PUBLIC MENTAL HEALTH FUNDING: CALIFORNIA AND SAN DIEGO COUNTY

San Diego County League of Women Voters,
Committee to Update Mental Health Care Position, February 2015

Realignments (1991, 2011, and Criminal Justice [AB 109])

1991 Realignment

The state's mental health communities and counties worked hard to obtain the realignment in 1991. Advocates felt that little of what had been promised for mental health had been delivered. Funds were supposed to follow the people who were released from state hospitals during the Reagan administration back to their communities, but the state funds were diverted elsewhere. As of 1978, counties were forced to rely almost completely on state funds by the enactment of Prop. 13. Year after year, bills to adequately fund community mental health didn't make it through appropriations or off the governor's desk.

The term 1991 Realignment refers to a fiscal arrangement between the state and counties that dedicates portions of Vehicle License Fees (VLF) and Sales Tax revenues to county health, mental health, and social services programs for their base budgets. Realignment simply means that state responsibilities are realigned to the counties.

Under the 1991 realignment funding structure, a county's previous funding levels determined its base allocation. Counties that had invested more local money in mental health programs received a greater portion of funding going forward. Counties anticipated that realignment revenue would grow over time, and that it would keep pace with inflation and increased demand for mental health services. However, actual revenues never met these expectations. A last-minute amendment to the original 1991 realignment growth formula eventually proved detrimental to mental health services funding. The growth formula determined how tax revenue was distributed after annual base allocations were met — this leftover revenue is referred to as growth funding. The sales tax growth funding was distributed first to meet increased caseloads in county-operated social services entitlement programs.

Any remaining sales tax growth funds and all vehicle license growth funds were then allocated proportionately among social services, public health, and mental health accounts. As social services caseloads increased over the subsequent 20 years, mental health programs received a smaller and smaller share of the growth allocation. Eventually, the mental health funding base stagnated because inflation in health care costs and increased caseloads exceeded the annual increase to the base allocation for mental health services, and in some years, these revenues actually declined. By 2010, the mental health realignment base revenues roughly equaled the original baseline amounts from 1992, after accounting for inflation.

Downturns in the economy and legislative reduction of the VLF also directly impacted counties' base mental health budgets.

2011 Realignment

The Brown administration was interested in moving more service decisions to the local level AND in reducing the state budget. Governor Brown consequently pushed a new realignment under the title of public safety programs that subsumed the previous 1991 realignment and did other shifting. The bills that implemented his proposals shifted all mental health responsibilities to the counties except for Medi-Cal services, which were taken back to the state and headquartered in the Department of Health Care Services.

The 2011 realignment structure established that a portion of a 1.0625% state sales tax be deposited in each county's behavioral health subaccount, which funds the following: various drug and alcohol treatment programs, the Medi-Cal Mental Health Managed Care Program, and Medi-Cal's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health program for children. Counties were already administering these programs, and with the 2011 realignment, they have become responsible for fully financing them as well.

The 2011 base allocation for the realignment mental health programs came from a one-time diversion of $860 million in Mental Health Services Act (MHSA – see below) funds approved by the state. The state Department of Finance, in collaboration with the California Mental Health Directors Association, developed an allocation formula to distribute the revenue among counties. Each county received a proportional share of the diverted MHSA funding based on the amount of program funds that the state otherwise would have distributed to each county in FY 2011–12.

The Proposition 30 ballot measure, which was passed by voters in November 2012, requires the state to provide counties with the redirected funds and gives counties legal grounds to resist new unfunded state mandates or obligations. Proposition 30 also prohibits the state from passing any new laws, regulations, or administrative orders that increase county costs without providing additional funding.

2011 Criminal Justice Realignment (AB 109)

Also passed and implemented in 2011, AB 109 provided the framework for the transfer of responsibility and funding for various adult offender populations and vested county Community Corrections Partnerships with the responsibility to advise county boards of supervisors how their county should implement realignment and invest resources at the local level. Counties are now responsible for low-level offenders (non-serious, non-violent, non-sex offenses), post-release community supervision, and parole violators.

Funding for this realignment comes from increased portions of state sales tax revenue and vehicle licensing fees. This realignment has been a challenge for all counties but many, including San Diego County, have found it to also be an opportunity to develop alternatives to putting people in cells.

Mental Health Services Act (MHSA)

In November 2004, voters in California passed Proposition 63, the Mental Health Services Act (MHSA), which was designed to expand and transform California's county mental health service systems. The MHSA is funded by an additional one percent tax on individual, but not corporate, taxable income in excess of one million dollars.

Passed before the economic downturn and the 2011 Realignment, it was anticipated that the MHSA would fund new programs that had been requested for a long time, but officials could not implement because all funds were being used for basic services.

To accomplish its objectives, the MHSA applied a specific portion of its funds to each of six system-building components:

Community program planning and administration (10%)
Community services and supports (45%)
Capital (buildings) and information technology (IT) (10%)
Education and training (human resources) (10%)
Prevention and early intervention (20%)
Innovation (5%)
Notably, none of these funds can be used for existing program allocation; all have to be put towards expansion or creation of programs, and 51% have to be spent on children's services.

Originally, the counties had to develop plans for use of the funds that had to be approved by both the California Department of Mental Health (that no longer exists) and the Mental Health Services Oversight and Accountability Commission (MHSOAC – most commonly just called the OAC) before funds could be issued. That was a long, tedious, costly process. It meant a two-year lag time between the tax year and the time the funds could be distributed so counties were never certain whether they would receive more or less than their plans called for.

Ten years into the MHSA, funds are distributed by the California controller's office according to a formula as they are received. Counties still must develop annual and three-year plans but no one at the state level has much power to do anything in a timely manner about it if the plan does not meet the act's criteria. The exception to that is the money for Innovation programs. Since those programs are expected to be out-of-the-box designs, the MHSOAC still needs to review them prior to implementation.

Because of the erosion of realignment funding for basic programs, counties have redesigned many of those basic programs to meet the criteria of the MHSA. At this point, the MHSA has saved community mental health.

Medi-Cal

Traditional Medi-Cal is California's Medicaid program. It is a needs-based program for people who meet the percentage of poverty level directives set by the Centers for Medicare and Medicaid Services (CMS) at the federal level and by California. The federal financial participation (FFP) is 50% in California. Eligible beneficiaries are children under 18, adults 65 or older, some parents of children, and people with determinations of disability. Counties have always sought to have as many of their clients covered by Medi-Cal as possible.

Medi-Cal for children and youth under 18 years of age is called Early Prevention, Screening, Diagnosis, and Treatment (EPSDT).

Expanded Medi-Cal, often called expanded Medicaid to differentiate it from traditional Medi-Cal and to reflect the 100% FFP at this time, picks up those who do not make enough money to obtain insurance through California's Affordable Care Act exchange (Covered California) and do not qualify for traditional Medi-Cal.

California has "carved out" mental health services for people with serious mental illnesses from the delivery system of traditional Medi-Cal. The counties were given the responsibility of developing, or contracting for, mental health plans to manage the mental health care of Medi-Cal beneficiaries. San Diego County contracts with Optum to do certain administrative duties for its plan, including contracting with providers, paying claims, authorizing acute and long-term hospital stays, and managing the data system.

The private health plans that manage care for the expanded Medicaid beneficiaries also manage their mental health care. These clients are described as having mild to moderate mental health needs versus meeting the CMS criteria for Specialty Mental Health Services.

The current integration movement is pointing to the likely "carving in" of specialty mental health services.

SAMHSA Block Grant

Mandated by Congress, SAMHSA's block grants are noncompetitive grants that provide funding for substance abuse and mental health services.

In general, SAMHSA allots for the block grants programs by:

1. Setting aside a percentage of the appropriated amount to cover its costs for data collection, technical assistance, and program evaluation
2. Calculating the baseline allotments based on certain factors
3. Adjusting the allotments, if necessary, so that the statutory minimum allotment constraints are satisfied

County General Fund

Counties must contribute a percentage of their budgets in a Maintenance of Effort (MOE) to be able to "draw down" the state sales tax revenue. Maintenance of Effort means that the County must provide some of its own money before California will forward any sales tax revenue. Think of it as the "deductible" similar to that required by your health plan. The percentage varies by county size, budget, and sales tax received. Counties' required MOE ranges from zero in the smallest counties to about $8.5 million in Los Angeles County. Counties occasionally contribute other funding such as the current FY expansion of the In Home Outreach Team (IHOT) program.

Leverages

Collaboration with other agencies can sometimes make County funds go further. San Diego County's mental health department developed one thousand housing beds by putting one-time funds together with other sources of funding, such as funding contributions from the now defunct redevelopment agency.