SPECIALTY BEHAVIORAL HEALTH FINANCE 101

CBHDA Behavioral Health Policy Forum

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AGENDA

Overview: California's Specialty Behavioral Health Delivery Systems

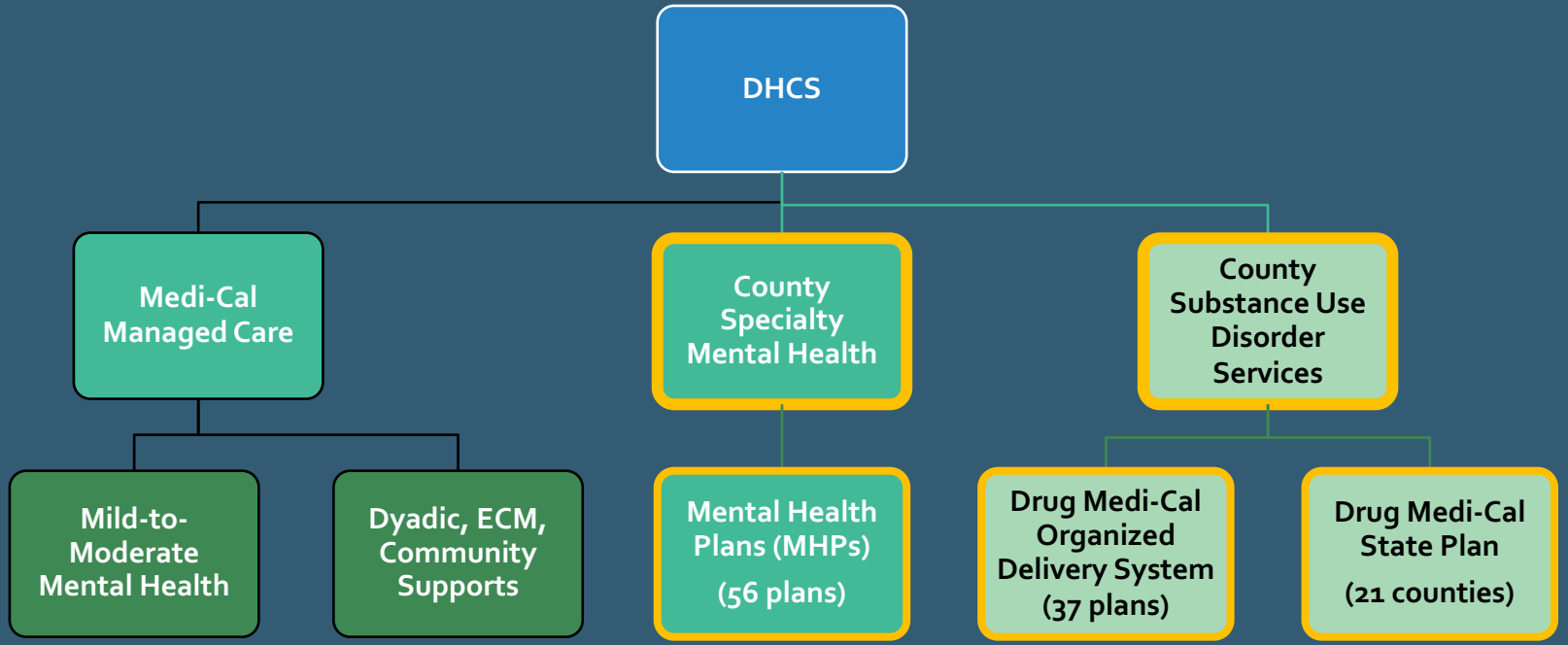
Specialty Behavioral Health Finance and Core Funding Sources

Conclusions and Considerations for the Future

Q & A

OVERVIEW: CALIFORNIA'S SPECIALTY BEHAVIORAL HEALTH DELIVERY SYSTEMS

MEDI-CAL
BEHAVIORAL HEALTH PLAN RESPONSIBILITIES



MEDI-CAL COVERED BEHAVIORAL HEALTH SERVICES

Managed Care Plan

- *Individual and group mental health evaluation and treatment (psychotherapy)*
- *Psychological testing*
- *Outpatient services to monitor drug therapy*
- *Outpatient lab, drugs, supplies and supplements*
- *Psychiatric consultation*

County Mental Health Plan

- Mental health services
- Medication support services
- Day treatment intensive
- Day rehabilitation
- Crisis intervention
- Crisis stabilization
- Adult residential treatment services
- Crisis residential treatment services
- Psychiatric health facility services
- Intensive Care Coordination (for beneficiaries under the age of 21)
- Intensive Home Based Services (for beneficiaries under the age of 21);
- Therapeutic Behavioral Services (for beneficiaries under the age of 21);
- Therapeutic Foster Care (for beneficiaries under the age of 21);
- Psychiatric Inpatient Hospital Services; and,
- Targeted Case Management
- Peers (optional benefit without dedicated funding)

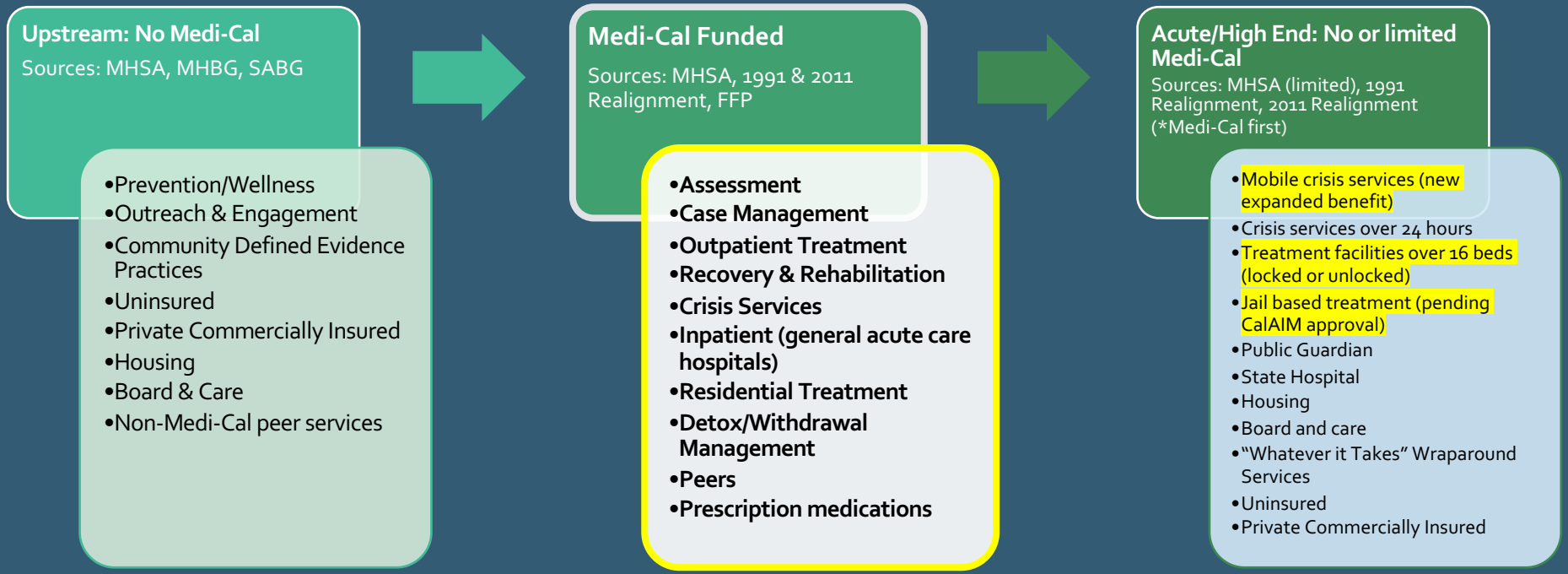
Drug Medi-Cal State Plan

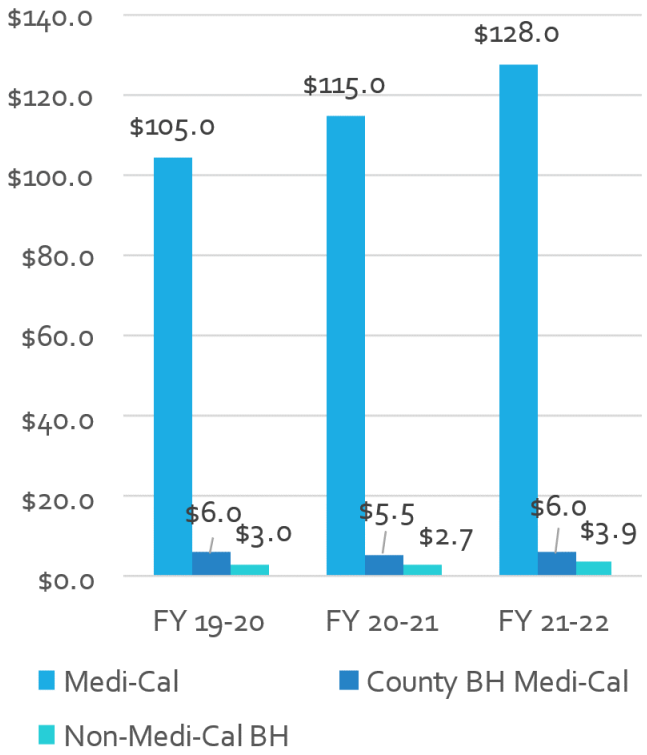
- Outpatient Drug-Free Treatment
- Perinatal Intensive Outpatient Treatment
- Perinatal Residential Treatment (16 beds only)
- Inpatient Hospital Detoxification
- Narcotic Treatment Program Services (methadone)

Drug Medi-Cal ODS

- Outpatient Treatment Services
- Intensive Outpatient Treatment
- Residential Treatment Services (no bed limit)3.1, 3.3,3.5
- WM (residential 3.2)
- NTP/OTP Services with Methadone, Buprenorphine, Disulfiram, and Naloxone
- Recovery Services
- Case Management
- Physician Consultation
- Additional MAT (optional)
- 3.7 and 4.0 Inpatient and Withdrawal Management

MEDI-CAL VS NON-MEDI-CAL FUNDED SERVICES
COUNTY BEHAVIORAL HEALTH



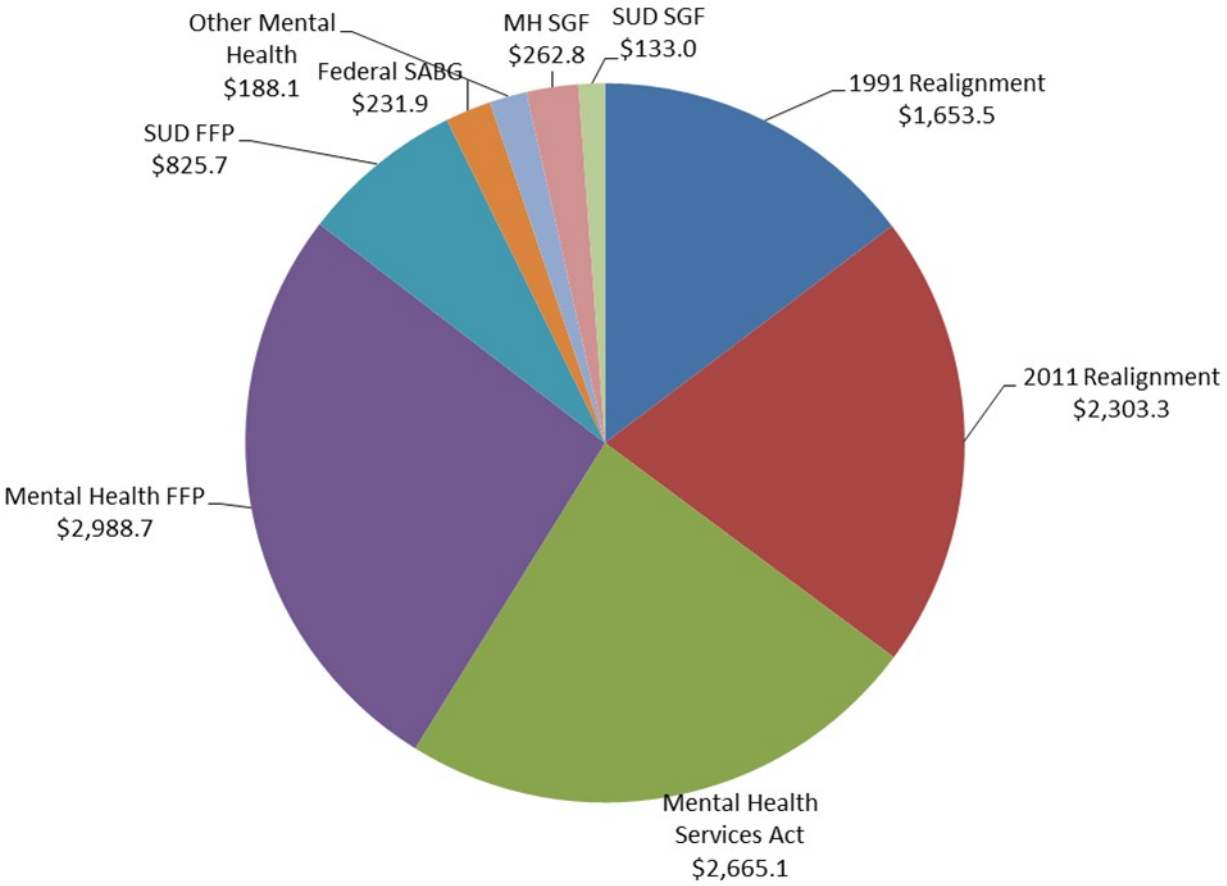


MEDI-CAL SPENDING VS. COUNTY BEHAVIORAL HEALTH SAFETY NET

(FIGURES LISTED ARE IN BILLIONS)

FY22-23 Estimated Behavioral Health Funding

$11.2 Billion
(Dollars in Millions)



SPECIALTY BH FINANCING AND CORE FUNDING SOURCES

PUBLIC BEHAVIORAL HEALTH FUNDING OVERVIEW

Non-Federal Core Funding

- Majority public behavioral health services are funded through county allocations of MHSA, 1991 Realignment, & 2011 Realignment
- Available funding driven by economic conditions and not demand for services
- Individual county allocations generally driven by county population and relative historical expenditures
- Different allocations have different obligations, rules, and reporting requirements

Medi-Cal Funding

- Counties claim federal Medicaid reimbursement for specialty BH services using Certified Public Expenditures
- County must incur expenditure in order to obtain reimbursement
- Subject to cost settlement and audit
- Changes coming with Payment Reform on July 1, 2023

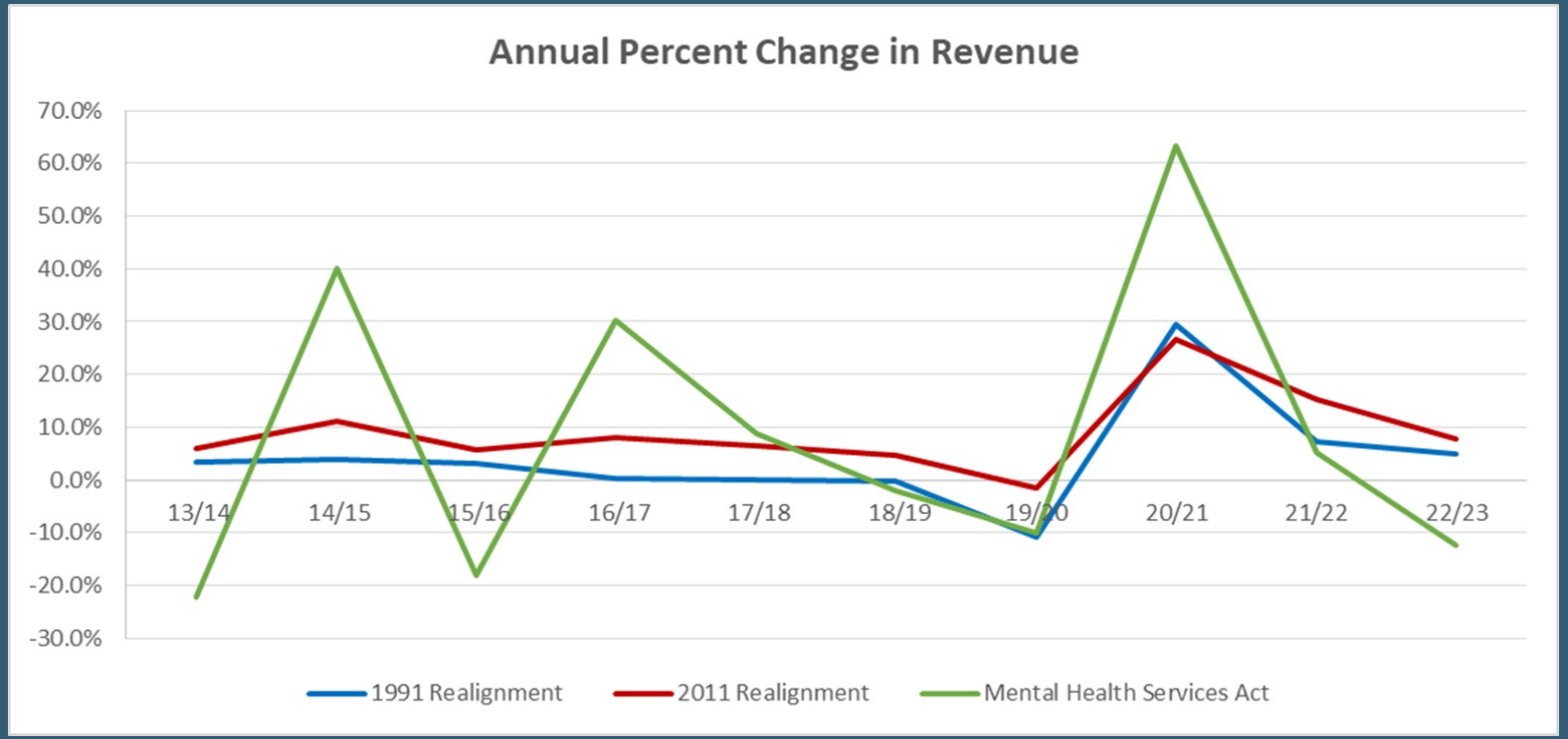
CORE (NON-FEDERAL) FUNDING SOURCES

Mental Health Services Act (MHSA)

1991 Realignment (Bronzan-McCorquodale Act)

2011 Realignment

VARIABILITY IN CORE REVENUES



FLEXIBILITIES & RESTRICTIONS BY FUNDING SOURCE

County GF

- Not available to all counties

1991 Realignment

- Most flexible funding source apart from county GF

2011 Realignment

- SUD and SMH services only
- No fixed allocations per program/service
- Can be used for all SMH services in addition to SUD & EPSDT

MHSA

- 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

REALIGNMENT

1991 AND 2011 REALIGNMENT

- Change in financing and administrative policy for Medi-Cal behavioral health obligations held by counties
- State formally "realigned" responsibility to counties for specified programs, and allocated ongoing, dedicated revenues
  - Medi-Cal specialty behavioral health (primary obligation)
  - Other behavioral health services as resources allow
- Policy goals:
  - Assign program and fiscal responsibility to the level of government that can best provide the service
  - Stable funding source
  - Flexibility to use funds for community-based services, reduce high-cost restrictive placements, place clients appropriately
- Key challenge:
  - Available revenue not tied to Medi-Cal enrollment, BH case loads, or costs/market factors

1991 & 2011 REALIGNMENT

Bronzan-McCorquodale Act of 1990/"1991 Realignment"

- All community-based mental health services, including those covered by Medi-Cal
- State hospital services for civil commitments
- "Institutions for Mental Disease": inpatient psychiatric services, residential mental health, or long-term nursing facility care in facilities of more than 16 beds

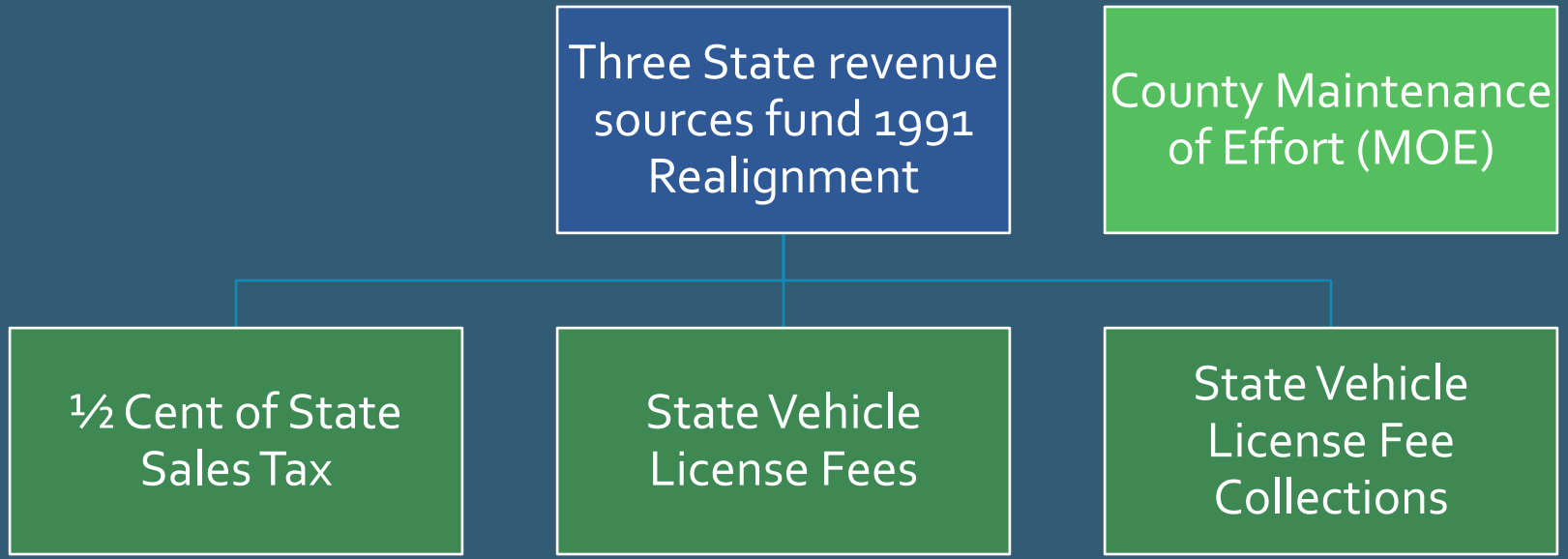
Public Safety 2011 Realignment/"2011 Realignment"

- Included Law Enforcement, Social Services, Behavioral Health
- Funds Medi-Cal SMH, EPSDT, Drug Medi-Cal, Drug Courts, Perinatal Drug Services, Non-Drug Medi-Cal
- Largest funding source to draw down Medi-Cal for SUD programs

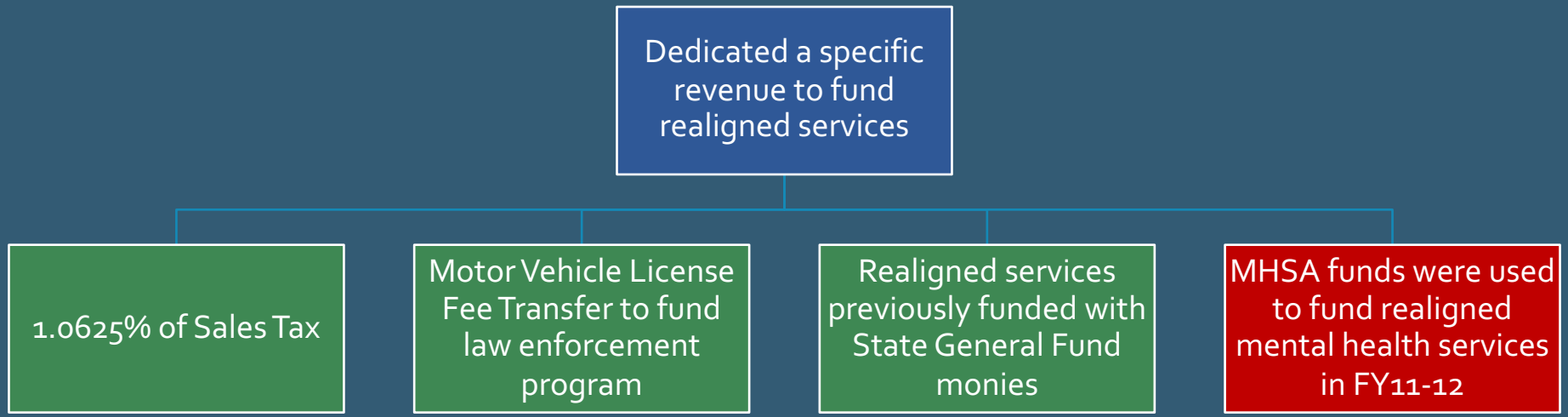
KEY FEATURE OF 2011 REALIGNMENT: PROP 30

- In the absence of new funding, counties may decline to implement any new state laws that increase costs of local services mandated by 2011 Realignment as follows:
  - New state laws (after 9/30/12)
  - New state regulations, executive orders, administrative directives (after 10/9/11)
- 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.

1991 REALIGNMENT REVENUE STRUCTURE



PUBLIC SAFETY 2011 REALIGNMENT REVENUE STRUCTURE



MENTAL HEALTH SERVICES ACT

MENTAL HEALTH SERVICES ACT

Prop 63 voter approved in 2004 – 1% tax on income in excess of $1 million

Expands the behavioral health system to better serve individuals with, and at risk of, serious mental health issues, and their families.

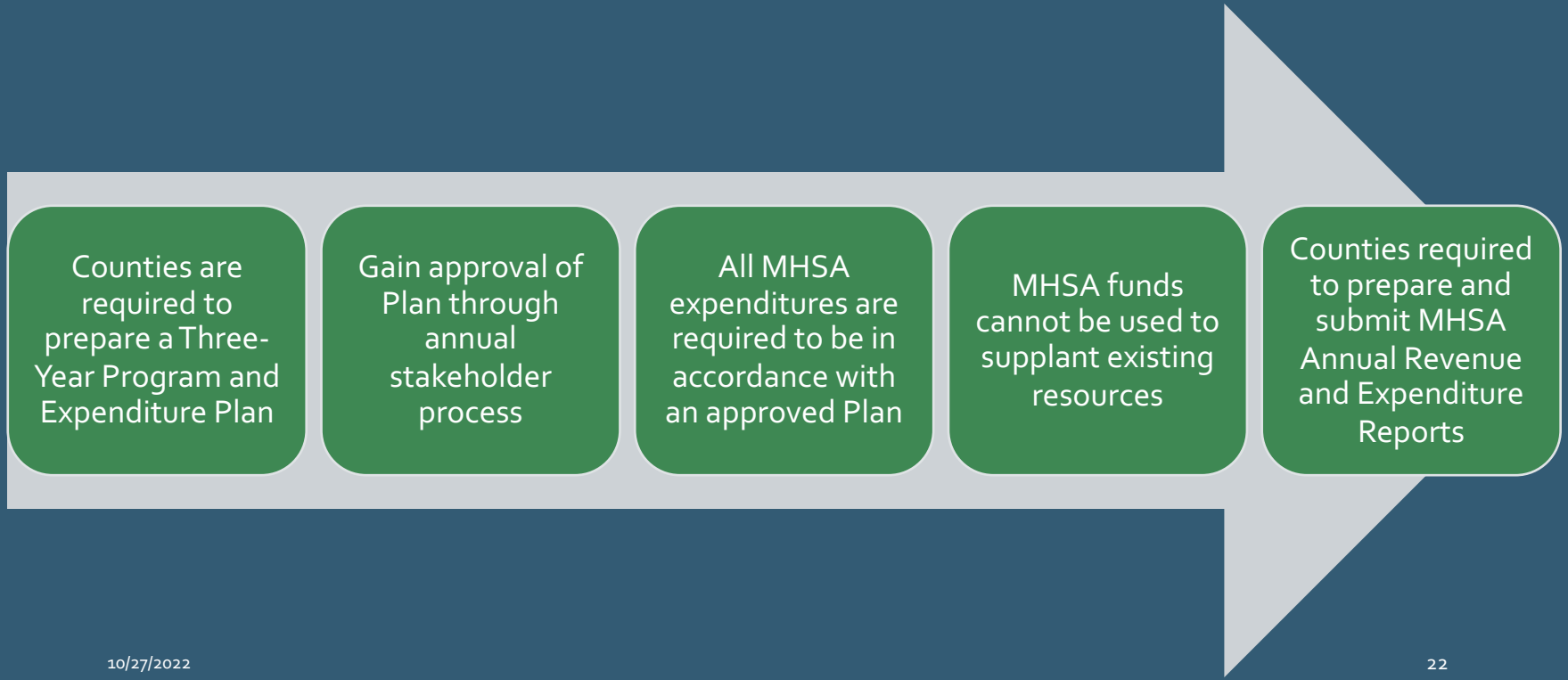
Five Components: *Community Services & Supports, Prevention & Early Intervention, Innovation, Workforce, Education, & Training, Capital Facilities/Technological Needs*

About 50% of MHSA revenue is used as non-federal share of Medi-Cal -- matched with federal funds

DEPOSITS INTO STATE MHS FUND:

- 1.76% of all monthly personal income tax (PIT) payments (Cash Transfers)
- Annual Adjustment based on actual tax returns
  - incredibly volatile due to two-year lag
- Settlement between monthly PIT payments and actual tax returns

MHSA COUNTY EXPENDITURES



MHSA PRUDENT RESERVE & REVERSION

PRUDENT RESERVE

- 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))

REVERSION

- MHSA 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
- Counties with a population of less than 200,000 have five years to expend funds

CONCLUSIONS AND CONSIDERATIONS FOR THE FUTURE

SPECIALTY BH PAYMENT REFORM: WHAT'S CHANGING IN JULY 2023?

Coding	Implement CPT coding transition for applicable services/providers • Guidance: https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx
BH plan FFS rates	Adopt fee-for-service rates and reimbursement for county BH plans
Financing mechanism	Change county mechanism for providing non-federal share: CPE to IGT • Eliminate current requirements for county and provider cost reporting and settlement

NOT CHANGING IN JULY 2023

Does not add new funds to public behavioral health system

- No change to available county sources of non-federal share

Fee-for-service rates established by DHCS are for BH plans

- Provider payments still negotiated with plans

COMMON MISPERCEPTIONS

Overall: "County behavioral health has plenty of funding."

- Funding is variable, categorical, and not tied to the number of Medi-Cal enrollees
- California's per capita Medicaid funding falls far behind levels in NY, WA, Oregon, and other comparable states

MHSA: Concerns regarding unspent MHSA or lack of transparency/accountability

- Less than 1% is reverted/unspent
- MHSA is highly regulated at the local and state level
- MHSA funding is restricted in terms of use
- MHSA funding leverages over $1 billion in Medicaid Federal Financial Participation

KEY POINTS

Majority of funding driven by economic conditions, not demand for services

Need for services is often countercyclical to health of the economy

Flexibility and restrictions with core funding

Each funding source is used for somewhat unique services and population groups

The funding sources increase at different rates which results in disparities among services and population groups

Payment reform transition changes risk profile: eliminates "backstop" of cost-based reimbursement

Not considered full risk-bearing plans so not entitled to retain underwriting gains to help manage risk from year to year

Increased State and Federal requirements to provide more services

Increasing levels of disability and severe illness in public safety net with pandemic

Growth in demand and costs outpacing growth in Realignment revenues

Workforce shortages impacting services provided

COUNTY BEHAVIORAL HEALTH OPPORTUNITIES & INVESTMENTS

- **CalAIM Reforms**
  - *Payment Reform*
  - *Access Criteria*
  - *Mental Health & SUD Integration*
  - *1115 IMD Waiver for Mental Health*
  - *Documentation Reform*
  - *BH Quality Incentive Program*
- **Children & Youth Behavioral Health Initiative ($4.4 billion)**
- **Behavioral Health Continuum Infrastructure Program ($2.2 billion)**
- **CHHS Data Exchange**
- **Peer Support Specialists Optional Medi-Cal Benefit**
- **Commercial Plan Parity Enforcement**
- **New:**
  - **Medi-Cal Mobile Crisis Benefit**
  - **$1.5 billion bridge housing solutions for behavioral health**

QUESTIONS & ANSWERS