



January 31, 2011

TO: Honorable Members, Assembly Budget Committee
Honorable Members, Senate Budget Committee

FROM: Patricia Ryan, Executive Director;
Kirsten Barlow, Associate Director, Legislation and Public Policy
California Mental Health Directors Association

SUBJECT: Governor's FY 2011-12 January State Budget for Community Mental Health

On behalf of the California Mental Health Directors Association (CMHDA), which represents the directors of public mental health authorities in counties throughout California, I am writing to communicate our thoughts thus far on the Governor's January state budget proposals for FY 2011-12, focusing particularly on the proposal to realign programs from the state to counties.

Governor's Realignment Proposal for Community Mental Health

Governor Brown's FY 2011-12 state budget proposes to ask California voters in June 2011 to extend for five years the temporary sales tax and vehicle license fee increases that were adopted in February 2009. Two of these tax increases would be dedicated to fund a new realignment of an array of programs from the state to local entities. In the area of community mental health, the Governor proposes giving counties full responsibility for administering and funding two mental health federal entitlement programs: the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and Medi-Cal Specialty Mental Health Managed Care. He also proposes to realign to counties the "AB 3632" special education mental health services program, which is both a state mandate on counties and a *federal education entitlement program*. All three newly realigned programs are proposed to be funded in FY 2011-12 by supplanting state General Fund obligations for the programs with \$861 million in Mental Health Services Act (MHSA) funds. In subsequent years, the costs of these newly realigned programs and existing realigned mental health programs would be covered by revenues generated by the two tax increase extensions, if approved by voters.

In general, CMHDA is approaching this proposal with an open mind, and we intend to be as collaborative and constructive as possible in finding ways to make the realignment work for counties, the state, and the populations served by these programs. However, we believe that only two out of the three programs proposed to be realigned to county mental health – EPSDT and Medi-Cal Specialty Mental Health Managed Care – could work well, assuming programmatic efficiencies and other appropriately aligned incentives are adequately addressed (discussed in more detail below). The third program – the AB 3632 special education mandate, which is also a federal education entitlement program – is more problematic, for the reasons outlined in this memo.

I. Realigning Medi-Cal Specialty Mental Health Managed Care and EPSDT

From a programmatic perspective, we believe the Medi-Cal Specialty Mental Health Managed Care and EPSDT programs are potentially good candidates for realignment to counties. County mental health plans (MHPs) – under contract with the state – already operate as Prepaid Inpatient Health Plans under a CMS-approved Medicaid 1915(b) “freedom of choice” waiver for both programs. Under this waiver and two state plan amendments, counties are responsible for assuring statewide access to medically necessary emergency, hospital, post-hospital stabilization, case management and rehabilitative mental health services for Medi-Cal beneficiaries. The state has also taken advantage of the Code of Federal Regulations Title 42 provision that allows local units of government to contribute funds to meet the state’s share of federal financial participation (FFP) for Medicaid services. 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 state plans and the waiver. Realigning this program entirely to counties, with a new dedicated revenue source, could lead to significant administrative efficiencies at the state and local levels, increased FFP, and more timely cash flow for counties.

Recommendation: In order to ensure that counties have adequate resources to comply with newly realigned program responsibilities for EPSDT and Medi-Cal Specialty Mental Health Managed Care, California must maximize federal reimbursement.

CMHDA recommends the state pursue the following strategies to increase the federal Medicaid funds available to California counties administering the Specialty Mental Health Managed Care program:

- Eliminate California’s use of administratively-established Statewide Maximum Allowances (SMAs), and instead utilize existing federal Medicaid Upper Payment Limits.
- Delete the provision in current law limiting administrative costs to 15% of the total cost of direct client services. Federal law allows government entities to be fully reimbursed for their federally eligible costs subject to audit and cost settlement.
- Require claims to be submitted by Mental Health Plans within the timeframes specified in federal Medicaid requirements and approved Medicaid state plan amendments and waivers (i.e., eliminate California’s use of an administratively-established submission deadline of six months for Specialty Medi-Cal Mental Health Managed Care claims).
- Allow counties to participate as government entities in the existing continuous appropriation of federal funds for reimbursement under Medi-Cal.

CMHDA has drafted legislative language for each of these strategies, which we are happy to provide.

Additional issues that would need to be addressed in order to make this work, from the county mental health perspective, are described below:

- It is important to recognize that realigning risk and responsibility for federal entitlement programs from the state to local government requires a different set of principles and agreements than the realignment of state-only program responsibilities.
- Federally-funded health programs require that financial, coverage and beneficiary protection provisions be specified in state plans and waivers that must be negotiated with and approved by CMS.

- The financial agreements between the state and CMS typically specify state maintenance of effort (MOE) requirements, state and local government CPE agreements, FMAP percentages, reimbursement methodologies and audit and settlement requirements. The state must provide certain assurances to CMS, and is subject to the terms and conditions of the state plan and waivers that can result in audits and penalties assessed to the state for non-compliance.
- Federal health care programs have beneficiary protection requirements that can be the subject of litigation in federal court, resulting in decisions that have financial consequences for the state. Provisions for addressing changes in state and local government risk and responsibility resulting from lawsuit settlements, audit exceptions, changes in state plans/waivers, legislative or administration actions or other significant policy shifts must be clearly specified.
- The financial risks associated with federal health care programs are best managed when all government entities that are participating have a little financial “skin in the game.” This is usually accomplished through agreements specifying MOE/base and growth, and shared percentage match provisions, as well as federal upper payment limits and eligible cost-reimbursement methodologies. Adequate revenue reserves must be available at the local level to cover the required CPE obligations until FFP and other sources of reimbursement become available to cover the local government expenditures. Access to federal financial participation by local government must occur based on a continuous appropriation of the federal funds received by the state from CMS.
- Provisions for the return of the federal health care responsibilities from local government to the state must be considered, to assure compliance with federal financial and beneficiary protection requirements, should the local government entity not be able to meet the state’s obligations.
- Dedicated tax revenues are critical to the success of realigned programs, but also can be volatile and require careful management of reserves to assure that matching funds are available during economic downturns. To assure revenue adequacy, careful consideration should be given to how many federal entitlement programs are realigned, what is the most appropriate and efficient mix, and whether access, utilization and cost incentives are appropriately aligned at the state and local levels.
- Beginning in FY 2009-10, state DMH began developing EPSDT funding estimates using questionable offsets, including “voluntary” MHSA contributions by counties. These practices have not been adequately explained by DMH, to date, from our perspective. The state budget allocation for this program has also been typically insufficient, causing DMH to seek deficiency appropriations in the state budget. Additionally, the state has settled lawsuits in the program requiring counties to produce increases in program utilization. In a realignment of the program to counties, it is vital that these issues be taken into account when establishing the appropriate base level of funding for the EPSDT program.

II. Realigning AB 3632 (Mental Health Services for Special Education Pupils)

The AB 3632 mental health special education mandate on counties has a long, complicated, and problematic history, from the counties’ perspective. Fiscally, the state has failed to fulfill its responsibility (and, since Prop. 1A in 2004, its constitutional obligation) to fully fund counties for this mandate. Most recently, former Governor Schwarzenegger vetoed \$133 million from the FY 2010-11 state budget on October 8, 2010 and declared the mandate on counties suspended. According to the most recent figures we have from the State Controller’s Office, the state currently owes counties nearly \$450 million for mandated services provided to students through FY 2008-09. Counties are also owed an as-yet unspecified amount for mandate reimbursement

funding of this program for FY 2009-10, and for services mandated through October 8, 2010 in FY 2010-11. The Governor's veto has created chaos at the local level, and there are currently three lawsuits pending that attempt to clarify the status of the Governor's action and counties' responsibilities to provide services absent state funding in the current fiscal year.

In addition to the state's long history of underfunding this local government mandate, we believe the program as currently constructed has a fundamental misalignment of incentives between schools and counties that ultimately increases counties' financial and legal risks, and are a waste of state and local resources. CMHDA agrees with the Legislative Analyst Office (LAO), which states in its overview of the Governor's budget: *"Realigning AB 3632 merits consideration, but not in the manner proposed by the administration. Instead, schools should have programmatic and financial responsibility for this program... While schools may wish to contract with county mental health departments to provide these programs, the primary fiscal and program responsibility should reside with schools."*

CMHDA does not believe that realignment of AB 3632 to counties would further the Governor's stated goals for realignment (i.e., increase cost-effectiveness, reduce duplication and overhead costs, provide flexibility to local government, etc.). Specifically, schools control access and utilization through the IEP process, and county mental health departments often disagree about the types or duration of services that schools and/or parents want included on the IEP. Realignment to counties is therefore inappropriate since counties would have little flexibility to manage the program. Further, if schools have no "skin in the game" financially for ensuring the provision of IEP-identified mental health services to students under the realigned program, how can counties appropriately manage their financial risk?

Realigning to counties would not change the current statutory framework for this program, which legally obligates *both* schools and counties to deliver IEP-identified mental health services to students. The shared legal obligations mean that both counties and schools incur costs if a parent legally challenges the services proposed to be provided. Also, duplication and overhead costs would not be reduced because both schools and counties would be responsible for complying with the federal entitlement program and/or the state mandate.

Aside from the above programmatic concerns with the structure of the AB 3632 program, we are also doubtful that the new realignment revenue source would be sufficient to pay for both the AB 3632 entitlement program and the other realigned entitlement and non-entitlement programs. According to the LAO, the Governor's proposal underestimates the true costs to counties in complying with this mandate by at least \$200 million per year. Additionally, by realigning the program, counties would no longer be able to submit SB 90 mandate reimbursement claims if the new revenue source is insufficient to pay for the state mandate. Another funding problem the LAO identified is that state mandates must be paid with state general purpose funds, thereby making it inappropriate to fund the AB 3632 mandate with MESA funds in 2011-12.

Rather than realign AB 3632 to counties, partnerships between schools and county mental health departments should be clarified in interagency agreements that describe their collaboration. This is already happening throughout the state, in the wake of Governor Schwarzenegger's line item veto of funding for this program in the FY 2010-11 state budget. Despite the chaos the veto of funding created, most counties in the state have already shown their commitment to serving the special education student population by entering into agreements with local schools to continue providing services. These agreements recognize that schools are required to comply with the federal education entitlement to provide special education students with services that enable them to benefit from a free and appropriate public

education. These agreements also recognize county mental health departments (and/or their contract agencies) have the expertise and experience to be the providers of mental health services for special education students, should the schools choose to contract with them. Further, they recognize that county mental health plans continue to have the responsibility to provide medically necessary EPSDT services to Medi-Cal eligible students.

Recommendation: Reject the Governor’s proposal to realign the AB 3632 program to counties. Instead, clarify in state law that it is the responsibility of local education agencies (LEAs) to ensure compliance with the Individuals with Disabilities Education Act (IDEA) – including mental health “related” services identified on a student’s IEP. Require schools and county mental health departments to enter into Memoranda of Understanding that clarify the appropriate roles and responsibilities of each in ensuring the provision of mental health “related” services to special education students.

III. Diversion of MHSA Funds to Support Newly Realigned Programs

The Governor proposes to supplant state General Funds with MHSA funds to pay for three realigned programs in 2011-12. The net result of this funding shift would be fewer resources for the public mental health safety net.

However, if the Governor’s proposal to utilize MHSA funds and realign EPSDT and Medi-Cal Specialty Mental Health Managed Care were adopted (excluding AB 3632), CMHDA urges that this be implemented in such a way that it minimizes harm to communities, avoids major amendments to MHSA statute, improves government efficiency, and maximizes federal reimbursement.

Additionally, it is vital that the state comply with the requirement of the MHSA [as validated by *Mental Health Assoc. v. Schwarzenegger*, 190 Cal. App. 4th 952 (2010)] to maintain annual General Fund support for mental health programs at the same level as FY 2003-04, which is \$557,948,000 – also known as the MHSA maintenance of effort (MOE)].

Recommendation: In order to avoid significant reductions and disruptions to current mental health services at the local level, CMHDA recommends the following sequence of strategies be utilized to allow MHSA funds to be used to fund the state’s obligations for EPSDT and Medi-Cal Specialty Mental Health Managed Care in FY 2011-12:

- Follow the existing statutory structure of the Mental Health Services (MHS) Fund, which was meant to be continuously appropriated, and align the Department of Mental Health’s MHSA fund distribution practices as such, including a significantly reduced and simplified MHSA county plan approval process;
- Remove DMH administrative policies that limit the amount and type of MHSA funds that counties can place into their local MHSA prudent reserves, as well as the circumstances under which counties may use their MHSA prudent reserves;
- Utilize existing and future revenue in the MHS Fund in the State Treasury, rather than reduce MHSA local assistance funds in 2011-12; and
- Adopt budget trailer bill language specifying that the state is *borrowing* \$557,948,000 (the MHSA MOE mentioned above) from the MHS Fund in the state treasury to cover its MHSA MOE for FY 2011-12. These funds would be included in the EPSDT and Medi-Cal Specialty Mental Health Managed Care realignment transfer for 2011-12, and be subject to repayment within 5 years.

Additionally, require the state to consult with counties on a formula to distribute the diverted MHSA funds to each county to meet the state's FY 2011-12 EPSDT and Medi-Cal Specialty Mental Health Managed Care obligations.

We would welcome the opportunity to provide you with additional details regarding the above proposal.

Recommendation: CMHDA recommends that the state ensure MHSA resources are prioritized for use in communities for direct mental health services.

The MHSA specifies that a maximum of 5% of all MHSA revenues may be used by the state to cover administrative activities. In addition, these MHSA state administrative funds are to be used to assist consumers and family members in ensuring state and county agencies consider their concerns, and to ensure adequate research and evaluation regarding the effectiveness of services being provided.

Particularly in the current fiscal environment, protecting vital services for California's most vulnerable and disabled populations should be the primary goal. Until the direct service obligations associated with both the proposed transfer and the current and future county plans for MHSA are met, the Legislature should limit its approval of new MHSA state administrative expenditures to those that are necessary for the operation of direct client services funded by MHSA. Once all service commitments are ensured funding, consideration could be given to prioritized requests for administrative appropriations from the MHS Fund.

Additionally, recent projections show a 13% reduction in MHSA resources to communities in FY 2011-12, and an additional 21% reduction in 2012-13. This will require counties to reduce MHSA expenditures by corresponding amounts. At minimum, state administrative activities should also correspondingly be reduced during these economically difficult times.

Significant Questions Still Remain

Significant unanswered questions about the Governor's realignment proposal remain at this writing. Therefore, this document represents CMHDA's preliminary assessment and recommendations. Until additional details are provided by the Administration about the adequacy of the new funding source, and specific details about the proposed state-county relationship as it would pertain to realigned mental health programs, we are unable to offer our full support or opposition to major components in the Governor's proposal. Some of our remaining questions include:

- What would be the state's role in meeting program cost growth that could result from future changes in federal or state law, court actions, or growth in entitlement costs that exceed a defined baseline threshold?
- What protections will be provided to local governments to specify the provisions under which the federal entitlement programs must be returned to the state if a county cannot meet federal entitlement requirements due to changes in law or insufficient revenue?
- What will be the role of the counties in the development, modification, and approval of the federally required Medicaid state plan amendments and waivers needed to implement realignment (e.g., financial, beneficiary protection and coverage, provider

limitations)? Language must be jointly developed by the counties and Department of Health Care Services prior to submission to CMS for review and approval.

We look forward to discussing our recommendations further with you. Please do not hesitate to contact Kirsten Barlow at kbarlow@cmhda.org, or Patricia Ryan at pryan@cmhda.org, or by phone at (916) 556-3477. Thank you for your consideration of our initial analysis of the Governor's 2011-12 state budget proposals.