

FINANCING CHILDREN'S MENTAL HEALTH PROGRAMS *REVISED EDITION*

Editor's Note: The Cathie Wright Center for Technical Assistance to Children's System of Care received some feedback concerning the clarity of some of the technical detail in its January/February issue of CWTAC Updates entitled "Financing Children's Mental Health Programs" (Volume 2, Issue 1). Pursuant to this feedback the document has been edited. This May/June issue represents that edited version. Please discard the January/February newsletter and replace it with this May/June issue. The Cathie Wright Center regrets any confusion.

A system of care approach to serving children and families offers participating human service agencies opportunities to develop collaborative fiscal strategies to meet their individual and joint goals and objectives. Collaborative fiscal strategies allow the participating agencies to maximize their existing revenue sources in ways that are not possible for individual agencies that act alone. For example, the county office of education may be able to access additional federal funds for mental health services provided in special education programs when they partner with county mental health. As a county generates additional federal and/or state revenue with collaborative fiscal strategies it is in a better position to expand its array of community-based services designed to maintain children with severe emotional disorders (SED) in the least restrictive setting. A county may also be able to serve the same number of children with less money as they serve them in less restrictive settings. These cost savings can be reinvested into expanded community-based services to meet the needs of more children and families at equal or less cost to the county.

The first step in developing a collaborative fiscal strategy is to have at least a basic understanding of the resources available to Children's System of Care partner agencies. This includes understanding the funding sources available to each partner agency, the services for which each funding source may be used, the children eligible to receive those services, and the process by which agencies may access those resources.

This article represents the first in a series intended to begin developing that understanding among Children's System of Care partner agencies. It provides an overview of the major funding sources available to county mental health departments that may be used to deliver children's mental health services. Forthcoming articles will provide similar overviews of the funding sources available in other system of care partner agencies, which include, but are not limited to county welfare, probation and special education.

The majority of California's public mental health services for children are delivered at the local level. Counties finance these services from a number of different funding sources, including:

- ❖ **Mental Health Realignment Funds**
- ❖ **Federal Medi-Cal Funds**
- ❖ **State Funded Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**
- ❖ **Children's System of Care Funding**
- ❖ **Mental Health Services for Special Education Pupils' Program (AB 3632, AB 2726, Chapter 26.5)**
- ❖ **Center for Mental Health Services Block Grant (CMHS)**
- ❖ **Healthy Families Program¹**

These funding sources target different populations of children, fund different services, and have different levels of flexibility.

FUNDING SOURCES

Mental Health Realignment

The 1991 program Realignment created the **Local Revenue Fund** in the State Treasury. The Local Revenue Fund is comprised of revenue collected from a half-cent sales tax and a portion of vehicle license fees. These funds are continuously allocated to each county's mental health, health, and social services accounts pursuant to statutory formulas and schedules.² Before the Local Revenue Fund dollars are deposited into a county's local mental health account, the county must provide a maintenance of effort (MOE) pursuant to a schedule developed by the State Department of Mental Health (SDMH) that is based upon each county's matching obligations for the 1990-91 Fiscal Year for mental health programs. In addition, counties with a population in excess of one hundred twenty-five thousand must also provide a ten-percent match for all state general fund mental health allocations not realigned. Counties may also deposit funds into the local mental health account that are in excess of their required ten percent match, referred to as overmatch. County Boards of Supervisors may shift up to ten percent of the funds allocated from the Local Revenue Fund to the local mental health account into the local social services or health accounts if certain conditions are met. However, the amount of the county maintenance of effort does not change as Local Revenue Fund dollars are shifted from the local mental health account into other local health and welfare trust

fund accounts or as realignment funds allocated to the county's local mental health fund increase.

The Local Revenue Fund dollars, county MOE, county match and county overmatch available in the local mental health account finance the base of a county mental health system. The Local Revenue Fund dollars, County MOE, and county match may be used to deliver any mental health service described in the Bronzan-McCorquodale Act. This includes meeting the state/local match required to draw down federal financial participation for mental health services delivered through the Medi-Cal or Healthy Families programs and meeting any county costs incurred in providing mental health services delivered to children who are eligible through the Mental Health Services for Special Education Pupils' Program (AB 3632). The county overmatch may be used to deliver those Bronzan-McCorquodale mental health services and any other mental health services the county decides to deliver. Mental Health Realignment funds finance the base of a county mental health system by leveraging federal funds and financing services delivered to children who are not eligible to receive mental health services through those federal programs or non-eligible services to eligible children.

Medi-Cal Funds

Children and families that meet Medi-Cal eligibility and medical necessity criteria are entitled to mental health services available through the **Medi-Cal** program. The manner in which these services are delivered and financed has changed over the past decade.

The Medi-Cal program has traditionally offered specialty mental health services through **two distinct service delivery systems, the Fee-For-Service Medi-Cal (FFS/MC) and Short-Doyle Medi-Cal (SD/MC) systems.** In the **FFS/MC** system, licensed psychologists and psychiatrists who were FFS/MC providers delivered inpatient and outpatient services (generally at 2 per month) to Medi-Cal beneficiaries. The majority of services delivered in the FFS/MC system were inpatient hospital services. The **SD/MC** system was a part of the Short-Doyle (now Bronzan-McCorquodale) County Mental Health Program. Medi-Cal beneficiaries that met medical necessity criteria could access mental health inpatient hospital, rehabilitative, and case management services through the SD/MC system.

In addition to providing different types of services, these

(Continued on page 3)

Mental Health Funding *(Continued from page 2)*
 two systems were financed differently. Medi-Cal eligible mental health services delivered through both systems were partially financed with federal funds (currently 51.23%). However, the state match to draw down the federal funds was appropriated differently in each system. The State Department of Health Services was responsible for meeting the match to draw down federal funds for all mental health services delivered through the FFS/MC system. Prior to Mental Health Realignment, counties received a State General Fund allocation to operate its Short-Doyle county mental health program. This allocation was subject to the budgetary process and varied from year to year. Counties were responsible for managing those funds to provide mental health services to non-Medi-Cal eligible clients as well as meeting the match to draw down federal funds for mental health services delivered through the SD/MC system. As discussed in the last section, Mental Health Realignment took the place of the State General Fund allocation and provided a stable source of funding that counties may use to meet those obligations.

California is currently in the process of implementing a **Medi-Cal Managed Care Mental Health Program**, which is changing the manner in which Medi-Cal mental health services are delivered and financed. As part of Managed Care, the State Department of Mental Health must contract with a Mental Health Plan (MHP) to serve each county. By contracting with the SDMH, the MHP takes responsibility for delivering specialty mental health services to all Medi-Cal beneficiaries within the county being served. While the county has the right of first refusal, each county, except Sierra County, has currently chosen to be the MHP.³ However, if a county chooses to no longer be the MHP or if its contract with the SDMH is terminated, the SDMH may designate another qualifying entity to be the MHP. Qualifying entities include:

- ❖ another county,
- ❖ other counties acting jointly, or
- ❖ other governmental and non-governmental entities

The Medi-Cal Managed Care Mental Health Program is also being implemented in phases. The first two phases, which have been completed, consolidated the FFS/MC and SD/MC systems. Phase One consolidated FFS/MC and SD/MC psychiatric inpatient hospital services. As a result of Phase One consolidation, each Mental Health Plan receives a State General

Fund allocation that is equal to its county's share of the state's total expenditure for the nonfederal cost of FFS/MC inpatient hospital services prior to Phase One consolidation. **Phase Two consolidated FFS/MC outpatient services.** As a result of Phase Two consolidation, each MHP receives a State General Fund allocation that is equal to its county's share of the state's total expenditures for the nonfederal cost of FFS/MC outpatient services delivered prior to Phase Two consolidation. Growth funds will also be allocated to MHP's serving counties that historically received the lowest amount of Medi-Cal funds for specialty mental health services per beneficiary. The methodology for determining the funding amounts and the manner in which those amounts are allocated may be changed in the future. Now that the FFS/MC and SD/MC systems have been consolidated, MHPs are responsible for authorizing and financing the delivery of Medi-Cal specialty mental health services, excluding medication, laboratory, and skilled nursing facility services.

The intent of moving towards a Managed Mental Health system is to eventually establish a system where federal funds are also pre-paid to counties.

Under a **pre-payment system**, the federal share of cost for Medi-Cal mental health services would be allocated to each mental health plan in a fixed dollar amount. Such a fiscal structure would place the mental health plan at **total** fiscal risk for delivering specialty mental health services, excluding medication, laboratory, and skilled nursing facility services. The SDMH is currently considering a number of other options that share the counties' risk for these services with the state and/or federal government.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Within the Medi-Cal program is the **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** benefit. The federal Omnibus Budget Reconciliation Act of 1989 required state EPSDT programs to provide the following services to Medicaid-eligible beneficiaries ages 0 to 21:

- ❖ Effectively inform individuals of the screening and treatment services available under the EPSDT program
- ❖ Provide screening services to identify defects, conditions and illnesses
- ❖ Provide the diagnostic and treatment services

(Continued on page 4)

Mental Health Funding *(Continued from page 3)*

needed to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan

In November 1993, a group of California based attorneys brought a lawsuit (*Smith v. Belshe*) against the Department of Health Services asking that the department expand its EPSDT benefit. The EPSDT mental health benefit implemented pursuant to the lawsuit provides increased state funding for Medi-Cal specialty mental health services, excluding hospital inpatient services, delivered to full scope Medi-Cal beneficiaries ages 0 to 21. For the purposes of EPSDT funding, specialty mental health services include substance abuse treatment to meet the mental health treatment needs of full scope Medi-Cal beneficiaries ages 0 to 21 (hereafter, these services will be referred to as EPSDT-eligible services). To implement this EPSDT mental health benefit, the State Department of Health Services developed an inter-agency agreement with the SDMH through which mental health plans are reimbursed the entire non-federal share of cost for all EPSDT-eligible services that are in excess of expenditures made beyond the Fiscal Year 1994-95 baseline in the county being served.

Beginning in Fiscal Year 1998-99, each county's Fiscal Year 1994-95 baseline will be adjusted in the following manner:⁴

- ❖ Each county's baseline will be increased annually by the home health care market basket cost of living adjustment unless the growth in realignment is less than the home health care market basket. If that is the case, the baseline will be adjusted by the expected growth in realignment. If there is no expected growth in realignment, the baseline will not be adjusted.
- ❖ Each county's baseline will also be increased by the amount of its managed care State General Fund (SGF) allocation based on its historical percentage of EPSDT services. This adjustment began in Fiscal Year 1997-98.
- ❖ In addition, each county's baseline will be increased in each fiscal year by the amount of other-source funds it uses to finance EPSDT-eligible services that are in excess of the amount it used for that purpose in Fiscal Year 1994-95.⁵

In addition to making changes to the EPSDT baseline, the SDMH has modified the manner in which mental

health plans receive advanced EPSDT payments. **Effective in Fiscal Year 1998-99, the SDMH will annually distribute to each mental health plan an amount that is equal to seventy-five percent of their estimated state funding for EPSDT expenditures in the prior fiscal year.** Mental health plans will be required to remit to the SDMH any advanced EPSDT funds they do not use. The SDMH will continue to provide State General Fund EPSDT reimbursements to mental health plans for the allowable cost of EPSDT services that are in excess of their advanced distribution.⁶ This change in how EPSDT state general fund reimbursements are distributed does not affect the process by which counties claim and receive Medi-Cal FFP.

As a result of state funding of EPSDT mental health services, each mental health plan is reimbursed 100 percent of the allowable treatment cost of providing EPSDT-eligible services once it reaches its adjusted baseline expenditures. However, the funding agreement that implements the EPSDT mental health benefit is subject to the annual state budgetary process and its future is currently being questioned by the Legislative Analyst's Office.

Children's System of Care Funding

Children's System of Care funding provides some counties, through a competitive application process, with a source of funding that can be used flexibly to meet the needs of children with multi-agency needs. **Children's System of Care is financed through three distinct funding streams:**

- ❖ **State General Fund (SGF) allocation**
- ❖ **Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant**
- ❖ **Federal Block Grant**

Counties awarded an SGF allocation will continue to receive those funds subject to the budgetary process. The DMH also awards counties funding to implement a Children's System of Care program from its federal SAMHSA Block Grant. A county that receives funding from the federal SAMHSA Block Grant will receive those funds subject to the federal budgetary process. Some counties also receive a direct Federal Block Grant from the SAMHSA to implement a Children's System of Care program. Counties receiving this Federal Block Grant receive funding on a declining basis for five

(Continued on page 5)

Mental Health Funding (Continued from page 4)
 years.

Children's System of Care funds may be used to finance any services and/or support costs needed to maintain children with a serious emotional disturbance in the least restrictive environment. While most funds are used to purchase treatment and support services, counties may purchase non-traditional services such as fixing a parent's automobile, purchasing a jacket for a child, providing support to a parent with a difficult child, or delivering other nontraditional mental health services to a child with a serious emotional disturbance.

Mental Health Services for Special Education Pupils' Program (AB 3632, AB 2726, and Chapter 26.5)

Pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, children who are referred to county mental health through their **Individual Education Plan (IEP)** and are determined to require mental health services to benefit from a free and appropriate public education are eligible to receive appropriate services. Counties receive a State General Fund categorical allocation to deliver these services pursuant to a historically based formula. Since children identified through their IEP as needing mental health services are entitled to necessary services, counties must provide those services even if they have exhausted their AB 3632 categorical allocation. History has demonstrated that the AB 3632 categorical allocation is insufficient to meet the mental health needs of special education pupils. Therefore, counties often have to identify additional resources (i.e., realignment, Children's System of Care, county general fund, Medi-Cal-EPSDT, or federal) to pay for the cost of services in excess of their AB 3632 categorical allocation.

The Commission on State Mandates has ruled that the Special Education Pupils' Program is a state mandated program and, therefore counties are entitled to State General Fund reimbursement for the costs they bear in implementing the Program. However, in its decision, the Commission distinguished between the county cost for administrative activities and mental health treatment services. The distinction is that mental health treatment services provided to special education pupils represent an expansion of the Short-Doyle Act (now the Bronzan-McCorquodale Act). Services delivered through the Short-Doyle Act in counties with populations in excess

of one hundred twenty-five thousand are financed at a sharing ratio of ninety percent state and ten percent county funds. Consequently, the county cost for treatment services mandated by the Special Education Pupils' Mental Health Program delivered in counties with population in excess of one hundred twenty-five thousand is ten percent. Counties with population less than or equal to one hundred twenty-five thousand do not have a share of cost for mental health services delivered through the Short-Doyle Program. Therefore, those counties may not claim state mandates reimbursement for mental health treatment services delivered to children eligible through the Special Education Pupils' Mental Health Program. However, the administrative activities (participation in IEP meetings, conducting assessments, and case management) that county mental health is required to perform do not represent an expansion of the Short-Doyle Act. Consequently, all counties may claim state mandates reimbursement for one hundred percent of the cost of those administrative activities.

A county wishing to recoup the costs for AB 3632 treatment services and administrative activities that are in excess of its AB 3632 categorical allocation must submit an annual claim to the State Controller's Office. A county may submit a claim of estimated costs for the Special Education Pupils' Mental Health Program prior to the beginning of the fiscal year to obtain up-front funding. Counties that request an estimated reimbursement are subject to a cost settlement process at the end of the fiscal year. Instead of submitting a claim that estimates costs for the program, a county may submit a claim for actual costs at the end of the fiscal year. The submission of these claims is subject to time-lines specified in the authorizing statute.

Center for Mental Health Services Block Grant (CMHS)

The SDMH receives an annual CMHS Block Grant from SAMHSA pursuant to Public Law (PL) 102-321. These funds are intended to finance mental health services for children with a serious emotional disturbance and adults and older adults with serious and persistent mental illness.⁷ Occasionally, the SDMH sets aside a small portion of the funds to establish pilot projects to address specific needs of the target population such as dual diagnosis or homelessness. However, the majority of CMHS Block Grant Funds are allocated to counties in the following manner:

(Continued on page 6)

Mental Health Funding *(Continued from page 5)*

- ❖ Each county may submit to the SDMH a SAMHSA plan that delineates the programs and services the county would use the CMHS funds to finance.
- ❖ The SDMH allocates the CMHS Block Grant Funds among those counties pursuant to a historically based formula.
- ❖ Finally, counties use the CMHS funds to implement the services they have identified in their plan.⁸

However, DMH policy regarding the administration of SAMHSA funds is flexible. Counties are generally allowed to amend their SAMHSA plan at a later date if they identify additional or different community needs.

Healthy Families Program

In addition to Medi-Cal, counties are also eligible to receive federal reimbursement for mental health services delivered to children through the **Healthy Families** program. Healthy Families is a new program designed to provide health insurance to children who are between 1 and 19 years of age, are not eligible for no-cost federal Medi-Cal, are below two hundred percent of federal poverty (between approximately one hundred percent and two hundred percent of federal poverty), and are not covered by third-party insurance.⁹ Children enrolled in the Healthy Families Program who are identified as having a **serious emotional disturbance (SED)** by county mental health are eligible to receive the full scope of Medi-Cal-like specialty mental health services to the extent county resources are available.¹⁰ These mental health services are financed with approximately sixty-six percent federal funds and thirty-four percent state and/or local funds.¹¹

Some of the children served in the Healthy Families Program are expected to be county mental health clients who were formerly served with one hundred percent realignment funds. Counties will save approximately sixty-six percent of the cost to provide the same level of care to those children, which can be used to expand services. However, the majority of children identified with SED in the Healthy Families program are expected to be new to the system. These new clients will place further strain upon the limited resources available to county mental health as counties will need to find the thirty-four percent state and/or local match to draw down the

sixty-six percent Federal Financial Participation (FFP) while continuing to meet their current obligations. This new need to find additional state and local resources creates an additional incentive for counties to pursue blended funding opportunities to leverage current resources for children's services.

GUIDELINES FOR EFFICIENT USE OF FUNDS

The goal for county children's mental health systems is to use their limited resources to best meet the mental health needs of their children and families. While the various children's mental health funding sources target different child populations, fund different services, and have different levels of flexibility, there are also areas where they overlap. As such, it is important for counties to carefully choose which funding sources they use to finance particular services so that they are able to stretch their limited resources and develop a comprehensive set of county mental health services for their communities. This section **highlights the issues a county should consider when choosing which funding sources to use for particular mental health services.**

- ❖ **Which state/local funds to use as match to draw down Medi-Cal FFP for specialty mental health services, excluding hospital inpatient services but including substance abuse treatment services intended to meet a mental health treatment need, delivered to full scope Medi-Cal beneficiaries ages 0 to 21?** Each County receives a State General Fund reimbursement that is the state/local match to draw down Medi-Cal FFP for the cost of those services that are in excess of its Fiscal Year 1994-95 adjusted baseline expenditures (EPSDT SGF reimbursement). However, the size of a county's Fiscal Year 1994-95 adjusted baseline depends upon the state and local funds it chooses as the state/local match to draw down Medi-Cal FFP for the cost of those services that are below its Fiscal Year 1994-95 adjusted baseline. Pursuant to DMH Information Notice #98-03 (March 6, 1998), each dollar of other source funds used to draw down Medi-Cal FFP for EPSDT-eligible services that are in excess of those used for that purpose in Fiscal Year 1994-95 decreases the State General Fund EPSDT reimbursement by one dollar. However, mental health realignment funds have no impact upon the EPSDT base and therefore the State General Fund

(Continued on page 7)

Mental Health Funding *(Continued from page 6)*

EPSDT reimbursement, when used as match to draw down Medi-Cal FFP for EPSDT-eligible services.

- ❖ **Which state/local funds to use as match to draw down Healthy Families FFP?** Realignment and other-source funds are equally valuable as a match for Healthy Families FFP. However, realignment funds may best be used as match for Medi-Cal FFP for EPSDT-eligible services until the baseline is reached. Consequently, other source funds are better targeted as match for Healthy Families FFP.
- ❖ **Which funds to use to finance service needs not met by the Medi-Cal and Healthy Families programs?** Federal and other source funds are often targeted for specific activities or for specific child populations. Obviously, those federal and other source funds should be used for their targeted purposes. However, after applying those targeted federal and other source funds, a county should first use its flexible federal funds (i.e. SAMHSA, and federal CSOC funds) to fill remaining service needs. The reason for this is that federal funds may not be used as match to draw down federal financial participation. After exhausting federal funds, counties should use other source funds to meet remaining mental health service needs. Mental Health realignment funds are the last source of funds a county should use to fill service needs not covered by the Medi-Cal and Healthy Families programs.

A county that contemplates these issues as it chooses which resources to use to finance particular mental health services will be able to stretch its limited mental health resources and build a more comprehensive set of county mental health services to meet a significant portion of mental health needs among its children and their families. ♦

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mental health, health, and social services account in order to receive funds from the Local Revenue Fund.

³Placer County has contracted with the SDMH to be the MHP serving Sierra County. This is consistent with the historical relationship between Placer County and Sierra County.

⁴The method for adjusting the EPSDT baseline is discussed in DMH Information Notice 98-03 (March 6, 1998) and DMH Information Notice 98-12 (August 12, 1998).

⁵Other-source funds include the Children's System of Care state general fund allocation and other county and state funds transferred to the county mental health department from other county agencies or schools through a contract or interagency agreement which puts those funds under the control of the county department of mental health.

⁶Please refer to the State Department of Mental Health letter, dated November 18, 1998, that was distributed to all Mental Health Plan Directors.

⁷CMHS employs the federal definition of serious emotional disturbance, which is slightly different from the state's definition. Consequently, these funds may not serve the exact population that is served with State General Fund dollars dedicated to providing mental health services to children with SED (i.e., Children's System of Care continuous allocation).

⁸Please note that only 10 percent of a county's CMHS Block Grant may be used to finance administration of CMHS programs.

⁹While this is the current eligibility standard, a number of bills have been introduced in the current legislative session that are designed to refine the Healthy Families eligibility standards.

¹⁰A conflict resolution process to resolve disagreements between the county mental health system and the Healthy Families health care provider will be identified in a Memorandum of Understanding between the two parties. This is specified in the contract between the Managed Risk Medical Insurance Board (MRMIB) and the Healthy Families health care provider.

¹¹Pursuant to the Healthy Families regulations and specified in the MOU between the health care provider and county mental health department, the health care provider retains responsibility for the annual 30 days of inpatient hospital services contained in the Healthy Families benefit package after a child begins receiving Medi-Cal-like specialty mental health services from county mental health. However, pursuant to DMH Information Notice 98-14, the health care provider is no longer responsible for the 20 days of outpatient services contained in the Healthy Families benefit package. Each inpatient hospital day may be substituted for two residential-treatment days or three day-treatment program days.

¹In addition to using these funding streams, mental health services may be partially financed by clients seeking those services based upon a Uniform Method of Determining Ability to Pay (UMDAP) or recouping costs from third party insurance or Medicare. These methods of recouping costs represent a very small portion of total mental health expenditures in any one fiscal year.

²A county must establish a local welfare trust fund comprised of a



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