



California Council of Community Mental Health Agencies

Leaders in the partnership that developed and promoted Proposition 63

California Council of Community Mental Health Agencies (CCCMHA) June 2008 Update on Priority Issues

by Rusty Selix - Executive Director and Harriet Markell – Associate Executive Director

**REVISED 6-25-08 –DISREGARD PREVIOUS VERSION
(ONLY CHANGE IS DELETION OF SANTA CLARA REFERENCE
ON P. 3)**

Agencies are drowning in paperwork.

Forty percent (40%) of the funds we get for services are spent on paperwork. That does not include the administrative costs incurred by counties, which use another 15%.

We are encouraged by a new effort of the OAC, state, counties, and providers to work together to evaluate all reporting and eliminate duplication. We supported the AB 2034 outcomes and accountability and thought that the MHSAs would use those, since the adult services were just an amendment to the Adult system of Care. However, the state decided to create completely paralyzing reporting requirements for counties and providers, despite the fact that it was not a new program, believing we had to start from scratch.

The result has been micro-management of every detail of the so-called flexible funding, making it actually very inflexible.

Our goal is to have the functional outcomes applied also to children's services and to eliminate the compliance oriented data reporting which ignores outcomes.

We are also committed to ensuring that functional outcomes are applied to children's programs and that reporting for outcomes and compliance is streamlined and non-duplicative, thus eliminating the need for a separate EPSDT audit.

As part of the 08-09 budget, a statewide Performance Improvement Project is being designed that has the potential to address the audit/paper-work redundancy problems as well as begin the development of outcome measures

Representing Non-Profit Community Mental Health Agencies Throughout California
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that will be critical in evaluating the success of an integrated service delivery system. Cost and effectiveness will both be addressed, thus enabling identification of programs and providers that reflect optimum practice. We also hope that ultimately the PIP will lead to the establishment of a flexible case rate on top of EPSDT (MediCal covered services), thus creating FSPs for EPSDT kids.

Budget challenges

We are concerned that many (if not most) counties are pressuring providers to concentrate on MediCal billable services for children (EPSDT) and are foregoing the available and flexible services that MHSAs can support. An ideal FSP type of program for children would include development of a flexible case rate from MHSAs that would be available to supplement (or patch) EPSDT-billable services, thereby providing “whatever it takes” for children as well as adults. This issue needs to be addressed with counties as quickly as possible.

At the provider level we are also attempting to address the lack of increase in the SMA – no COLA is budgeted. For those providers at or above the SMA (notably, LA and Bay Area), their increasing administrative costs are not covered. One solution we want to see implemented as soon as possible (and which is currently being considered by DMH) is allowing providers to take their UR/QA expenses out of their rate and bill those separately – according to federal guidelines. This would give them some breathing room to incorporate other administrative expense that is currently not being reimbursed.

Other priorities include the loss of \$55 million in AB 2034 funds. We support the lawsuit to recover the funds and avoid the precedent of the state cutting underlying mental health programs.

Due to the lack of realignment growth in 07-08, county budget problems are affecting many providers. Counties had assumed \$90 million in growth, which did not materialize, and this creates a deficit in 07-08 and 08-09. We believe that with the ability to expand programs with MHSAs in 09-10, unspent CSS funds can be used to transform many programs and keep services at current levels. In addition, because one-time PEI, Capital and Technology, and WET funds are now available, and original CSS plans included activities that qualify for those funds, some funding of CSS activities can be moved to those other categories, thus freeing up the CSS funds for program expansion and/or creation.

We are asking affected counties to put all \$\$ and services on the table and find a way to continue services which they see as part of a well-funded system of care. The mental health system doesn't look very good to the public when we are cutting services that MHSAs were intended to fund, while more than \$2 billion sits unspent. It is difficult for the public to understand the argument that we can't spend that money to avoid cuts in services.

Integrated Planning for Future

We see the 3 year Integrated Plans for 2009-10 to 11-12 as the critical planning opportunity. We expect each county to develop a long-range, comprehensive plan which combines all funding sources to serve all eligible families.

These plans should estimate ultimate needs, recognizing that the funding growth could take anywhere from 5 to 50 years. The need would be based on quantifying the number of people with mental illnesses experiencing societal failures due to not getting the necessary services – this would look at data from jail, Hospital, Foster System Age Out, etc. The plan would set priorities by identifying the use of each funding increment and would gradually phase out the two-tiered system whereby some people get what are being called Cadillac FSP level of care, while others get minimal services.

Adult Full Service Partnerships

The range of services and costs are not widely understood. These should not be limited to high need clients. There are actually four levels of rates and needs, each with functional outcome goals and indicators such as housing, employment, and social support. Clients would move through the levels based on need at any given time, but always would get whatever it takes to support their continued progress and/or stabilization. Ideally the services would also address each client's physical well being - smoking, diet, exercise.

FSP for Kids + EPSDT/3632

Most high need kids get EPSDT (MediCal) or AB 3632 (special education-funded mental health). These programs won't pay for all needs such as respite care and other family support including adult alcohol and drug needs. AB 3632 does not pay for crisis care.

As noted above, we are seeking to have a case rate developed using MHSA funds to supplement EPSDT or AB 3632. The supplemental aspect of MHSA is frequently not understood or being used, and in fact, some children's FSPs use pure MHSA funds for kids who are probably eligible for one of the other programs that bring in state and federal funds to supplement county funds.

Prison Mental Health Reform

The "Promise Program" was approved in the 07-08 state budget to offer AB 2034 FSP services to 300 parolees. The 08-09 Budget expands this from \$4 million to \$10 million. It has the potential to serve and divert 30,000 people if expanded to meet the level of need. CDCR is not yet implementing it, and we are seeking dialogue to get this program started.

We are also encouraged by the concept of small re-entry facilities for prisoners in the last year before discharge and by a proposal in the 08-09 budget for the use of mental health courts to re-evaluate parole violations. This process would allow people to remain out of prison rather than, as in the past, minor violations sending them back to prison instead of making available the necessary mental health and related services to support their continued community adjustment.

Fair Share for Private Providers in Education Training Capital and IT

Workforce Education and Training is critical to our ability to attract and retain quality staff. We are working to ensure that county and state plans designate a fair share of funds for private providers. We have the same concern regarding Capital Facilities and Technology. It is unreasonable for counties to take care only of the programs they operate directly when 70% of services are provided by contract providers.

Prevention and Early Intervention

This is one of our highest priorities, and nearly every member agency has had experience developing and implementing one or more programs; however, the funding has come from other county agencies or private state or federal grants. These sorts of activities are totally new for County mental health systems.

Public systems are not built for change. What do we know will work? What must be tried and tested? We wrote this part of the Act with a clear goal of reducing delays in identification and treatment of potentially disabling conditions; however, the terms prevention and early intervention are very general, and there will be many interests seeking funding for other purposes.

NORA (Nonviolent Offender Rehabilitation Act) – Nov 08 - son of Prop 36

This ballot measure, which was just certified for the November election, expands funding for treatment of qualifying drug offenders from \$125 million annually under Prop 36 to about \$500 million; it also adds an annual COLA and includes teens.

It requires Prop 63 coordination for those with co-occurring mental illnesses, and we are in support and urge other mental health organizations to join us. They will soon be getting a letter from us.

Unprecedented Opportunities

With Darrell Steinberg becoming the President Pro Tem of the Senate and Karen Bass a Champion of Foster Care Reform as Speaker of the Assembly, there is a unique window of opportunity; we think it is a time to be bold and proactive and are looking at what we should propose for 2009.