



DEVELOPING BLENDED FUNDING PROGRAMS FOR CHILDREN'S MENTAL HEALTH CARE SYSTEMS

**A MANUAL OF FINANCIAL
STRATEGIES
BY SUSAN EDELMAN**

**CALIFORNIA
INSTITUTE
FOR MENTAL HEALTH**

Promoting Excellence in Mental Health Services



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BY SUSAN EDELMAN

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WHAT IS BLENDED FUNDING?

The idea of Blended Funding is simple. It provides a mechanism that allows service providers of different agencies to collaborate on programs and access federal funds that might not otherwise be available to them.

Blended Funding takes the ideas of coordination, collaboration, and integration one step further and introduces... *more money for more services*.

The practice of Blended Funding doesn't merely redirect existing dollars but generates *new revenue* to provide more services to more clients in more programs.

Within Mental Health, Blended Funding has been used principally to access the Federal Title XIX Medicaid Program, called Medi-Cal in California. In order to participate in Medi-Cal, and claim reimbursement for services, a program is required to have local funds that qualify as an “eligible match” for Medi-Cal funds.

Potentially eligible funds are often not legally available as a local match because the funds are in the “wrong” agency. Although services and target populations in different agencies may be similar (and even overlapping), only one of these agencies generally has the legal authority to claim federal dollars for a particular service. *By combining and transferring funds to that authorized agency* — by creating a “blending” of funds — more federal dollars can be accessed and additional service can be provided.

When a Blended Funding arrangement is undertaken, the funds from a non-mental-health agency are made available to a certified Medi-Cal provider permitting those funds to then be used as the required local match for Medi-Cal reimbursement. The end result is Medi-Cal funding for the mental health component of programs that originate in agencies that otherwise could not directly access Medi-Cal funds. Yes, it’s a bit of bureaucratic fund shifting — but it’s legal and it works!

Blended Funding is a generic concept, of course, and can apply to agencies other than mental health. Departments, such as social services, also have access to federal funds, (e.g., Title IV-E¹) from which mental health and other agencies could benefit. In this instance, the Blended Funding models presented here work in reverse, with the

¹ Title IV-E is an entitlement program that provides funding for the foster care of eligible children.

Department of Mental Health providing the state/local funds for a match and the other agency providing the access to additional funds through a federal program.

The use of Blended Funding strategies can:

- Expand services without additional state/local funds.
- Foster increased communication and integration among agencies.
- Promote coordination of care among multiple agencies — avoiding a collision of multiple treatment case managers, multiple treatment specialists, and multiple approaches for the same child and family.
- Improve cooperation among agencies. Blending funds from several agencies obviously makes contractual or interagency agreements a necessity. As a side benefit, these agreements can help expand each agency's commitment to increased collaborative ventures as part of a “System of Care.”

PUBLIC AND INSTITUTIONAL SUPPORT

A convergence of factors helped Blended Funding get started in California:

- The adoption of the *Medi-Cal Rehabilitation Option* by California in 1993 significantly increased the flexibility with which mental health professionals could claim reimbursement for services that they provided. Clients no longer have to come to clinics to see their therapists, the therapists can see them wherever and whenever it is most appropriate – at home, at school, or even at the park. Other professionals besides licensed clinicians (i.e., *licensed practitioners of the healing arts*) are now allowed to be reimbursed by Medi-Cal for a broad spectrum of mental health services, including rehabilitation. In other words, the *who*, *where*, and *what* of mental health services has been expanded.
- We have begun to view related public service agencies as partners who need to work together in a *System of Care*. The resulting collaboration among agencies has reduced boundaries and promoted a better understanding of each other’s mission, legal responsibilities, and target population. Along with this collaboration has come a

deep awareness of the duplication, overlaps, and gaps in the existing system.

- The move towards *Managed Care, and the potential of block-grant federal funding*, along with the realization that *California is 48th in the nation* in per capita Medicaid funding, has spurred new efforts to find creative ways to increase funding.
- Clearly, if California is 48th, other states and counties throughout the nation are making changes in their service delivery systems and are more effectively accessing federal funds. California has begun to benefit from their experiences and there is a growing sophistication about how to implement these changes in our own state.

WHERE WE ARE NOW

Blended Funding is already happening in some parts of our state. Each county that has implemented blended funding has developed its own approach. The results must be successful — no one, to our knowledge, has *unblended* any funds!

Without a doubt, it takes a long time to develop the trust, work out the details, receive the support of boards of supervisors and county counsels, develop funding mechanisms, and finally implement a Blended Funding program. Implementation is a process with a steep learning curve. Rather than being a barrier, however, these twists in the road often foster camaraderie and fresh approaches to System of Care partnerships among different county agencies.

THE BASIC MODEL

This manual introduces Four Basic Models that have been used successfully in California. Other models are possible, of course, and should be used if they are a better fit for a particular situation. The purpose of the manual is to discuss concepts, parameters, guidelines and problems to give counties a jumping off point.

Although the examples in the manual emphasize children’s programs, the models can be used for adults, older adults, and any other population group where there is potential access to federal funds.

Note:

Worksheets for each model can be found at the end of this manual.

THE 3-E PRINCIPLE

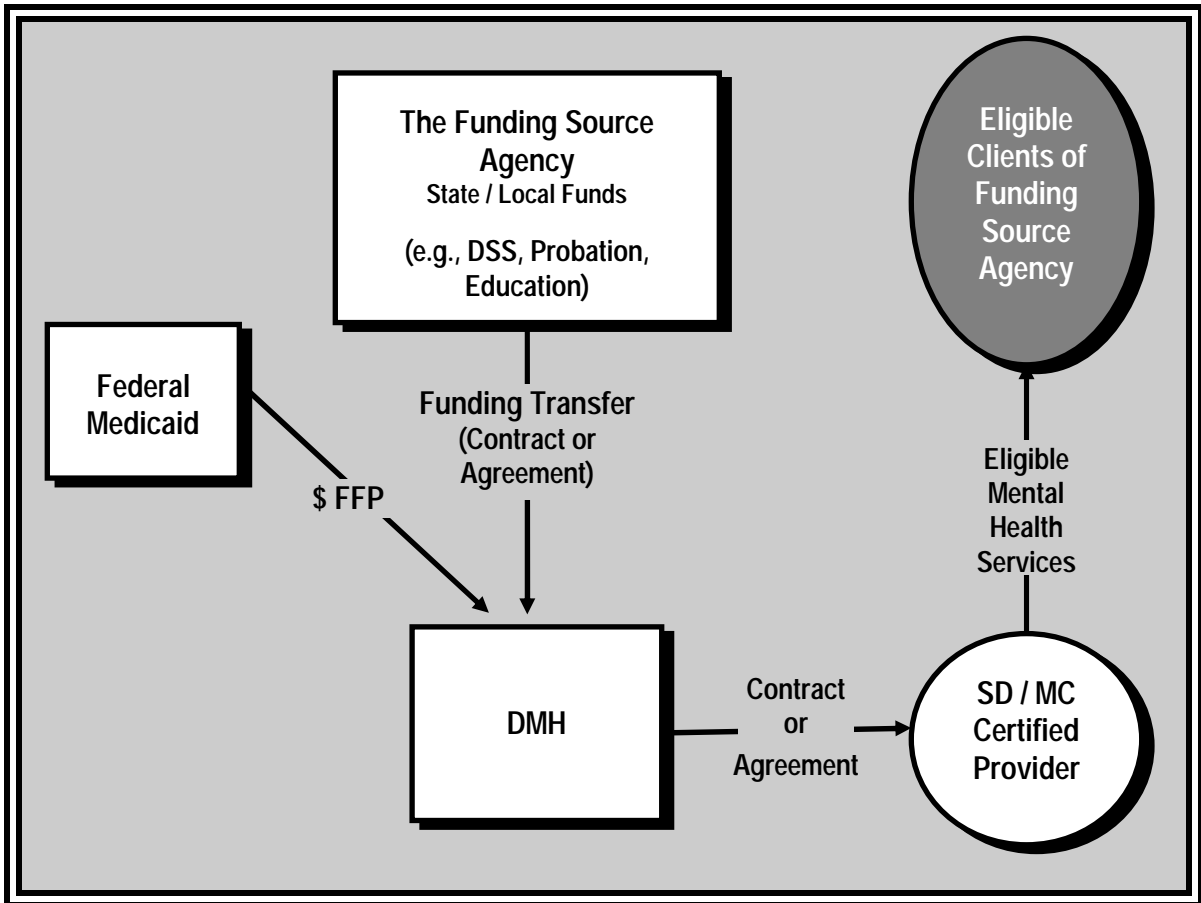
The **3-E Principle** applies to all Medi-Cal programs and is assumed in all of the models about to be presented in this manual. The three E’s apply to Medi-Cal Eligibility. They are:

Eligible Services
for
Eligible Clients
by
Eligible Providers

All three of these eligibility components must be met to meet the requirements of the Medi-Cal program. Therefore, in the models that follow, wherever you read “**MEDI-CAL ELIGIBLE**,” it assumes these three criteria.

The following diagram illustrates the basic model. The models presented in the remainder of the manual may vary but they all contain these components.

THE BASIC MODEL



GLOSSARY OF TERMS USED IN MODELS

Medi-Cal

California's Medicaid program. Each state has some flexibility in implementing the federal program. California's Plan is based upon the Rehabilitation Option.

Short-Doyle Medi-Cal (SD/MC)

The Medi-Cal funds that flow to public agencies are called *Short-Doyle* after the two legislators who authored the bill that created the program. The Fee-For-Service Medi-Cal system has been a parallel system that funded private Medi-Cal providers. After June 1998, the Short-Doyle Medi-Cal system consolidated with the Fee-For-Service Medi-Cal system. Therefore, when a model refers to Short-Doyle Medi-Cal (SD/MC) it means any Medi-Cal funds for mental health services.

Funding Source Agency

This is the agency (such as a school system or department of social services) requesting mental health services and providing eligible local funds to be used for:

- a match for Title XIX Medi-Cal
- non-eligible mental health services which are not reimbursed by Medi-Cal

DMH

A County Department of Mental Health

- is responsible for the delivery and direction of mental health services
- provides training, technical assistance, and monitoring for compliance with Medi-Cal standards and requirements
- acts as a fiscal agent between the Funding Source Agency and Medi-Cal
- acts as the liaison with the State for SD/MC certification if certification is needed (the county will have the authority to certify after June 1998)

SD/MC Certified Provider

Services must be provided by a certified Short-Doyle Medi-Cal (SD/MC) provider. Typically, these providers include DMH and private providers who are certified by the State. A contract with DMH is one of the requirements for certification. New programs, including those in the Funding Source Agency, can become certified once they meet the necessary requirements.

CGF or SGF

County General Fund (CGF) or State General Fund (SGF) dollars will be used generically in the models to refer to local/state funds. These can be county general funds, state general funds, re-alignment funds, school district funds, etc. — these funds cannot be federal dollars and must meet federal requirements for qualifying as an eligible local funds match.

FFP

Federal Financial Participation (FFP) is the federal funding made available through the Medicaid (Medi-Cal) program. It represents approximately half of the cost of an eligible service billed to Medi-Cal.² The remaining portion of the service cost is provided by the local agency and constitutes the required “match.” The examples in this manual will assume the FFP to be 50% of the billable service cost.

Contract or Interagency Agreement

Once DMH has the commitment from the Funding Source Agency and estimates the FFP that will be generated, a Mental Health Services contract is prepared (Interagency Agreements are used for “contracts” with other county departments) for the provision of mental health services.

Funding Transfer

The transfer of funds from the Funding Source Agency to DMH. In the models, funding transfers among county departments will be referred to as a **DSO** (Department Service Order). A **revenue contract** is used to transfer funds to DMH by a non-county agency.

WHICH FUNDS ARE APPROPRIATE TO BLEND?

Only state and county public funds (local funds) may be used as a match for Title XIX Medi-Cal funds (known as the **Federal Financial Participation or FFP**). These funds must have no other restrictions placed on them by the State or local governments nor can they be used as a match for another program. Federal funds may not be used for the "local match."

² The reimbursement is currently a fraction more than 50% and applies when the cost of service is at or below the statewide maximum rate. The rate may change—be sure to check the current rate.

Unrestricted private donations to a county *may* qualify as a local match for Medi-Cal. Because regulations regarding the use of donations as match are quite restrictive, legal counsel should always be consulted to insure compliance with federal regulations.

WHO PROVIDES THE SERVICES?

- Any existing Short-Doyle Medi-Cal certified provider, including the Department of Mental Health.
- The program itself can become certified to provide Short-Doyle Medi-Cal mental health services if it meets the necessary staffing standards, service specifications, and other requirements. Before June 1998, once a contract between a county department of mental health and the provider had been established, certification applications were made to the county department and then sent on to the State Department of Mental Health. As of June 1998, the State relinquished this authority to the counties with respect to contract providers.

WHO RECEIVES THE SERVICES?

Anyone who meets Medi-Cal financial criteria and demonstrates medical necessity is eligible for Medi-Cal services. *Medical necessity* requires clients to have a DSM IV (Diagnostic and Statistical Manual of Mental Disorders) diagnosis and exhibit functional impairment as defined by Medi-Cal standards. With Blended Funding, the Department of Mental Health's more limited target population – limited because of funding restrictions – can potentially be expanded to include all individuals who meet Medi-Cal criteria.

WHY SCHOOLS MIGHT PREFER SHORT-DOYLE MEDI-CAL INSTEAD OF LEA OPTION MEDI-CAL?

It pays better for a higher level of care.

Title XIX, under Short-Doyle Medi-Cal, pays slightly more than \$.50 on the dollar for the cost of an eligible mental health service in California. (This reimbursement will be

unaffected by the consolidation of Fee-For-Service Medi-Cal with Short-Doyle Medi-Cal.) In other words, local agencies can potentially double their money: for every dollar they provide, the federal government will provide a dollar as match. For Fiscal Year 1996-97, maximum payment for 60 minutes of an outpatient mental health service was **\$111.60** (\$55.80 match, \$55.80 FFP).

In the school-based Local Educational Agency (LEA) Medi-Cal program, Medi-Cal reimbursement is approximately \$15.00 for counseling services, ranging from a minimum of 15 minutes to a maximum of 90 minutes. The requirements for an eligible service are also lower with respect to treatment plan (not required), charting (short checklist), and medical necessity and functional impairment (both need not be established).

School districts with a significant Medi-Cal eligible student population needing mental health services may find it advantageous to do a Blended Funding contract with their local department of mental health. Blended Funding may allow them to expand services and provide a higher level of care by accessing Title XIX Medi-Cal funds instead of LEA Medi-Cal funds.

WHY DO BLENDED FUNDING WHEN EPSDT IS AVAILABLE?

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally-mandated program that requires that the State provide medically necessary services to full-scope Medi-Cal eligible beneficiaries under 21 years of age to “correct or ameliorate a physical or mental defect, or a condition.”

- EPSDT is limited to full scope Medi-Cal eligible children up to the age of 21. Blended Funding has no age restrictions.
- Blended funding eliminates the possible cash-flow problems that may occur with EPSDT. Because of the limited interim EPSDT loan funds that were made available by the State, there can be a long wait to be reimbursed by EPSDT match funds. This can create a cash-flow problem that would not be an issue with Blended Funding.
- Blended Funding fosters greater interagency collaboration by requiring formal contracts and agreements.

- EPSDT should be accessed for *new* programs for which local eligible funds are not available as a match for Medi-Cal. Blending Funding is preferable for the expansion of services that are *currently* being provided and for which there is a local match available.

WHAT ARE THE BENEFITS?

- Because Blended Funding requires intense collaboration among agencies, the resulting program improves service coordination and integration. Duplicative services are easier to spot and eliminate.
- Contracts, Memoranda of Understanding, and Interagency Agreements provide a "legal" framework that further integrates the efforts of the involved parties.
- Services to target populations may be expanded beyond the traditional funding limitations of DMH. Blended Funding creates a means for other agencies to offer eligible mental health services to their Medi-Cal eligible constituent groups by an eligible mental health provider (the 3-E Principle).
- Because Blended Funding accesses additional revenue for mental health services, it provides the opportunity to expand services and create new programs.
- Alternatively, if there is a funding shortfall, Blended Funding can be used to maintain the existing level of mental health service.
- A funding source agency entering into a Blended Funding agreement retains control of its service priorities, its clients, and its funding level. The Department of Mental Health, in addition to acting as the fiscal agent to Medi-Cal, is responsible for determining if the program is clinically sound and meets Medi-Cal criteria.
- With Blended Funding, certified providers are required to comply with the requirements of the federal government and the State Medi-Cal plan, which is a more rigorous and uniform service standard.

- All increases in Medi-Cal services assist in raising the Medicaid per capita rate in California. This should increase the total amount of funds California receives if Medicaid is block granted.

WHAT ARE THE DISADVANTAGES?

- Blended Funding applies only to eligible Medi-Cal beneficiaries. Additional funds may need to be budgeted to cover the cost of service to other clients, e.g., indigent clients who are not eligible for Medi-Cal.
- Claiming services to Short-Doyle Medi-Cal is cumbersome and complicated. Services need to be carefully documented, there needs to be an annual Treatment Plan, and the agency must participate in Quality Assurance committees. Because DMH handles all Medi-Cal billing, the service provider must comply with all data entry requirements and billing procedures.
- Reimbursement for approved Medi-Cal claims usually takes 3 months or more from the date of service.
- The service provider will need to prepare a state-required annual Cost Report at the end of the fiscal year.
- There is always a fiscal risk. The provider is subject to county, state and federal audits.
- The local department of mental health may impose an administrative fee.
- Blended Funding may create unwanted incentives to providers to change program priorities in order to access the additional funds — that is, to pursue Medi-Cal services at the expense of indigent services or preventive services not eligible for Medi-Cal reimbursement.

THE MODELS

The following sections describe different Blended Funding models with diagrams and examples.

Models I and II build in complexity and focus on a contract agency or another department as the provider of service.

Models III and IV address how DMH can be the provider of service either alone or in concert with staffing from another department.

MODEL I CERTIFYING ANOTHER DEPARTMENT OR GOVERNMENT AGENCY TO DELIVER SHORT-DOYLE MEDI-CAL SERVICES

This model is appropriate when another county department or agency has the staffing and mental health service experience to become a certified Medi-Cal provider in its own right. Examples include:

- A Department of Social Services directly-operated program for Family Maintenance Over 12 (certified only for case management). In this Family Maintenance Program, the source of funding shifts from the State to the county after 12 months. Blended Funding may be able to offset part of the cost to the county for Medi-Cal eligible families.
- A large school district that maintains its own mental health division (certified for mental health services).
- A county's emergency shelter for children staying beyond 30 days (certified for day treatment).

Model I A explains how Medi-Cal revenue can be used to expand services.

Model I B explains how Medi-Cal revenue can be used to maintain services while freeing existing general funds.

Model I C falls in-between both of these.

MODEL IA: SERVICE EXPANSION

The example used below is that of a large school district which has its own mental health services division.

Assume:

- The Mental Health Division of McConner Unified School District (McUSD) has a budget of **\$500,000 State General Funds (SGF)** allocated to mental health services provided by the District.
- The District has licensed (or licensed-waivered) staff to provide clinical treatment.
- Roughly **60%** of the students to whom they provide mental health treatment (both outpatient and case management) are eligible for Medi-Cal, have a DSM IV diagnosis and are functionally impaired. The District estimates that it can serve twice as many Medi-Cal students if there were more funds available.
- There is also a need for more mental health services to students not eligible for Medi-Cal.
- The McConner School Board agrees that the additional revenue should be used to expand their mental health services.

Next Steps:

- McUSD *becomes certified* as a Short-Doyle Medi-Cal provider.
- McUSD develops a *Medi-Cal Revenue Contract* with DMH in which the McConner District requests mental health services for their Medi-Cal eligible students. They commit \$300,000 of State General Funds to be used as a match for Medi-Cal. Since

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Medi-Cal reimburses dollar for dollar, a \$600,000 Medi-Cal program is developed. The District has \$200,000 remaining for services to non Medi-Cal eligible clients.

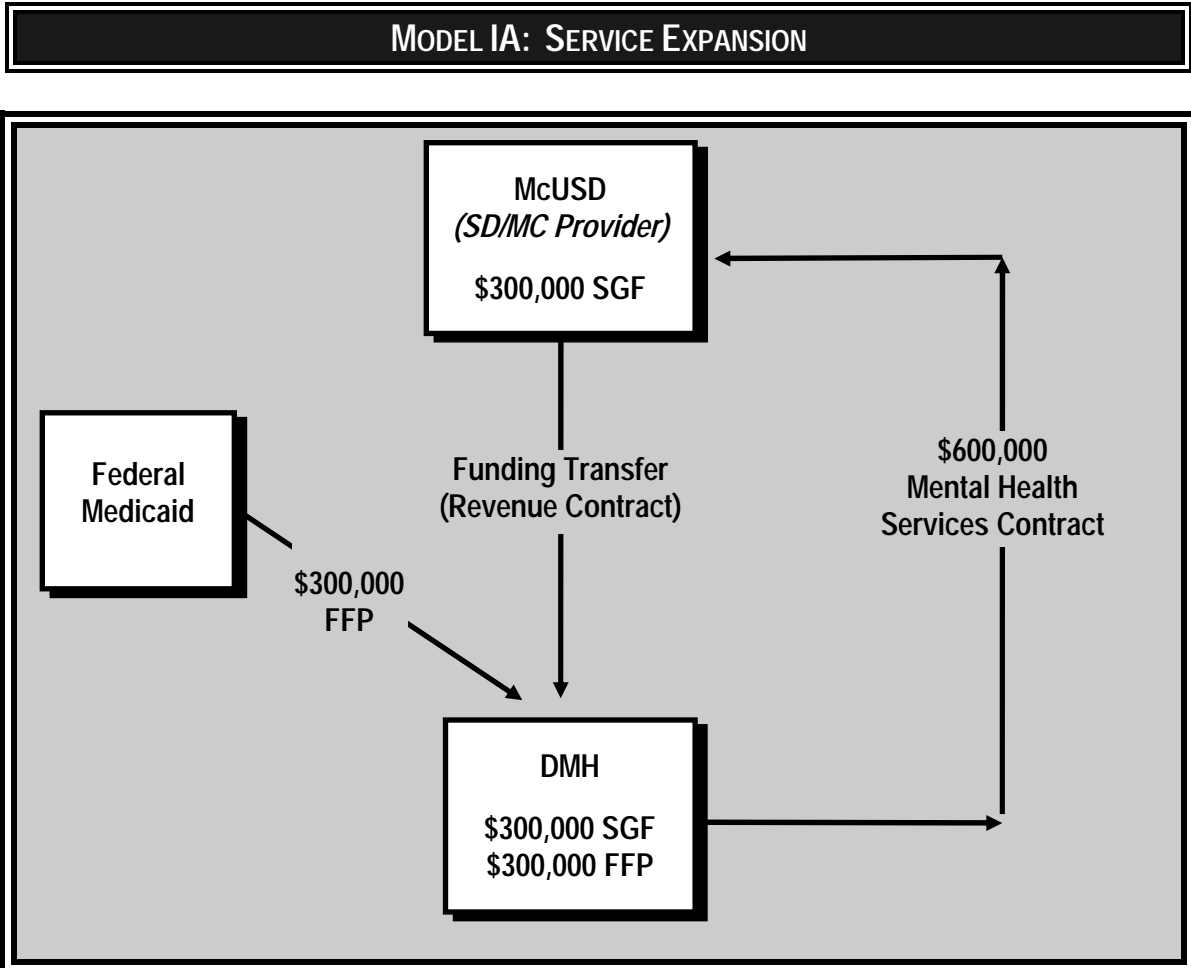
The mental health budget for McUSD is increased from the \$500,000 provided solely with State General Funds (SGF) to \$800,000 with the addition of Medi-Cal revenue:

MEDI-CAL ELIGIBILITY	CURRENT BUDGET	BLENDED FUNDING BUDGET
<i>NON MEDI-CAL ELIGIBLE</i>	\$200,000 (SGF)	\$200,000 (SGF)
<i>MEDI-CAL ELIGIBLE</i>	\$300,000 (SGF)	\$600,000 (\$300,000 SGF; \$300,000 FFP)
<i>TOTAL</i>	\$500,000 (SGF)	\$800,000 (\$500,000 SGF; \$300,000 FFP)

Note:

The worksheet for Model IA, found at the end of this manual, shows how the potential \$600,000 gross Medi-Cal revenue is generated.

This is how it works:



Comments:

- **The clear beneficiary in this model is the McUSD student** since there are more funds available for services. The District continues to provide the same level of service to its non Medi-Cal students (\$200,000).
- When DMH is notified that the Medi-Cal claim is approved, the School District is

DEVELOPING BLENDED FUNDING PROGRAMS – A MANUAL OF FINANCIAL STRATEGIES

contacted and sends DMH a *Certification of Funds form*³ certifying that the school has funds available for matching. DMH then releases the FFP to the School District.

- In addition to a *Certification of Funds* document, the School District could be required (depending upon a county’s requirements) to send DMH a check for the amount of the school funds available for the FFP match. DMH returns the school funds when it releases the FFP to the School District.
- Technically, the school district could transfer \$500,000 to DMH and bill all of its mental health services through that department. This would create a more accurate representation of the school’s total mental health services program. The major drawback is the additional paperwork between the two agencies.
- If the DMH charges an administrative fee for its work, the fee would be billed to the School District in the first example above or subtracted from the proceeds to the District in the second example.

Option:

The district may prefer a different service distribution and decide to shift more funds to non Medi-Cal services:

MEDI-CAL ELIGIBILITY	CURRENT BUDGET	BLENDED FUNDING BUDGET
<i>NON MEDI-CAL ELIGIBLE</i>	\$200,000 (SGF)	\$300,000 (SGF)
<i>MEDI-CAL ELIGIBLE</i>	\$300,000 (SGF)	\$400,000 ((\$200,000 SGF; \$200,000 FFP)
<i>TOTAL</i>	\$500,000 (SGF)	\$700,000 ((\$500,000 SGF; \$200,000 FFP)

With this scenario, only \$200,000 of additional revenue has been added to the program instead of the \$300,000 in the Model IA example above. However, services have been increased to both Medi-Cal and non Medi-Cal clients. The SGF remains at \$500,000.

³ A sample Certification of Funds form can be found in Exhibit I.

MODEL IB: SAME LEVEL OF SERVICE WITH COST SAVINGS

Assume:

- McUSD has a **\$150,000** budget shortfall for its mental health services program. Without the benefit of Blended Funding the services will have to decrease. In this situation McUSD is trying to maintain, not expand, the existing level of service with less base funding.
- With the additional revenue from FFP that Blended Funding generates, McUSD can replace the reduced portion of its State General Funds with the new FFP revenue. This allows McUSD to maintain the same level of service despite its reduced state appropriation.
- An alternative scenario is one in which McUSD, rather than experiencing a budget reduction, has a need to use some of its funds elsewhere in the school system. The State General Funds that are replaced with FFP revenue can be freed to accomplish this.

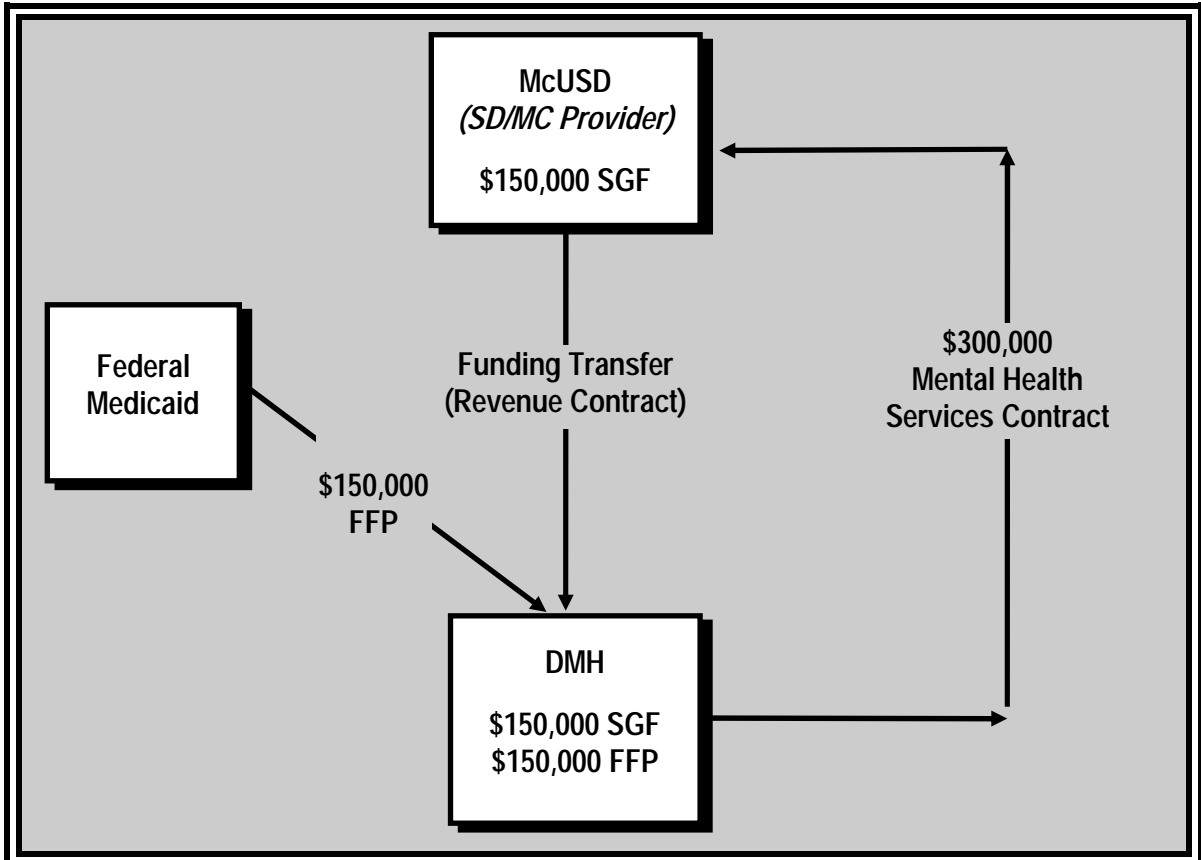
The new mental health budget for McUSD remains the same, \$500,000, despite a \$150,000 reduction in State General Funds (SGF):

MEDI-CAL ELIGIBILITY	CURRENT BUDGET	BLENDED FUNDING BUDGET
<i>NON MEDI-CAL ELIGIBLE</i>	\$200,000 (SGF)	\$200,000 (SGF)
<i>MEDI-CAL ELIGIBLE</i>	\$300,000 (SGF)	\$300,000 ($\$150,000$ SGF; $\$150,000$ FFP)
<i>TOTAL</i>	\$500,000 (SGF-before reduction)	\$500,000 ($\$350,000$ SGF; $\$150,000$ FFP)

\$500,000 SGF was previously required by McUSD to take care of their clients. Now, only \$350,000 SGF is required to maintain the same level of service. The \$150,000 reduction is replaced with FFP revenue.

This is how it works:

MODEL IB: SAME LEVEL OF SERVICE WITH COST SAVINGS



Comments:

- **The clear beneficiary in this model is the client treated by the School District.** The proportion of Medi-Cal and non Medi-Cal students and funding has not changed, only the source of funds has changed. The level of service has remained the same. Unfortunately, paperwork, billing, and audit liabilities have increased.

MODEL IC: REDUCED GENERAL FUNDS AND SERVICE EXPANSION

Assume:

- McUSD experiences a **\$100,000** budget shortfall for its mental health services program. McUSD is able to use the additional Medi-Cal revenue from Blended Funding to achieve a modest increase in service despite the reduction in SGF.

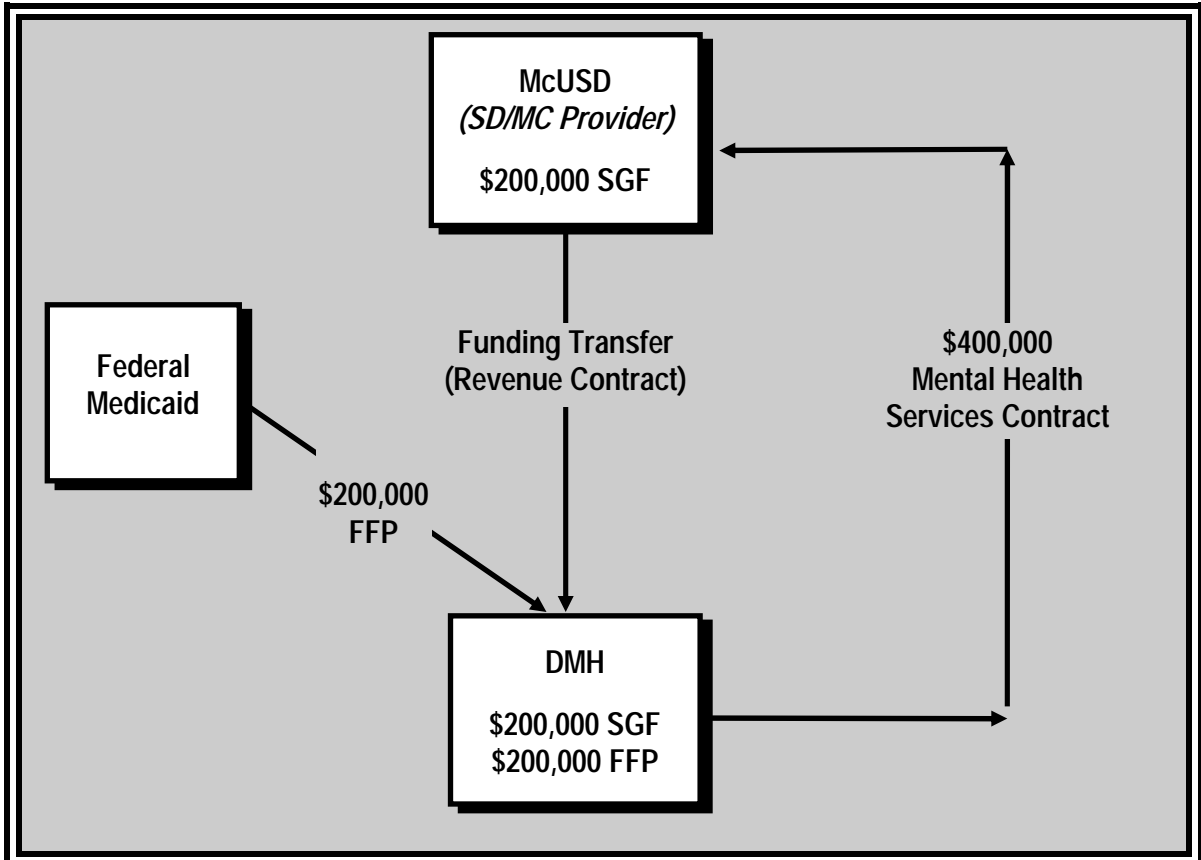
The new mental health budget for McUSD is increased from the \$500,000 provided solely from State General Funds to \$600,000 with the addition of Medi-Cal revenue:

MEDI-CAL ELIGIBILITY	CURRENT BUDGET	BLENDED FUNDING BUDGET
<i>NON MEDI-CAL ELIGIBLE</i>	\$200,000 (SGF)	\$200,000 (SGF)
<i>MEDI-CAL ELIGIBLE</i>	\$300,000 (SGF)	\$400,000 (\$200,000 SGF; \$200,000 FFP)
<i>TOTAL</i>	\$500,000 (SGF-before reduction)	\$600,000 (\$400,000 SGF; \$200,000 FFP)

\$500,000 SGF was previously budgeted by McUSD to take care of their clients. Although only \$400,000 SGF is now available, the additional FFP revenue increases the budget to \$600,000. The \$100,000 reduction of SGF is made up with FFP revenue; moreover, services have increased by \$100,000.

This is how it works:

MODEL IC: REDUCED GENERAL FUNDS AND SERVICE EXPANSION



Comments:

- **The beneficiaries in this model are both the clients and the District.** Medi-Cal services have expanded \$100,000, \$100,000 SGF has been freed for other uses, and the amount of funding for non Medi-Cal students remains the same.

MODEL II MENTAL HEALTH SERVICES THROUGH AN EXISTING SD/MC PROVIDER

This model can be used by agencies that do not have the expertise, nor the desire to develop the expertise, to become a certified mental health provider in their own right. Examples include:

- school districts
- Special Education Local Planning Areas (SELPA)
- juvenile courts and community schools
- other county departments

MODEL IIA: MENTAL HEALTH SERVICES THROUGH A CONTRACT AGENCY

The following example illustrates how the Department of Social Services (DSS) — which cannot directly access Title XIX Medi-Cal — can access Medi-Cal funds for its Family Preservation program by partnering with DMH.

Assume:

- **DSS has allocated \$250,000 of its Family Preservation funds** to each of its networks for mental health treatment services. DSS realizes that these funds are insufficient to meet the mental health service needs of all of the families.
- DSS requests that mental health treatment services be provided by a Short-Doyle Medi-Cal (SD/MC) certified agency. DSS determines which SD/MC agencies will receive the mental health funds and provide the service.
- It is estimated that approximately **60%** of the Family Preservation clients referred for mental health treatment services will be eligible for Medi-Cal.

Next Steps:

- The DSS Family Preservation funds are transferred to DMH via a Department Service Order (DSO). *(The funds need to come to DMH first because DMH is the intermediary with Medi-Cal. If the funds were transferred from DSS directly to the selected SD/MC agency, the funds would be ineligible to use as match.)*⁴ In other words, the DSS funds need to come into DMH’s hands for one hot second before they can be given to another agency.
- Since a SD/MC certified agency must already have a contract with DMH, it is only necessary for DMH to augment that contract.
- *If DSS does not determine which SD/MC agencies will receive the Family Preservation funds, DMH will probably need to initiate a Request for Proposal (RFP).*

The new mental health budget for the Family Preservation Agency is increased from the \$250,000 provided solely by the CGF to \$400,000 with the addition of Medi-Cal revenue:

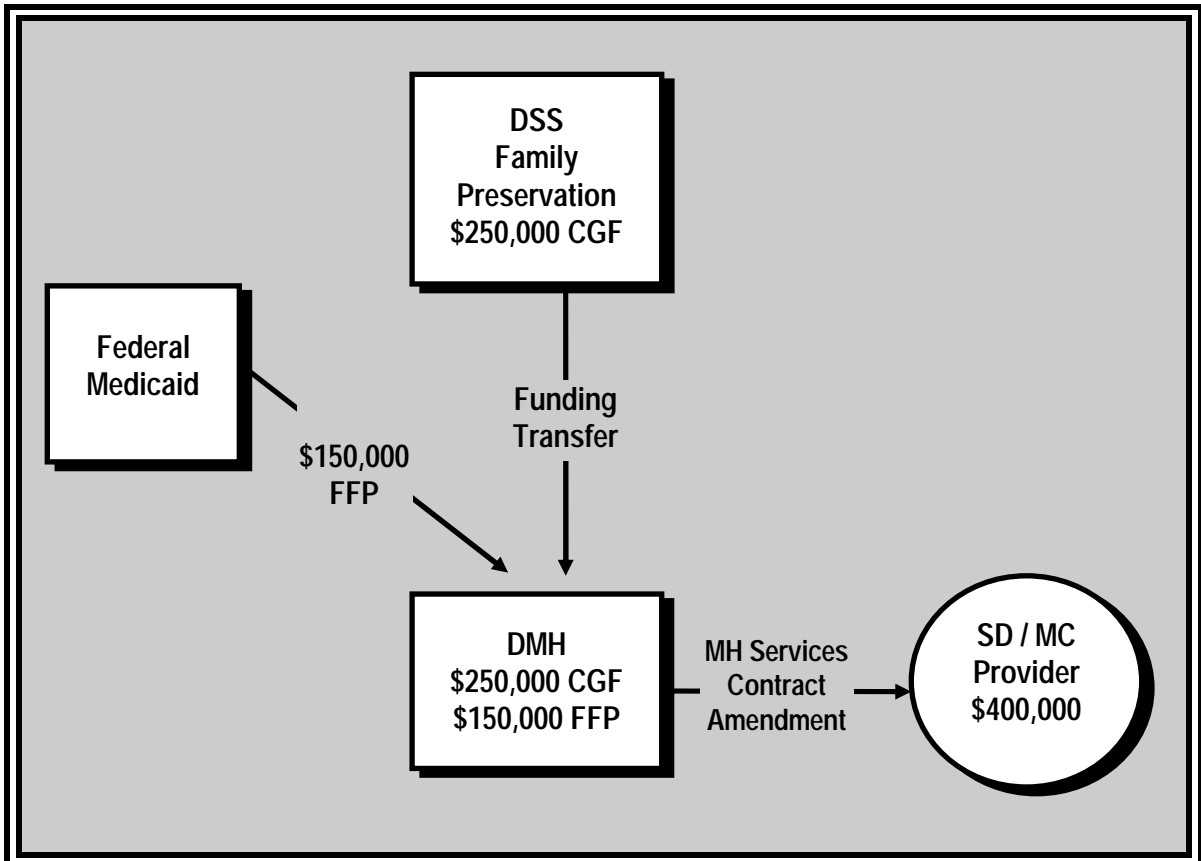
MEDI-CAL ELIGIBILITY	CURRENT BUDGET	BLENDED FUNDING BUDGET
<i>NON MEDI-CAL ELIGIBLE</i>	\$100,000 (CGF)	\$100,000 (CGF)
<i>MEDI-CAL ELIGIBLE</i>	\$150,000 (CGF)	\$300,000 ((\$150,000 CGF; \$150,000 FFP))
<i>TOTAL</i>	\$250,000 (CGF)	\$400,000 ((\$250,000 CGF; \$150,000 FFP))

As illustrated in Model IA Option on Page 19, resources can be shifted to permit an expansion of non Medi-Cal eligible services as well as Medi-Cal eligible services.

This is how it works:

⁴This is the legal opinion in some counties; other counties are comfortable with the direct transfer of funds from a public agency to a private non-profit agency. Each county should seek its own legal counsel on this matter.

MODEL IIA: EXISTING SHORT-DOYLE MEDI-CAL PROVIDER



Comments:

- DMH uses the invoice it receives from the SD/MC contractor (who provides the Family Preservation mental health services) to bill DSS for the cost of the service.
- It is important to bill DSS for the full cost of service to avoid potential Medi-Cal audit conflicts with lower cost of charges.

- When the Medi-Cal FFP revenue is received by the Department of Mental Health, it is then credited to the amount owed to DMH by the Department of Social Services.
- DSS is contractually responsible for all costs not recovered by Medi-Cal (or other) revenue up to their DSO maximum.

MODEL IIB: CONVERSION OF CONTRACT FROM DSS TO DMH

Providers may prefer to participate in the Medi-Cal program because Medi-Cal's rate of reimbursement is frequently more adequate in covering the true cost of services.

Government agencies are interested in accessing Medi-Cal because they hope to receive more services for their limited dollars.

These two desires can be in conflict. If DMH and DSS are not careful in their contract negotiations, the new Medi-Cal revenue may be funneled back into higher rates for the provider with no increase or improvement in services.

The following example demonstrates a successful transfer of an existing AB 1733/2994 (Child Abuse and Neglect) contract from DSS to DMH that will produce 24% more services with the additional Medi-Cal revenue that is generated.

Assume:

- DSS has \$500,000 of AB 1733/2994 funds that will be distributed among several agencies.
- One of these agencies, *Strong Families Inc.*, is a core provider (a provider offering a full spectrum of services) and is awarded a **\$100,000** contract by DSS to provide a range of child abuse and neglect services to children and families who are referred to them. Approximately **60%** of these clients need mental health treatment services, meet medical necessity criteria, and are eligible for Medi-Cal.
- Strong Families is also a SD/MC certified provider with an existing DMH contract.
- DSS has been paying Strong Families \$65 an hour per visit with a mental health professional. Strong Families demonstrates that this hourly amount is insufficient to cover its costs. For the same visit, Medi-Cal will pay \$85 an hour.
- DSS also pays Strong Families \$45 an hour for services provided by a para-professional. These services include case management, teaching and demonstration,

and parenting classes. Strong Families demonstrates that the actual cost of these case management and other services is \$60 an hour.

- DSS wants Strong Families to expand services, particularly for prevention and early intervention.
- Prevention and early intervention services (community outreach) are not reimbursed by Medi-Cal. In our hypothetical agency, the hourly rate budgeted for community outreach is \$45 per hour both in the DSS and the Blended Funding budgets.

Next Steps:

- DSS, instead of contracting directly with Strong Families, gives DMH the \$100,000. DMH now negotiates a Medi-Cal contract with Strong Families.
- Realizing that Strong Families' increase in rates will absorb most of the additional Medi-Cal revenue, DMH and DSS stipulate that they will agree to the contract conversion only if there is **a minimum 20% increase in service.**
- Strong Families is able to meet this new goal by expanding its case management, community outreach, and mental health treatment services.

DEVELOPING BLENDED FUNDING PROGRAMS – A MANUAL OF FINANCIAL STRATEGIES

The mental health budget for Strong Families is increased from \$100,000 to \$152,055 with the addition of Medi-Cal revenue. Services are increased 24%:

MEDI-CAL ELIGIBILITY	RATE	HOURS	CURRENT BUDGET	RATE	HOURS	BLENDED FUNDING BUDGET
<i>MH TREATMENT</i>						
<i>Non M-C Eligible</i>	\$65	308	\$20,020	\$85	308	\$26,180 (CGF)
<i>M-C Eligible</i>	\$65	846	\$54,990	\$85	874	\$74,290 (\$37,145 CGF; \$37,145 FFP)
<i>CASE MANAGEMENT</i>						
<i>Non M-C Eligible</i>	\$45	111	\$4,995	\$60	112	\$6,720 (CGF)
<i>M-C Eligible</i>	\$45	333	\$14,985	\$60	498	\$29,880 (\$14,940 CGF; \$14,940 FFP)
<i>COMMUNITY OUTREACH</i>						
	\$45	111	\$4,995	\$45	333	\$14,985 (CGF)
<i>TOTAL</i>						
		1709	\$99,985		2125	\$152,055 (\$99,970 CGF; \$52,085 FFP)

Comments:

- All parties are beneficiaries in this model. DSS, Mental Health, Strong Families, and the clients are all in better positions.
- The new rates of reimbursement are not arbitrary and must reflect actual costs of providing the services. The State needs to approve the requested Short-Doyle Medi-Cal rates for contractors and has a maximum reimbursement rate.
- With DSS direct payment to Strong Families, the agency was able to provide 1709 hours of service. By switching to a Medi-Cal program, the agency can provide 2125 hours — an overall increase of 24%.
- There has been a 200% increase in community outreach services, a 37% increase in case management, and a 3% increase in mental health services.

MODEL III DMH PROVIDES SERVICES DIRECTLY

There are instances when it is preferable for DMH to provide the mental health services directly rather than through a contract provider. The next two models illustrate variations using DMH as the direct provider of mental health services:

- In the first model, DMH uses its existing staff or hires additional staff to provide the service.
- In the second model, DMH elects to use independent contractors or consultants acting under DMH's auspices — in essence, they become an adjunct to DMH's staff.

MODEL IIIA: DMH PROVIDES SERVICES WITH DMH STAFF

This is the classic example of DMH providing services with its own staff at the request of another public agency. The other agency is willing to contribute the matching funds.

Assume:

- The Division of Juvenile Courts and Community Schools, County Office of Education wants to hire a social worker (LCSW) to expand mental health treatment services to juvenile probationers who attend a special community school. The Office of Education has **\$40,000** available for this purpose and they anticipate that the program will continue for several years. The program is called Teen Time.
- Approximately **73%** of the Teen Time youth are eligible for full scope Medi-Cal and meet medical necessity criteria.
- DMH hires a new employee for this program.
- DMH charges Education a 2.5% administrative fee which must be paid with Education's state general fund dollars and not FFP revenue. **(FFP must always be used for services.)**

DEVELOPING BLENDED FUNDING PROGRAMS – A MANUAL OF FINANCIAL STRATEGIES

Next Steps:

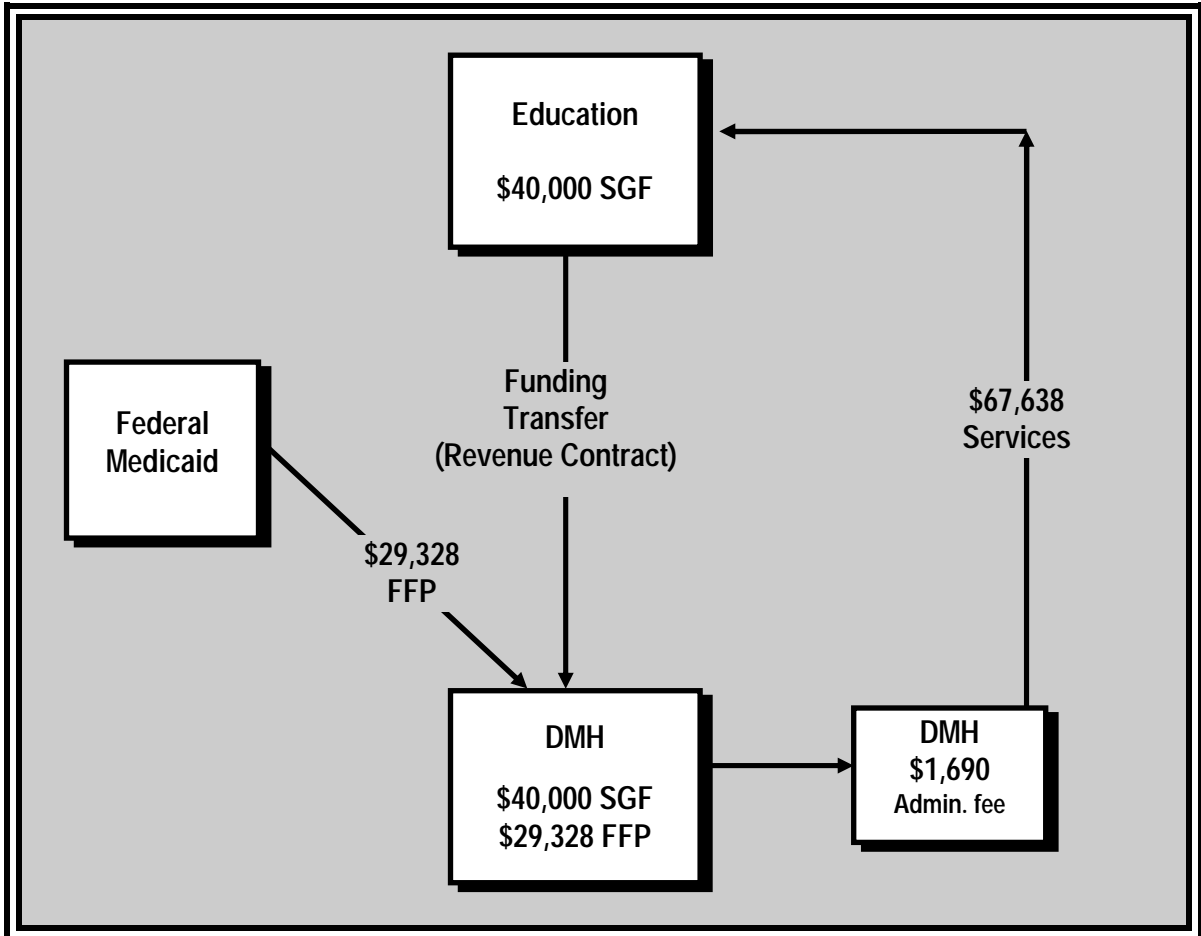
- The County Office of Education enters into a **\$69,328** contract with DMH.
- DMH bills Medi-Cal, as appropriate, for the services it has rendered to Teen Time. DMH charges the County Office of Education the full cost of service for the mental health services it provides. DMH then credits the Office of Education with the FFP revenue in the month it is received by DMH from the federal government.

The County Office of Education’s budget for mental health is increased from \$40,000 to \$67,638 for treatment services (a 69% increase) as well as an additional \$1,690 for administrative fees:

MEDI-CAL ELIGIBILITY	CURRENT BUDGET	BLENDED FUNDING BUDGET
<i>NON M-C ELIGIBLE</i>	\$8,000 (SGF)	\$8,982 (SGF)
<i>M-C ELIGIBLE</i>	\$32,000 (SGF)	\$58,656 (\$29,328 SGF; \$29,328 FFP)
<i>Administrative Costs</i>	\$0	\$1,690 (SGF)
<i>TOTAL</i>	\$40,000 (SGF)	\$69,328 (\$40,000 SGF; \$29,328 FFP)

This is how it works:

Model IIIA: DMH Provides Services with DMH Staff



Comments:

- DHM decided to hire new staff based on the fact that funding would be available for several years. If the time period were shorter, DMH would need to consider other options, such as contracting with independent contractors (see next section).

MODEL IIIB: DMH PROVIDES SERVICES WITH INDEPENDENT CONTRACTORS

The model presented below is useful when a project is time-limited and DMH decides to use independent contractors instead of hiring new DMH staff. In this model, an independent licensed contractor (LCSW or psychologist), working under the umbrella of the DMH, is paid directly for a product — a completed assessment.

Assume:

- The Department of Social Services (DSS) requests that DMH provide assessments for children in D-Rate Foster Care Homes (D-Rate Homes receive an enhanced rate for accepting children who are Seriously Emotionally Disturbed).
- DSS has **\$50,000** to spend for these assessments.
- DMH hires licensed clinical social workers (LCSW) and clinical psychologists from its list of independent contractors. These professionals have signed a contract with DMH to provide assessments on an as-needed basis.
- DMH pays the assessors at the rate of \$50 per hour for a LCSW and \$80 per hour for a clinical psychologist, up to 6 hours per assessment.
- Children placed in Foster Care are eligible for Medi-Cal by virtue of being placed out-of-home.

Next Steps:

- The Department of Social Services (DSS) establishes a Departmental Service Order (DSO) in the amount of \$50,000 for DMH to bill against for services rendered by the independent contractors. DMH charges DSS 2.5% of the Blended Funding budget as an administrative fee.
- As DSS provides names of children to be assessed, DMH hires independent contractors to complete the assessments. DMH supervises the assessors, reviews the

DEVELOPING BLENDED FUNDING PROGRAMS – A MANUAL OF FINANCIAL STRATEGIES

completed work product, and authorizes payment to the assessors per the rate established by their contract.

- DMH bills Medi-Cal at the DMH Legal Entity rate.
- DMH invoices DSS for the full cost of service that is claimed to Medi-Cal.
- When the Medi-Cal FFP revenue is received by the Department of Mental Health, it is credited to the amount owed to DMH by DSS.

DSS’s mental health services budget is increased from \$50,000 provided solely by CGF to \$97,526 with the addition of Medi-Cal revenue. Funds available for services are increased by 91%:

MEDI-CAL ELIGIBILITY	CURRENT BUDGET	BLENDED FUNDING BUDGET
<i>NON M-C ELIGIBLE</i>	\$0	\$0
<i>M-C Eligible</i>	\$50,000 (CGF)	\$95,526 (\$47,763 CGF; \$47,763 FFP)
<i>Administrative Fee</i>	\$0	\$2,237* (CGF)
<i>TOTAL</i>	\$50,000 (CGF)	\$97,763 (\$50,000 CGF; \$47,763 FFP)

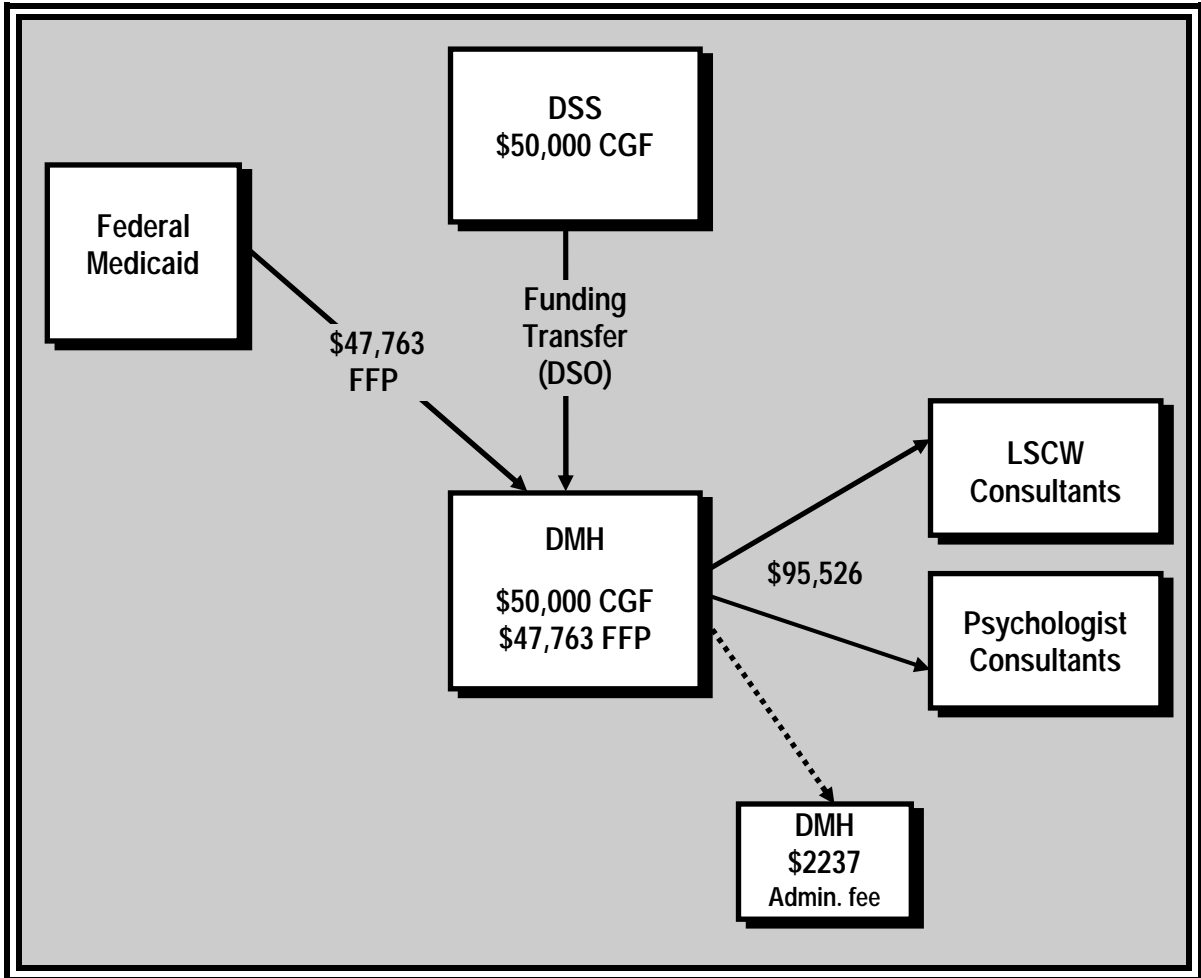
Note:

There is a discrepancy between the amount DMH pays the assessor (either \$300 or \$480 depending on whether the assessor is a social worker or psychologist) and the \$522 billed to Medi-Cal (using Fiscal Year 1996-97 maximum rates). A discrepancy such as this can occur in any program that is part of a Legal Entity since there can be only one rate for that Legal Entity.

**DMH’s typical 2.5% administrative fee in this example is actually 2.34% to accommodate simplification.*

This is how it works:

MODEL IIIB: DMH PROVIDES SERVICES WITH INDEPENDENT CONTRACTORS



MODEL IV: JOINT STAFFING FROM MORE THAN TWO DEPARTMENTS

Model IV will become more and more frequently used as programs integrate a “System of Care” approach to providing services. Health and Human Services grants now often require the collaboration of more than one department or agency with the goal of providing better, more responsive services to clients who are served by several agencies. Since the Departments of Probation, Social Service, and Mental Health are “natural” partners, the example below describes a joint effort intended to help youth who are dependents of the court (“300s”) and at high risk of entering, or re-entering, the juvenile justice system (“600s”). The program is known as the “300/600 Intensive Case Management Program.”

Assume:

- DSS allocates **\$69,500** to augment their case management services in the county’s Shelter Center with a clinical psychologist from DMH and a case manager from the probation department. The new personnel will join with existing DSS social workers to create an intensive case management program focused on high-risk “300” youth (i.e., dependents of the court) focused on deterring their entry into the juvenile justice system. These youths reside in the county’s Shelter Center operated by DSS.
- DMH maintains a SD/MC certified program adjacent to the Shelter Center.
- By Blending Funds through DMH, DSS anticipates receiving **80%** matching funds from Medi-Cal for the services of the psychologist (assessment) and the case manager (case management). Although each of the program’s participants is eligible for Medi-Cal by virtue of being placed out-of-home and meeting the requirements for medical necessity, only 80% have resided in the Shelter Center over 30 days (a Medi-Cal requirement).
- The \$69,500 covers 50% of the salaries of the two new hires. The remaining funds needed to cover the salaries will come from the revenue generated by Medi-Cal. (However, since Medi-Cal approvals can never be guaranteed, one of the Departments needs to be contractually willing to pick up any residual costs.)
- DSS will not pursue Blended Funding or Medi-Cal reimbursement for their own Children Services Workers because these staff members qualify for funding through Title IV-E which has a higher reimbursement percentage than Medi-Cal.

DEVELOPING BLENDED FUNDING PROGRAMS – A MANUAL OF FINANCIAL STRATEGIES

- In this example, DMH waives its fee for administrative costs.

Next Steps:

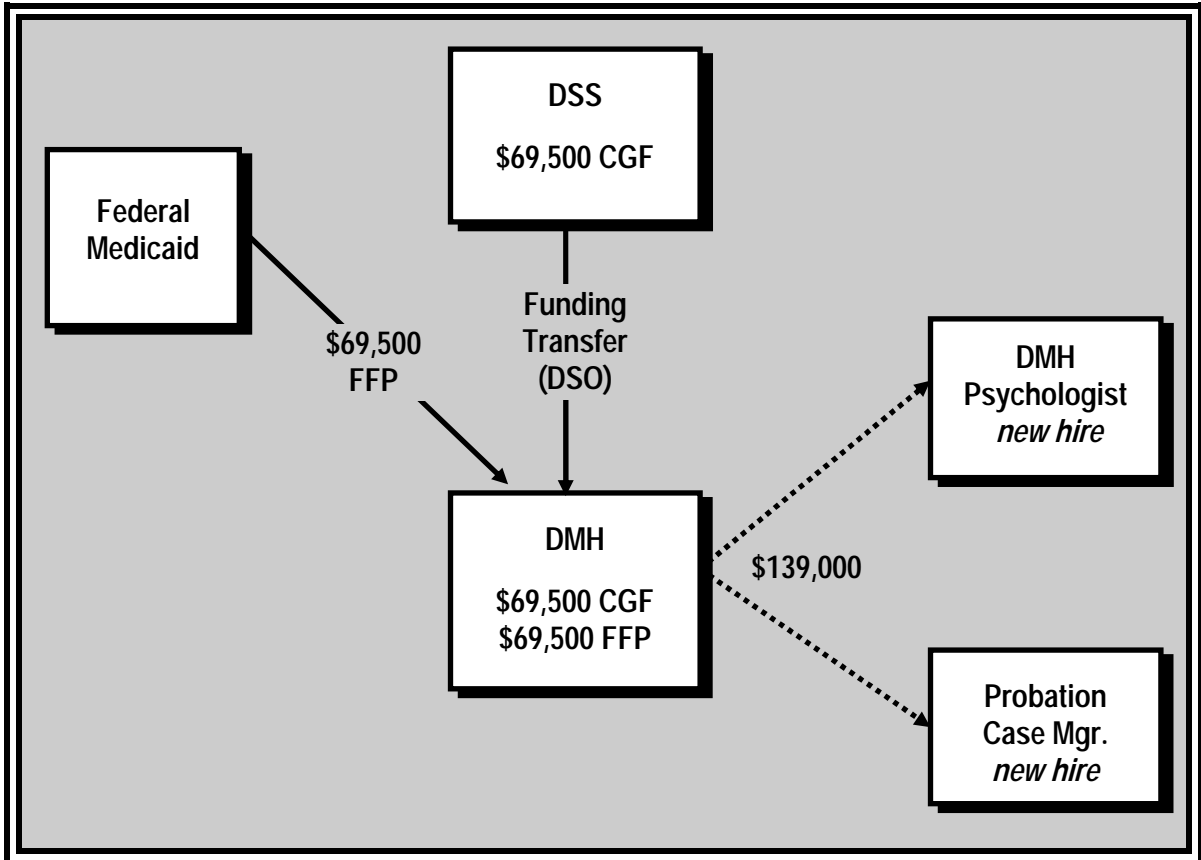
- DSS provides DMH with a Department Service Order (DSO) for \$69,500.
- DMH uses \$39,500 (matched with an equal amount of Medi-Cal revenue) to hire a new psychologist to work in the program.
- DMH covers the \$60,000 cost of the case manager from Probation (who happens to be a Deputy Probation Officer) with \$30,000 of the original DSS money and \$30,000 of matching Medi-Cal funds. DMH then issues a second DSO for \$60,000 and “hires” the case manager from Probation. *It is critical that funding for the case manager be part of the DMH budget so that it can qualify as a match for Medi-Cal.*
- Both the psychologist and the case manager bill Medi-Cal for their services. The psychologist bills mental health assessment and treatment services; the case manager bills case management services.

The budget for mental health services provided by DMH for the “300/600” Intensive Case Management program is increased from \$69,500 to \$139,000:

MEDI-CAL ELIGIBILITY	CURRENT BUDGET	BLENDED FUNDING BUDGET
<i>NON M-C ELIGIBLE</i>	\$0	\$0
<i>M-C ELIGIBLE</i>	\$69,500 (CGF)	\$139,000 ((\$69,500 CGF; \$69,500 FFP)
<i>Administrative Costs</i>	\$0	(Waived)
<i>TOTAL</i>	\$69,500 (CGF)	\$139,000 ((\$69,500 CGF; \$69,500 FFP)

This is how it works:

MODEL IV: JOINT STAFFING FROM MORE THAN TWO DEPARTMENTS



Comments:

- DSS, Probation, and Mental Health are now all partners in a new collaborative program focusing on high-need, multi-agency youth.
- Probation benefits because youth are potentially deterred from entering their system and their staffing costs are covered.

- DMH benefits because they can provide mental health services to a new target population and all of their costs will be covered if the two new staff generate enough Medi-Cal revenue. *The Interagency Agreement needs to stipulate which department is liable if enough Medi-Cal revenue is not generated to cover the costs of the new staff.*
- DSS benefits because they are able to provide additional services to their high-risk youth at reduced cost to their department.

CRITICAL ELEMENTS AND PRINCIPLES FOR FEASIBILITY AND COST EFFECTIVENESS

ELEMENTS

Before a Blended Funding program plan is implemented, it needs to be evaluated for financial feasibility and cost-effectiveness. There are several elements to consider:

Define the Goal

Is the goal to expand services with the additional Medi-Cal revenue or to offset general fund expenditures for existing mental health services? Or both?

Define the Service

Day Treatment, Mental Health Services, or only Case Management. (Case Management may especially apply to programs operated by Probation or Social Services.)

Base Funds

Are there enough eligible state/local funds available to use as a match?

Number and Percentage of Clients Meeting Full-Scope Medi-Cal Eligibility Requirements (Both Financial Need and Medical Necessity)

Blended Funding financing is *all about Medi-Cal* and will be effective only if there is a substantial number of eligible clients.

Number Of Clients Not Meeting Medi-Cal Eligibility Requirements

Enough funds need to be set aside to provide services to these clients. This is a good place to use federal or other funds that cannot be used as a match for Medi-Cal.

Licensed and Unlicensed Staff

Are there enough licensed (or licensed-waivered) staff members to meet program and Medi-Cal requirements? Since different types of Medi-Cal programs require different levels of staffing, this is an important consideration to keep in mind when deciding what type of program is feasible.

Administrative Fee

The Department of Mental Health should consider its internal cost of managing a Blended Funding project. Charging a modest administrative fee will enable an infrastructure to be developed to handle the volume of additional work (technical assistance, monitoring, billing, contracting, legal counsel, provider reimbursement, etc.) that will be required.

Rate Structure

With a program's conversion to Medi-Cal, the program may be reimbursed at a higher rate per unit of service than before, depending on whether or not its costs had been adequately covered. The potential problem here is that the new Medi-Cal revenue may merely be funneled into a higher reimbursement rate with no increase in client service. The object of Blended Funding, of course, is to use the additional Medi-Cal revenue to provide more services (or replace existing general fund dollars).

PRINCIPLES

- The Department of Mental Health must not be made financially liable in its role as the financial agent for Blended Funding programs.
- The Department of Mental Health has the right to determine which programs can apply for Short-Doyle Medi-Cal certification and the right to establish a time frame for processing applications for certification.
- The Department of Mental Health has the authority to set standards and policy to ensure that all Medi-Cal requirements are met.
- The Department of Mental Health maintains its authority to determine if the program is clinically sound and constitutes a valid mental health treatment program as defined by Medi-Cal.
- The Department of Mental Health should have a signed interagency agreement or contract with the funding source agency *before* a Blended Funding program is implemented.

SAMPLE DOCUMENTS

The three exhibits on the following pages are meant to be used only as starting points and examples. Do not attempt to use them “as is” — **Consult legal counsel to draft appropriate documents!**

EXHIBIT II — SAMPLE INTERAGENCY AGREEMENT

This Interagency Agreement is entered into by the _____ County Department of Mental Health (DMH) and the _____ County Department of Social Services (DSS) for the purpose of implementing a Blended Funding program for children and families. The Interagency Agreement establishes each participating department's commitment to the programs and describes the roles and responsibilities of each.

OBJECTIVE

Blended funding enables DSS to access Federal Title XIX Medi-Cal revenues through the Short-Doyle Medi-Cal system for the reimbursement of eligible Short-Doyle Medi-Cal services to children who are Medi-Cal beneficiaries. DMH is the responsible agency in the County for the determination of provider participation in the Short-Doyle Medi-Cal system. The participation of DSS in the Short-Doyle Medi-Cal system would expand/maintain mental health services under their responsibility.

Under this agreement, DMH will contract for and/or directly provide mental health services on the behalf of DSS. DSS will be responsible for the total cost of care provided to its clients less the reimbursement received from the Medi-Cal program. DSS shall provide a certification, in the format described by DMH, that the funds provided by DSS for the cost of services under this agreement are government funds that qualify as eligible match as defined by Title XIX.

A Blended Funding approach is consistent with, and supports, System of Care planning efforts in _____ County. All services provided are jointly administered and conform to the standards required by the federal government.

INDIVIDUAL PROGRAMS

The individual program descriptions and the respective responsibilities of each department can be found in the Attachments. The Financial Schedules can be found in Exhibit I.

FINANCIAL CONDITIONS

1. DMH agrees that, when appropriate, services associated with Blended Funding programs will be claimed to Title XIX Medi-Cal.
2. DSS will prepare individual Department Service Orders (DSO) to DMH for the

amount(s) agreed upon by both departments. DSS agrees to pay DMH all actual costs, less applicable Medi-Cal revenues, up to the established DSO amount(s).

3. Funds designated for the Blended Funding programs described herein shall only be expended for mental health services provided to the designated DSS clients.
4. DMH will bill DSS for the total cost of services rendered each month, less the actual Medi-Cal revenue that is received in the same month.
5. For Blended Funding programs involving staffing costs, DMH will bill DSS for the cost of assigned staff, up to the established DSO amounts.
6. DMH will charge an Administrative Fee, equal to 2½% of program expenditures, unless otherwise determined.

TERMS OF INTERAGENCY AGREEMENT

This Interagency Agreement will be effective from the date of execution until such time as it is either:

- (1) terminated by either party with a 30-day notification; or
- (2) amended by mutual concurrence.

The Financial Schedules, in the attached Exhibit of this Interagency Agreement, may be revised at any time with the mutual agreement of both DMH and DSS.

Director
Department of Social Services

Date

Director
Department of Mental Health

Date

**EXHIBIT III
SAMPLE MENTAL HEALTH REVENUE CONTRACT**

Sample Agreement between DMH and County Office of Education for the provision of a Day Treatment program:

THIS AGREEMENT is made and entered into this _____ day of _____, 199__, by and between the County of _____ (hereafter "County") and _____ County Office of Education.

Business Address:

WHEREAS, County, through its Department of Mental Health, provides various mental health services to residents of _____ County who qualify therefor; and

WHEREAS, County and _____ County Office of Education, will develop and implement a day treatment program in the _____; and

WHEREAS, in order to implement the day treatment program, contractor will provide matchable funds, to the Federal Matching Assistance Percentage (FMAP) pursuant to Title XIX of the Social Security Act, 42 U.S.C. Section 1396 et. seq., and 42 C.F.R. 433.51, that qualify for Federal Financial Participation (FFP) directly to the County. Contractor shall execute and provide to County a "certification regarding source of funds for Short-Doyle/Medi-Cal expenditures" for each term of this agreement.

These funds will be used to provide a day treatment program only; and

WHEREAS, Contractor authorizes County to subcontract for the delivery of such day treatment program services; and

WHEREAS, Contractor authorizes County to reimburse the Provider of such services both Contractor's matching funds and FFP; and

WHEREAS, the following terms, as used in this Agreement, shall have the following meanings:

- A. "CCR" means the California Code of Regulations;
- B. "CR/DC Manual" means SDMH's Cost Reporting/Data Collection Manual and all amendments thereto;
- C. "FFP" means Federal Financial Participation for Short Doyle/Medi-Cal services as authorized by Title XIX of the Social Security Act, 42 United States Code Section 1396 et seq.;
- D. "Director" means County's Director of Mental Health or an authorized designee;

- E. "DMH" means County's Department of Mental Health;
- F. "Fiscal Year" means County's Fiscal Year which commences July 1 and ends the following June 30;
- G. "MIS" means DMH's Management Information System;
- H. "SDMH" means DMH's State's Department of Mental Health; and
- I. "State" means the State of California.

WHEREAS, this agreement is authorized by California Education Code Section 8800 et seq., California Government Code Sections 23004, 26227 and 53703, California Welfare and Institutions Code Section 5600 et seq., and otherwise.

NOW, THEREFORE, Contractor and County agree as follows:

1. **TERM:**

A. Initial Period:

The Initial Period of this Agreement shall commence on _____ and shall continue in full force and effect through _____.

B. Automatic Renewal Period:

After the Initial Period, this Agreement shall be automatically renewed without further action by the parties hereto unless either party desires to terminate this Agreement at the end of the Initial Period and gives written notice to the other party not less than thirty days prior to the end of the Initial Period.

(1) **First Automatic Renewal Period:** If this Agreement is automatically renewed, the First Automatic Renewal Period shall commence on _____ and shall continue in full force and effect through _____.

(2) **Second Automatic Renewal Period:** If this Agreement is automatically renewed, the Second Automatic Renewal period shall commence on _____ and shall continue in full force and effect through _____.

C. Termination:

This Agreement may be terminated without cause at any time by either party by giving at least thirty days prior written notice to the other party.

2. **ADMINISTRATION:**

Director shall have the authority to administer this Agreement on behalf of County. Contractor shall designate in writing a Contract Manager who shall function as liaison with County regarding Contractor's performance hereunder. Director shall designate a DMH employee to function as liaison with Contractor regarding county's performance hereunder.

3. **SERVICES AND RESPONSIBILITIES:**

A. For the initial period contractor shall provide funds that qualify for match to Federal Financial Participation funds in the amount of _____ (Maximum Contract Amount) directly to the County. These funds provided to County by Contractor can be used to match Federal Financial Participation or to reimburse contract for the cost of services provided to non-Medi-Cal clients. For any subsequent years Contractor shall provide funds that qualify for Federal Financial Participation in the amount of _____ (Maximum Contract Amount) directly to the County.

B. For the initial term of the contract, contractor shall provide an executed *Certification Regarding Source of Funds for Short-Doyle/Medi-Cal Expenditures* directly to the County.

4. **PAYMENT:**

Contractor shall reimburse County for services provided under this Agreement within forty-five days from the date on County's invoice. All County invoices hereunder shall be a copy of the invoice submitted to County by the Provider of service and shall be submitted by County to Contractor at the following address:

All Contractor payments hereunder shall be submitted to County at the following address:

WORKSHEETS FOR MODELS

Model IA:

Certifying Another Agency - Service Expansion

Model IB:

Certifying Another Agency - Maintaining the Same Service Level with Cost Savings

Model IC:

Certifying Another Agency - Cost Savings and Service Expansion

Model IIA:

Providing Mental Health Services through a SD/MC Contract Provider

Model IIIA:

DMH: Providing Services with DMH Staff

Model IIIB:

DMH: Providing Services with Independent Contractors

Model IV:

Joint Staffing from More than Two Departments

DEVELOPING BLENDED FUNDING PROGRAMS – A MANUAL OF FINANCIAL STRATEGIES

MODEL IA - SERVICE EXPANSION**McCONNER UNIFIED SCHOOL DISTRICT
MEDI-CAL BLENDED FUNDING****PROPOSED FY 97-98 ANNUALIZED BUDGET****PERSONNEL**

<u>Position</u>	<u>5th Step Annual Salary</u>	<u>Total S & EB</u>	<u>FTE</u>	<u>Total</u>
Director	80,100	98,924	0.5	49,462
Assistant Director	60,000	74,100	1.0	74,100
Psychiatrist	103,100	127,329	0.3	31,832
Psychologist, Clinical	53,300	65,826	1.0	65,826
Psychologist, Educational	50,000	61,750	1.5	92,625
Licensed Clinical Social Worker	48,000	59,280	4.0	237,120
Marriage & Family Counselor	43,000	53,105	2.0	106,210
Secretary	35,200	43,472	1.0	43,472
Typist Clerk	26,000	32,110	1.0	32,110
Financial Worker	32,300	39,891	1.0	39,891
<u>Total Personnel</u>			<u>13.3</u>	<u>\$ 772,647</u>

SERVICES & SUPPLIES

Mileage	12,353
Overtime	0
Other	15,000
<u>Total Services & Supplies</u>	<u>\$ 27,353</u>

TOTAL PROGRAM COST

<u>TOTAL PROGRAM COST</u>	<u>\$ 800,000</u>
Proposed Medi-Cal FFP Revenue (100%). See attached Revenue Chart.	300,000
<u>ADJUSTED PROGRAM COST (CGF)</u>	<u>\$ 500,000</u>

MODEL IA - SERVICE EXPANSION

**McCONNER UNIFIED SCHOOL DISTRICT
MEDI-CAL BLENDED FUNDING PROPOSAL**

POTENTIAL MEDI-CAL REVENUE

<u>Services</u>	<u>Units of Service</u>	<u>Rate</u>	<u>MH Services Claim</u>
<u>Mental Health Services</u>			
Individual, Collateral (43 children x 60 min. x 44 wks.)	<u>113,520</u>	<u>\$1.86</u>	<u>211,147</u>
Group (3 x 2 clinicians x 6 children x 90 min. x 44 wks.)	<u>142,560</u>	<u>\$1.86</u>	<u>265,162</u>
Case Management Brokerage (25 children x 60 min. x 44 wks.)	<u>66,000</u>	<u>\$1.45</u>	<u>95,700</u>
<u>Medication Services</u>			
(3 hrs. x 60 min. x 44 wks.)	<u>7,920</u>	<u>\$3.46</u>	<u>27,403</u>
<u>TOTAL GROSS REVENUE</u>			<u>\$ 599,412</u>
<u>TOTAL GROSS MEDI-CAL REVENUE</u>			<u>\$599,412</u>
Only Medi-Cal eligible services are claimed on this contract.			
	M/C : <u>\$599,412</u>	{ CGF: FFP:	<u>\$299,706</u> <u>\$299,706</u>

DEVELOPING BLENDED FUNDING PROGRAMS – A MANUAL OF FINANCIAL STRATEGIES

MODEL IB - SAME LEVEL OF SERVICE WITH COST SAVINGS

**McCONNOR UNIFIED SCHOOL DISTRICT
MEDI-CAL BLENDED FUNDING**

PROPOSED FY 97-98 ANNUALIZED BUDGET

PERSONNEL

<u>Position</u>	<u>5th Step Annual Salary</u>	<u>Total S & EB</u>	<u>FTE</u>	<u>Total</u>
Director	80,100	98,924	0.5	49,462
Assistant Director	60,000	74,100	0.5	37,050
Psychiatrist	103,100	127,329	0.3	31,832
Psychologist, Clinical	53,300	65,826	1.0	65,826
Psychologist, Educational	50,000	61,750	1.0	61,750
Licensed Clinical Social Worker	48,000	59,280	2.0	118,560
Marriage & Family Counselor	43,000	53,105	1.0	53,105
Secretary	35,200	43,472	0.5	21,736
Financial Worker	32,300	39,891	1.0	39,891
<u>Total Personnel</u>			<u>7.75</u>	<u>\$ 479,211</u>

SERVICES & SUPPLIES

Mileage	13,289
Overtime	0
Other	7,500
<u>Total Services & Supplies</u>	<u>\$ 20,789</u>

TOTAL PROGRAM COST

TOTAL PROGRAM COST	<u>\$ 500,000</u>
Proposed Medi-Cal FFP Revenue (100%). See attached Revenue Chart.	150,000
<u>ADJUSTED PROGRAM COST (CGF)</u>	<u>\$ 350,000</u>

MODEL IB - SAME LEVEL OF SERVICE WITH COST SAVINGS

**McCONNER UNIFIED SCHOOL DISTRICT
MEDI-CAL BLENDED FUNDING PROPOSAL**

POTENTIAL MEDI-CAL REVENUE

<u>Services</u>	<u>Units of Service</u>	<u>Rate</u>	<u>MH Services Claim</u>
<u>Mental Health Services</u>			
Individual, Collateral (12 children x 60 min. x 44 wks.)	<u>31,680</u>	<u>\$1.86</u>	<u>58,925</u>
Group (2 x 2 clinicians x 6 children x 90 min. x 44 wks.)	<u>95,040</u>	<u>\$1.86</u>	<u>176,774</u>
Case Management Brokerage (12 children x 60 min. x 44 wks.)	<u>31,680</u>	<u>\$1.45</u>	<u>45,936</u>
<u>Medication Services</u>			
(2 hrs. x 60 min. x 44 wks.)	<u>5,280</u>	<u>\$3.46</u>	<u>18,269</u>
<u>TOTAL GROSS REVENUE</u>			<u>\$ 299,904</u>
<u>TOTAL GROSS MEDI-CAL REVENUE</u>			<u>\$299,904</u>

Only Medi-Cal eligible services are claimed on this contract.

M/C :	<u>\$299,904</u>		CGF:	<u>\$149,952</u>
			FFP:	<u>\$149,952</u>

DEVELOPING BLENDED FUNDING PROGRAMS – A MANUAL OF FINANCIAL STRATEGIES

MODEL IC - REDUCED GENERAL FUNDS AND SERVICE EXPANSION

**McCONNER UNIFIED SCHOOL DISTRICT
MEDI-CAL BLENDED FUNDING**

PROPOSED FY 97-98 ANNUALIZED BUDGET

PERSONNEL				
<u>Position</u>	<u>5th Step Annual Salary</u>	<u>Total S & EB</u>	<u>FTE</u>	<u>Total</u>
Director	80,100	98,924	0.5	49,462
Assistant Director	60,000	74,100	0.5	37,050
Psychiatrist	103,100	127,329	0.3	31,832
Psychologist, Clinical	53,300	65,826	1.0	65,826
Psychologist, Educational	50,000	61,750	1.0	61,750
Licensed Clinical Social Worker	45,570	56,279	3.0	168,837
Marriage & Family Counselor	43,000	53,105	2.0	106,210
Secretary	35,200	43,472	0.5	21,736
Financial Worker/Clerk	32,300	39,891	1.0	39,891
<u>Total Personnel</u>			<u>9.8</u>	<u>\$ 582,593</u>
SERVICES & SUPPLIES				
Mileage				3,000
Overtime				0
Other				14,407
<u>Total Services & Supplies</u>				<u>\$ 17,407</u>
<u>TOTAL PROGRAM COST</u>				<u>\$ 600,000</u>
Proposed Medi-Cal FFP Revenue (100%). See attached Revenue Chart.				200,000
<u>ADJUSTED PROGRAM COST (CGF)</u>				<u>\$ 400,000</u>

DEVELOPING BLENDED FUNDING PROGRAMS – A MANUAL OF FINANCIAL STRATEGIES

MODEL IC - REDUCED GENERAL FUNDS AND SERVICE EXPANSION

**McCONNER UNIFIED SCHOOL DISTRICT
MEDI-CAL BLENDED FUNDING PROPOSAL**

POTENTIAL MEDI-CAL REVENUE

<u>Services</u>	<u>Units of Service</u>	<u>Rate</u>	<u>MH Services Claim</u>
<u>Mental Health Services</u>			
Individual, Collateral (26 children x 60 min. x 44 wks.)	<u>68,640</u>	<u>\$1.86</u>	<u>127,670</u>
Group (2 x 2 clinicians x 6 children x 90 min. x 44 wks.)	<u>95,040</u>	<u>\$1.86</u>	<u>176,774</u>
Case Management Brokerage (20 children x 60 min. x 44 wks.)	<u>52,800</u>	<u>\$1.45</u>	<u>76,560</u>
<u>Medication Services</u>			
(2 hrs. x 60 min. x 44 wks.)	<u>5,280</u>	<u>\$3.46</u>	<u>18,269</u>
<u>TOTAL GROSS REVENUE</u>			<u>\$ 399,274</u>

TOTAL GROSS MEDI-CAL REVENUE

Only Medi-Cal eligible services are claimed on this contract.

M/C :	<u>\$399,274</u>		CGF:	<u>\$199,637</u>
			FFP:	<u>\$199,637</u>

DEVELOPING BLENDED FUNDING PROGRAMS – A MANUAL OF FINANCIAL STRATEGIES

MODEL IIA - MH SERVICES THROUGH A CONTRACT AGENCY**DMH/DSS FAMILY PRESERVATION
MEDI-CAL BLENDED FUNDING****PROPOSED FY 97-98 ANNUALIZED BUDGET****PERSONNEL**

<u>Position</u>	<u>5th Step Annual Salary</u>	<u>Total S & EB</u>	<u>FTE</u>	<u>Total</u>
Psychiatrist	103,100	127,329	0.1	12,733
Psychologist, Clinical (Director)	53,300	65,826	1.0	65,826
Licensed Clinical Social Worker	48,000	59,280	1.0	59,280
Marriage & Family Counselor	43,000	53,105	4.0	212,420
Secretary	26,000	32,110	1.0	32,110
<u>Total Personnel</u>			<u>7.1</u>	<u>\$ 382,368</u>

SERVICES & SUPPLIES

Mileage	7,632
Overtime	0
Other	10,000
<u>Total Services & Supplies</u>	<u>\$ 17,632</u>

TOTAL PROGRAM COST**\$ 400,000**

Proposed Medi-Cal FFP Revenue (60%). See attached Revenue Chart.

150,000**ADJUSTED PROGRAM COST (CGF)****\$ 250,000**

MODEL IIA - MH SERVICES THROUGH A CONTRACT AGENCY

**DMH/DSS FAMILY PRESERVATION
MEDI-CAL BLENDED FUNDING PROPOSAL**

POTENTIAL MEDI-CAL REVENUE

<u>Services</u>	<u>Units of Service</u>	<u>Rate</u>	<u>MH Services Claim</u>
<u>Mental Health Services</u>			
Individual, Collateral (45 children x 60 min. x 52 wks.)	<u>140,400</u>	<u>\$1.86</u>	<u>261,144</u>
Case Management Brokerage (44 children x 60 min. x 52 wks.)	<u>137,280</u>	<u>\$1.43</u>	<u>196,310</u>
<u>Medication Services</u>			
(4 hrs. x 60 min. x 52 wks.)	<u>12,480</u>	<u>\$3.46</u>	<u>43,181</u>
<u>TOTAL GROSS REVENUE</u>			<u>\$ 500,635</u>
<u>TOTAL GROSS MEDI-CAL CLAIM</u>			<u>\$300,380</u>
60% of the services are M/C eligible			
	M/C : <u>\$300,380</u>	{ CGF: FFP:	<u>\$150,190</u> <u>\$150,190</u>

DEVELOPING BLENDED FUNDING PROGRAMS – A MANUAL OF FINANCIAL STRATEGIES

MODEL IIIA - DMH PROVIDES SERVICES WITH DMH STAFF**TEEN TIME
MEDI-CAL BLENDED FUNDING****PROPOSED FY 97-98 ANNUALIZED BUDGET****PERSONNEL**

<u>Position</u>	<u>5th Step Annual Salary</u>	<u>Total S & EB</u>	<u>FTE</u>	<u>Total</u>
Licensed Clinical Social Worker	46,500	57,428	0.4	22,971
Licensed Clinical Social Worker	46,500	57,428	0.4	22,971
Community Worker	34,000	41,990	0.5	20,995
<u>Total Personnel</u>			<u>1.3</u>	<u>\$ 66,937</u>

SERVICES & SUPPLIES

Mileage				701
Other				0
<u>Total Services & Supplies</u>				<u>\$ 701</u>

PROGRAM SERVICES COST

DMH Administrative Fee (2.5% of Program Services Cost)				1,690
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TOTAL PROGRAM COST

Proposed Medi-Cal FFP Revenue (73%). See attached Revenue Chart.				29,328
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ADJUSTED PROGRAM COST (CGF)

				<u>\$ 40,000</u>
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MODEL IIIA - DMH PROVIDES SERVICES WITH DMH STAFF

**TEEN TIME
MEDI-CAL BLENDED FUNDING PROPOSAL**

POTENTIAL MEDI-CAL REVENUE

<u>Services</u>	<u>Units of Service</u>	<u>Rate</u>	<u>MH Services Claim</u>
<u>Mental Health Services</u>			
Individual, Collateral (12 youth x 60 min. x 48 wks.)	<u>34,560</u>	<u>\$1.86</u>	<u>64,282</u>
Group (2 clinicians x 90 min. x 48 wks.)	<u>8,640</u>	<u>\$1.86</u>	<u>16,070</u>
<u>TOTAL GROSS REVENUE</u>			<u>\$80,352</u>
<u>TOTAL GROSS MEDI-CAL CLAIM</u>			<u>\$58,656</u>
73% of the services are M/C eligible			
	M/C : <u>\$58,656</u>	{ CGF: FFP:	<u>\$29,328</u> <u>\$29,328</u>

MODEL IIIB - DMH PROVIDES WITH INDEPENDENT CONTRACTORS

**D-RATE FOSTER CARE
MEDI-CAL BLENDED FUNDING**

PROPOSED FY 97-98 ANNUALIZED BUDGET

PERSONNEL

None

0

SERVICES & SUPPLIES

183 Assessments @ \$522 each

95,526

PROGRAM SERVICES COST

\$ 95,526

DMH Administrative Fee (2.5% of Program Services Cost)

2,237

TOTAL PROGRAM COST

\$ 97,763

Proposed Medi-Cal FFP Revenue (100%). See attached Revenue Chart.

47,763

ADJUSTED PROGRAM COST (CGF)

\$ 50,000

MODEL IIIB - DMH PROVIDES WITH INDEPENDENT CONTRACTORS

**D-RATE FOSTER CARE
MEDI-CAL BLENDED FUNDING PROPOSAL**

POTENTIAL MEDI-CAL REVENUE

<u>Services</u>	<u>Units of Service</u>	<u>Rate</u>	<u>MH Services Claim</u>
<u>Case Management Brokerage *</u> (183 Assessments x 6 hrs. x 60 min.)	<u>65,880</u>	<u>\$1.45</u>	<u>95,526</u>
<u>TOTAL GROSS REVENUE</u> 100% of the services are M/C eligible			<u>\$ 95,526</u>
	M/C :	<u>\$95,526</u>	
		CGF:	<u>\$47,763</u>
		FFP:	<u>\$47,763</u>

* Case Management Brokerage is claimed for these one-time assessments.

DEVELOPING BLENDED FUNDING PROGRAMS – A MANUAL OF FINANCIAL STRATEGIES

MODEL IV - JOINT STAFFING FROM MORE THAN TWO DEPARTMENTS

**300/600 INTENSIVE CASE MANAGEMENT
MEDI-CAL BLENDED FUNDING**

PROPOSED FY 97-98 ANNUALIZED BUDGET

DMH PERSONNEL

<u>Position</u>	<u>5th Step Annual Salary</u>	<u>Total S & EB</u>	<u>FTE</u>	<u>Total</u>
Psychologist, Clinical	63,968	79,000	1.0	79,000
<u>Total - DMH Personnel</u>			<u>1.0</u>	<u>\$ 79,000</u>

PROBATION PERSONNEL

<u>Position</u>	<u>5th Step Annual Salary</u>	<u>Total S & EB</u>	<u>FTE</u>	<u>Total</u>
Deputy Probation Officer II	48,583	60,000	1.0	60,000
<u>Total - Probation Personnel</u>			<u>1.0</u>	<u>\$ 60,000</u>

<u>TOTAL PERSONNEL</u>			<u>2.0</u>	<u>\$ 139,000</u>
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<u>TOTAL PROGRAM COST</u>				<u>\$ 139,000</u>
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Proposed Medi-Cal FFP Revenue (80%). See attached Revenue Chart.				69,500
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<u>ADJUSTED PROGRAM COST (CGF)</u>				<u>\$ 69,500</u>
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MODEL IV - JOINT STAFFING FROM MORE THAN TWO DEPARTMEN

**300/600 INTENSIVE CASE MANAGEMENT
MEDI-CAL BLENDED FUNDING PROPOSAL**

POTENTIAL MEDI-CAL REVENUE

<u>Services</u>	<u>Units of Service</u>	<u>Rate</u>	<u>MH Services Claim</u>
<u>Mental Health Services</u> (220 days x 4 hrs. x 60 min.)	<u>52,800</u>	<u>\$1.86</u>	<u>98,208</u>
<u>Case Management Brokerage</u> (220 days x 4 hrs. x 60 min.)	<u>52,800</u>	<u>\$1.45</u>	<u>76,560</u>
<u>TOTAL GROSS REVENUE</u>			<u>\$ 174,768</u>
<u>TOTAL GROSS MEDI-CAL REVENUE</u> 80% of the services are M/C eligible			<u>\$139,000</u>
	M/C : <u>\$139,000</u>	<div style="display: inline-block; vertical-align: middle;"> <div style="font-size: 2em; margin-right: 5px;">{</div> <div style="display: inline-block; vertical-align: middle;"> CGF: <u>\$69,500</u> FFP: <u>\$69,500</u> </div> </div>	

About the Author

Susan Edelman received her Masters Degree in Economics from the University of Minnesota. She is presently the Chief, Revenue Expansion and Development for the Children and Family Services Bureau, Los Angeles County Department of Mental Health. She has made presentations on the subject of Blended Funding for a variety of public service agencies and conferences throughout the State of California.