



June 3, 2013

TO: Honorable Chair and Members, Budget Conference Committee

FROM: Kelly Brooks-Lindsey, CSAC Senior Legislative Representative
Patricia Ryan, CMHDA Executive Director;
Kirsten Barlow, CMHDA Associate Director, Legislation and Public Policy
California Mental Health Directors Association

SUBJECT: ITEM 4260 Medicaid Expansion: Medi-Cal Specialty Mental Health – OPPOSE

Within the last week, California State Association of Counties (CSAC) and the California Mental Health Directors Association (CMHDA) learned of new Administration proposals related to Medicaid expansion and mental health/substance use benefits. Counties have identified a number of concerns with the proposals, including that they have not been formally presented to the Legislature or heard in a public setting. Counties believe the proposals would exacerbate the long-standing underfunding and uncertainty for mental health services and revenues.

The Administration's proposals and assumptions, as well as the specific details as counties currently understand them, are outlined below, along with our reasons for opposition to each. Counties urge you to carefully consider our concerns as the Legislature and Budget Conference Committee make final decisions on the 2013-14 state budget and Medicaid expansion over the coming weeks.

First, the counties believe the Administration's estimates of county savings to mental health services associated with the Medicaid expansion are overstated. The Administration is projecting that counties will realize \$400 million in savings for mental health services currently provided to indigent adults that will be covered under the Medicaid expansion. The Administration is proposing new county obligations for the non-federal costs of Medi-Cal Specialty Mental Health and Drug Medi-Cal for the Medicaid expansion population based on these savings projections.

While counties' current provision of indigent medical care to individuals who may become covered by Medi-Cal in 2014 may result in county indigent health care savings, counties do not presume county mental health departments will experience substantial savings as a result of Medicaid expansion. Most counties do not currently have sufficient resources to provide mental health care to sizable numbers of indigent individuals who will become Medi-Cal eligible in 2014. Additionally, the Administration used expenditure data from 2007-08 and 2009-10 and trended it forward. Given the Great Recession, this trending does not reflect the realities of county budgets and levels of mental health services to indigent adults during this time period.

In addition, counties will continue to have the full risk and responsibility to provide uncovered services to individuals who may have health coverage, but for whom Medi-Cal does not pay for services when they are delivered to:

- Individuals in Institutions for Mental Disease (IMDs), a type of skilled nursing facility for which federal Medicaid funding is excluded;
- Adults and youth in county jails and juvenile probation settings;
- Individuals identified by law enforcement as being a danger to self/others or gravely disabled under the Lanterman-Petris-Short Act; and
- Individuals who are civilly committed for care in a state hospital.

The only permissible funding source for these uncovered services is 1991 Mental Health Realignment. The Administration's savings estimate does not appear to take into account the rising costs of the remaining responsibilities that are funded with 1991 Realignment funds. Therefore, the Administration's savings estimate is an incomplete estimate of the impacts on county mental health departments will experience as a result of Medicaid expansion.

The Administration is proposing that counties cover the following costs with 1991 Realignment Mental Health Realignment funds.

- **Mandatory Expansion Costs.** Counties will have increased costs for county mental health plans (approximately \$40 million to \$80 million) and the Drug Medi-Cal program (estimate unknown) to provide services to individuals who are currently eligible for Medi-Cal, but enroll after January 1, 2014 as a result of the "mandatory" streamlining and simplification of Medi-Cal enrollment. Only 50% federal matching funds will be available for services provided to these current eligibles.
- **Optional Medicaid Expansion Costs.** The Administration is proposing that counties bear the non-federal share of cost for future year "optional" Medicaid expansion associated with mental health benefits (which the Administration estimates to cost approximately \$30 million) and substance use disorder benefits (which the Administration estimates to cost approximately \$4.2 million). The state's non-federal share for Medicaid expansion will be 2.5 percent beginning in 2016-17, rising to ten percent in year 2020-21.

As a reminder, as part of 2011 Realignment, counties have 100 percent of the financial responsibility and risk for Medi-Cal specialty mental health for existing Medi-Cal eligibles. However, counties negotiated constitutional protections within Proposition 30 of 2012 that require the state to cover the costs of future law changes associated with the programs realigned to counties in 2011. Therefore, counties believe the Administration's proposal would violate those provisions.

- **Enhanced Drug Medi-Cal Services.** The Administration is also proposing that counties, at county option, bear the non-federal share of costs for a proposed expansion of benefits for the Drug Medi-Cal program. Individual counties would have the option to finance and provide both current and newly eligible beneficiaries with an expanded substance use disorder benefit that exceeds California's current Drug Medi-Cal program. The Administration estimates the cost for providing optional Drug Medi-Cal services to be \$5.8 million for new eligibles. However, an estimate of cost to provide the optional services to current eligibles, for whom only 50 percent federal match is available, is still being developed.

The Administration has also identified 2011 Realignment Behavioral Health Subaccount funds as potential funding sources for the new funding obligations. However, when the baseline funding levels were established last year and estimates of growth funds developed, the costs of the optional Medi-Cal expansion or different Drug Medi-Cal benefits were not considered.

Given the substantial unmet needs in California for community mental health services, the substantial volatility and stagnation of 1991 Mental Health Realignment funding over the past decade, and the degree to which counties rely on 1991 and 2011 Realignment revenues to meet their existing obligations, counties strongly oppose these proposals.

Second, county mental health services are still recovering from a decade of insufficient and volatile revenue. Therefore, it is important to understand the following mental health funding context and background in considering the viability of the Administration's proposals.

- Over the past decade, 1991 Mental Health Realignment sales tax and Vehicle License Fee (VLF) revenues have shown significant volatility and stagnation. Specifically, revenues for FY 2013-14 (\$1.145 billion) are projected to be *lower* than levels from 10 years ago in FY 2003-04 (\$1.159 billion), with swings in the tens of millions of dollars each year in between and an overall reduction of approximately \$700 million. It has taken 10 years for this revenue source to recover to FY 2003-04 "base" levels, even though costs and needs grew significantly during that same period.
- Mental Health Services Act (MHSA, Proposition 63) personal income tax revenues – which voters approved to expand, and not supplant, already existing programs – have great annual volatility due to the nature of the tax source. The amount of funds available to counties for the largest MHSA direct service component, Community Services and Supports, has swung by as much as \$200 million per year. For example, MHSA distributions to counties for Community Services and Supports were \$873.2 million in FY 2011-12, then increased by 19 percent to \$1.04 billion in FY 2012-13, and are projected to diminish by 20 percent to \$830.9 million in 2013-14.

Additionally, the state diverted \$861 million in Mental Health Services Act funds in 2011-12 that would have gone to counties to help balance the state budget and pay for the state's Medi-Cal specialty mental health, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health, and special education mental health obligations.

- The 2011 Realignment Behavioral Health Subaccount growth funding distribution that is meant to pay for existing Medi-Cal specialty mental health and Drug Medi-Cal and other substance use programs will grow at a slower rate for the first few years, until a child welfare services funding gap of \$200 million is addressed. If 2011 Realignment revenues do not match caseload increases and costs, it may increase the initial burden on the other dedicated tax revenue sources (1991 Realignment, MHSA) to pay for counties' mental health obligations.
- The costs of providing EPSDT Drug Medi-Cal services to children transitioning from Healthy Families to Medi-Cal were not factored into the Drug Medi-Cal base funding level during 2011 Realignment, and the full costs to the Medi-Cal Specialty Mental Health program from the Healthy Families transition were not incorporated into 2012-13 funding levels.

- County mental health departments continue to experience cash flow problems due to substantial delays in federal financial Medi-Cal reimbursement associated with Short Doyle 2 claims adjudication and cost settlement.

Finally, despite insufficient and volatile revenue, counties must respond to increased demand for mental health services and rising costs.

Since the dedicated sales tax, VLF, and personal income tax revenues that fund counties' obligations for mental health programs depend on the state's economic health, there is no 1:1 relationship between program costs, caseload growth and the revenue sources. In fact, sales and income taxes often trend countercyclical to service needs in entitlement programs. In addition, historical and annual volatility of these revenue sources can substantially impact the accuracy of financial projections.

Despite this, counties' annual Medi-Cal specialty mental health obligations have increased over the past decade by 53 percent, from \$1.974 billion in FY 2003-04 to \$3.022 billion (projected) in FY 2013-14. Additionally, the realignment of low-level offenders, many of whom have mental health needs, has placed new pressures on counties' mental health systems.

The cost of services counties provide with 1991 Mental Health Realignment funds have substantially increased as well. Counties' costs for Institutions for Mental Disease (IMDs) – which are excluded from federal Medicaid reimbursement – have statutorily increased each year by 6.5 percent (FY 2005-06 to FY 2007-08) and 4.7 percent (FY 2008-09 to FY 2009-10, and 2012-13 forward). Additionally, counties' state hospital costs increased in FY 2012-13 by \$20 million. Most recently, the Healthy Families transition to Medi-Cal added approximately 800,000 new beneficiaries to the Medi-Cal program, including those who are eligible for EPSDT specialty mental health services.

In conclusion, since the Medicaid expansion for mental health and substance use expansion will be fully covered by the federal government for three years, there is no urgency to the Administration's proposal to substantially change mental health obligations and funding. The State and counties will have the benefit of time – to see how the Medicaid expansion unfolds and how the delivery and costs of behavioral health services change over the coming fiscal years. There is no imperative to enact funding changes before the full impacts of reform to behavioral health are realized. Further, if California wishes to continue to be a leader in health reform, the state will need to ensure there are adequate resources in our communities to meet the needs of people with mental health disorders. For these reasons, we urge you to reject the Administration's proposals as outlined above.

Please do not hesitate to contact us at (916) 327-7500, ext. 531, kbrooks@counties.org or (916) 556-3477, pryan@cmhda.org, or kbarlow@cmhda.org with any questions or concerns you may have.

cc: The Honorable President Pro Tempore Darrell Steinberg, California State Senate
The Honorable John A. Pérez, Speaker, California Assembly
Honorable Members, Senate and Assembly Budget Committees
Honorable Members, Senate Mental Health Caucus
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