History and Funding Sources of California's Public Mental Health System March 2006

In the 1960s California led the nation in community mental health development and civil rights for persons with mental illness, only to lapse into decades of funding instability and program confusion. Since the 1990s, with mental health reform, program and funding realignment, meaningful consumer and family involvement, and strong state and county leadership, California has re-established its pre-eminence in public mental health.

Important principles underlying the mental health system in California include the value of choice and self-determination in treatment for Californians with psychiatric disabilities, children with emotional disturbance, and adults and older adults with mental health issues; the philosophy that recovery is possible and a goal for persons with mental illnesses; prevention, early intervention, education and outreach are effective; treatment works; cultural competence in the delivery of mental health services is essential; consumer and family involvement in policy development is crucial; and stigma and discrimination have no place in our society.

Our system must continue to be based on availability and accessibility of a continuum of quality community-based treatment; focus on meaningful outcomes and quality of life; interface with other components of the health care and human services systems; protection of individuals with mental illness from dangerous environments; and accountability at all levels.

Key Funding Elements/Current Issues in California's Public Mental Health System

Realignment

In 1991, a major change occurred in the funding of human service programs in the State of California with enactment of the Bronzan-McCorquodale Act, (Chapter 89, Statutes of 1991), referred to as "realignment." Realignment transferred financial responsibility for most of the state's mental health and public health programs, and some of the social service programs, from the state to local governments, and provided counties with a dedicated revenue source to pay for these changes. For mental health, realignment transferred the amounts associated with pre-realignment categorical programs, general community mental health funding, state hospital civil commitment funding, and Institutions for Mental Disease (IMD) funding.

In order to fund the program transfers and shifts in cost-sharing ratios, the Legislature enacted two tax increases in 1991, with the increased revenues deposited into a state Local Revenue Fund and dedicated to funding the realigned programs. Each county created three program accounts, one each for mental health, social services, and health. Through a series of accounts and sub-accounts at the state level, counties receive deposits into their three accounts for spending on programs in the respective policy areas. The basic formula, which determines the amount to each county and each sub-account, was included in the statute.

- *Sales Tax***.** In 1991, the statewide sales tax rate was increased by a half-cent. The half-cent sales tax generated $1.3 billion in 1991-92 and was expected to generate approximately $2.4 billion in FY 2001-02.

- *Vehicle License Fee***.** The VLF, an annual fee on the ownership of registered vehicles in California, is based on the estimated current value of the vehicle

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 a growth account. 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 service programs. Any remaining growth from the Sales Tax Account and all VLF growth are then distributed according to a formula developed in statute.

Realignment represented a new partnership between the state and the counties governing the provision of services. The core principle under realignment was to provide expanded discretion and flexibility to counties to expend state funding. It shifted program and funding responsibilities from the state to counties, adjusted cost-sharing ratios, and provided counties a dedicated revenue stream to pay for these changes in the areas of mental health, social and health services. State oversight was to be increasingly focused on outcome and performance based measures.

Fourteen years later, mental health programs throughout the state have benefited from this dedicated funding source and increased flexibility to develop programs.

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.

- Greater fiscal flexibility, discretion and control.

- The ability to streamline bureaucracy and reduce overhead costs.

- The ability to use funds to reduce high-cost restrictive placements, and to place clients appropriately.

- Financial incentives for counties to properly manage mental health resources, including the ability to "roll-over" funds from one year to the next, which enables long-term planning and multi-year funding of projects.

- The emphasis on a clear mission and defined target populations under realignment has allowed counties to develop comprehensive community-based systems of care for individuals with severe mental illness and serious emotional disorders. Increased county flexibility has further allowed counties to institute best practices, and to focus on the recovery process for individuals with severe mental illness and serious emotional disturbance.

Medi-Cal

The second largest revenue source for county mental health programs is federal Medicaid dollars. *Understanding the changes in California's Mental Health Medi-Cal program since realignment and the interaction of Medi-Cal revenues with realignment are critical to analyzing the current structure and status of public mental health services in California.*

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).

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

A Medicaid State Plan Amendment implemented in July of 1993 added services available under the Rehabilitation Option to the SD/MC scope of benefits, and broadened the range of personnel who could provide services and the locations at which services could be delivered. This change is significant in analyzing the financial status of mental health programs because it enabled counties to greatly increase their claiming of federal Medicaid funds.

The SD/MC program now includes inpatient hospital, psychiatric health facility, adult residential treatment, crisis residential treatment, crisis stabilization, intensive day treatment, day rehabilitation, linkage and brokerage, mental health services, medication support, and crisis intervention.

The two separate Medi-Cal mental health systems -- FFS/MC (the original Medi-Cal mental health system) and SD/MC -- continued as separate programs until Medi-Cal mental health consolidation began in January 1995. From 1995 through 1998, there was a major shift in county obligations within the Medi-Cal program. In order to provide counties more flexibility in the use of state funding, and to enable more integrated and coordinated care, the state developed a plan to consolidate the two Medi-Cal funding streams for mental health services. This strategy was intended to allow a prudent purchaser of services to obtain maximum benefit for its expenditures, and would allow for increased access to specialty mental health services within the same level of funding.

Since research demonstrated that a single integrated system of care is critical for successful treatment of persistent mental illness and emotional disturbance, and that the needs of persons with mental illness do not always receive adequate attention in an all-inclusive health care managed care system, a decision was made to “carve out” specialty mental health services from the rest of Medi-Cal managed care in the mid-1990s. County mental health departments were given the “first right of refusal” in choosing to be the Medi-Cal “Mental Health Plan” for the county. All but two counties in California (including two cities) chose to become the MHP for their beneficiaries, although there are statutory provisions for DMH to choose another entity to be the MHP if the county chooses not to assume that role. Those two counties chose to partner with another county to be the MHP, which makes California’s Medi-Cal mental health program entirely managed by local government.

This program operates under a federal Freedom of Choice waiver. Under this waiver program, each MHP contracts with DMH to provide medically necessary specialty mental health services to the beneficiaries of the county. Medi-Cal beneficiaries must receive Medi-Cal reimbursed specialty mental health services through the MHPs. A distinction is made between specialty mental health care (those services requiring the services of a specialist in mental health) and general mental health care needs (those needs that could be met by a general health care practitioner). General mental health care needs for Medi-Cal beneficiaries remain under the purview of DHS, either through their managed care plans or through the FFS/MC system.

Under consolidation, SGF are appropriated by DHS each year to DMH based upon the estimated amount DHS would have incurred for psychiatric inpatient hospital services and psychiatrist and

psychologist services absent consolidation. In general, each MHP receives, at a minimum, SGF equal to the amount spent in their county prior to consolidation. This SGF allocation is available to be used as Medi-Cal match by MHPs prior to using realignment funds.

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*. 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. 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. In FY 2002-03, a 10% county share of cost was imposed by the Administration for EPSDT services above a baseline expenditure level. These funds, together with realignment funds, may be used as the state Medicaid match for claiming federal matching funds.

Another lawsuit against the state, filed in 1998, resulted in the approval of a new EPSDT supplemental specialty mental health service for the Medi-Cal program. This new benefit is called Therapeutic Behavioral Services (TBS). Since these services were not included in the original realigned services, new SGF are provided to MHPs as match for these services as well.

Current Realignment/Medi-Cal Issues

- Realignment funding was based upon the current funding going to each county at the time of implementation, and did not take into consideration the inadequacy of funding prior to 1991.

- Under the current funding structure, funds appropriated to the counties under realignment have not kept pace with 1991-92 levels when population changes and medical inflation are taken into account. Generally, the percentage increase in medical inflation and client growth combined, along with increased acuity of clients, has been substantially greater than the increase in realignment revenues.

- Due to continued caseload growth in Child Welfare Services and Foster Care, as well as significant (and unanticipated) cost increases in the In Home Supportive Services (IHSS) Program, growth distributions to the Mental Health Subaccount and Health Subaccount have been substantially reduced. This is because the first claim on the Sales Tax Growth Account goes to caseload-driven social services programs. **With current trends, the Mental Health Subaccount will receive no sales tax growth for the foreseeable future.**

- Many counties must use an increasing proportion of their realignment funds to draw the federal Medicaid (Medi-Cal) match, since Medi-Cal is an entitlement program. As such, they have decreased the amount of funds available for their "targeted" indigent clients.

- 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%.**

- ***As these trends continue, some counties will have difficulty complying with Medi-Cal requirements, even if devoting as much of their realignment funds as possible toward that population.***

- *The recent failure of the state to fully reimburse counties for their costs in providing state mandated mental health services to Special Education Pupils (see below) have put an additional severe strain on county realignment and other mental health resources.*

AB 3632, Mental Health Services to Special Education Pupils

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. 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. *These services are a federal entitlement, and children can receive services irrespective of their parents' income-level.*

Prior to 1984, school districts were responsible for providing all special education services to children. In 1984, the Legislature enacted AB 3632, the Special Education Pupils Program, which, among other things, transferred responsibility for providing mental health services to special education pupils from school districts to county mental health departments. This program (Chapter 26.5 of the Government Code) was intended to build on the counties' existing responsibilities and expertise in providing mental health treatment, and provide needed collaboration between schools and public mental health in serving students.

While counties are required by state law to provide these services, the services they provide are for the purpose of assisting public education to fulfill its mandate under federal law to provide a free, appropriate education to students with special needs in the least restrictive educational environment. The state Department of Education currently receives over $1 billion annually from the federal government for implementing IDEA throughout the state, and for complying with all IDEA requirements.

Current AB 3632 Issues/Funding Crisis

Prior to enactment of the state's FY 2002/03 budget, a total of $12 million had been budgeted for counties statewide as categorical funding to pay for the services required under Chapter 26.5. Because the costs incurred by counties in providing those state-mandated services have far exceeded the categorical funding for many years, counties have been reimbursed for their additional costs through the SB 90 local mandate reimbursement process.

In FY 2000/01, the SB 90 claims paid to counties for this program exceeded $100 million. In the FY 2002/03 state budget, the $12 million of categorical funding for counties was eliminated entirely, and counties were told that they could receive all of their funding through the mandate reimbursement process. **However, the budget also placed a moratorium on mandate reimbursements for local government**. During that year, counties received **no funding** from the state to pay for this federal education entitlement program.

In the FY 2004-05 budget, the local mandate reimbursement moratorium was extended for an additional year. However, the Governor proposed allocating $69 million in federal IDEA funds to partially pay for the AB 3632 mental health program. The Legislature ultimately approved that funding, which was still not nearly enough to fully fund counties for the costs of providing services under this mandate.

Some counties – particularly small and rural – have no county general funds that can be used to fund this program. That leaves the counties no choice but to use scarce realignment funds, which are meant to serve their "target" low-income and uninsured population of seriously

emotionally disturbed (SED) children, and seriously mentally ill adults (to the extent resources are available). ***The state currently owes counties over $300 million for this program alone.***

Adult Systems of Care/Integrated Services for Homeless Adults (AB 2034)

It is estimated that there are currently over 50,000 homeless Californians with severe mental illness. Many of these individuals do not have access to needed mental health or other community services, and end up in the criminal justice system for minor crimes, often leading to citations or arrests. This population also experiences frequent high cost inpatient hospitalizations because their mental health needs are addressed only when they reach crisis levels.

The Integrated Services for Homeless Adults (AB 34/2034) program provides outreach and comprehensive services to adults and older adults with severe mental illness who are homeless, or at risk being homeless. It began as a $10 million 3-county pilot in 1999. The data collected from the experiences of those counties in the first year showed clearly that the programs were both successful in getting homeless individuals the services they needed, and extremely cost effective. It has since been expanded to 32-34 counties. This is a categorical program that is funded through the state general fund, with a total current budget of $55 million (following a reduction in 02-03 of $10 million). The program is overseen by the state Department of Mental Health. A basic principle of the program is its flexible funding, which assures that counties may provide whatever services necessary to help the homeless individual access needed resources.

Services offered by local programs include assessment of the individual's needs, providing shelter/housing, establishing identification and legal assistance needs, and providing food, clothing, showers, medical, psychiatric and dental care, alcohol/drug treatment and social rehabilitation.

The data collected from the experiences of those counties in the first year showed clearly that the programs were both successful in getting homeless individuals the services they needed, and extremely cost effective. Outcomes data indicates that those enrolled in the program experienced a 65.6 percent drop in the number of hospital days; an 81.5 percent drop in the number of days spent in jail; and a 79.1 percent drop in the number of days spent homeless. An increase in the level of employment of enrollees was also achieved. The initial success of the pilot programs served as the impetus for strong support from the Administration and the Legislature to provide continued funding for this program and the target population.

The Mental Health Services Act (Prop. 63)

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November of 2004 provides the first opportunity in many years for increased funding to support California's county mental health programs. The MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system, with the purpose of promoting recovery for individuals with serious mental illness.

The MHSA imposes a 1% income tax on personal income in excess of $1 million. Statewide, the Act was projected to generate approximately $254 million in fiscal year 2004-05, $683 million in 2005-06 and increasing amounts thereafter.

According to the Act, no funds may be provided from the state to the counties unless such spending is in accordance with a plan developed in accordance with numerous requirements, including that it must provide for significant local stakeholder input and involvement. The local plans must be approved by the State Department of Mental Health, after review and comment by the Oversight and Accountability Commission.

Each plan is a three-year plan that must be updated annually, and each update must also be submitted to the state for review.

While these new revenues are an exciting new addition to California's public mental health system, it is important to note that funds must be used to expand, not supplant, existing services.

This means that while counties struggle to keep their existing Medi-Cal and realignment-funded programs running with a declining revenue source, they are looking to build new programs. This will inevitably lead to service reductions on the one hand, and limited service expansion on the other. Counties will face increasing challenges as they attempt to make sense of this dynamic while trying to manage their communities' high expectations for systems improvements through the MHSA.