



Bringing California's Behavioral Health Systems into Full Alignment

January 31, 2011

The California Mental Health Directors Association (CMHDA) supports Governor Brown's stated goal of "returning decisions and authority to cities and counties, closer to the people." Informed by our nearly 30 years of experience managing California's community mental health system, we have put together the ideas below for increased efficiencies in the state/local relationship regarding the delivery of mental/behavioral health services that we believe are worth exploring.

There is no question that California government – both state and local – is in fiscal crisis. As we prepare to consider painful cuts that would substantially impact the lives of those in greatest need, we must not ignore opportunities to become more efficient in how we administer the programs on which they depend. This will allow us to preserve resources to continue to provide as great a level of service as is possible.

One real silver lining is that we have opportunities under federal health care reform – and specifically through implementation of the state's recently approved waiver for the financing of its Medicaid program – to improve health and mental health coverage and health status for millions of uncovered persons.

In order to more efficiently administer mental/behavioral health programs, there are several important steps that could be taken to build on their largely successful realignment that occurred in the 1990s. These recommendations would, in a sense, "align realignment" to clarify lines of responsibility and accountability in a way that allows these programs to operate at maximum effectiveness. These steps would include:

1. Streamlining and consolidating state administration of the Medi-Cal Specialty Mental Health Managed Care Program, in preparation for federal health reform and mental health parity implementation;
2. Consolidating administration of state psychiatric hospitals with other state institutional responsibilities;
3. Empowering local communities to implement their Mental Health Services Act (MHSA) priorities and focus on measuring performance; and
4. Assuring effective and efficient access to federal Medicaid reimbursement.

These steps would build on the public and political consensus that government programs should spend taxpayer dollars efficiently, bring services closer to the people, and

focus on measuring and achieving desired outcomes. They also have as a foundation the significant progress that California has already made in achieving these goals in community mental health. According to the Legislative Analyst's Office (LAO), "the implementation of realignment has generally succeeded in establishing better coordinated, more flexible, and less costly mental health programs in the community."¹ The three primary funding components² are coordinated and managed relatively seamlessly by county mental health agencies, with varying levels of state and federal oversight. County mental health programs have successfully integrated outpatient, inpatient, emergency and long-term care responsibilities pursuant to the community-based, recovery-focused goals of realignment, Medi-Cal Specialty Mental Health consolidation and the MHSA.

The result of this integrated approach has been a reduction in costly inpatient and long-term care institutional placements, homelessness, children's out-of-home placements, and incarceration rates. Increases in school performance and attendance, employment, health and mental health status and consumer satisfaction have also been documented. For example, a U.C. Berkeley Petris Center analysis of MHSA Full Service Partnership programs statewide found³ that they have achieved: 100% reductions to homelessness; 25% increases in employment rates; and 56% fewer arrests. By the close of 2009, over 420,000 individuals had been served with MHSA funds. However, as community-based mental health programs have evolved under this consolidated structure to meet local needs, the state's administrative structure has remained relatively unchanged, or has actually grown. The ongoing fiscal crisis actually represents the ideal time to truly realign responsibilities and resources where they are most effective and efficient.

1. Streamline and consolidate state administration of the Medi-Cal Specialty Mental Health Managed Care program, in preparation for federal health reform and mental health parity implementation.⁴

The state should seriously consider granting to the California Department of Health Care Services (DHCS) oversight, program, and claims payment responsibility for the Medi-Cal Specialty Mental Health Managed Care program. Numerous inefficiencies in how California currently manages this program have been pointed out in both federal Centers for Medicare & Medicaid Services (CMS) and the California Department of Finance - Office of State Audits and Evaluations (OSAE) audits. A possible solution is to consolidate oversight of the mental health waiver program with the state's other waiver programs under the single state Medicaid agency – DHCS – thus reducing administrative redundancy and more closely aligning the accountability structure with that recommended by CMS. Additionally, with growing focus on the need to coordinate specialty mental health with other health programs covered by state waivers and plans, and in anticipation of federal health care reform and parity, important policy objectives could be advanced in this more integrated structure. The federal and state financial and data requirements associated with the Medi-Cal certified public expenditure (CPE), supplemental payments, EPSDT and interim claims payment and cost settlement could also be administered by DHCS.

The functions performed by the state and the counties should be considered in the total fiscal and program context of the realigned/contracted programs to assure that the efficiencies gained are measured at both state and local levels, and that the indirect and administrative costs are minimized for both. Wherever possible, the state and counties should integrate the realigned/contracted administrative and fiscal requirements into existing structures to reduce overhead and maximize federal reimbursement, whenever available. Administrative redundancies and duplication at the state or county levels increases indirect costs and reduces

the availability of state and local funds as federal match for direct client services. State and local government responsibilities should be clearly defined and differentiated, taking maximum advantage of the fact that both are government entities from a federal perspective.

2. Consolidate administration of state psychiatric hospitals with other state institutional responsibilities

Currently, state psychiatric hospitals are administered by DMH, and are funded almost exclusively by state general funds, except for a small percentage of civil commitment beds that are purchased as needed by counties (under realignment provisions). The bulk of the beds are occupied by criminal commitments and prison inmates, under the supervision of the state criminal justice programs and DMH. The care for these inmate patients costs approximately \$184,000 per inmate per year, a cost that has been steadily increasing due to the need for increased security, wage parity with criminal justice staff and federal settlement requirements. By comparison, providing comprehensive “whatever it takes” services at the local level costs an average of \$30,000 per year.

Consideration should be given to whether it would be more administratively efficient and fiscally beneficial to separate the state’s community mental health oversight functions from its administration of the state hospitals, perhaps combining the hospitals with other institutional responsibilities under the direction of a Department of Institutions that would consolidate administrative and staffing resources, and could include other state facilities such as the Developmental Centers. This would reduce the apparent conflicting priorities that exist for the state mental health department between its responsibilities to administer state institutional and correctional mental health services, while at the same time administering community mental health services. Each system clearly has very different goals, access, and services criteria. It could also lead to efficiencies, with one entity managing all institutional health and mental health care. Another potential policy benefit of separating the state’s institutional functions from its community mental health oversight functions would be better alignment of the incentives for planning for community integration of parolees with mental health needs. Currently, the department must first and foremost meet the federal requirements associated with its state hospital treatment responsibilities, which leaves few resources to address the community integration needs of non-institutional parolees returning to the community.

As a complement to this step, California should consider whether to restructure its current mental health administration to form a new Community Behavioral Health Services Department/Division under the Health and Human Services Agency. The new Department/Division would not administer state psychiatric hospitals, but instead would only manage the oversight, compliance and plan approval responsibilities necessary to administer the Mental Health Services Act (MHSA), SAMSHA block grant funds, and mental health realignment requirements. This new department could administer programs that are funded through dedicated state tax and fee revenues or federal block grant funds, and would be supported by these sources for the minimum overhead necessary for the administration of these programs. Current state and county obligations for these programs are specified in state statute, regulations, and federal block grant provisions. The statutorily-required annual state/county Performance Contract is intended to cover both realignment and MHSA obligations, and thus could form the basis for the administration and oversight of these programs by the new Department/Division. The financial administration of these programs does not require complicated claims adjudication and county payment structures, thus simplifying the fiscal requirements to be managed. This new entity would need to coordinate its oversight functions

with the DHCS waiver unit, to the extent that program compliance issues cross over with the Medi-Cal programs operated by county Medi-Cal mental health plans.

3. Empower local communities to implement their MHSA priorities and focus on measuring performance

An objective review of the MHSA statutory language proves that it was not intended to be a categorical program, which is how it is currently being administered. Rather, it was meant to be a locally-implemented, community-driven program that builds on the existing, realigned community-based system. The goals outlined in the voter-approved Act are simple and clear:

- Reduce the long-term negative impact of mental illness for individuals and families (such as suicide, homelessness, incarceration, hospitalization, the removal of children from their homes, school failure and unemployment);
- Expand upon successful and innovative system of care services across the lifespan, as already described in Welfare & Institutions Code (WIC) Sections 5600 and 5800;
- Fill in gaps, but not replace, existing state and local funds that are used to serve individuals and families experiencing serious mental illness;
- Make needed investments in programs that prevent mental illnesses from becoming severe and disabling, including improving access to services for historically underserved ethnic, racial and cultural groups; and
- Ensure that all funds are expended in a cost effective manner.

Prescriptive requirements developed administratively have led to barriers for communities in implementing local programs that are flexible enough to efficiently transform their systems and respond to the priorities set by each community. According to the MHSA statute, each local community must decide who will be served and how, with very broad guidance from the state. Implementation of MHSA at both the state and local levels should support outcomes-based accountability mechanisms. All data required to be submitted by counties should help California measure whether or not taxpayers' investments with MHSA funds are resulting in the intended outcomes for consumers and families who are served. Therefore, the state's requirements for counties' MHSA reporting should be more consistent with the reporting requirements already outlined in WIC Sections 5847 and 5848. This would save significant administrative costs for both the state and counties.

To support a focus on measuring performance, the state should spend the majority of its MHSA state administrative expenditures (roughly \$40 million per year) to "ensure adequate research and evaluation regarding the effectiveness of the service," as required in WIC Section 5892(c). In doing so, addressing inadequacies in performance or compliance could more efficiently and appropriately be targeted to those counties and/or programs that need to improve outcomes, creating administrative efficiencies. Rather than prescriptive practices that cast a wide net, oversight and technical assistance should only be provided to counties demonstrating a need for it. Specific suggestions to improve outcomes-based accountability and productive administrative efficiencies include:

- Support counties in their efforts to collect and analyze data by providing support to those that might need assistance in conducting more rigorous data collection and evaluation.
- Facilitate county quality improvement efforts and ensure that the technology at the state level is able to accept and meaningfully use the information it receives from counties.

- Provide more flexibility for counties and remove reporting requirements that do not actually measure performance.

4. Assure effective and efficient access to Federal Medicaid reimbursement

We believe there are opportunities to assure effective and efficient access to federal Medicaid funds, with no State General Fund impact, in order to support direct mental health services to consumers. Specifically, changes are needed to eliminate a number of California-only requirements that are not required by federal law in order to ensure timely federal reimbursement for Specialty Medi-Cal Mental Health Managed Care services. We welcome the opportunity to share the specific changes we have identified.

Conclusion

Consistent with Governor Brown's stated goal of "returning decisions and authority to cities and counties, closer to the people," the California Mental Health Directors Association's members and staff would welcome the opportunity to participate in serious discussions about these and other ideas that would accomplish that goal in a meaningful way. We also are prepared to provide more details on how we believe some of these general concepts might be most effectively implemented.

CMHDA Contacts:

Patricia Ryan, Executive Director
916-556-3477, ext. 108
pryan@cmhda.org

Don Kingdon, PhD Deputy Director
916-556-3477, ext. 120
dkingdon@cmhda.org

Kirsten Barlow, Associate Director, Legislation and Public Policy
916-556-3477, ext. 112
kbarlow@cmhda.org

¹ Legislative Analyst's Office, "Realignment Revisited: An Evaluation of the 1991 Experiment in State-County Relations," February 2001.

²These are 1) realigned mental health program responsibilities for individuals who meet "target population" criteria under the Bronzan-McCorquodale Act; 2) the Medi-Cal Specialty Mental Health Managed Care program, which operates under a 1915(b) Medicaid waiver and two state plan amendments; and 3) expanded programs and services under the Mental Health Services Act (MHSA). Federal Financial Participation is currently the largest source of revenue (35%) for the community-based mental health program (approximately \$1.5 billion annually). To the extent possible, counties are maximizing federal reimbursement using both MHSA and realignment funds as match.

³³ Nicolas C. Petris Center on Health Care Markets and Consumer Welfare, School of Public Health, The University of California, “Evaluation of Full Service Partnership Programs under the Mental Health Services Act: May 2010.” An executive summary and six separate analyses can be downloaded at <http://www.petris.org>.

⁴ In order to transfer responsibility for federally required hospital and emergency mental health treatment from the state to the counties, California has a CMS-approved, mandatory enrollment, 1915(b) managed care waiver for Medi-Cal beneficiaries who need specialty mental health services. As a result, county “Mental Health Plans” are considered by CMS to be Prepaid Inpatient Health Plans (PIHP), which are responsible for assuring statewide access to medically necessary emergency, hospital and post-hospital stabilization mental health services for Medi-Cal beneficiaries. The state has also taken advantage of the Medicaid provision that allows local units of government to contribute funds to meet the state’s share of federal financial participation for Medicaid services for this program. In this case, the county utilizes the federal certified public expenditure (CPE) provisions to act as the contributing unit of government for the mental health services specified in the Medicaid state plan and the 1915(b) waiver. As a result of this transfer of match obligation to the counties, California has been able to expand the mental health benefits offered under the waiver program. The state has an approved state plan amendment (SPA) for mental health Rehabilitation Option services, which allows for a broader array of services, rendering providers and service locations than is available under the basic state Medicaid Plan. The state also has an approved SPA for Targeted Case Management (TCM) services specifically for children and adults with serious mental illness who are enrolled in the county waiver program. The counties use a combination of mental health realignment, MHSA funds and some state general funds to meet the federal certified public expenditure requirements associated with the specialty mental health waiver and SPAs. This results in approximately \$1.5 billion in federal financial participation for inpatient, emergency and outpatient services delivered by counties. The state’s partnership with counties allows it to cost-effectively manage the contribution of state general fund to this program while still offering both required emergency and optional rehabilitative mental health services to the neediest Californians with serious mental illness. When the Medi-Cal Specialty Mental Health “consolidation” occurred in 1995-97, it was determined that DMH – rather than DHCS, the “single state agency” – would manage, provide oversight and process MHP claims. Since then, many things have changed in the program, not the least of which is that federal Medicaid managed care regulations were adopted, which changed the structure of the program from a federal perspective. It has also become clear, through communication with CMS, that county mental health plans must fulfill the role of the state in providing the CPE under this structure.