California’s Public Mental Health System and the Mental Health Services Act

Carol Hood
Deputy Director
California Department of Mental Health
March, 2007
Agenda

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