



May 14, 2012

TO: CMHDA Members

FROM: Patricia Ryan, Executive Director
Kirsten Barlow, Associate Director, Legislation and Public Policy

SUBJECT: Governor's FY 2012-13 May Revise

This morning, Governor Jerry Brown released his May Revise State Budget proposal for fiscal year 2012-13. This memo provides a preliminary description of the provisions that will impact community mental health programs and the communities they serve. As of this writing, only the Governor's May Revise "Summary" has been made available to the public. Once additional details and anticipated trailer bill language related to the fiscal structure of 2011 realignment are made available, we will provide you with additional details. For your reference, the Governor's state budget proposals are available online at <http://www.ebudget.ca.gov>. As always, if you have any questions about the budget, please feel free to contact us at (916) 556-3477, pryan@cmhda.org or kbarlow@cmhda.org.

Overall Budget Picture

The Governor's May Revise presents a significantly larger 2012-13 state budget deficit of \$15.7 billion, compared to the \$9.2 billion deficit estimated in the January Budget. The deficit grew since January due to three primary factors: (1) the January revenue forecast for tax revenues was \$4.3 billion too optimistic; (2) year-over-year state revenue increases now obligate the state to spend \$1.2 billion in additional General Funds toward the Prop. 98 guarantee for education; and (3) the federal government and courts have blocked \$1.7 billion in earlier proposed budget reductions that would have imposed Medi-Cal co-pays, reduced Medi-Cal provider rates, and imposed In Home Supportive Services (IHSS) provider fees.

Altogether, the Governor proposes to balance the 2012-13 state budget through cuts (representing half the solution), over a third (35%) through the November initiative's temporary taxes and other revenues, and 15% through other mechanisms (loan repayment extensions, transfers and loans from special funds, etc.). The proposal continues to rely significantly on passage of the Governor's November ballot measure, which is estimated to generate \$8.5 billion through temporary personal income tax increases on the wealthiest taxpayers, and by one-half percent increase to the sales tax. These revenues will benefit the General Fund by \$5.6 billion by providing funds for 2011 realigned programs, while also enabling the state to meet its current Prop. 98 obligations and increase by \$2.9 billion the funding available for schools and community colleges.

The Governor proposes \$4.1 billion in spending reductions that are *in addition to* those proposed in January to address the widening budget deficit. These include using local reserves to offset state costs for local trial courts on a one-time basis, a 5% reduction to the costs of the state employee payroll to be achieved through furloughs, and additional reductions to health and welfare, described later in this document.

The Governor's May Revise would reduce the University of California budget by \$38 million more (which would likely result in higher tuition for students), and make additional cuts to Cal Grants for low-income students. Additionally, the May Revise maintains the Governor's January proposals for additional "trigger cuts" to schools and higher education on January 1, 2013 if voters reject the November ballot initiative. If the initiative fails, funding for schools and community colleges would be reduced by \$5.5 billion, funding for UC and CSU would each be reduced by \$250 million, and a variety of public safety programs in the areas of forestry, fire protection, fish and game, and parks would be reduced.

2011 Realignment Baseline Allocations

As you may recall, the Governor's January Budget included a proposed permanent funding structure for the 2011 Realignment base and growth funding, as well a conceptual framework for realignment growth funding and a reserve account. It is our understanding that the Administration plans to issue additional details and a budget trailer bill later today. CMHDA will provide members with this information as it becomes available. Below is information that was included in the Governor's May Revise Summary, which provides updated figures from the Governor's January Budget baseline allocations for each of the realigned programs.

Note that the funding base for each of the programs included in 2011 Realignment will ultimately become a "rolling base" in which the prior year's allocation level – plus growth – will become the new base allocation level for the following year. The base for all programs realigned in 2011-12 was established that fiscal year, while the base for Medi-Cal Specialty Mental Health and EPSDT will be established in the budget year, since these programs are not realigned to counties until 2012-13.

The May Revise provides updated amounts of Realignment 2011 funding to be allocated to realigned programs, including Medi-Cal Specialty Mental Health, EPSDT, and 1991 Mental Health Realignment. In Fiscal Year 2012-13, the May Revise provides \$4.3 million more than the January Budget in net additional funding for the three realigned mental health programs. As illustrated in the table on the following page, the May Revise figures compared to the January figures for 2012-13 provide \$7.9 million more for Mental Health Managed Care, \$40.2 million more for EPSDT, and \$43.8 million less for existing 1991 mental health responsibilities. While the allocation for 1991 mental health is less than the January budget provided, dedicated growth is proposed to be provided as well.

In addition to modifying the baseline allocation levels for mental health realignment, the May Revise increased the allocation for Substance Use Treatment programs by \$3.9 million (from \$179.9 million to \$183.6 million), and increased the allocation to Foster Care, Child Welfare Services, and Adult Protective Services by \$5.5 million (from \$1.616 million to \$1.622 million). The May Revise notes that the allocations for Foster Care and Child Welfare in 2012-13 through 2014-15 reflect the costs for counties to expand foster care eligibility (phased in over the three year period) up to age 21, as authorized by AB 12 signed into law in 2010. The May Revise indicates that these funding levels for 2012-13 are higher than estimated costs, but that this will

better position counties to adapt to future caseload changes in these federal entitlement programs.

Funding for Mental Health Realignment: Comparison of Governor's January and May State Budget Proposals (Dollars in millions)

	Fiscal Year 2011-12		2012-13 and Subsequent Fiscal Years	
	Jan. Budget	May Revise	Jan. Budget	May Revise
Mental Health Managed Care	-	-	\$188.8	\$196.7
EPSDT	-	-	\$544.0	\$584.2
1991 Mental Health	\$1,104.8	\$1,083.6	\$1,164.4	\$1,120.6
TOTAL	\$1,104.8	\$1,083.6	\$1,897.2	\$1,901.5

State Reorganization of Mental Health Administration

The Governor's May Revise Summary continues his proposal to eliminate the Department of Mental Health (DMH) and establish the Department of State Hospitals. The May Revise Summary does not include new or additional details about the state reorganization of mental health or substance use disorder administration, and notes that the state hospital population is projected to reach 6,439 in 2012-13.

Mental Health Services Act (MHSA) Projects

The Governor's May Revise Summary provides an increase of \$15 million in Mental Health Services Act (MHSA) funds for the Department of Public Health (DPH) in 2012-13 for the California Reducing Disparities Project, along with the following statement: "...with the intent of providing a total of \$60 million toward the project. This funding continues statewide efforts to improve access to mental health services and quality of care, and increased positive outcomes for underserved communities." While additional details about this proposal were not released with the Governor's May Revise Summary as of this writing, CMHDA was contacted by the Administration and provided with the additional explanation of the Governor's May Revise proposal:

- The Governor's January Budget proposed to amend the Mental Health Services Act to appropriate \$60 million in county MHSA funds to the Department of Public Health's proposed and newly created Office of Health Equity for the California Reducing Disparities Project (CRDP), as well as to provide MHSA funds to the Office of Statewide Health Planning and Development (OSHPD) for Workforce Education and Training (WET) projects.
- CMHDA and others expressed concern about the precedent of amending the Act in this manner.
- The Governor's May Revise proposes to appropriate \$60 million over four years (\$15 million per year) in MHSA *state administrative funds* to DPH. This appropriation of MHSA funds will keep the state's support of the project under the statutory limit of 3.5% of MHSA funds that can be expended by state agencies for implementation of MHSA.

The authority for DPH to appropriate these funds will be provided through budget bill language, and will not result in amending the MHSAs statutes.

- Similarly, the Governor proposes to provide OSHPD with appropriation authority through budget bill language, rather than amending the MHSAs statutes. According to the Administration, the Department of Mental Health (DMH) recently conducted a reconciliation of MHSAs-WET funds, which concluded that a total of \$444 million in MHSAs revenues were available over four years to be expended on WET. The California Mental Health Planning Council's five-year WET plan apparently identified investments that were \$6 million short of this figure. The Governor proposes to ensure OSHPD will comply with the MHSAs statutes and devise a plan for expending these \$6 million in available MHSAs-WET funds. Additionally, the recent DMH MHSAs-WET reconciliation identified \$9 million in available MHSAs-WET revenues, which will be expended to support regional partnerships in FY 2014-15.

CMHDA will provide further information to members, as any additional details about the Administration's proposals related to MHSAs become available.

Healthy Families and Managed Risk Medical Insurance Board (MRMIB)

In January, the Governor proposed to reduce Healthy Families managed care rates by 25.7% (effective October 1, 2012), transfer approximately 875,000 Healthy Families Program beneficiaries to Medi-Cal over a 9-month period, beginning October 2012, and to eliminate MRMIB. As we noted in January, this transition of Healthy Families enrollees to the Medi-Cal program will presumably impact the EPSDT program.

The May Revision maintains this proposal, but reflects a lower General Fund savings estimate of \$48.6 million (compared to \$64.4 million), primarily due to revising the per-member, per-month average cost of a Medi-Cal beneficiary from \$76.86 to \$83.91. According to the May Revision Summary, this new rate "includes additional administrative costs and accounts for mental health benefits that are carved out of the Medi-Cal managed care rate." CMHDA will seek additional information about this proposal and the extent to which the May Revision has provided sufficient funding for EPSDT to account for this population shift in the Governor's proposed Realignment 2011 allocations.

In-Home Support Services (IHSS) Reductions

The January budget proposed \$1.4 billion for the IHSS program in 2012-13, which included a reduction of \$292.3 million from 2011-12 to be achieved by eliminating domestic and related services for certain recipients and a 20% across-the-board reduction in IHSS hours (presuming success in the pending court injunction). The May Revision provides a much lower decrease to IHSS, but would still decrease General Fund spending on IHSS by \$99.2 million through a 7% across-the-board reduction in service hours, effective August 1, 2012. Additionally, the May Revision reflects saving \$125.3 million General Fund from eliminated domestic and related services for beneficiaries in a shared living arrangement.

Coordinated Care Initiative for Dual Eligible Beneficiaries

The January budget proposed a Coordinated Care Initiative (CCI) to improve care coordination for seniors and persons with disabilities, including "dual eligibles" who are eligible for both Medi-Cal and Medicare. The January budget proposed to have the same health plan responsible for all of a dual eligible person's services over three years, with long-term care

benefits integrated into the single benefit package during the first year. All counties would implement managed care. Additionally, the January budget proposed to expand the existing dual eligible beneficiary pilot from four to ten counties, over a three-year period.

The May Revise continues to propose a CCI for dual eligible beneficiaries, but with some changes. Specifically, the long-term care benefits would be phased in as each county transitions to managed care, and the dual eligible pilot would be expanded to eight (not ten) counties. The start date would be delayed from January 1, 2013 to March 1, 2013, and counties would continue their role in assessing and authorizing IHHS hours. In addition, consumers would continue to select and direct their providers. County-specific maintenance of effort levels would hold county expenditures at the estimated level, absent the CCI. The modified proposal would save the state \$663.3 million in 2012-13, and \$887 million once fully implemented.

Medi-Cal Savings Associated with Hospitals and Nursing Homes

The May Revise includes several new 2012-13 General Fund Medi-Cal savings proposals that would impact hospitals and nursing homes, including:

- Reduce supplemental payments to private hospitals, eliminate public hospital grants, and eliminate increases to managed care plans for supplemental payments to designated public hospitals (\$150 million);
- Split equally between the state and designated public hospitals (rather than provide the funds exclusively to the hospitals) all unexpended prior year 1115 "Bridge to Reform" Waiver funds (\$100 million);
- Align non-designated hospital Medi-Cal funding with the designated public hospital funding methodology for inpatient Medi-Cal fee-for-service (\$75 million); and
- Rescind the 2% rate increase authorized in current law for nursing homes, while continuing the maximum amount of fee revenue collection (\$47.6 million). CMHDA members should note that this does not address the requirement that counties provide skilled nursing facilities licensed as Institutions for Mental Disease (IMDs) with a 4.7% rate increase in FY 2012-13. As you may recall, CMHDA successfully sponsored a bill that froze IMD rates for two years (from July 1, 2010, to June 30, 2012). However, current law will reinstate the mandatory IMD rate increase on July 1, 2013.

Also of note in the Medi-Cal area is a proposal to provide \$40 million in First 5 California Children & Families Commission funds to support the Department of Developmental Services Early State Program for children ages birth through five.

California Work Opportunity and Responsibility to Kids (CalWORKs) Redesign

The January budget proposed sweeping changes to redesign the CalWORKs program, resulting in nearly \$1 billion in GF savings. The Governor's May Revise did scale back on some of his original January proposals for CalWORKs, but General Fund savings in 2012-13 are still estimated at \$879.9 million. CalWORKs policy changes in the May Revise include:

- Allowing work participation to be met through any combination of state-allowable work activities in the first 2 years and federally-allowable activities for up to 4 years (rather than solely through paid employment);
- Eliminating the retroactive county of previously exempt and sanctioned months toward the 4-year time limit; and
- Starting Oct. 2012, implementing a phased in approach to reengage cases previously exempted.

Corrections and Rehabilitation

The May Revise provides a comprehensive description of the Governor's proposals for Department of Corrections and Rehabilitation (CDCR) funding. Given the significant interaction between state prisons, local jails, and local health and social services due to 2011 Realignment, a few highlights from the May Revise Summary that may be of interest to county mental health departments are provided below:

- The Administration released a comprehensive plan in April 2012 to save billions of dollars, end federal court oversight, and improve the prison system. [This plan is available online at: <http://www.cdcr.ca.gov/2012plan/index.html>]. As part of this plan:
 - CDCR will establish reentry hubs with concentrated programming resources at existing prisons to better prepare inmates as they near release. Within the first year of release, approximately 70% of parolees who need substance-abuse treatment, employment services, or education will have access to these programs.
 - The plan includes trailer bill language that requires the Department of Finance - Office of State Audits and Evaluations to monitor CDCR's implementation of this plan and provide annual reports to the Governor and Legislature.
- As a result of public safety realignment, the active adult parolee population is projected to decline to approximately 30,000 offenders by 2015-16.
- In May 2012, the state filed a report to terminate the Receivership that, in 2006 under the *Plata v. Brown* case, appointed a Receiver with full authority over prison medical care.
- The May Revise retains the CDCR-Division of Juvenile Justice (DJJ) for the housing and treatment of the most serious and violent juvenile offenders. In order to balance the state budget, the May Revise proposes the following efficiencies:
 - Reduce administrative staff at headquarters and DJJ facilities;
 - End juvenile parole on January 1, 2013 (instead of July 1, 2014);
 - Reduce DJJ's age of jurisdiction from 25 to 23 years old; and
 - Implement a new fee structure to charge counties \$24,000 per year for each offender committed by a juvenile court to the DJJ.
- Under the 2011 Budget Act, the Board of State and Community Corrections was established, effective July 1, 2012. The Board will assume previous functions of the Corrections Standards Authority, as well as other public safety programs. The Board will be "*coordinating with and assisting local governments as they implement the realignment of many adult offenders to local government...*"



May 25, 2012

TO: Honorable Chair and Members, Senate Budget Subcommittee #3
Honorable Chair and Members, Assembly Budget Subcommittee #1

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

SUBJECT: Governor's May Revise for 2012-13: 2011 Realignment

On behalf of the California Mental Health Directors Association (CMHDA), which represents the directors of public mental health authorities in counties throughout California, we are writing to communicate our perspective on the Governor's May Revise proposals for FY 2012-13 related to 2011 Realignment, and our concerns about the consequences for California's community mental health system.

Enacted through the 2011 Budget, "Public Safety Realignment" moves program and fiscal responsibility for a number of programs, including Medi-Cal Specialty Mental Health, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), from the state to counties, with a dedicated revenue source for the programs. While CMHDA has been generally supportive of 2011 Realignment, we have continuously communicated the importance of adequate funding for the realigned mental health programs, which are federal entitlements.

We appreciate the Administration's May Revise updates to the 2011 Realignment funding allocations for 2012-13, which would provide \$7.9 million more for Mental Health Managed Care and \$40 million more for EPSDT than was proposed in the January Budget, to more accurately reflect caseload and other cost factors of those programs.

However, the Realignment Fiscal Superstructure trailer bill (#1009) significantly changes the approach to funding the "Mental Health/CalWORKs Swap" enacted in the 2011 Budget. **We are concerned that this change reintroduces a significant amount of unpredictability for 1991 community mental health funding. It could also result in substantially diminished funding for counties' ongoing 1991 Realignment mental health responsibilities, as compared to FY 2011-12, unless the 2011-12 1991 realignment funding is considered to be our new base for 2012-13.**

The Mental Health/CalWORKs Swap Enacted in 2011-12

Last year, 2011 Realignment legislation enacted a "Mental Health/CalWORKs swap" that changed the revenue source for counties' 1991 Realignment mental health responsibilities in order to provide funds for a new, increased county share of CalWORKs grants. Specifically, current statute provides that counties' 1991 Realignment mental health responsibilities are now to be funded by a guaranteed, specific amount (\$90.3 million/month in FY 2011-12) from the

new Local Revenue Fund 2011 -- rather than receive funding from 1991 Realignment Vehicle License Fee and sales tax revenues. The freed-up 1991 Realignment funds were then provided to counties for a new, increased share of CalWORKs grant costs. Since this was a change to the revenue source and a specified level of funding was provided to counties on a monthly basis, this swap was intended to have no detrimental effects on the community mental health system. The legislation enacted last year, and all communication we have had with the Administration since then, had led us to believe this approach would be ongoing in future years. Despite the fact that much of the legislation for 2011 Realignment from last session only addressed Fiscal Year 2011-12, the budget trailer bill (AB 118) required this approach to *begin* in the 2011-12 Fiscal Year.

The Administration's Proposed Change to the Mental Health/CalWORKs Swap

The Realignment Superstructure trailer bill would significantly change the approach to funding the mental health/CalWORKs swap enacted last session by providing an undetermined amount of 1991 Realignment funds to counties for their 1991 mental health responsibilities, and the county share of CalWORKs grants would be funded with a guaranteed, specific amount (\$93 million/month) of Local Realignment Fund 2011 funds.

The May Revise indicates that the Administration anticipates that 1991 VLF and sales tax revenues will generate \$93 million per month for 1991 community mental health services, making it appear that this is an "equal" swap. However, by simply looking at how those revenues performed this year, our more conservative projections are that the 1991 Realignment revenues would likely be 5-9% lower than this, which would mean that counties would receive between \$50 million and \$100 million less in 1991 mental health realignment funding in 2012-13 than they are receiving this year. While the May Revise would provide a dedicated level of Local Revenue Fund 2011 "growth funds" to 1991 mental health (5%), the Administration projects this would likely be only about \$7 million statewide in 2012-13.

Potential Impact on Local Communities

This potential loss to 1991 community mental health resources could have substantial consequences in our communities. As a reminder, counties use 1991 mental health Realignment funds to pay for long-term treatment for those who are civilly committed in state hospitals and community facilities, as local match for Medi-Cal Specialty Mental Health and EPSDT services, for indigent mental health services, and for emergency and crisis response services on which all Californians in mental health crisis rely. For some of these functions, no other funding source available to counties can be used.

Our concern about this potential loss in 1991 mental health Realignment resources is compounded by the uncertainty about the overall adequacy of resources being provided to counties for 2011 Realignment. For example, while the May Revise factored in a projected cost for counties to implement the *Katie A.* lawsuit and absorb thousands of Healthy Families beneficiaries into EPSDT, the true costs of new beneficiaries is not known today. Also, the effect of the interaction between Drug Medi-Cal and Medi-Cal mental health entitlement programs within the 2011 Realignment "Behavioral Health Subaccount" is also unknown. Drug Medi-Cal costs are unpredictable, it is not a managed care program, and many significant aspects of it are controlled by the state, rather than the counties. Lastly, the Administration has indicated that counties will be able to use Realignment growth funds to deal with cost or caseload increases in realigned programs. However, since the Administration's proposal establishes a multi-year priority for growth funds to provide \$200 million of additional funding for realigned child welfare

services, counties will not receive the full proportion of growth funds for Medi-Cal Specialty Mental Health, EPSDT, Drug Medi-Cal and other realigned alcohol and drug programs within the Behavioral Health Subaccount for a number of years.

Additionally, the Realignment Superstructure Trailer Bill prohibits the use of the new 2011 Realignment sales tax revenues deposited into the Behavioral Health Subaccount for the "required" ten percent match on new EPSDT growth. This further increases the uncertainty as to how each county will address the needs of EPSDT eligible children and the increases in caseload associated with the Healthy Families Program transfer, as well as implementation of the Katie A. lawsuit settlement. While CMHDA acknowledges that counties have had an historical maintenance of effort and share of cost on growth obligation for the EPSDT program, we are concerned that the current manner in which this is written could cause unintended and administratively burdensome financial auditing consequences for counties. Also, the current language references a "required" 10% county match on any "new" growth to EPSDT. We are concerned that this implies that counties will be responsible for not only the county match requirements in existence today, but also "new growth" in the future. CMHDA has proposed to the Administration alternative language that we believe better defines this baseline obligation in the context of 2011 Realignment (see attached).

We respectfully request that the Legislature carefully consider the impact of these new Realignment Superstructure proposals that could significantly impact counties' ability to manage, on behalf of the state, both 1991 and 2011 Realignment responsibilities. Please do not hesitate to contact us at (916) 556-3477, pryan@cmhda.org, or kbarlow@cmhda.org with any questions or concerns you may have.

cc:

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Jane Adcock, Executive Director, California Mental Health Planning Council
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May 29, 2012

To: County Administrative Officers and County Executives

From: Paul McIntosh, Executive Director

RE: **Realignment Superstructure: 2011 and 1991 Interactions**

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CSAC has received questions from counties about the interaction between the 1991 realignment and the 2011 realignment, specifically as it pertains to mental health. This memo is intended to clarify how the 2011 realignment superstructure is crafted, which is consistent with the Administration's previously stated intention that the 1991 Mental Health Subaccount (Community Mental Health) would receive funding equal to what it would otherwise have received from 1991 Realignment revenue streams.

How Funds Flow Between 1991 and 2011 Accounts and Subaccounts

- \$93.4 million is deposited each month into the Mental Health Account of the Local Revenue Fund 2011.
- \$93.4 million is deposited each month from the Mental Health Account of the Local Revenue Fund 2011 into the 1991 Realignment Mental Health Subaccount.
- \$93.4 million is deposited each month from the 1991 Realignment Mental Health Subaccount into the CalWORKs MOE Subaccount.
- 5 percent of the Supportive Services Growth will be deposited into a Mental Health Growth Subaccount in the 1991 Realignment structure. This growth will not be used for purposes of calculating 1991 Realignment growth.

It has come to our attention that there is confusion about the \$93.4 million. The \$93.4 million is not a guarantee for the 1991 Mental Health Subaccount. Net funding for the 1991 Mental Health Subaccount will be what it would have otherwise received with 1991 Realignment revenue sources (as if 2011 revenues were not being deposited into that subaccount). For FY 2012-13, counties should be estimating funding for the 1991 Mental Health Subaccount (Community Mental Health) using projections of 1991 sales tax and VLF.

It is very likely that the 1991 Realignment Mental Health Subaccount funds will decline from 2011-12 to 2012-13. The 2011-12 Community Mental Health funds were artificially inflated due to the structure of AB 118 (realignment implementing legislation from 2011), which was intended to partially compensate for the one-year diversion of Proposition 63 funds in another portion of last year's state budget.

Please keep this in mind as you plan your 2012-13 budgets. If you have additional questions, contact Kelly Brooks of our staff (kbrooks@counties.org or 916-327-7500, ext. 531).

Reorganization of Department of Mental Health Functions

Future placement of DMH Community Mental Health functions, programs, funding, and positions

Function or Program	Recipient Department	State Operations	Local Assistance	Positions	Total
<ul style="list-style-type: none"> • Certification Compliance for <ul style="list-style-type: none"> ➢ Crisis Stabilization Units (CSUs) ➢ Skilled Nursing Facilities with Special Treatment Programs (SNFs/SSTPs) ➢ Social Rehabilitation Program/Community Residential Treatment systems (CRTs) ➢ Community Treatment Facilities (CTFs) • Data Management Client Services Information system (CSI) & Data Collection and Reporting system (DCR) • MHSA Legal, Fiscal, and Policy <ul style="list-style-type: none"> ➢ Regulations & County Notification Clean-up ➢ Legislative Reports • MHSA Housing Program, Administrative Staff -- Accounting • Mental Health Services Act (MHSA or Prop 63) Issue Resolution • Office of Suicide Prevention • MHSA Student Mental Health Initiative • MHSA Stigma and Discrimination Reduction Project • Veterans Mental Health • Substance Abuse and Mental Health Services Administration (SAMHSA) grants: <ul style="list-style-type: none"> ➢ Community Mental Health Services Block Grant (MHBG) ➢ Projects for Assistance in Transition from Homelessness (PATH) ➢ Data Infrastructure Grant (DIG) ➢ Olnstead grant • Training Contracts -- California Institute for Mental Health (CiMH) • California Health Interview Survey (CHIS) • Policy Management • Administrative Staff -- IT • The California Mental Health Planning Council (CMHPC) • County Cultural Competence Plan Requirement (CCPR) 	Department of Health Care Services (DHCS)	\$11,086,000	\$61,235,000	41.0	\$72,321,000
<ul style="list-style-type: none"> • Licensing Mental Health Rehabilitation Centers • Licensing Psychiatric Health Facilities • Approval of Lanterman-Petris-Short (LPS) Act County Designated Facilities (WIC 5150/5685 55) 	Department of Social Services (DSS)	\$1,124,000	\$0	12.0	\$1,124,000

Reorganization of Department of Mental Health Functions

Future placement of DMH Community Mental Health functions, programs, funding, and positions

Function or Program	Recipient Department	State Operations	Local Assistance	Positions	Total
<ul style="list-style-type: none"> Training Contracts (Consumer Groups, MHSA Technical Assistance, and MHSA Program Evaluation) 	Mental Health Services Oversight and Accountability Commission (MHSOAC)	\$1,651,000	\$0	0.0	\$1,651,000
<ul style="list-style-type: none"> Office of Multicultural Services Cultural Competence Advisory Committee California Reducing Disparities Project (CRDP) -- (7 contracts currently funded with \$1.5 million on-going MHSA state administrative funds for Ethnically and Culturally Specific Programs and Interventions) CRDP Prevention Early Intervention Statewide Project - DMH Information Notice 07-19, delineates \$15 million per year for four years (\$60 million total) to be set aside from the MHSA PEI component Translation Contract Multi-Provider (Cultural Competence Consultant Contract) Cultural Competence and Interpreter Training Contracts 	Department of Public Health (CDPH)	\$2,349,000	\$0	4.0	\$2,349,000
<ul style="list-style-type: none"> Early Mental Health Initiative (EMHI) 	Department of Education (CDE)	\$0	\$15,000,000	0.0	\$15,000,000
<ul style="list-style-type: none"> Mental Health Services Act Workforce Education and Training (WET) Contracts: <ul style="list-style-type: none"> > Stipends (11, one of which is monitoring students) > Psychiatric Residency (3) > Statewide Technical Assistance Center (1) 	Office of Statewide Health Planning and Development (OSHPD)	\$105,000	\$12,150,000	1.0	\$12,255,000
TOTALS		\$16,315,000	\$88,385,000	58.0	\$104,700,000



CMHDA/CADPAAC Joint Policy Statement Regarding Proposed State Department Reorganization

May 2, 2012

California counties have increasingly recognized the value of coordinating and integrating mental health and substance use disorder services at the local level in order to provide more efficient and effective services to their residents – particularly those who have co-occurring mental health and substance use disorders. Today, over 50 of California's 58 counties have organized and integrated their mental health and substance use disorder services under a "Behavioral Health" division. Many counties combine these functions under a Health Agency model, recognizing that serving the whole person in an integrated health care system makes sense for their communities, and is consistent with the goals outlined in the federal Patient Protection and Affordable Care Act (PPACA).

Given what is already happening in most counties, we can appreciate the positive potential of the Administration's reorganization proposal to consolidate and integrate many of the state Mental Health and Alcohol and Drug Program administrative functions into a new division of Mental Health and Alcohol and Drug Programs at the Department of Health Care Services (DHCS). We believe this proposal – ***if appropriately implemented*** – can help both state and local governments meet the immediate and near future challenges posed by federal health reform, mental health parity, 2011 realignment, etc.

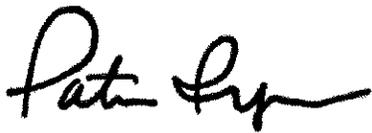
Further, CMHDA and CADPAAC jointly support a state reorganization that will preserve the MH & SUD continuums of care (including prevention and early intervention), and promote wellness and recovery. Our fields have too often developed outside of the traditional health care system, largely because of stigma and discrimination. The fact is, mental health and substance use disorders are the major under-addressed health issues of our time. Undiagnosed and untreated MH & SU disorders drive the preventable costs of the medical care system, child welfare system, criminal justice system, and others. The goals of health care reform and efficient federal, state and local government cannot be realized without a strong and comprehensive system of care for both fields. The state's reorganization should be focused on how to address these issues effectively.

Again, how this proposed reorganization is implemented is critical to its success. CMHDA and CADPAAC support a division at DHCS for Mental Health/Substance Use Disorder services that would preserve the integrity of both fields, but also foster better policy and program coordination for those individuals who have co-occurring mental health and substance use disorders. Mental health (MH) and substance use disorder (SUD) services should each maintain a distinct identity at the state level, while supporting collaboration on integrated services at the state and local levels. This includes not only integrated co-occurring services for MH & SUD, but also integration of both fields with primary care.

Regardless of where our services end up being located in state government, it is critical that there is a strong and effective statewide voice on MH and SUD policy. Also, given the additional responsibilities assumed by counties under realignment, it is imperative that state MH/SUD leaders will be responsive to and work closely with counties. Effective leadership at DHCS requires Deputy Director and Director-level leaders who:

- Are experienced and articulate in both MH and SUD issues, who have demonstrated knowledge and credibility in MH & SUD and will be strong statewide advocates for both fields;
- Have the ability to move our fields forward in health care reform;
- Can provide direction across all state departments that are affected by MH & SUD;
- Understand and can address federal issues (such as federal Maintenance of Effort requirements for SUD, federal mental health parity, maximizing federal reimbursement, etc.), and can develop linkages to federal structures;
- Can improve administrative efficiencies and provide common solutions to information technology implementation.
- Will be strong voices in addressing cultural disparities.

CMHDA and CADPAAC look forward to working closely with the Administration and the Legislature to proactively and collaboratively accomplish these goals. If you have questions about this statement, please feel free to contact Patricia Ryan at pryan@cmhda.org, or Tom Renfree at tom@slgs.org.



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State of California HEALTH AND HUMAN SERVICES AGENCY



DIANA S. DOOLEY
SECRETARY

Coordination and Policy Leadership:

Reorganization of the Department of Alcohol and Drug Programs

At the May Revision, the Administration maintains its proposal to consolidate the functions of the Department of Alcohol and Drug Programs (ADP) in departments within the Health and Human Services Agency.

Program Consolidation and Policy Leadership at DHCS

- Aging
- Alcohol and Drug Programs
- Child Support Services
- Community Services and Development
- Developmental Services
- Emergency Medical Services Authority
- Health Care Services
- Managed Risk Medical Insurance Board
- Mental Health
- Public Health
- Rehabilitation
- Social Services
- Statewide Health Planning and Development

- California needs to align with its partners at the county and federal levels, as other states have already done. Currently, more than 50 of the 58 counties, the federal Substance Abuse and Mental Health Services Administration (SAMHSA), and over 30 states and territories have already moved to administratively integrate these critical areas of health.
- There is a growing recognition of the relationship between high costs and poor client outcomes for individuals with co-occurring substance use disorders, mental illnesses, and chronic health conditions. State-level integration of the administration of our substance use disorder treatment system with mental health and primary care will improve the overall health status of individuals with substance use disorders.
- A new Division of Mental Health and Substance Use Disorder Services within the **Department of Health Care Services (DHCS)** will administer the two substance use disorder programs: Drug Medi-Cal and the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. This will be headed by a Deputy Director appointed by the Governor, and confirmed by the Senate.

The remaining ADP functions and activities, along with staff and necessary infrastructure, will be transferred to two other departments within the Health and Human Services Agency.

Licensing and other Remaining Functions Most Appropriate at DPH and DSS

- **The Department of Social Services (DSS)** will create a new branch for the substance use disorder and mental health facility licensing program and staff it will receive. This branch will be headed by a Branch Chief who will report directly to the Deputy Director of Community Care Licensing (CCL) at DSS. Prior to the creation of the Department of Alcohol and Drug Programs, the early alcohol and other drug (AOD) residential licensing program started at CCL at DSS. This transfer will incorporate substance abuse disorder programs into DSS' current licensing functions. At the same time, this will ensure consistency for residential facilities by preserving the existing expertise of ADP staff.
- For DSS, this also will benefit its current CCL programs. Individuals with substance use disorders are served in many of the care arrangements currently licensed by CCL. Program expertise has the potential to enable licensing programs to adapt licensing standards while safely and flexibly regulating the provision of specialized services in whatever living arrangements are necessary.

- One of the essential public health functions of the **Department of Public Health (DPH)** is to link individuals to needed personal health services. DPH is the largest licensor of medical facilities and will be responsible for the licensure of Narcotic Treatment Programs (NTPs), which are treatment programs offering medical services. Leadership on policy related to NTPs will reside at DHCS.
- The Office of Problem Gambling, Driving Under the Influence programs, and alcohol and other drug counselor certification, which will also transfer to DPH, are consistent with prevention and intervention programs at DPH.

Departments Will Coordinate With Each Other and Consult with Counties and Stakeholders

- To ensure open and consistent communication with counties and stakeholders, the three departments (DHCS, DSS, DPH) will maintain ADP's existing stakeholder advisory groups. *See attachment for a description of the advisory groups.*
- The Deputy Director of Mental Health and Substance Use Disorder Services will convene the counties and stakeholders on a regular basis for the purpose of seeking input on policy decisions.
- All three departments (DHCS, DSS, and DPH) will hold regular internal coordination meetings to ensure information sharing and collaboration in their operations.
- To ensure coordination on the licensing and certification of alcohol and drug facilities, DSS and DHCS will enter into a Memorandum of Understanding (MOU).
- So that the licensing and monitoring of Narcotic Treatment Programs (NTPs) is informed by policy in this critical piece of the continuum of care, DHCS and DPH will enter into a MOU to ensure a feedback loop, whereby they each regularly share information related to NTPs.

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