    - Access will be easier
    - Services more effective
    - Out-of-home and institutional care are reduced
    - Stigma no longer exists

# Revenues

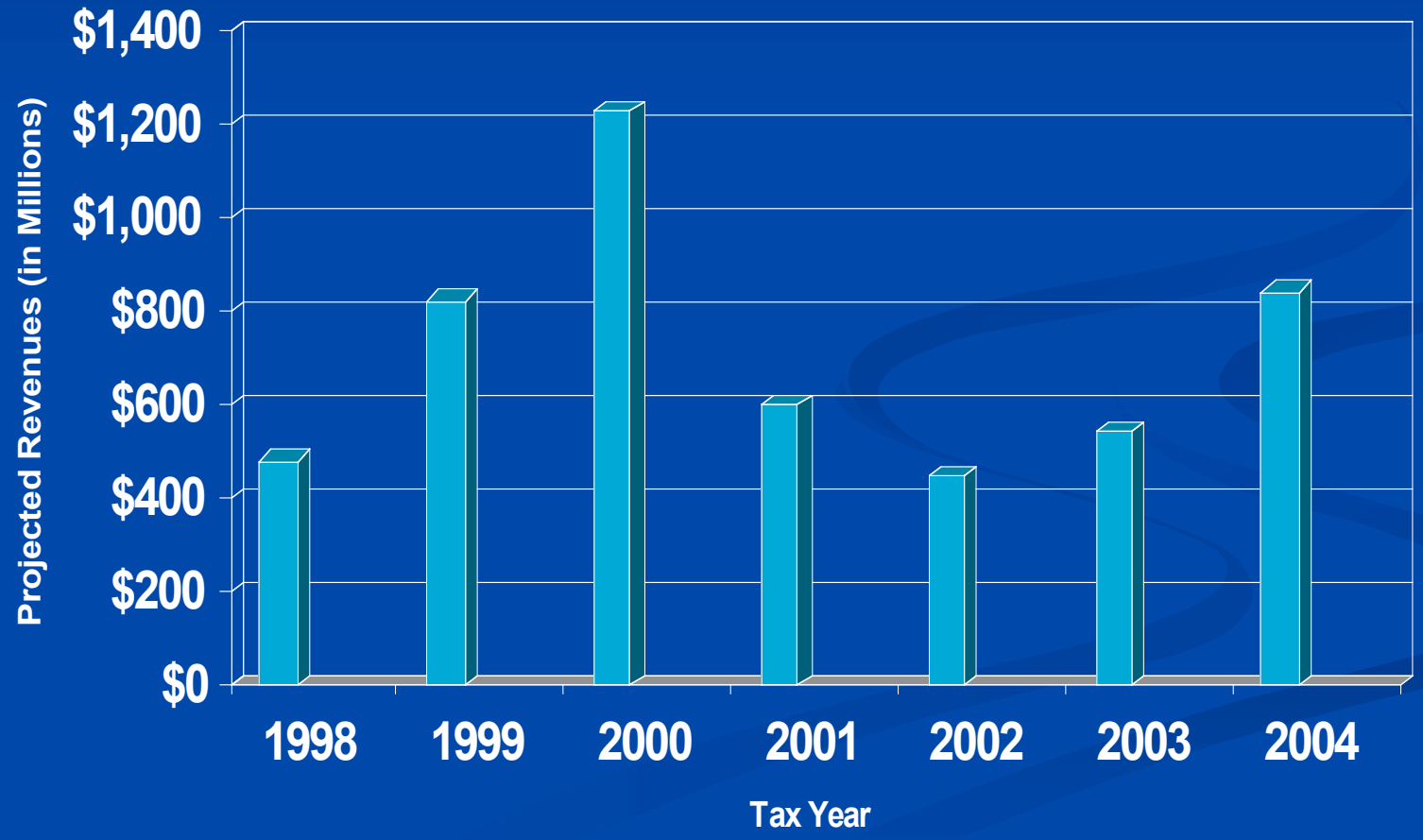
- Cash Transfers
  - 1.76% of deposits into the Personal Income Tax Fund
- Accrued Revenue from Prior Years
  - Deposits adjusted 18 months after end of tax year to actual amounts.
- Interest Income
  - State Monetary Investment Fund

# Why a Prudent Reserve

- Because of volatility of funding, the Act allowed funding to be set aside in good years to be used when revenue declines to maintain stability of programs and services
- Target is 50% of annual funding for client services.
  - Use unexpected additional revenues to fully fund CSS prudent reserve by FY 08/09

# *Fund Source Volatility*

*(projected revenues in millions for prior years)*



# Non-Supplantation

- State
  - Maintain entitlements/formula distributions
  - Amounts of allocations from SGF in FY 03/04
- County
  - MHSA funds must expand services and/or program capacity beyond 11/2/04 levels
  - Cannot replace state or county funds required to be used for services/supports in FY 04/05
    - Excludes 10% realignment shift and county overmatch

# Status and Challenges

# Community Program Planning

- Status
  - Significant Outreach and Participation at State and Local Level
  - Expanding strategies to engage unserved and underserved communities
- Challenges
  - Identifying and Engaging new partners
  - Involving stakeholders in implementation and evaluation

# Community Services and Supports

- Status
  - Initial local funding of $315M/year
    - Most counties approved and implementing
  - $114.5M/year Local Expansion for FY 07/08
  - $115M/year for Permanent Supportive Housing
    - For individuals who are homeless or at-risk
- Challenges
  - Determine how best to move system toward transformation
  - Determining, measuring and reporting on outcomes

# Education and Training
## Local Strategies

- Status
  - Funding $100M through FY 08/09
  - $15M for early implementation
  - Activities
    - Workforce Staffing Support
    - Training and Technical Assistance
    - Mental Health Career Pathway Programs
    - Residency and Internship Programs
    - Financial Incentive Programs
- Challenges
  - Additional skilled workforce needed now
  - Capacity of training programs is limited

# Education and Training State Strategies

- Status--$100M in funding through FY 08/09
  - Strategies
    - Workforce Staffing Support—e.g. Regional Partnerships
    - Training and TA—e.g. Blended Learning
    - MH Career Pathways--e.g. Consumer/family entry level preparation programs
    - Residency/Internship--e.g. physician assistant
    - Financial Incentive--e.g. Loan forgiveness
- Challenges
  - Additional skilled workforce needed now
  - Capacity of training programs is limited

# Capital
# Status and Challenges

- Status
  - Capital $ will be for treatment/service or administrative facilities
  - No funding dedicated to capital after FY 08/09
- Challenges
  - Locally determining how much to invest in capital and how much in technology

# Technology
# Status and Challenges

- Status
  - DMH proposing that Counties must meet electronic health record requirements before other technology requests will be approved
    - Eventually moving to health information exchange requirements
- Challenges
  - On cutting edge of technology for interoperability
  - Locally determining how much to invest in capital and how much in technology

# Prevention/Early Intervention Status and Challenges

- Status
  - Commission selected principles and priorities
  - DMH developing requirements for local plans
- Challenges
  - Designing an evaluation system
  - DMH proposes to determining a limited number of strategies from which counties can select
  - Broadening the stakeholder input

# Innovation
## Status

- Oversight and Accountability Commission has the lead on establishing principles
  - Commission Subcommittee working on this.
- DMH will develop the local plan requirements.

# Overall Challenges

- Implementation
  - Expedite implementation/Inclusive process
  - Workforce
  - Infrastructure
- Managing Expectations
  - Amount of change/new services
  - Timeframes
- Funding
  - Distribution formula to counties
  - Supplantation
  - Volatility

# Overall Challenges

- Governance
  - Who makes critical decisions and how are those decisions made?
    - Commission, County, Planning Council, State DMH
- Integration
  - How will MHSA be integrated into existing system so that
    - We achieve our goals for transformation and
    - Preserve core programs
- Establishing culture of continuous improvement

# Overall Opportunities

- Transform public mental health system
- Increase access
- Provider earlier interventions/prevention
- Engage unserved and underserved communities
- Increase efficiency and quality

# Implementation Next Steps

# Estimated Timeline

- Process
  - Draft guidelines 2-6 months
  - Stakeholder input/final approval 3 months
  - Local plan development/review 3 months
  - DMH/OAC review/approval 2 months

# Estimated Timeline for Components--DRAFT

- Education and Training
  - Draft guidelines 2/07
  - Local funding 10/07
- Capital and Technology
  - Draft guidelines 4/07
  - Local funding 12/07
- Prevention/Early Intervention
  - Draft guidelines 6/07
  - Local funding 1/08