Behavioral Health Financing 201

County Behavioral Health Directors Association

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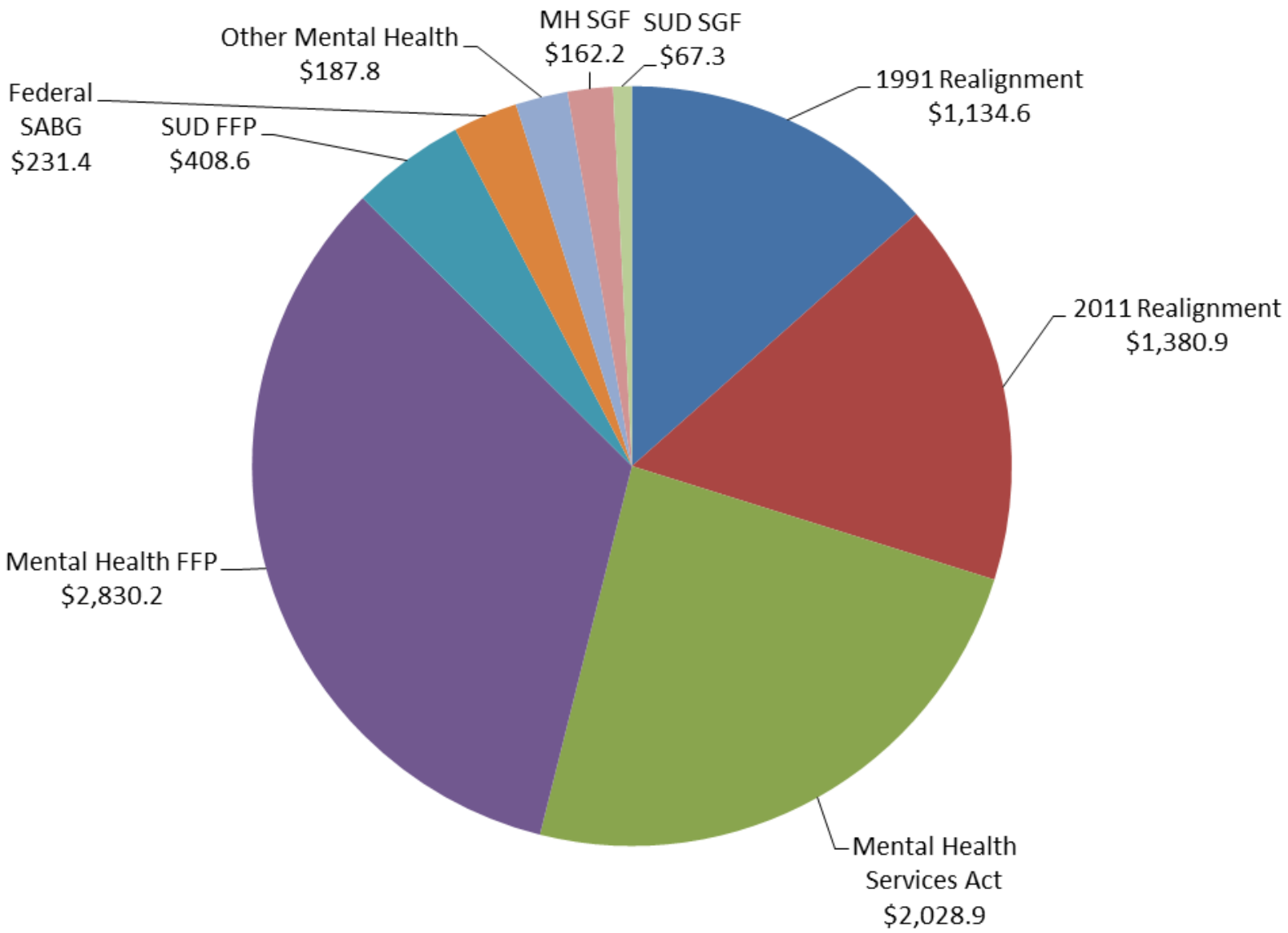
FY21-22 Estimated Behavioral Health Funding

$8,432 Million
(Dollars in Millions)



MENTAL HEALTH ALLOCATIONS

Core funding sources

1991 Realignment

2011 Realignment

MHSA

Mental Health Allocations

In general, the three core mental health funding sources are allocated to counties irrespective of actual costs or demand for services

- Adjustments effectively redistribute funds between counties

1991 Realignment is based on fixed percentages that are not influenced by a county

- Similar to Global Budgeting approach under managed care

2011 Realignment is based on historical experience, and subsequent growth and corresponding base distributions are influenced by county expenditures and growth in Medi-Cal beneficiaries

- Similar to a mix of cost-based reimbursement and per member per month approach under managed care

MHSA is primarily based on population, and to a lesser extent cost of living and existing resources

- Similar to per member per month approach under managed care

1991 Realignment Allocations

1991 Realignment was enacted in 1991 with passage of the Bronzan-McCorquodale Act

- Realignment transferred program responsibility from the state to counties
  - Pre-Realignment categorical programs
  - General community mental health funding
  - State Hospital civil commitment funding
  - Institutions for Mental Diseases (IMD)
- Provided dedicated revenue sources
  - Sales Tax
  - Vehicle License Fees
  - Vehicle License Fee Collections

Prior to 1991 Realignment, county mental health services were funded primarily with State General Funds

- State General Funds were administered by the state similar to grant funds
- Amount of State General Funds allocated to each county was not based on statistics
- State General Funds did not take into account adequacy of funding prior to 1991

1991 Realignment Allocations

1991 Realignment allocations were intended to replicate the amount of State General Funds provided to each county	• Initial revenue shortfall meant revenues did not equal prior year funding levels until FY1994-95
Growth included “equity” distributions	• Goal was to provide similar level of funding to each county based on poverty population formula • “Under equity” counties allocation percentages were less than share of poverty population • “Over equity” counties allocation percentages were greater than share of poverty population • “Equity” growth distributions eliminated with revenue decline in FY2001-02
CalWORKS MOE swap in FY2011-12	• Counties receive fixed guaranteed amount • **Individual county allocation percentages are based on overall percentage of Sales Tax and VLF revenues received in FY2010-11**

1991 Realignment Growth Funds

Mental Health began receiving growth in 1991 Realignment funds once funding for CalWORKs MOE equaled the guaranteed minimum amount of Mental Health funding in FY13-14

- Separate growth amounts for Sales Tax and VLF

Rolling base concept applied to 1991 Realignment distributions

- Next year's base equals prior year base plus prior year growth

First claim on the Sales Tax Growth Account goes to caseload-driven social services entitlement programs (IHSS and child welfare)

- Any remaining growth from the Sales Tax Account and all VLF growth are then distributed according to a formula developed in statute
- Mental Health also receives 5% of the annual growth in the 2011 Realignment Support Services Account

Growth distributed in the year after it is collected

- Distributed based on each county's share of the base allocation

Decrease applied proportionally to all programs

Counties know their individual allocation percentages for both base and growth

- Allocation percentages are not influenced by expenditures or population

Current Structure of 1991 Mental Health Realignment

Realignment revenues are distributed to counties on a monthly basis as funds are collected until each county receives funds equal to previous year's total

Separate distributions for:

- Mental Health (fixed, guaranteed amount)
- Mental Health Sales Tax Base
- Mental Health VLF Base
- Mental Health VLF Collections

CalWORKs MOE funded prior to the funding of Mental Health Sales Tax Base and Mental Health VLF Base

Revenues above that amount are placed into growth accounts

Sales Tax

VLF

2011 Realignment

Additional realignment occurred as part of FY11-12 State Budget

Dedicated a specific revenue to fund realigned services

- 1.0625% of Sales Tax
- Motor Vehicle License Fee Transfer to fund law enforcement program
- Realigned services previously funded with State General Fund monies
- MHSA funds were used to fund realigned mental health services in FY11-12

The 2011 Realignment statute does not specify how much needs to be spent on each program

2011 Realignment Behavioral Health Subaccount

Medi-Cal Specialty Mental Health Managed Care, including:

- MH Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children and youth

Drug Medi-Cal, including EPSDT

Drug Courts

Perinatal Drug Services

Non Drug Medi-Cal Services

2011 Realignment Distributions

Individual county base allocation percentages determined through rolling base concept

- Current year base equals prior year base plus prior year growth

FY16-17 established individual county base allocations

- Explained in Information Notice 16-052

Target Allocation for each county

- Non-federal share of FY13-14 EPSDT approved claims by county of service
- Non-federal share of FY13-14 D/MC approved claims based on county of responsibility adjusted to include $100,000 minimum
- Historical amounts for Managed Care allocations, Non-Drug/Medi-Cal allocations and Drug Court allocations
  - Allocation amounts from FY12-13

Remaining Balance

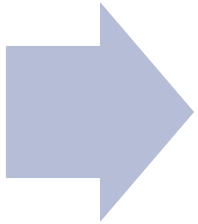
- Each county's average Medi-Cal beneficiaries for the months of December 2014 through November 2015

Hold Harmless adjustment so no county was reduced by more than 15%

2011 Realignment Growth Distributions

Growth for each county determined through formula

- 50% based on most recent D/MC and EPSDT claims (experience)
- 50% based on weighted Medi-Cal beneficiaries (risk)
  - Adjusted for the cost of Disabled and Foster Care aid codes



Department of Finance generally adjusts the base schedule in October once growth amounts have been calculated

2011 Realignment Distributions

FY16-17 individual county allocations established each county's base

- Historical expenditures/allocations
- Information Notice 16-052

Subsequent fiscal year allocations based on rolling base concept

- Current year base equals prior year base plus prior year growth

Behavioral Health Subaccount growth

- Growth distributed based on a formula driven by actual claims and population
  - Fund two entitlement programs at based on actual claims
  - Balance distributed based on percentage of average monthly Medi-Cal enrollment

MHSA County Funding

Funds distributed on a monthly basis (W&I Code Section 5892(j)(5))	• Unexpended and unreserved funds on deposit in the State MHS Fund at the end of the month are distributed by the 15th of the next month • State reserves entire administrative appropriation at the beginning of the fiscal year
Individual county allocation percentages are based on:	• Estimated need for services • Self-sufficiency and resources • Small county minimum allocations • Information Notice 20-038 describes methodology

Counties receive one warrant (check) from the state	• County responsible for ensuring compliance with C.C.R. Title 9, Section 3420(b)
	  • 5% of total funding shall be utilized for Innovative programs
	  • 19% for Prevention and Early Intervention programs
	  • 76% for Community Services and Supports (System of Care)

Each county required to have a local Mental Health Services fund	• Interest earned remains in the fund to be used for MHSA expenditures

MHSA County Allocations

Prior to the implementation of AB100 in FY2012-13, counties were provided a Planning Estimate which represented the amount of funding a county could apply for through the annual plan process

AB100 eliminated the Planning Estimate process

- Funds distributed as deposits are made into the State Mental Health Services Fund

State implemented allocation process in FY2017-18

- Each county receives base amount equal to amount allocated in FY2012-13
- Estimated growth allocated based on same approach used to establish prior Planning Estimates with updated statistics

Currently have fixed base equal to FY2012-13 funding plus growth recalculated each year

- Different than a rolling base
- Determines individual county allocation percentages
- Is not modified when revenues differ from amounts used to estimate growth

2011 REALIGNMENT AND PROP 30

Proposition 30 Constitutional Protections

State must fund any new laws that increase costs of local services mandated by 2011 Realignment as follows:	Unless the state provides funding, state cannot submit federal plans/waivers/SPAs that increase local costs.	State provides 50% of needed funds for changes to federal statutes/regulations or federal judicial or administrative proceedings.
• New laws (after 9/30/12) • New regulations, executive orders, administrative directives (after 10/9/11)		

Proposition 30 (California Constitution, Article 13, Section 36)

- Constitutional protection for counties against unfunded mandates to expand 2011 realigned programs
- Requires state to contribute additional funds for new requirements that have "*an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by the 2011 Realignment Legislation.*"
- Covers legislation and administrative actions
  - E.g., regulations, executive orders, waiver proposals, state plan amendments
- State-imposed mandate = state must fund increased costs at 100%
- Federal mandate that alters requirements to obtain FFP = state must cover at least 50% of increased non-federal share
- Sometimes art rather than science . . .

Prop 30 case studies

- Continuum of Care Reform
- Managed Care Final Rule
- FURS
- SB 803/Peers
- DMC-ODS

MHSA FISCAL POLICIES

MHSA Prudent Reserves

Counties are required to establish and maintain a prudent reserve to ensure the county can continue services in years in which revenues are below recent averages (W&I Code Section 5847(b)(7))

Counties can include an allocation of funds from their prudent reserve in years in which there is not adequate funding to continue to serve the same number of individuals as in the prior year (W&I Code Section 5847(f))

DHCS finalized MHSA Financial Regulations that clarify the standards that must be met to use reserves.

MHSA Prudent Reserve Limits

SB 192 (Beall) of 2018

- Limits prudent reserves to 33% of the average CSS revenue received in the preceding five years
- Counties can still transfer up to 20% of the average amount of total funds allocated to the county in the preceding five years from CSS to WET, CF/TN and/or the Prudent Reserve

DHCS Information Notice 19-037

- Provides individual county maximum prudent reserve amounts
- Based on five fiscal years (FY13-14 through FY17-18)
- Sum of total distributions from July 2013 through June 2018 multiplied by 76 percent divided by 5 multiplied by 33 percent
- Can be reassessed periodically

California Code of Regulations Section 3420.30

- Requires minimum 5% prudent reserve

DHCS Information Notice 20-040

- Allows counties to transfer funds from the Prudent Reserve into CSS and/or PEI to meet local needs
- Must report transfer in next MHSA Plan or Annual Update as well as the FY20-21 Revenue and Expenditure Report
- Must notify DHCS within 10 business days of the decision to transfer funds

MHSA Reversion

Funds must be spent within a certain timeframe or returned to the state	• CSS, PEI and Innovation must be spent within three years • WET and CFTN must be spent within 10 years • Funds dedicated to Prudent Reserve are exempt from reversion
AB 114 of 2017 modified the MHSA Reversion statute	• Counties with a population of less than 200,000 have five years to expend funds • The expenditure period for Innovation Funds does not begin until the MHS Oversight and Accountability Commission approves an Innovation program
SB 79 of 2019	• Funds encumbered in an approved OAC Innovation project plan will not be subject to reversion unless unspent when the project plan timeline approved by the OAC, including any timeline amended and approved by the OAC, has expired

MHSA Reversion

Unspent funds subject to reversion as of July 1, 2017 are “reverted” and reallocated to the county of origin	• Effect is no funds are subject to reversion prior to July 1, 2017 • County must provide a plan for how reallocated funds will be spent • Reallocated funds must be spent by July 1, 2020
DHCS redistributing funds subject to reversion after July 1, 2017	• Identified as “Reallocated Funds” on remittance advice • Counties need to maintain component specificity with redistributed funds
DHCS Information Notice 20-040 provided additional time to expend funds due to COVID-19	• The reversion date for unspent funds originally subject to reversion on July 1, 2019 and July 1, 2020 is extended to July 1, 2021 • Includes AB114 reversion funds • Includes interest

MHSA Non-Supplant

Welfare and Institutions Code Section 5891(a) specifies that MHSA funds cannot be used to supplant existing resources

California Code of Regulations Section 3410 specifies that MHSA funds cannot be used to supplant funds required to be used for services and/or supports that were in existence in FY2004-05

DMH Policy Letter 05-08 identifies the aggregate funding amount for each county that must be spent in order to comply with the non-supplant policy

- Includes State General Fund allocation for Community Services which represented funding for the AB2034 homeless program that was eliminated by the State in FY2007-08

MEDI-CAL FISCAL POLICIES

Medi-Cal Behavioral Health Reimbursement

Medi-Cal Behavioral Health Cost Reports

Cost Reports	• Multiple detailed cost reports for each provider
Costs are identified by cost objective	• Direct Services • Administration • Utilization Review
Direct service costs are further identified by service	• Includes MAA (Medi-Cal Administrative Activities) • Includes non-reimbursable/non-Medi-Cal services (housing, vocational services, etc.)

Medi-Cal Behavioral Health Cost Reports

Service costs are apportioned between Medi-Cal and non-Medi-Cal based on units of service	Administration is apportioned between Medi-Cal and non-Medi-Cal	Medi-Cal administrative costs limited to no more than 15% of Medi-Cal direct service costs	Utilization review costs
• MAA apportioned between Medi-Cal and non-Medi-Cal based on percentage of program beneficiaries of the population served by the county	• Percentage of program beneficiaries of the population served by the county • Relative values based on units and charges • Gross costs of each program	• Direct service costs include Medi-Cal contractors and hospitals	• Skilled Professional Medical Personnel • Non-SPMP Medi-Cal • Non-Medi-Cal

Medi-Cal Behavioral Health Reimbursement Risks

SMH Units of Service	Identifying costs by cost objective	Allocation of administrative costs between Medi-Cal and non-Medi-Cal	Allocation of direct service costs to services	Length of time from when cost incurred until knowing final reimbursement
•Must be supported with County records •DHCS uses lowest of County records or State records for each service function and Medi-Cal program (Medi-Cal, MCHIP, ACA, etc.)	•Administration versus indirect costs	•Support for percentage of program beneficiaries of the population served by the county	•Costs identified as treatment service costs must generally have a correlation with treatment units of service	• SMH Currently being audited for FY2012-13 and FY2013-14

Cost-based, fee-for-service reimbursement

Cons

- Creates a “ceiling” – no opportunity for revenue in excess of costs
- Limits system reinvestment
- Disincentivizes outside contracts (3rd party payments/revenue)
- Limits opportunity to explore APMs with subcontractors
- Primarily incentivizes volume of services provided
- Administrative burden of detailed cost reporting, cost settlement and audit processes
- Risk carried over many years due to lag in audit and reconciliation

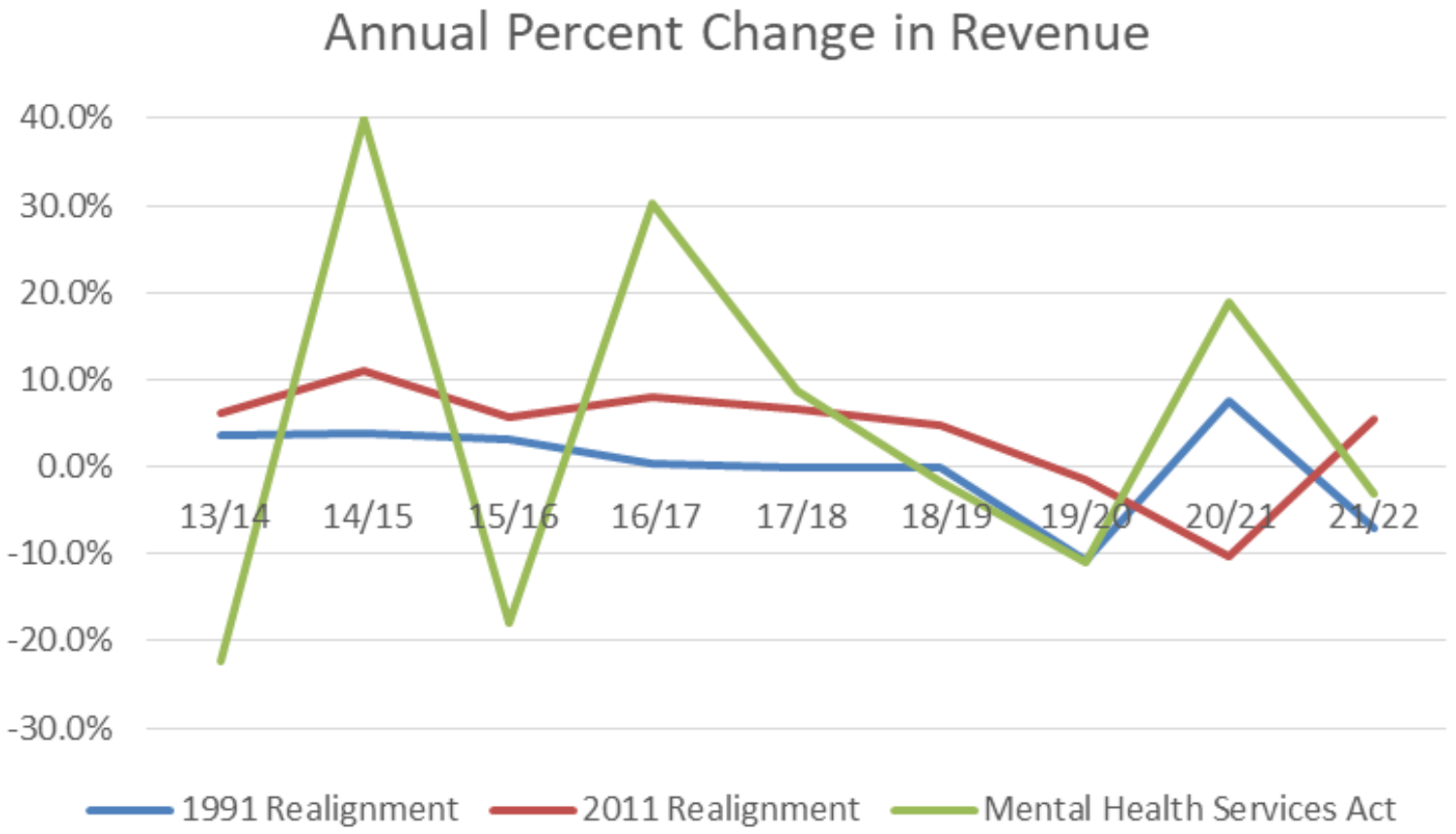
Pros

- Creates a “floor” – should receive reimbursement at cost
- Preserves opportunity to increase per-unit reimbursement rate to reflect costs
  - E.g., COVID-19 flexibilities
- “The Devil We Know”
  - Counties have learned how to cope within this system and to some extent risk/reimbursement feels predictable

MANAGING RISK

Variability in Core Revenues

- 1991 and 2011 Realignment are relatively predictable
- MHSA is incredibly volatile



1991 Mental Health Realignment Estimated Revenues

(Dollars in Millions)

	18/19	19/20	20/21	21/22	22/23
Base Amount					
Mental Health (CalWORKS MOE Swap)	$1,120.6	$1,120.6	$1,120.6	$1,120.6	$1,120.6
Mental Health Sales Tax Base	$34.0	$0.0	$0.0	$0.0	$0.0
Mental Health Vehicle License Fee Base	$95.3	$0.0	$0.0	$0.0	$0.0
Mental Health Vehicle License Fee Collections	$14.0	$14.0	$14.0	$14.0	$14.0
Total Base	$1,263.9	$1,134.6	$1,134.6	$1,134.6	$1,134.6
Growth in Base					
Sales Tax	$0.0	$0.0	$0.0	$0.0	$0.0
Vehicle License Fees	$0.0	$0.0	$0.0	$0.0	$0.0
One-Time Realignment Backfill					
State Funds			$86.7		
Federal Funds			$0.0		
One-Time Growth					
5% of Support Services Account Growth	$6.8	$0.0	$0.0	$0.0	$0.0
Total	$1,270.7	$1,134.6	$1,221.3	$1,134.6	$1,134.6

2011 Realignment Behavioral Health Subaccount Estimated Revenues
(Dollars in Millions)

	18/19	19/20	20/21	21/22	22/23
Base Amount					
Total Base	$1,415.4	$1,461.0	$1,223.0	$1,380.9	$1,443.9
Growth in Base					
New Growth	$67.8	$0.0	$0.0	$0.0	$0.0
One-Time Realignment Backfill					
State Funds			$86.7		
Federal Funds			$0.0		
Total	$1,483.2	$1,461.0	$1,309.7	$1,380.9	$1,443.9
Percent Change	4.8%	-1.5%	-10.4%	5.4%	4.6%

Excluding Women and Children's Residential Treatment Services Special Account which is a fixed amount.

MHSA Statewide Estimated Revenues

(Cash Basis-Millions of Dollars)

	Fiscal Year				
	Estimated				
	18/19	19/20	20/21	21/22	22/23
Cash Transfers	$1,824.0	$1,452.1	$1,749.70	$1,489.7	$1,578.9
Annual Adjustment	$272.5	$443.6	$523.0	$750.0	$172.9
Interest	$8.8	$10.7	$10.7	$10.0	$7.0
Total	$2,105.3	$1,906.4	$2,283.4	$2,249.7	$1,758.8

MHSA Estimated Component Funding

(Cash Basis-Millions of Dollars)

	Fiscal Year				
	Actual		Estimated		
	18/19	19/20	20/21	21/22	22/23
CSS	$1,501.4	$1,337.2	$1,589.7	$1,542.0	$1,176.0
PEI	$375.3	$334.3	$397.4	$385.5	$294.0
Innovation	$98.8	$88.0	$104.6	$101.4	$77.4
Total	$1,975.5	$1,759.5	$2,091.7	$2,028.9	$1,547.4

Flexibilities & Restrictions by Funding Source

County GF	1991 Realignment	2011 Realignment	MHSA
• Not available to all counties	• Most flexible funding source apart from county GF	• SUD and SMH services only • No fixed allocations per program/service • Can be used for all SMH services in addition to SUD & EPSDT	• MHSA funds can only be used when other funding is not available • MHSA can only be spent consistent with an approved MHSA Plan • MHSA funds revert after a specified period of time

Additional Risks

Management of "block granted" budget for Medi-Cal and non Medi-Cal services	• No easy solution when demand/costs increase • Criticism for maintaining reserves • Pressure to expand services, increase penetration rates
MHSA funds subject to reversion and public perception	• Different groups want access to funds for specific purposes • Decline in State revenues could cause increase in pressure to use MHSA funds for other purposes
Medi-Cal cost report audits and long-term liability	• Delay in audit cycle • Auditors reinterpreting statutes and regulations

Risk Management Strategies

Counties assume more risk than managed care plans

- Realignment and MHSA function like a “block grant” to counties for non-federal share
- Typical managed care risk management strategies are not available
  - Risk corridor and/or risk reinsurance aren’t an option

Counties currently manage risk through fiscal planning and reserves

- Local budget cycle requires current year and budget year planning but many counties develop three to five year fiscal plans
- MHSA requires a reserve and provides a reversion period to retain unspent funds for up to three years
- Counties are allowed to create reserves with 1991 Realignment funding
- Counties can roll-over unspent 1991 Realignment and 2011 Realignment funds
- Counties set aside funds for cost report repayment liabilities

Existential Questions

- **Distinct considerations for any Medi-Cal payment model:**
  - Risk management
  - Opportunities to maximize FFP
  - Limitations on non-federal share
    - Changing payment models can shift approach to managing risk and bring in more FFP. It will not necessarily compensate for inadequate non-federal share.

- **What is the gap between funding currently available to county BH and the amount needed to:**
  - Fulfill Medi-Cal obligations for a larger population (increase penetration rates)?
  - Fully fund non Medi-Cal obligations (e.g. crisis care)?
  - Fund activities that are not obligations but can improve outcomes?
  - Reinvest in the delivery system?

- **What is our vision for the public behavioral health system (structure, benefits, populations served)? What fiscal strategies could the state adopt to support that vision?**
  - Realignment modifications or supplements
  - Dedicated/sustainable funding for SUD as well as MH

APPENDIX

2011 Realignment Distributions

Prior State EPSDT Funding

- Mental Health Plans were initially reimbursed the entire non-federal share of cost for all EPSDT eligible services in excess of expenditures made in the baseline year (1994-95)
  - Baseline was based on the cost of care provided to eligible recipients in fiscal year 1994-95
  - Baseline was adjusted annually based on cost of living and other factors
- Later, Mental Health Plans became responsible for a county match of 10% of the growth of the state/local match above a second baseline year (2001-02) cost settled amounts
  - 10% match on state/local match above baseline 2 cost settled amounts for fiscal year 2001-02
- Created different state/local match percentages for each individual county for a federal entitlement
- State reimbursement was a portion of the actual cost of care for direct services (not administrative costs)

EPSDT state/local matching percentages eliminated with implementation of 2011 Realignment

- Counties required to fully fund match

2011 Realignment Distributions

Prior State Managed Care Allocations

- From 1995 through 1998, the state consolidated Fee for Service and Short-Doyle programs into one “carved out” specialty mental health managed care program
  - Phase 1 – Inpatient Consolidation
  - Phase 2 – Professional Services Consolidation
  - Phase 3 – Capitation (never implemented)
- Counties were provided State General Funds equal to the amount that was previously paid by the State for the consolidated services
  - Managed Care Allocation
- Amount was adjusted annually
  - Change in number of Medi-Cal beneficiaries
  - Change in cost of living (eliminated after FY2000-01)
- Growth was distributed among counties based on weighted relative need
  - Intended to allocate similar amount per weighted Medi-Cal beneficiary to each county
  - Risk adjusted number of beneficiaries in each county

MHSA County Allocations

Estimated Need for Services

- Overall population (50% weighting)
  - Each county's population as published by Department of Finance
- Population most likely to apply for services (30% weighting)
  - Each county's population with income below the federal poverty level
- Population most likely to access services (20% weighting)
  - Each county's prevalence rate based on county demographics

Adjustments

- Self-Sufficiency Adjustment
  - Cost of being self-sufficient in a county is used to adjust 40% of the estimated need for services
    - Weighted average of a single, childless adult (67%) and a single adult with two children (33%)
- Resources Adjustment
  - Resources provided to each county including 1991 Realignment, 2011 Realignment BH Subaccount, Mental Health Block Grants, and PATH Grants
  - Used to adjust 20% of the estimated need for services

Small County Minimum Allocations

- CSS - $250,000 minimum allocation for counties with population of less than 20,000; $350,000 minimum for all other counties
- PEI - $100,000 minimum allocation for all counties