Mental Health/Substance Use Policy Forum

Realignment: Mental Health/Substance Use

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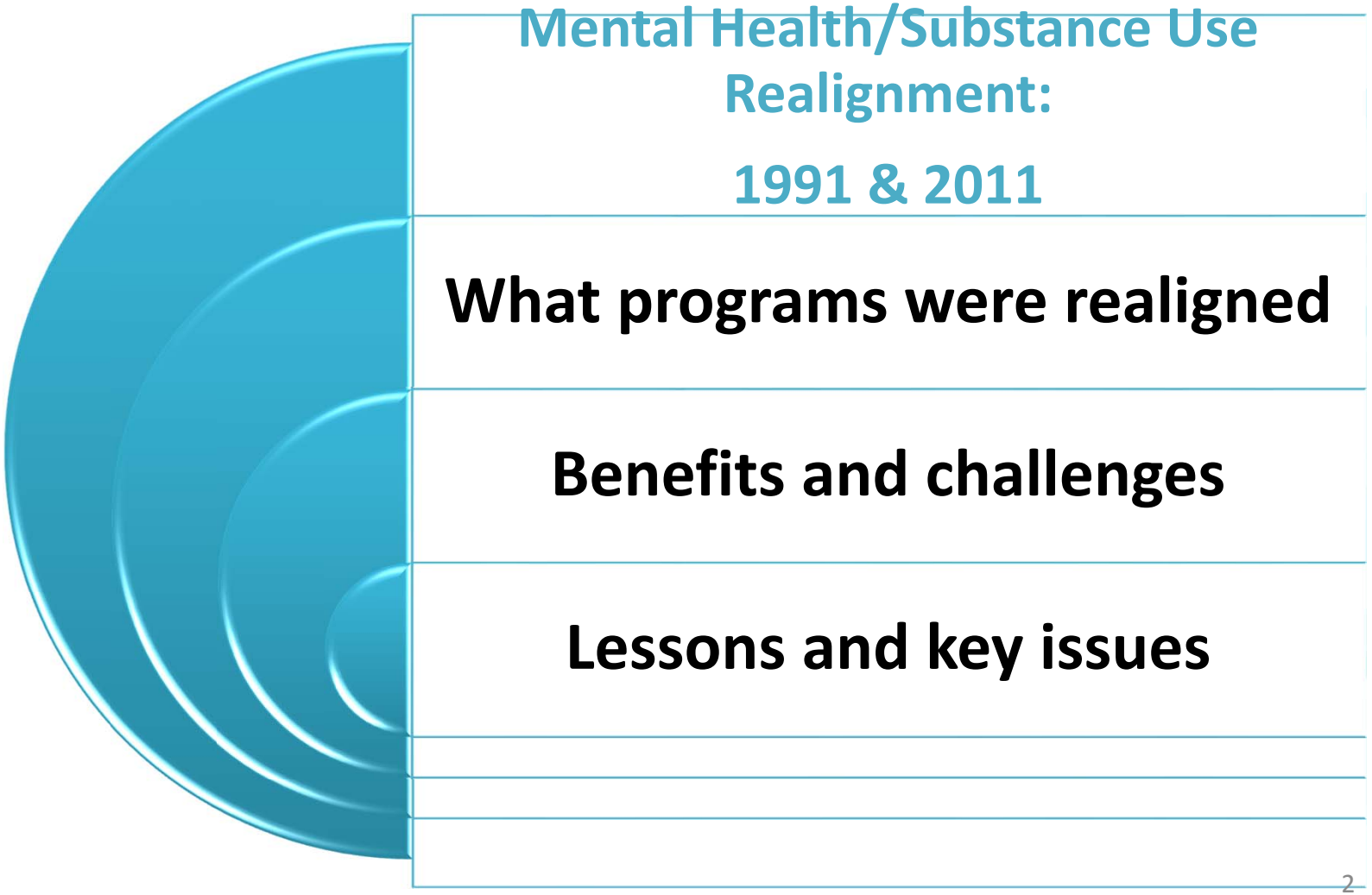
Patricia Ryan, MPA
Executive Director, CMHDA

Tom Renfree
Executive Director, CADPAAC

What We Will Discuss



Realignment 1991: Mental Health Programs Realigned from the State to Counties

All community-based mental health services

State hospital services for civil commitments

Mental health services for those in “Institutions for Mental Disease (IMDs),” which provide long-term psychiatric nursing facility care. By definition, services to Medi-Cal beneficiaries in IMDs **are not eligible** for federal reimbursement.

Benefits of 1991 Realignment

A stable funding source for programs, which made a long-term investment in mental health infrastructure financially practical.

The ability to use funds to reduce high-cost restrictive placements, and to serve clients appropriately in the community.

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.

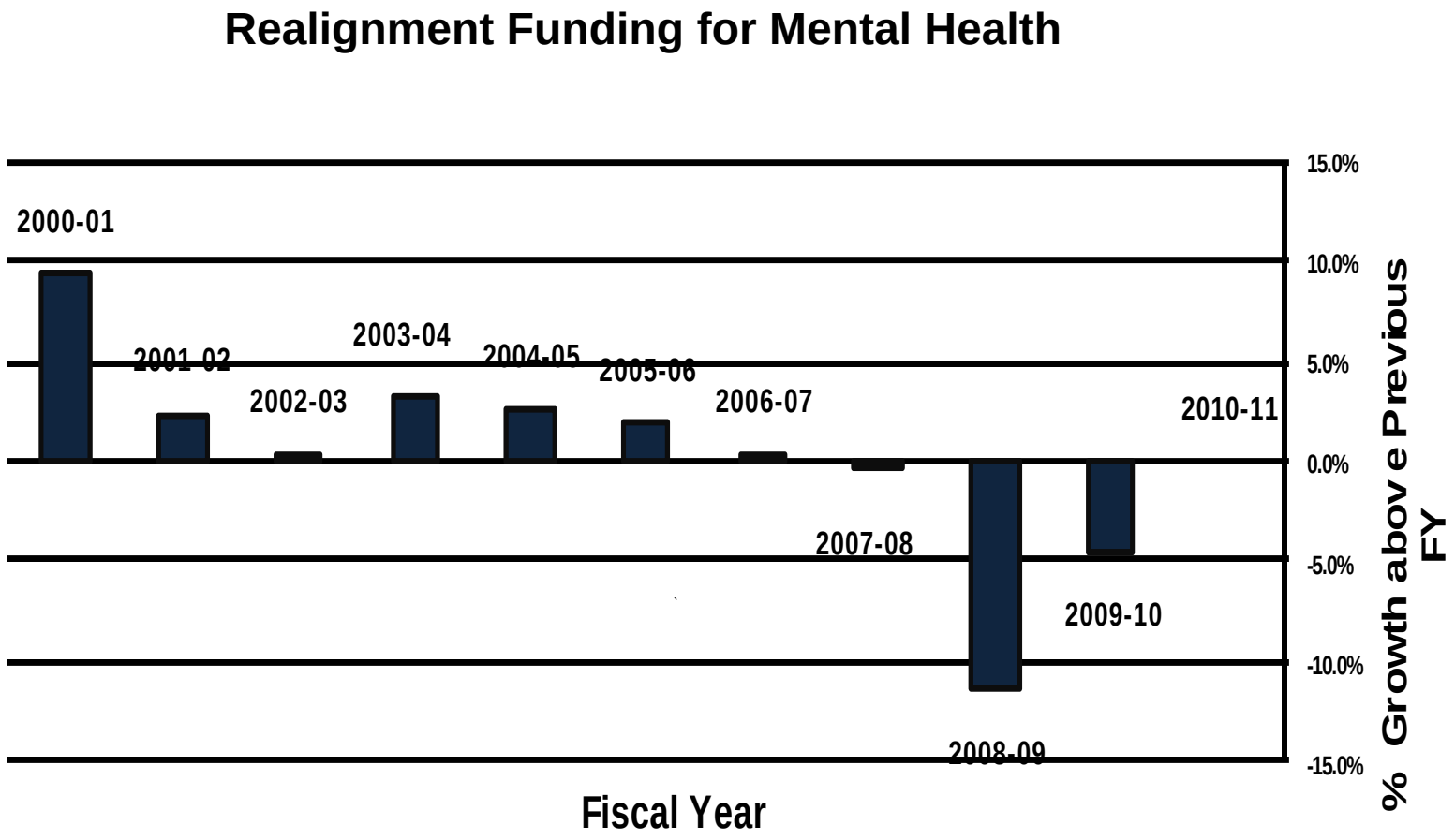
1991 MH Realignment
Lessons Learned/Challenges

Guaranteed Caseload Growth to Realignment Social Service entitlement programs

Statutory changes to realigned child welfare and In-Home Supportive Services Program after realignment

Insufficient growth for Mental Health programs

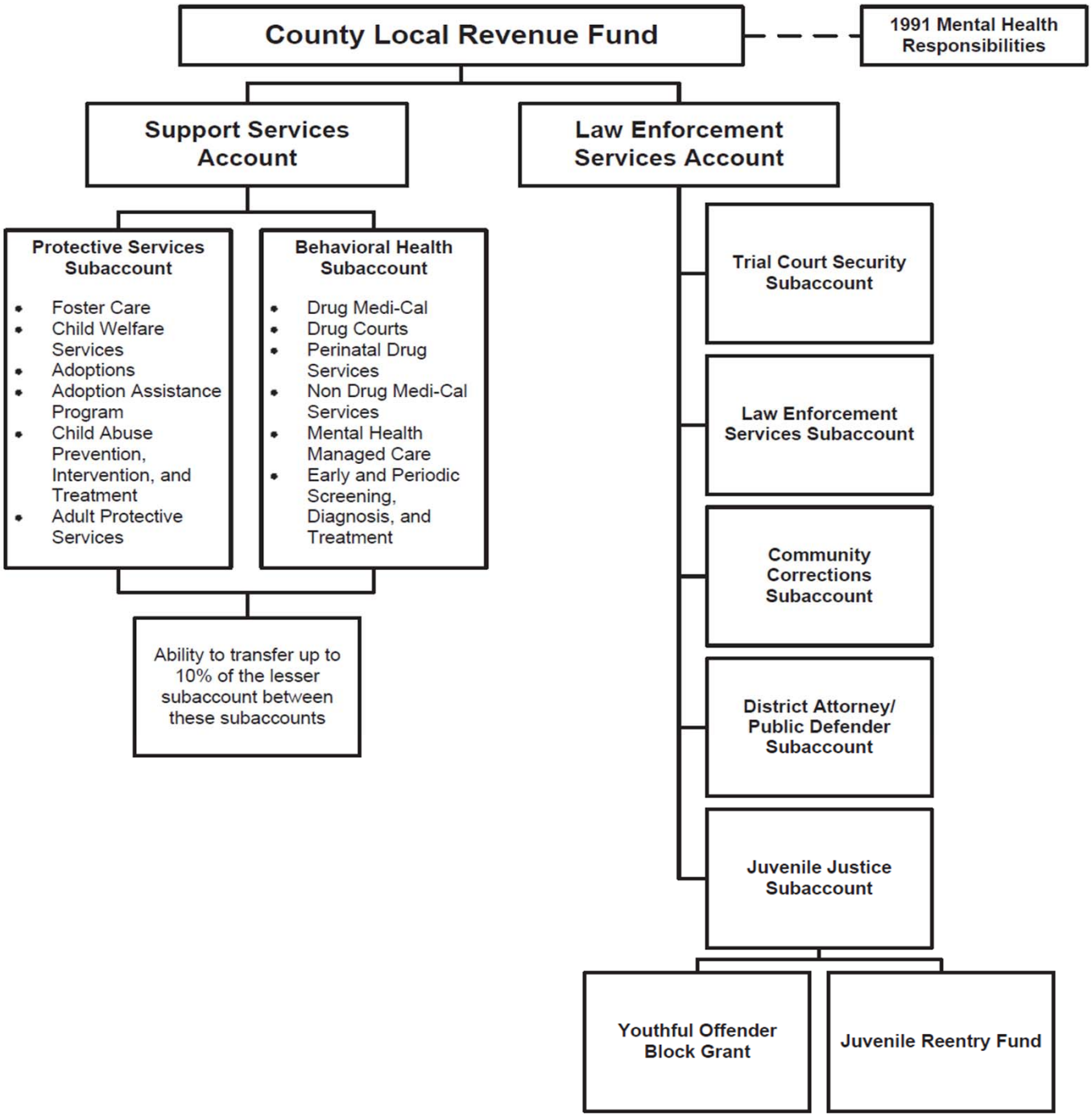
1991 MH Realignment Growth: Fiscal Years 2000/01 to 2010/11



Public Safety Realignment 2011: Goals

- Protect California's essential public services
- Create a government structure that meets public needs in the most effective and efficient manner
- Have government focus its resources on core functions
- Assign program and fiscal responsibility to the level of government that can best provide the service
- Have interconnected services provided at a single level of government
- Provide dedicated revenues to fund these programs
- ***Provide as much flexibility as possible to the level of government providing the service***
- Reduce duplication and minimize overhead costs

2011 Realignment Funding Structure



Prop. 30: Constitutional Protections

State must provide funds for new laws (after 9/30/12) or new regulations, executive orders, administrative directives (after 10/9/11) that increase costs of local services mandated by 2011 Realignment legislation.

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.

Realignment 2011: Behavioral Health Subaccount

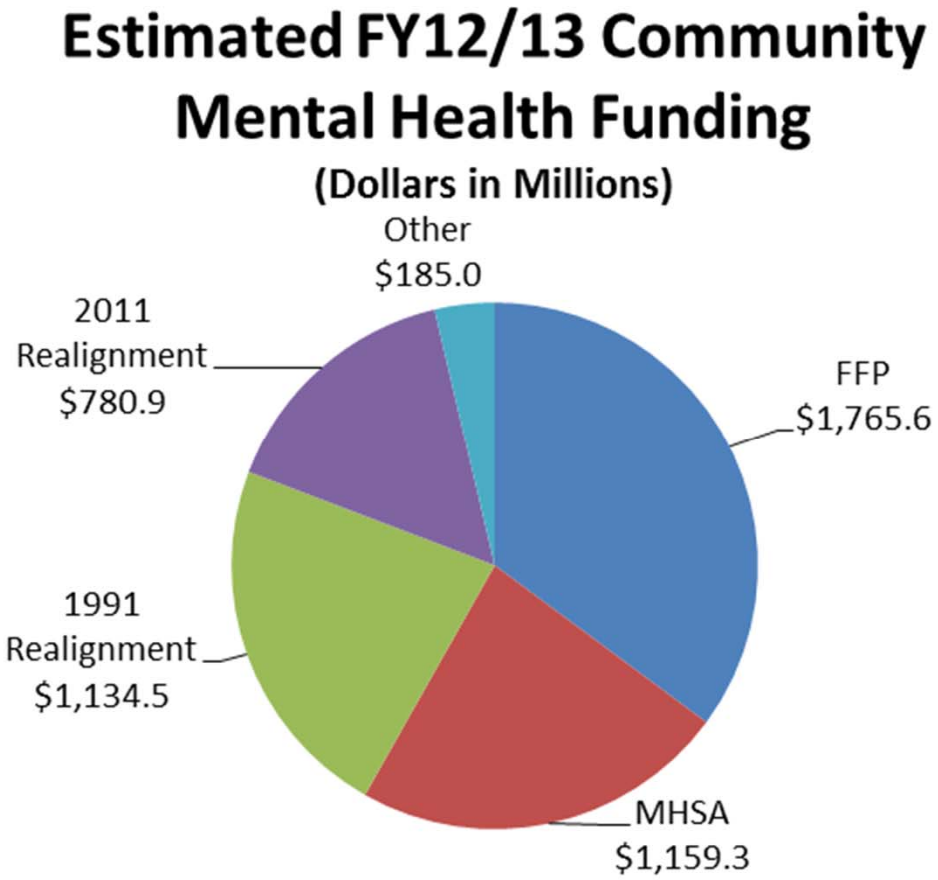
- Medi-Cal Specialty Mental Health Managed Care, including:
- MH Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children and youth
- Drug Medi-Cal, *including EPSDT*
- Drug Courts
- Perinatal Drug Services
- Non Drug Medi-Cal Services
- Medi-Cal Managed Care
- Substance Use Early and Periodic Screening, Diagnosis and Treatment

Realignment 2011 and Medi-Cal Specialty Mental Health

Counties must fund Medi-Cal Specialty Mental Health Services, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), from moneys received from:

- The 2011 Behavioral Health Subaccount and the Behavioral Health Growth Special Account
- The 1991 Realignment Mental Health Subaccount
- MHSA funds, to the extent permissible under the Act

Community Mental Health Services Funding



Issues/Concerns for Mental Health

In order to make the 2011 realignment of Medi-Cal Specialty Mental Health work, counties must have sufficient funds to ensure their ability to comply with the entitlement program, but also fulfill their responsibilities under Realignment 1991, and

Maintain a recovery and rehabilitation-focused overall public mental health system.

Issues/Concerns for Mental Health

Realignment mental health and substance use entitlement responsibilities requires a partnership between state and county government to maximize federal resources and minimize unnecessary administrative requirements, focusing on quality and results for the covered population.

Another key element of realignment is the hope that the dedicated sales tax revenues will generate enough growth to match the expansion of Medi-Cal enrollment and need that will occur over time. This is particularly important as the implementation of the ACA and other Medi-Cal coverage expansion occurs in the coming years.

Issues/Concerns for Mental Health

Current Medi-Cal expansion efforts include the Healthy Families transition to EPSDT Medi-Cal, Katie A. settlement requirements for EPSDT Medi-Cal MH services expansion, and the mandatory coverage enrollment requirements associated with the implementation of the ACA.

California has made a significant commitment to the development and maintenance of an integrated community-based and county operated rehabilitative mental health treatment system.

Under the provisions of 1991 realignment and Medi-Cal Consolidation, this system integrates the delivery of mental health emergency, LPS long term care, rehabilitative outpatient and case management services at the county level. ***2011 Realignment completed the transfer of the financial risk for this community based system to the counties.***

Issues Related to Drug Medi-Cal

Under the 2011 Realignment legislation in California, the state retains the responsibility for the certification and monitoring of D/MC programs, and will continue to set rates, while counties assume the responsibility and financial risk for administering and funding D/MC services at the local level.

As an entitlement program D/MC cannot be capped and, operating on a fee-for-service basis, does not have administrative and clinical controls on utilization.

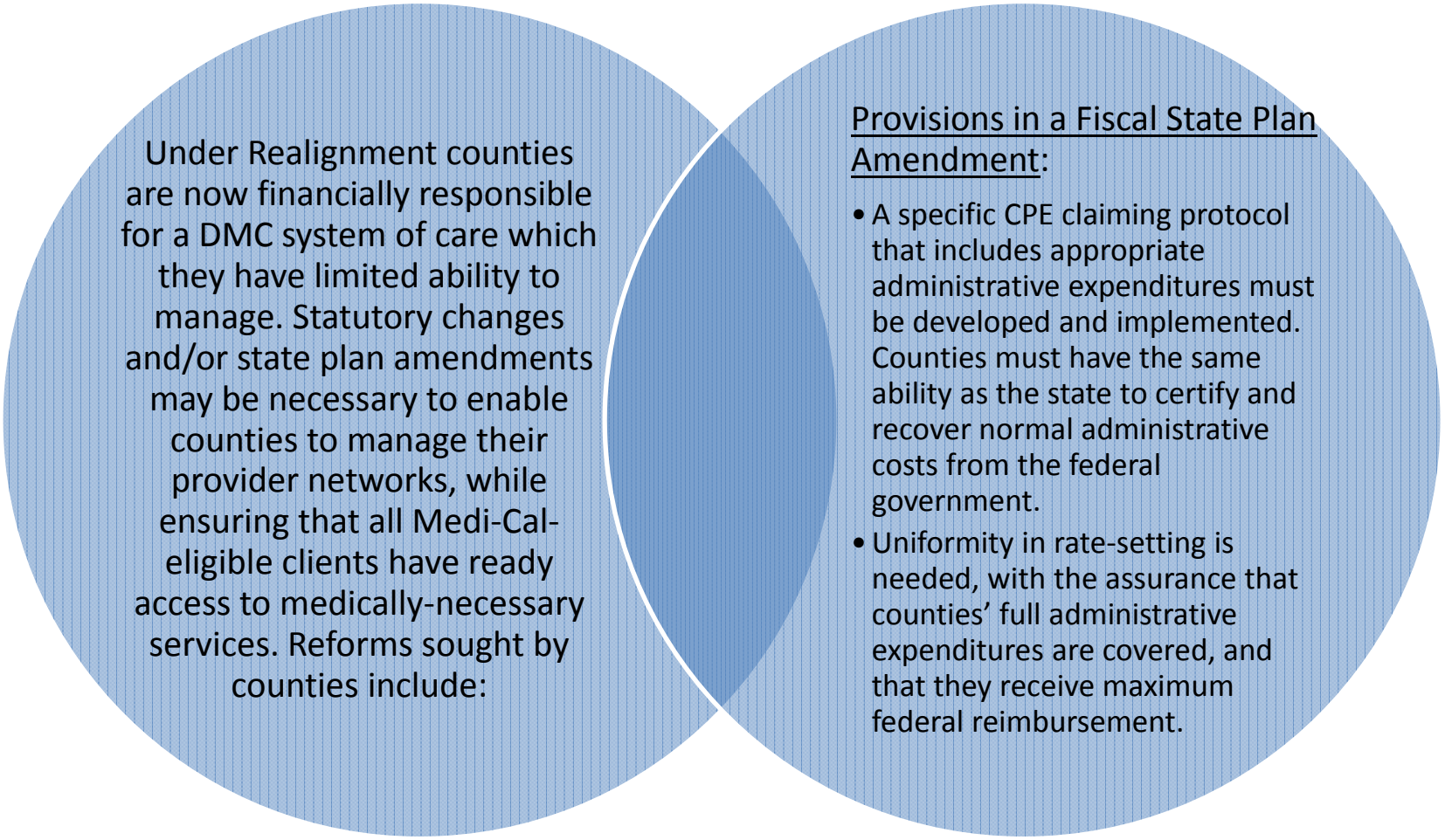
Financing D/MC caseload growth becomes a local responsibility under Realignment, but the specific mechanisms for accommodating and funding caseload growth are not defined.

Issues Related to Drug Medi-Cal

The current State Plan for Drug Medi-Cal, as approved by CMS, delineates the basic Medicaid requirements which, absent waivers, must apply to the DMC program:

- **Comparability of Services** – Benefits for eligible individuals must be equal in amount, scope, and duration for all beneficiaries in a covered group.
- **Statewideness** – Benefits offered to any individual must be available throughout the state.
- **Reasonable Promptness** – Eligible individuals cannot be required to be placed on waiting lists for services.
- **Choice of Providers** – An eligible individual may obtain DMC services from any institution, agency, person or organization that is qualified to perform the services.
- **EPSDT Assurances –** The state must provide assurance to CMS that EPSDT-eligible children will receive all federally covered services even if they are not specified in the state's Medicaid plan. Additionally, the transfer of Healthy Families youth to Medi-Cal will increase county responsibilities to provide SUD services to those youth who need them.

Issues Related to Drug Medi-Cal



Issues Related to Drug Medi-Cal

Budget, cost reporting requirements, billing and claims adjudication processes for DMC that conform to practices for Short-Doyle Medi-Cal to ensure quality and efficiency.

Statutory Provisions:

- Seek statutory changes to eliminate overly-proscriptive and restrictive state-only statutes, i.e. limitations on group sizes and length of therapy sessions, one service per day restrictions, limitations on evidence-based medication-assisted therapies, etc.
- Require that state DMC certification standards be strengthened according to a uniform set of statewide criteria, and give counties authority to apply these standards to certify and enroll providers into the local SUD treatment network.
- Require that all DMC providers who receive public funds must be licensed or certified by the appropriate state agency.

Issues Related to Drug Medi-Cal

Counties must have the ability to select and de-select providers on the basis of the county's need for services and potential providers' compliance with county fiscal, quality and performance standards.

Require that the standards for state-direct contracts be strengthened to conform to county contract standards, and limit the state's ability to enter into direct contracts with providers who choose not to contract with counties, or whose contracts with counties are terminated for cause.

Since counties provide the certified public expenditures for DMC, the rate-setting process should be an annual collaborative venture between the state and counties.

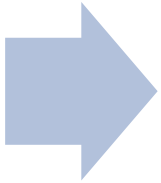
Issues Related to Drug Medi-Cal

In order for counties to be able to manage the program appropriately:

- All D/MC providers who receive public funds must be licensed or certified by the appropriate state agency.
- The state should not enter into direct contracts with providers who choose not to contract with counties, or whose contracts with counties are terminated for cause.
- Counties must have the ability to select and de-select providers on the basis of the county's need for services and potential providers' compliance with county fiscal, quality and performance standards.
- Since counties provide the certified public expenditures for DMC, the rate-setting process should be an annual collaborative venture between the state and counties, and should be undertaken each year with the goal of maximizing federal reimbursement.

Issues Related to Drug Medi-Cal

Even though D/MC has a limited set of benefits, counties do not operate local managed systems of care for D/MC clients . Waivers and/or state plan amendments may be necessary to enable counties to manage their provider networks, while ensuring that all Medi-Cal-eligible clients have ready access to medically-necessary services.



County recommendations for improving the Drug Medi-Cal program include:

- Eliminate state-only restrictions on D/MC services.
- Require that DMC certification standards be strengthened according to a uniform set of statewide criteria, and give counties authority to apply these standards to enroll providers into the local SUD treatment network.

Other MH/SU Realignment 2011 Issues

If DHCS determines that s county is failing or at risk of failing to perform the functions of a Behavioral Health Subaccount program to the extent federal funds are at risk:

- It notifies the State Controller, Department of Finance, and the county
- Determines the amount needed from the subaccount to perform the function
- Controller deposits county's allocation attributable to program into the "County Intervention Support Services Subaccount" (for access by DHCS for the program). DHCS determines when this may cease.

AB 109 and MH/SUD

- Under the Public Safety Realignment, counties may use AB 109 funds to provide mental health and substance use disorder treatment and rehab services to offenders who are under community supervision.
- A recent survey of counties conducted jointly by CMHDA and CADPAAC indicated the following results from 52 responses:
  - To the question, what percentage of AB 109 funding is designated for behavioral health services?

	SUD	MH	Co-Occuring	BHS
0%	7	10	28	4
1-5%	7	10	3	6
6-10%	11	12	2	5
11-15%	7			8
16-20%		1		2
21-25%				6
26-30%				2
31-35%				1

AB 109 and MH/SUD

- To the question, what is the mechanism in your county for reimbursement of treatment services provided to clients under AB 109?

	Totals
Direct reimbursement for services through AB 109	4
Contracts through BH departments, invoiced later to AB 109 funds	10
AB 109 paying for staff positions	8
Utilizing AB 109 funds to "match" Medi-Cal	5
Set allocation for services out of AB 109 funds	17
Interdepartmental transfers, journal vouchers, etc.	19
Fee for service for SUD tx services	14

AB 109 and MH/SUD

- To the question, how is treatment need/level determined for AB 109 referrals?

	Totals
BH Access team/unit screens all referrals	22
Probation screens with COMPAS	4
Collaborative screening Probation /BH (MH and/or SUD)	16
ASI	1
ASAM	4
STRONG (probation)	1
Sheriff Office assesses	1
Probation department assesses	10
COJAC	1
AC/OK	1
CAIS	3
ONG	1

AB 109 and MH/SUD

- To the question, what areas of concern do you have in your county for BH treatment services to the AB 109 population?

	Totals
Low referral to treatment	2
Need for other services such as housing, medication, cont. of care, jobs	20
Hiring more staff	2
Case Management	1
Community Supervision	1
Funding	7
Staff Training	2
Compliance and Consistency with other agencies	3
Needs increase/waitlist increase	3
Clients return who require state hospitalization	1

Unknowns/Future Issues

How the state will comply with federal mental health substance use parity requirements, including any impact on “carved out” and realigned MH/SU programs.

The impact of increased enrollment of the Medi-Cal “mandatory” population due to health care reform eligibility rule changes and the ability of counties to absorb the increase.

Contact Information

Patricia Ryan, Executive Director
California Mental Health Directors Association
(916) 556-3477, ext. 108
pryan@cmhda.org

Tom Renfree, Executive Director
County Alcohol and Drug Program Administrators Association of California
(916) 441-1850
tom@slgs.org