



Date: March 18, 2014

To: Honorable Mark Leno, Chair, and Members, Senate Budget and Fiscal Review Committee  
Honorable Nancy Skinner, Chair, and Members, Assembly Budget Committee  
Honorable Ellen Corbett, Chair, and Members, Senate Budget and Fiscal Review, Subcommittee #3 on Health and Human Services  
Honorable Shirley Weber, Chair, and Members, Assembly Budget Subcommittee #1 on Health and Human Services

From: Robert E. Oakes, Executive Director  
California Mental Health Directors Association

**Subject: CMHDA Fiscal Year 2014-15 Budget Priorities**

On behalf of the California Mental Health Directors Association (CMHDA), which represents the public mental health authorities in counties throughout California, I am writing to communicate CMHDA's top budget priorities for Fiscal Year 2014-15.

#### **State Mandates / 2011 Realignment**

Counties remain committed to providing medically necessary services to the Medi-Cal eligible children and adults in our communities under the new fiscal realignment. It is imperative that counties be adequately funded to meet their obligations for the Medi-Cal Specialty Mental Health (SMH) and Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) programs for which realignment now makes counties responsible. Additionally, as new program requirements are identified, the State must honor its obligation under Proposition 30. CMHDA welcomes continued dialogue with the administration and legislature about funding new responsibilities, including the additional tasks the State is now requiring counties to perform as part of its implementation of the Katie A. v. Bonta settlement (*Katie A.*).

#### Katie A.

State funding for county implementation of *Katie A.* must be sufficient to meet the State's implementation obligations. CMHDA is very concerned about any attempt by the State to expand (through new definitions) or require new programs and/or services that the counties then are made to provide without the State paying for those *Katie A.* budget burdens that, without the State paying its obligations, shifts the costs to counties. If the State redefines (i.e., expands) or requires new programs/services that fall outside of

existing county obligations, the State should pay for those changes. Specifically, All County Letter (ACL) 13-73 States:

*Pursuant to federal and State EPSDT and Specialty Mental Health Services law and their current contract with DHCS [Department of Health Care Services], the MHPs [Mental Health Plans] have an existing obligation to provide Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS). Accordingly, the mental health plans are expected to provide ICC and IHBS services to the subclass as follows....*

The current mental health plan contract does not contain the administrative *Katie A.* implementation requirements outlined in ACL 13-73. To the contrary, negotiations over the most recent mental health plan contract amendment repeatedly referenced the need to amend the contract in 2014 to include the *Katie A.* Implementation Plan requirements. CMHDA was clear during those negotiations that any new *Katie A.* duties must be added to the mental health plan contract as new county obligations, including State funding provided to counties for them to fulfill the State's *Katie A.* settlement agreement. Existing federal and State EPSDT and SMH services law does not require counties to perform all of the Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) included in the Implementation Plan. ICC and IHBS are not existing statutory programs; they were only created to implement the *Katie A.* settlement. While some of the services provided to subclass members as a result of the settlement *may* also be required by existing federal and State law, many of the administrative requirements (e.g., general semi-annual progress reports that include specified statistics) are not in existing State or federal law. ACL 13-73 attempts to impose these new cost obligations to counties through administrative directives for the State to meet its *Katie A.* obligations.

Proposition 30 protects counties from this type of attempted cost shift from the State to counties. Under Proposition 30, counties are entitled to at least 50 percent of cost increases that result from federal settlements or judicial orders, including the Implementation Manuals adopted by the court in *Katie A.* (Cal. Const., art. XIII, § 36(c)(5)(B); Gov. Code, § 30026.5, subd. (e)(3)). Counties are also entitled to funds for cost increases that result from administrative directives not required to implement 2011 Realignment. The new administrative processes outlined in ACL 13-73 (and others that will be issued -- as contemplated by the Implementation Manuals and the Special Master reports) are such administrative directives; they are not necessary to implement any realigned programs. They are designed to meet the specific requirements for reporting and data gathering required from a federal settlement. The State's attempts at characterizing the activities outlined in ACL 13-73 as required by existing law (or included in an existing contract) are wrong. ACL 13-73 imposes new requirements that will increase costs for counties. Funding, from sources besides Proposition 30 revenues, ad valorem property taxes, or the Social Services Subaccount of the Sales Tax Account of the Local Revenue Fund, are therefore required. (Cal. Const., art. XIII, § 36(c)(4)(e)).

Counties are dedicated to providing ICC and IHBS services, which will benefit the *Katie A.* subclass members. As implementation continues, the State must honor its obligations under Proposition 30. CMHDA welcomes continued dialogue with the Department of Health Care Services (DHCS) and the Department of Social Services (DSS) about funding the newly required county tasks as part of the State's *Katie A.* implementation.

## **Drug Medi-Cal**

CMHDA strongly supports the expansion of California's Bridge to Reform Demonstration (Section 1115(a) Medicaid Demonstration Waiver) to try new and innovative organized service delivery system models that improve care, increase efficiency, and reduce costs in the Drug Medi-Cal Program. The Drug Medi-Cal program provides substance use disorder treatment services to Medi-Cal beneficiaries. Funding for the program was realigned to the counties as part of 2011 Public Safety Realignment, but the delivery system remained unchanged. California's Budget Act for Fiscal Year 13-14 substantially expanded the benefits available through the Drug Medi-Cal program; it also expanded eligibility for the entire Medi-Cal program as part of California's implementation of the Affordable Care Act. Given these important changes, an organized delivery system must be created as soon as possible to meet the needs of the thousands of new Medi-Cal beneficiaries potentially seeking substance use disorder treatment.

The Centers for Medicare and Medicaid Services (CMS), as part of the special terms and conditions of the Bridge to Reform Demonstration, required California to develop a detailed plan outlining the steps and infrastructure necessary to meet requirements of a benchmark plan and assure strong availability of behavioral health services -- including substance use disorder services. 2011 Realignment, expanded Medi-Cal eligibility, and expanded Drug Medi-Cal benefits make the expansion of the Bridge to Reform Demonstration more urgent than ever if California is going to offer real access to substance use disorder services.

A demonstration waiver is the best way to increase access to substance use services. A robust service infrastructure will substantially contribute to reducing incarceration recidivism rates because a primary reason for recidivism is substance use. The Bridge to Reform Demonstration is California's best opportunity to create an organized substance use disorder service delivery system that improves public safety by increasing the coordination of mental health and substance use disorder services to better support offender re-entry into the community.

## **Corrections**

### Mentally Ill Offender Crime Reduction Program (MIOCR)

The original Mentally Ill Offender Crime Reduction Program (MIOCR) proved successful -- collaboration with law enforcement to deliver mental health services reduces incarceration and recidivism rates of persons with mental illness. Though MIOCR was dismantled due to budget constraints, the legislature can now fund the rebuilding and expansion of this successful, cost-effective program across California. CMHDA strongly supports MIOCR; it is now more important than when originally created. Public Safety Realignment makes it necessary that evidenced based mental health services are delivered in full collaboration with sheriffs, probation, and community based organizations -- a cornerstone of MIOCR. The original MIOCR program succeeded in addressing important public policy issues, including access to treatment for persons with mental illness and improving public safety. The proposed \$50 million (\$25 million for adults and \$25 million for juvenile justice) is the minimum investment that should be made. CMHDA members recommend a MIOCR investment of \$100 million for adults and \$25 million for juvenile justice.

Other considerations

Realignment and expanded Drug Medi-Cal means counties will confront serving some of the most challenging individuals in their communities. California has the opportunity to realize increased public safety, lower costs, and improved human lives. To succeed, a continuum of services must be expanded and improved. Stable housing options that allow each county the flexibility necessary to meet its unique housing needs, and other “wrap-around” services, will be needed to maximize the return on the State’s investment. CMHDA, working in collaboration with the California State Association of Counties (CSAC) and its other affiliates, welcomes dialogue with the legislature to explore potential one-time “incentive” investments that build the service continuum.

**State Hospitals**

CMHDA and the California Mental Health Service Authority (*CalMHSA jpa*) have been working with the California Department of State Hospitals (*DSH*) the last year to address rates and access to Lanterman Petris-Short (*LPS*) civil commitment beds. The 1991 Mental Health Realignment makes counties responsible for reimbursing the State for the daily cost of LPS beds when the county places an individual under the mental health conservatorship provisions of the LPS Act. These discussions have been productive, and CMHDA gratefully acknowledges the efforts of DSH leadership to address concerns. The counties and the State are close to finalizing a Memorandum of Understanding (*MOU*) that provides for the use of, and reimbursement for, LPS beds.

**Mental Health Services Act**

The Mental Health Services Act (*MHSA*) funded programs are inextricably intertwined threads of county mental health services. Counties are eager to meet the Act’s mandate for alternatives to expensive and inappropriate services for individuals in crisis, as evidenced by the strong response to the Mental Health Services Oversight and Accountability Commission’s (*MHSOAC*) administration of Triage Personnel Grants. Qualified county applications for these grants to fund intervention teams of personnel for crisis outreach far exceeded the available funding, underscoring the need for continued funding for this critical need. The unexpended funds (\$19 million) only exist because of mid-year awarding of the grants, so that at annual full funding (\$32 million) for this program would have exceeded the State’s 5% cap on MHSA administrative expenditures in Fiscal Year 13-14. CMHDA strongly urges that the balance of unexpended funds roll-over and fund qualified counties in the next fiscal year.

The grant program administrated by the California Health Facilities Financing Authority (*CHFFA*) will also assist counties in addressing serious gaps in emergency care and programs in California. CMHDA supports full funding for this program.

Peer Respite

California now lacks “pre-acute crisis” options for people who want help when they need it. With nowhere to turn when they know they need support, they are not served until full-blown crisis acute hospitalization occurs.

**Mental Health Services Act - continued**

Three peer respite programs are already running in Los Angeles and Santa Cruz counties. Several other counties hope/plan to implement peer respites. Many consumer-operated service programs/agencies exist that could efficiently implement these programs; however, start-up funding and costs of evaluation are challenging to secure.

CMHDA proposes a one-time program, funded over four years, to provide core support through peer respite for people experiencing psychological distress who do not initially meet the threshold for involuntary hospitalization but will if their illness is left untreated (and at much higher taxpayer cost). Peer respite programs also provide a critical link for people with lived experience, employing them (giving them work experience, income, and a sense of purpose and value) while filling a gap in low cost services for people experiencing a mental health condition.

Programs	\$18.0M	(funding for 4-5 peer respite programs across the State over four years)
Evaluation	\$ 1.25M	(evaluation of peer respites, health economics and recovery outcomes)
Quality Improvement/Learning	\$ .75M	(Statewide "Peer Respite Learning Collaborative")

Peer supportive programs cost-effectively help people with mental health conditions succeed; enhance employment opportunities for peers; promote recovery for individuals with lived experience; and offer crucial resources for consumers that promote prevention, early intervention, and recovery.

Peer specialists in mobile crisis outreach, support roles on inter-disciplinary teams, and peer respite houses offer opportunities for positive engagement, self-help, and symptom management. Peer supports are evidence-based programs as defined by the Substance Abuse and Mental Health Services Administration. Peer respite services, as operated by mental health, consumer-run organizations put people to work, and intervene at a lower cost point-in-time for individuals in distress.

Acute psychiatric inpatient and related urgent/emergency services are among the highest cost services. The majority of hospital/psychiatric health facilities only take individuals who are LPS or on a 5150 hold. High human resource, public safety, and law enforcement costs are built into acute care response, and most people experiencing intense psychological distress have little, if any, options if they are not at imminent risk to themselves, others, or gravely disabled. Trained peer specialists who have been through their own intense crisis work in a supportive environment are uniquely qualified to help others going through crisis.

