



# California Mental Health Financing 101: History and Context

The Mental Health Services Act in the  
Context of  
Overall County Mental Health  
Financing Pressures  
January, 2007



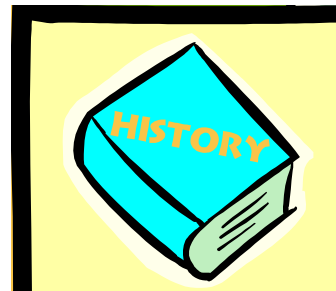
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# Historical Perspective

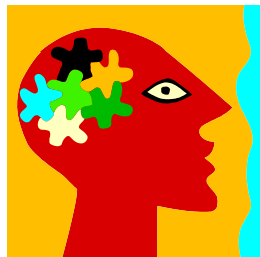
The California Community Mental Health Services Act 1969 was a national model of mental health legislation that “deinstitutionalized” mental health services, serving people with mental disabilities in the community rather than in state hospitals.



# Origins of the Community Mental Health System

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.



# 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.”

# No Entitlement for Mental Health Services

This essential difference built rationing of services into the framework of mental health service delivery...

# Major Sources of Mental Health Funding Today

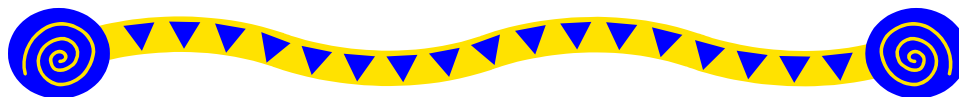
- ◆ Realignment Revenues
- ◆ Medi-Cal Specialty Mental Health Managed Care SGF Allocation
- ◆ State Categorical (AB 2034, AB 3632)
- ◆ Medi-Cal EPSDT SGF
- ◆ Federal Funding (SAMHSA, Medi-Cal FFP)
- ◆ Mental Health Services Act

# Community Mental Health System in Crisis

Beginning with an inadequate funding base, state allocations to counties were severely diminished due to inflation throughout the 1970s and 80s.

From 1982 to 1987 there were no cost of living or caseload adjustments to support community mental health.

In 1990, California faced a \$15 billion state budget shortfall which would certainly have resulted in even more drastic cuts to mental health.



# Transition to Realignment

Community mental health programs were already near collapse and overwhelmed with unmet need. This crisis propelled the enactment of “Realignment.”

# Realignment

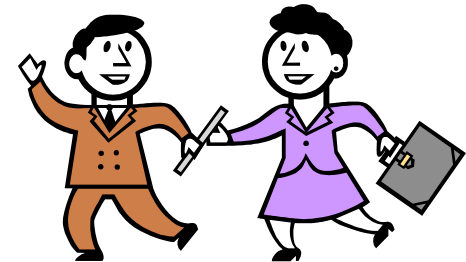
- “Realignment” was enacted in 1991 with passage of the Bronzan-McCorquodale Act.
- Instead of community mental health being funded by the State General Fund, new “Realigned” revenues flow directly to counties.
- Realignment represented a major shift of authority from state to counties for mental health programs.

# Realignment Assigned Two Dedicated Funding Streams

- Realignment was given two dedicated funding streams:
  - ½ Cent Increase in State Sales Tax
  - State Vehicle License Fee
- From the start, revenues fell short of expectations due to the recession.

# Mental Health Programs That Were Realigned from the State to Counties

- All community-based mental health services
- State hospital services for civil commitments
- “Institutions for Mental Disease” which provided long-term nursing facility care



## Realignment Expanded to Public Health and Social Services

- Although it was begun as an effort to reform mental health financing, at the last minute pressure was exerted to expand Realignment.
- Public health programs and some social services (such as In-Home Supportive Services and Foster Care) were added to the Realignment formula.

# Realignment Structure

*Over time, this structure has contributed to many of the shortcomings of Realignment to keep pace with mental health needs.*



# Benefits of Realignment

Realignment has generally provided counties with many advantages, including:

- A stable funding source for programs, which has made a long-term investment in mental health infrastructure financially practical.
- The ability to use funds to reduce high-cost restrictive placements, and to place clients appropriately.

## Benefits of Realignment Cont'd

- 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, allowing counties to develop comprehensive community-based systems of care, institute best practices and focus scarce resources on supporting recovery.

# Realignment Funds Distributed by Formula

Annually, Realignment revenues are distributed to counties until each county receives funds equal to the previous year's total.

Funds received above that amount are placed into growth accounts – Sales Tax and VLF.

## Realignment Funds Distributed by Formula Cont'd

- The distribution of growth funds is complex. However, it is a fixed amount annually and ***the first claim on the Sales Tax Growth Account goes to caseload-driven social services programs.***
- Any remaining growth from the Sales Tax Account and all VLF growth are then distributed according to a formula developed in statute.

## Realignment Formula Flawed – Insufficient Growth for Mental Health

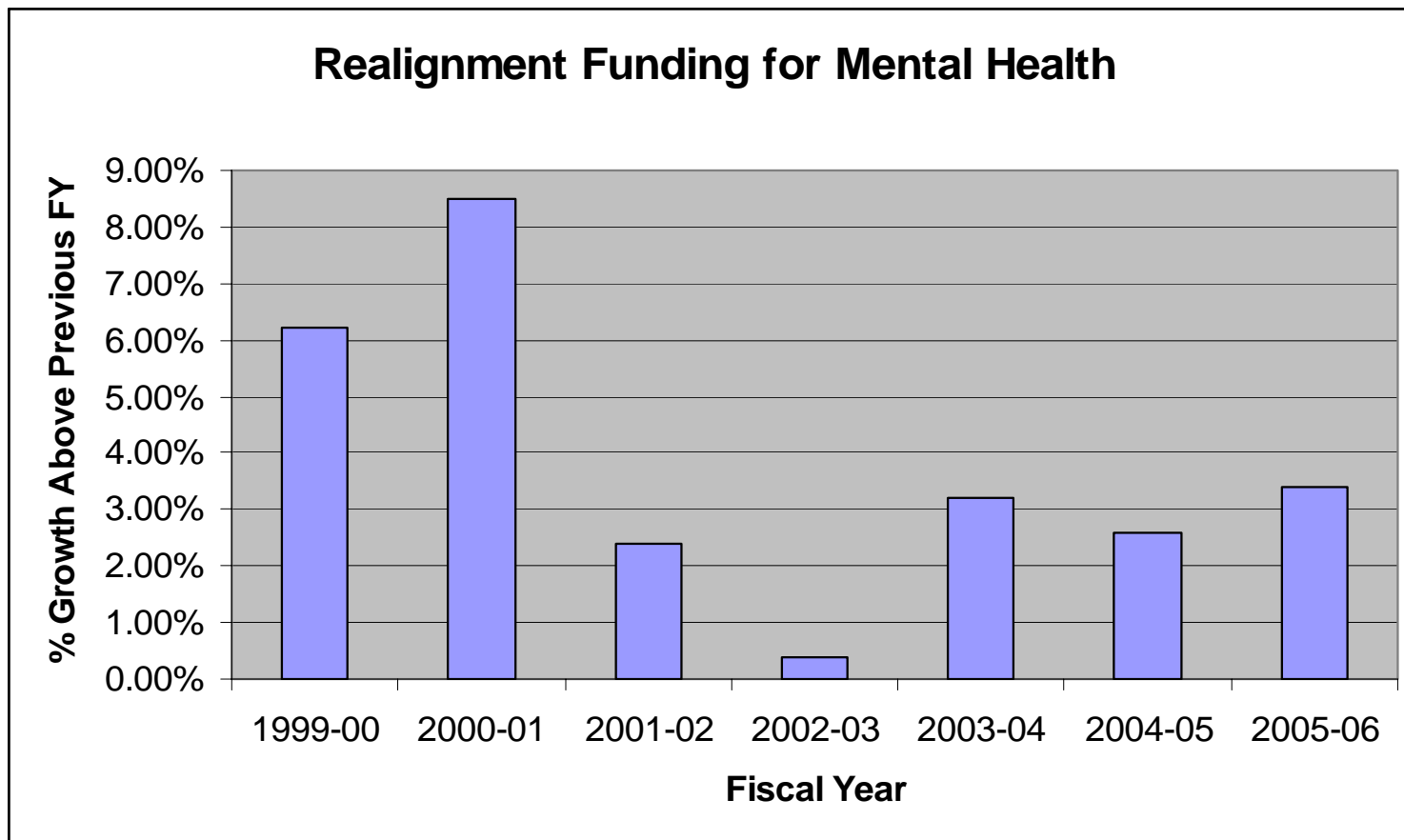
- Because the Realignment formula is weighted in favor of caseload-driven entitlement programs, ***mental health did not receive Sales Tax growth for several years, and in FY 2005-06 received only a small amount.***
- ***Mental health is expected to receive reduced amounts of sales tax growth, if any, for the foreseeable future.***
- VLF growth has averaged less than 3% a year for the past 4 years.

# Realignment Formula Flawed – Insufficient Growth for Mental Health

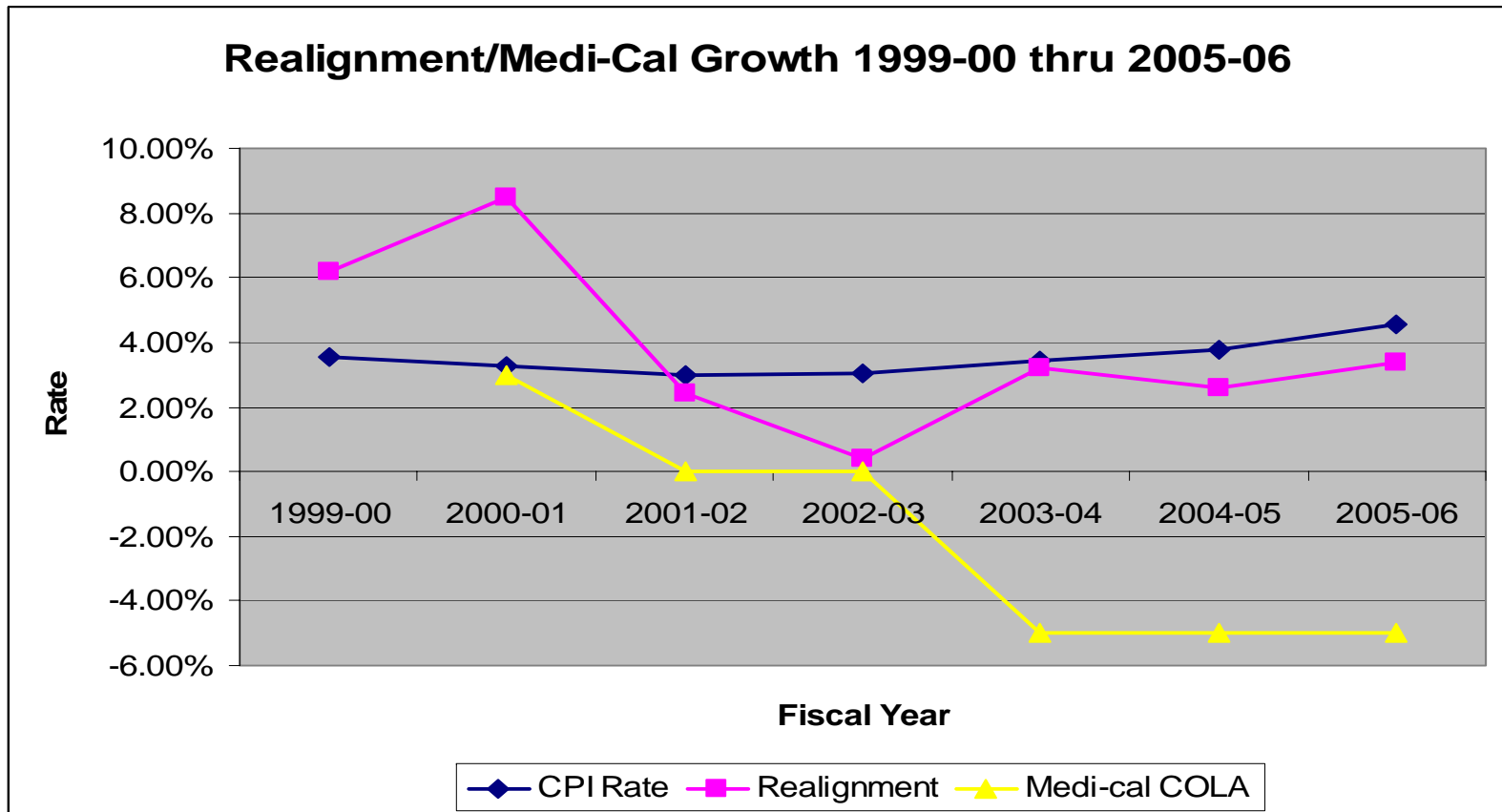
Meanwhile, costs of services and other demands steadily rise...



# Realignment Growth for MH -- Fiscal Year 1999/00 to 2005/06



# Realignment/Medi-Cal Growth 1999-00 thru 2005-06





# Medi-Cal Mental Health Services



Federal Medicaid dollars constitute the second largest revenue source for county mental health programs, after Realignment.

# 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.*

# Medi-Cal Mental Health Services

- The 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).

# Medi-Cal Mental Health Services

- There was no federal funding of the county Short-Doyle mental health program until the early 1970s, when it was recognized that these programs were treating many Medi-Cal beneficiaries.

# Medi-Cal Mental Health Services

- Short-Doyle/Medi-Cal (SD/MC) started as a pilot project in 1971, and counties were able to obtain federal funds to match their own funding to provide certain mental health services to Medi-Cal eligible individuals.

# Medi-Cal Mental Health Services

- The SD/MC program offered a broader range of mental health services than those provided by the original Medi-Cal program.

# Medi-Cal Rehabilitation Option

- A Medicaid State Plan Amendment in 1993 added more services under the federal Medicaid “Rehab Option” to the scope of benefits, including:
  - Psychiatric health facility
  - Adult residential treatment
  - Crisis residential
  - Crisis intervention and stabilization
  - Intensive day treatment
  - Day rehabilitation
  - Linkage and brokerage
  - Mental health services
  - Medication support

## The Medicaid “Rehab Option”

- The Rehab Option\* allows services that reduce institutionalization and help persons with mental disabilities live in the community.

*\* There have been recent federal discussions about cutting the Rehab Option, which could have a severe negative impact on the progress of transforming the mental health system.*

# Medi-Cal Specialty Mental Health Consolidation

- From 1995 through 1998, the state consolidated FFS and Short-Doyle programs into one “carved out” specialty mental health managed care program.
- Counties are given the “first right of refusal” for taking on this new responsibility
- All Medi-Cal beneficiaries must receive their specialty mental health services through the County Mental Health Plan.

## Medi-Cal Consolidation Cont'd

- General mental health care needs for Medi-Cal beneficiaries remain under the responsibility of the Department of Health Services, rather than DMH.
- DHS FFS is also responsible for all pharmaceutical costs for carve-out beneficiaries.

## Medi-Cal Consolidation Cont'd

- The state DHS transferred the funds that 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 that MHPs would receive additional funds yearly beyond the base allocation for increases in Medi-Cal beneficiary caseloads, and for COLAs.

# Medi-Cal and Realignment

- Any costs beyond that allocation for the state match for Medi-Cal specialty mental health services were to come from county Realignment revenues.
- In other words, the risk for this entitlement program shifted from the state to the counties...

## Impact of Medi-Cal on Realignment Funds

- Since Medi-Cal Consolidation, administrative requirements by DMH have grown dramatically.
- **Counties have not received COLAs for the Medi-Cal program since 2000. In the FY 03/04 state budget, the Medi-Cal allocation to counties was actually reduced by 5% (\$11 million SGF).**

# Medi-Cal and Realignment

- Cumulatively, since FY 2000/01, counties have lost over \$60 million SGF due to both the lack of a COLA, and the 5% reduction in 2003-04.
- *The 5% rate reduction was recently restored for other Medi-Cal managed care plans and providers, but not for county Mental Health Plans.*

## Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

- A lawsuit against the state in 1995 resulted in the expansion of Medi-Cal services to Medi-Cal beneficiaries less than 21 years of age who need specialty mental health services to correct or ameliorate mental illnesses, ***whether or not such services are covered under the Medicaid State Plan.***

## EPSDT Cont'd

- As a result of the settlement, the state agreed to provide SGF to counties as the match for these expanded specialty mental health services.
- These services qualify under the EPSDT Medi-Cal benefit and are commonly referred to as EPSDT services.

## EPSDT Cont'd

- DMH developed an interagency agreement with DHS through which county mental health plans were reimbursed the entire non-federal share of cost for all EPSDT-eligible services in excess of the expenditures made by each county for such services during FY 1994-95.

# State Policy Shifts Part of EPSDT Costs to Counties

- In FY 2002-03, a 10% county share of cost (including FFP) was imposed by the Administration for EPSDT services above a baseline expenditure level.
- This means that counties must pay for 10% of all EPSDT services (including FFP) beyond a threshold level with funds from their Realignment account.

# AB 3632 – Special Education Services to Students

- The federal Individuals with Disabilities Education Act (IDEA) entitles all children with disabilities to a free, appropriate public education that prepares them to live and work in the community.

## AB 3632 Cont'd

IDEA entitlement includes mental health treatment for children and adolescents who are less than twenty-two years of age, have an emotional disturbance, and are in need of mental health services to benefit from a “free and appropriate public education”.

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## AB 3632 Cont'd

- ***These services are a federal entitlement, and children must receive services irrespective of their parents' income-level.***
- In 1984, the state mandated county mental health departments to provide mental health services to students who qualify under the federal IDEA.

## AB 3632 (Cont'd)

- For several years (in the early 2000s), the state failed to pay counties for providing these mandated services, which created a severe a cash flow crisis.
- While the state has since recognized its responsibility to fully pay counties for this program, it still owes them approximately \$300 million for past mandate reimbursement claims.

## Bottom Line:

- Realignment, which never fully funded mental health needs, was intended to grow over time.
- That growth has not occurred.
- In fact, Realignment does not keep up with the costs of providing services.

## Bottom Line:

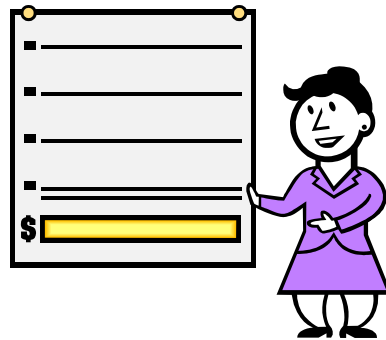
- Medi-Cal services managed by counties for the state have also not received cost of living adjustments, which constitutes a cost shift from the state to counties.
- Realignment funds must be used to pay for these increased costs.

## Bottom Line:

Failure of the state to fully reimburse counties for AB 3632 services has forced counties to re-direct Realignment funds away from their target population.

# Bottom Line Client Impacts:

**The mental health system in California was underfunded from the start.**



## Bottom Line Client Impacts:

**This system still serves only about 40% of persons with serious, disabling mental illness.**

## **Bottom Line Client Impacts:**

**California ranks near the bottom nationally in resources available for persons receiving Medicaid.**

## Bottom Line Client Impacts:

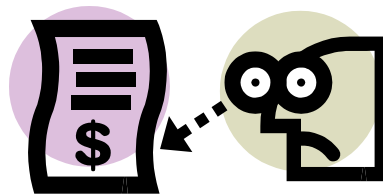
- **Each year, the services that can be delivered erode under multiple demands on scarce dollars.**
- **Realignment funding has not kept pace with growth in population nor the consumer price index since it began.**

## Realistic Expectations in Context of MHSA

While the new Mental Health Services Act (MHSA) will bring an exciting and much-needed infusion of new funds into California's public mental health system, it will not fix the structural financing problems counties face.

# Realistic Expectations in the Context of MHSA

It is inevitable that counties will need to reduce services in their non-MHSA systems, at the same time they are building new services under MHSA.



## Realistic Expectations in the Context of the MHSA

- ***Until these structural problems are addressed, we should work together to help “tell the story” to the public about our challenges and our MHSA victories.***