

**Department of Mental Health (DMH)
Mental Health Services Act (MHSA)
Community Services and Supports Component
Stakeholder Input Process**

**Financing Workgroup
March 30, 2005**

**Meeting Summary
For Discussion Only**

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I. Background

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Act has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the MHSA are designed to support one another in leading to a transformed culturally competent mental health system. This is reflected in the California Department of Mental Health's (DMH) *Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act* of February 16, 2005: "As a designated partner in this critical and historic undertaking, the California Department of Mental Health will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA, DMH pledges to look beyond "business as usual" to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists."

On March 21, 2005, DMH released a draft of the *Principles Regarding Distribution of Funds and budget worksheets* relating to Community Services and Supports (CSS) DRAFT Plan Requirements for the Mental Health Services Act (MHSA). DMH scheduled three sessions to obtain broad-based stakeholder input on components of the CSS DRAFT Plan Requirements.

The Financing Workgroup held on March 30, 2005 in Sacramento was the last of three related workgroups to solicit stakeholder feedback on the CSS DRAFT Plan Requirements. The first workgroup meeting covered the first four sections, I – IV and the second workgroup covered Sections V, VI, VII and IX. The March 30 workgroup covered general financial concepts for public mental health services, the *CSS DRAFT Principles Regarding Distribution of Funds*, the budget worksheets and other financing issues relating to CSS.

A client and family member (CFM) pre-meeting, held from 9:30 – 11:30 a.m., provided an opportunity for clients and family members to discuss the afternoon workgroup session purpose, review the workgroup agenda, ask questions, provide feedback and network with each other. Both the pre-meeting and the workgroup session were introduced with the same general overview. The Financing Workgroup was held from 1:00 – 4:00 p.m.

Forty-nine (49) people attended the morning client and family member (CFM) pre-meeting and 129 attended the afternoon Financing Workgroup.

A. Anticipated Outcomes

The outcomes of the workgroup meeting were:

1. To obtain feedback on the CSS Principles regarding distribution of funds
2. To discuss pre-implementation funding
3. To obtain feedback on funding limitations and how to implement them
4. To review budget worksheet forms and respond to questions about the budget worksheet forms
5. To understand how transformation of the mental health system is reflected in the budget process

B. Schedule of Meetings

Upcoming workgroup and conference call dates are:

- Tuesday, April 5, Burbank, and Wednesday, April 6, Sacramento: second series of general stakeholder meetings. Each of these meetings will cover the same materials and have been divided into north and south locations to make each meeting more accessible. Participants need attend only one of these meetings. There will be one combined summary of both meetings, as though it were one meeting. The Los Angeles meeting will be held at the Burbank Hilton Hotel; the Sacramento meeting will be held at the Holiday Inn Capitol Plaza. DMH will update stakeholders on what has transpired in the stakeholder process and in MHSA implementation since the December 17, 2004 general stakeholder meeting. DMH will also discuss what approach they will use to address stakeholder concerns and recommendations.
- After the general stakeholders meetings on April 5 and 6, another set of workgroup meetings on new topics will be scheduled for May and June, followed by another set of general stakeholders meetings in July.

The summary of the March 23 meeting was posted on the DMH website on March 29.

II. Client and Family Member Pre-Meeting (9:30 – 11:30 am)

Forty-nine (49) people attended the morning Client and Family Member (CFM) pre-meeting.

Bobbie Wunsch, Pacific Health Consulting Group (PHCG) and facilitator of the MHSA stakeholder process, introduced the Client and Family Member Pre-Meeting session by reminding people of upcoming dates for the MHSA stakeholder input, listed above.

Next, Ms. Wunsch reviewed the agenda for the afternoon meeting and for the pre-meeting. The pre-meeting was designed 1) to provide a basic background in accounting and financial terms to familiarize clients and family members with the terms as they relate to MHSA and 2) to review new DMH documents and worksheets related to financing. Carol Hood, DMH Deputy Director, was available to answer questions.

CFM Question: Will the Sacramento stakeholder meeting be in this room?

DMH Response (Carol Hood (CH)): Yes.

CFM Question: Will lunch be served at the general stakeholder meetings?

Facilitator (PHCG) Response: No.

CFM Question: Will there be a report back from the break-out sessions?

PHCG Response: There will be no report back at the meeting, because we need the time to discuss many issues today. The discussions will be included in the meeting summaries.

CFM Question: Will the summary be posted in two days?

PHCG Response: The summary will be posted within five days, hopefully next Monday night before the general stakeholder meeting.

CFM Question: Will the group have choices of break-out sessions this morning?

PHCG Response: No, this morning we are staying together in one large group. This afternoon the group will divide into two smaller groups. Group One will address the budget worksheet forms; Group Two will discuss broader issues related to CSS financing and transformation. DMH has identified some questions to address, and is seeking input from participants.

Ms. Wunsch then introduced Michael Geiss, consultant to DMH, who is advising DMH design of the financing component that will accompany the CSS DRAFT Plan Requirements. Mr. Geiss explained that the goal of his presentation was to make sure participants have an understanding of financing terms and concepts relating to CSS.

A. Review of Financial Glossary

Mr. Geiss reviewed the content of the handout, Financial Glossary, which is posted on the DMH website.

Client and Family Member Questions and Comments

City Issues

CFM Question: The glossary states that the government entities eligible for CSS funds include the City of Berkeley. Why?

DMH Response (Michael Geiss (MG)): For many years, DMH has included the City of Berkeley along with the counties. This has also applied to Tri-City in Southern California. MHSA language includes both cities and counties. DMH recognizes that Berkeley is also part of Alameda County, but it is unclear at this time how that will be taken into account in Alameda County's MHSA allocation.

CFM Question: Is Tri-City still included as a city for the purposes of MHSA?

DMH Response (CH): Tri-City is currently in bankruptcy proceedings. Until their situation is resolved, DMH is not including them in the same way as the City of Berkeley.

CFM Question: As these proceedings move forward, will you take into consideration Tri-City clients and family members?

DMH Response (CH): We'll take that suggestion as a recommendation.

Per-Member Per-Month Questions

CFM Question: Is the proposed per-member per-month (PMPM) calculation an average?

DMH Response (MG): Yes. This calculation will be used only for comparison purposes.

CFM Question: How is an underserved person who is not an enrolled member counted?

DMH Response (MG): They would be considered members for this calculation. Counties will have a certain budget with which they will serve some new clients and some existing clients. This calculation will help to assess what it will cost to serve all participants or clients.

CFM Question: What happens in regards to PMPM when, for example, a county wants to design a crisis system, for which the numbers are not easy to estimate?

DMH Response (MG): The county should make an estimate and DMH will look at numbers. Remember PMPM is just a formula for comparison purposes across counties.

CFM Question: Will DMH be able to discern the level of care from PMPM costs?

DMH Response (CH): This is just one of many factors DMH will rely on. The program narrative is most important. PMPM will supplement the narrative. AB 2034 counties already submit this information. Some have a PMPM of \$9,000, others \$17,000, with an average of about \$13,000. DMH found that some programs had less favorable outcomes because they did not spend enough or provide enough housing, etc. DMH will use the calculation to help to understand the proposal. It is one factor among many, one that is particularly helpful in member services.

CFM Question: The calculation of PMPM is confusing. It makes sense at program level. A given program will be an enrollment-based program or system capacity program serving everyone. It will be hard to say how many people are served in a system capacity program. At a county level, when adding up all the programs, both enrollment and system capacity, it seems like adding apples and oranges. Put something in writing that clarifies it.

DMH Response (MG): These budget worksheet forms are specifically for the program level, not the county level. Rolling up all these program budgets to a county level will indeed leave you with apples and oranges. DMH will work to clarify the language about members, participants and clients. Please remember that the CSS DRAFT Plan Requirements are driving the language, not the other way around.

CFM Question: Which is more significant, the median or average?

DMH Response (MG): DMH only has the average at this time, because counties will not know how much is spent on each member until after the fact. DMH will decide after the first year how much information is needed. DMH is asking for the average for these purposes.

Supplantation and Maintenance of Effort Questions

CFM Question: In terms of supplantation: our county closed some programs with the latest round of budget cuts. Will they be able to use these funds to reopen these programs? What if we secured one-time funding to keep them active? Will continuing a program that was funded with one-time funds represent supplantation?

DMH Response (CH): We are in the process of finalizing the definition of supplantation. This is one aspect of MHSA for which DMH will not solicit feedback as DMH considers it primarily a legal issue. It will be released in its final form with the rest of the final requirements in May.

CFM Question: When you say that supplantation is under legal review, does this mean it is in court?

DMH Response (MG): No, it means that DMH attorneys are looking at the issue and providing legal opinions.

CFM Question: I think supplantation is a huge issue. It is very disempowering to not be able to discuss it. It is so important that clients and family members are allowed to give an opinion on it, along with the legal staff.

DMH Response (CH): DMH staff have heard the message and will bring it back to the Department and its legal staff. We recognize that this is a frustrating issue for stakeholders.

CFM Question: I am concerned about the DMH decision not to seek feedback on the supplantation requirements. It seems contrary to everything we are doing in the stakeholder process. It also provides the highest opportunity for shenanigans. Clients and family members have important feedback on this issue.

DMH Response (CH): This is the direction we have been given. I will take this feedback back to DMH legal staff.

CFM Question: Please explain maintenance of effort.

DMH Response (MG): Maintenance of effort (MOE) means that counties have to continue to contribute a basic level of funding that has traditionally been provided to receive the new money. The MOE policy for MHSA has not been determined yet. DMH wanted to provide a definition for the term, but not the policy at this time.

CFM Question: If maintenance of effort is required and our county has no level to maintain, will DMH give us funding?

DMH Response (MG): There is a requirement of a maintenance of effort. It falls into the supplantation issues. We are waiting to hear from legal staff.

CFM Question: Does MHSA say there has to be a maintenance of effort?

DMH Response (MG): MHSA mentions supplantation. DMH is asking the question, “Do you require the county to maintain the same level of money?” The State is required to contribute the same amount of money as when the MHSA was passed.

CFM Comment: Because you are not yet sure if maintenance of effort will be required, add “if it is required” to the definition in the Financial Glossary.

DMH Response (CH): This is a good point. DMH will modify the glossary before posting it on the DMH website. DMH staff do not have an answer yet about the requirement for maintenance of effort on a county level. MHSA says a lot about state maintenance of effort, but less about counties. DMH staff are trying to clarify whether it applies to counties.

CFM Question: Will there be any provisions to sue the State on behalf of the counties in the event that the counties want to do their funding with supplantation?

DMH Response (MG): The recourse available to counties is probably suing the State.

DMH Response (CH): Many initiatives are stopped by lawsuits. DMH hopes to hold the coalition of advocacy groups together to help minimize these threats. We are also paying close attention to the concerns of the Legislature to make sure we understand and can address those as well.

CFM Question: Who pays for the litigation if counties were to sue DMH?

DMH Response (CH): The counties must address that. Oftentimes, the State pays for litigation if it loses. There is one lawsuit already.

CFM Question: In terms of supplantation: under CSS, there is a statement about involuntary treatment. How does funding for involuntary treatment correlate with non-supplantation?

DMH Response (CH): The whole issue of supplantation is a fiscal calculation. DMH needs a definition from legal staff. If supplantation is based on an overall county mental health budget basis, it has nothing to do with involuntary treatment specifically. It depends on the definition of supplantation.

CFM Comment: Involuntary treatment may mean one thing for children, youth and transition-age youth, and another for adults.

DMH Response (CH): The difference for adults and children and youth is a good point.

CFM Comment: Involuntary vs. voluntary services is the elephant in the room when we talk about care. Are we talking about continuum of care to transform? I fear that we may be leaving out a piece of the continuum if we say no money can be spent on involuntary services. Everyone wants to reduce it, but it needs to be part of the continuum.

Other Questions and Comments

CFM Question: Does the reserve refer to the state or county?

DMH Response (MG): It definitely refers to the county level, to provide for a time when state revenues may not be as high as expected. It may also be required on the state level for the same reason.

CFM Question: Will the cost report be for all kinds of funding or only Medi-Cal funding?

DMH Response (MG): The cost report will report the revenues and costs associated with providing mental health services in the county. There will be a revenue page to identify what the different revenue sources are.

CFM Question: At the program level, what if an enrolled person uses a system capacity program?

DMH Response (MG): We are grappling with this issue and appreciate the feedback.

B. Financial Provisions of MHSA and Excerpts from the Welfare and Institutions Code

Mr. Geiss reviewed the listing of the financial provisions in the MHSA and the specific code sections created in the California Welfare and Institutions Code (WIC) as listed in the handout, *Financial Provisions of MHSA and Excerpts from the Welfare and Institutions Code*.

Client and Family Member Questions and Comments

Stakeholder Input in County Plans

CFM Question: What does “developed with local stakeholders” mean? What happens with comments? Will DMH oversee the response? What kind of guidance will DMH provide? What kind of assurance is there that public input will be authentically included and that plans will not merely reflect administrative priorities and agenda? Does the public comment need to be recorded?

DMH Response (CH): A requirement of MHSA says counties must respond to substantive comments made during the public review period.

CFM Comment: We are concerned that counties will use a thorough public input process, but then will process this information behind closed doors and write the plan from an administrative point-of-view and not reveal it to stakeholders.

CFM Question: DMH says it will give more weight to a large population of underserved; does this mean if a county does a rotten job of serving clients, they get more money?

DMH Response (CH): This refers to the fact that some counties have more resources to meet their need. For example, Riverside County, which has grown so quickly, has less money for a growing population. The level of available resources to meet the changing need is highly variable across the State.

Collaboration

CFM Question: The MHSA and these budget worksheet forms recommend collaboration. Our county told us that we cannot use MHSA funds to pay for liaison staff from other departments, such as probation or schools.

DMH Response (MG): I do not think that is correct. There is a funding line on the budget worksheet forms for other government agencies' collaboration and services.

CFM Question: Our county says there is no money for collaboration.

DMH Response (MG): MHSA funding goes to the counties and the counties decide. DMH can clarify the position about collaboration with other government agencies.

CFM Question: Can counties fund a particular person from schools to collaborate or liaison?

DMH Response (MG): Counties can do this; there is nothing in the Act that precludes it. DMH has made room for these issues in the budget worksheet forms. There is no funding for contractor administrative costs, but there is funding for contractors.

DMH Response (CH): MHSA is very flexible, which is one of its greatest strengths and one its major vulnerabilities. Counties can do many things, but given that the funds will not pay for everything needed, counties must make hard decisions. There is no active prohibition against funding interagency collaborators.

CFM Question: In the youth and children arena, active collaboration with schools is essential. Where is the help for the children?

CFM Response: Interagency collaborations are included in the MHSA. There is confusion about whether counties can give money to another government agency, but collaboration is in the Act. There is some gray area, but it is there.

CFM Comment: Intergovernmental agencies are included in the budget worksheet forms.

Transformation

CFM Comment: Where MHSA describes the purpose of the funding to expand services: I thought expansion included change from top-down to bottom-up.

DMH Response (MG): MHSA uses the term "funding to expand." DMH generally interprets it as "transformation."

CFM Comment: On the children's side and adult side, there need to be new standards. If you want to expand a program using new standards, you can expand, but the expanded program has to change to meet new standards.

DMH Response (MG): DMH is seeking input into how the system transforms. This is not "business as usual." California needs to transform its mental health system. Hopefully through the local processes, clients and family members will make sure this happens.

Other Issues

CFM Question: Who is more powerful, counties or DMH?

DMH Response (CH): The power is different; each has different roles. DMH's role is to set policy and the counties' role is to provide services.

CFM Question: Does this come down to how much we can ask for and how much we can get?

DMH Response (MG): Yes. It comes down to how much is available and how it will be spent.

CFM Question: Is any one group or person responsible for final decisions?

DMH Response (CH): The Legislature does not have a role in deciding how much goes to the counties. But it does decide what the DMH budget is.

C. Summary of Estimated Funding Amounts

Mr. Geiss then circulated the hand-out, *Summary of Estimated Funding Amount*, and highlighted the fact that the percentages allotted to each component of the Act was written into the initiative itself. DMH, then, has made estimates of funding based on those percentages.

D. Funding Limitations and Pre-Implementation Funding

Using a PowerPoint presentation that has also been posted on the DMH website, Mr. Geiss reviewed the requirements about pre-implementation funding between the time of submission of county plans and approval of those plans by DMH. Counties may not begin to incur service expenditures until their plan is approved. But pre-implementation funding is available for the interim period to do more planning and/or prepare for implementation. The requirements are that all expenditures must be consistent with the MHSAs and in line with what the county says it will do in its county plan.

Client and Family Member Questions and Comments

Medi-Cal Match

CFM Question: In terms of the statement that funds may be used for Medi-Cal match, please clarify if that is in the MHSA or is a DMH interpretation?

DMH Response (MG): It is not a requirement for counties to use funds in this way. However, it is a way to leverage funds beyond MHSA. This is more limited by federal requirements as to whether the services themselves are Medi-Cal eligible. For example, if half of a county's clients are Medi-Cal eligible, the county can expand the services beyond what MHSA will fund.

CFM Question: How is use of MHSA funding to match Medi-Cal not supplantation?

DMH Response (MG): It would not be supplanting insofar as it would either be for any new participant a county serves or for new services provided to existing clients. It requires an expansion of services, as does all of MHSA. It could not take the place of existing Medi-Cal revenues.

CFM Comment: There is concern that if county mental health departments know they can use MHSA as Medi-Cal match, they will continue not to serve the many people who do not qualify for Medi-Cal. It takes services away from this group of unserved and underserved who are a priority for MHSA.

DMH Response (CH): The state's proposed priorities depend on the age group. The first priority for children and youth is those who do not qualify for Medi-Cal. The first priority for transition-age youth is those who are aging out of foster care; some may still be eligible for Medi-Cal.

CFM Comment: I still believe that some counties will hold the Medi-Cal match as a goal and take services away from those who are not Medi-Cal eligible. DMH may have those priorities, but counties may not.

DMH Response (CH): This may be up to advocacy groups to ensure, because the MHSA does allow this flexibility.

CFM Comment: Using MHSA funding for Medi-Cal match extends the reach, but it may also exclude those not eligible for Medi-Cal. Providers have been known to tell clients who are in programs that are working for them that they need to "graduate" to make room for others.

Other Questions

CFM Question: In terms of expansion for services: if you have a case management program with a caseload of 50-60 people, but you want to lower the caseload to 10 people per worker, you have to hire more people. The people in the program are not new; they are getting more services. How does this work with maintenance of effort?

DMH Response (CH): Yes, this is an example of an expansion of services. The number of people served is not going up, but services are.

CFM Comment: Cost report audits are so far behind. I am concerned that counties will not get funding until the cost report is audited.

DMH Response (MG): Counties receive their MHSA funding with the approval of their county plan, not with the submission of the cost report or the state audit. The audit comes years later, getting into the detail of expenditures, certifying that the information on cost report is correct. The county would already have the funds, distributed quarterly and then reported to justify expenditures after receiving the funding.

E. Budget Worksheet Forms and Worksheets

Mr. Geiss then reviewed the *Draft Mental Health Services Act Community Services and Supports Budget Worksheets*, which are posted on the DMH website. He explained that in order to tie both to the cost report and the program plan together, DMH is requiring budgets at the program level.

Client and Family Member Questions and Comments

Client and Family Member Programs and Staffing

CFM Comment: There is concern about categories of staff. The personnel section lists client and family member staff segregated out. This will either be a duplication of staff or make us appear so separate. Identify clients and family member staff in the budget narrative.

DMH Response (MG): The reason for breaking it out was to emphasize the importance of identifying and hiring this group of staff.

CFM Comment: Have a separate category for CFM-run programs. It is important that the documents county administrators have to fill out support transformation. Spell out the importance of CFM-run programs.

DMH Response (MG): The entire budget worksheet is by program; each sheet describes only one program. If it is a CFM-run program, it should be identified at the top of the form.

CFM Comment: I want to advocate for CFM programs. I am concerned if they are placed in the category of “other programs,” they will get lost. Not all self-help groups are run by clients and family members.

DMH Question: Can you clarify if you want positions that are dedicated to client and family member support or you are referring to identifying the number of clients and family members in positions in the county mental health system overall? What are we trying to achieve?

CFM Responses

Peer-run

- We are looking for peer-run programs. One place where you might be able to capture the other piece about clients and family members as mental health staff

in any position, is at the Human Resources level, where you look for overall availability for slots for clients and family member employment opportunities. I would like to see a major emphasis on peer-run programs and services.

Any Staff Position

- Our county hires clients and family members who are well integrated into various staff levels. We train them if they do not have the skills. Some counties have not dealt with clients and family members in this way. Our county has many resources to offer these counties.
- When you talk about staffing, it goes from Dr. Mayberg to the van driver. Every county should have administrative staff with life experience as a client or family member. When we have counties with limited resources, we need to require certain personnel, cultural competence officers, an Office of Empowerment which include clients and family members. It is vital to build these positions into the county base because some counties will not have them unless they are required to do so.
- I am concerned that if current consumer advocates are hired, we will lose valuable advocates and potential Mental Health Board members.
- Consumer staff should be tracked in the same way as other affirmative action monitoring to make sure that we are built into the program and that there is not discrimination against them.

Both Peer-run and Any Staff Position

- In hiring general staff, e.g., case managers or therapists, give clients and family members preference, just like veterans are given. In client-run programs, it should be a priority to use client and family member-run programs. For example, counties should contract with NAMI Family-to-Family program.
- I believe that when the MHSA states client and family member involvement, it is not only self-help, but rather that we are supposed to be involved from top to bottom, at the state, county, department, and program levels.
- The consumers put client and family member staffing and programs on the table and will direct the transformation.
- Have it in both categories. I am concerned about separating client and family member staff. Use Human Resources to find our numbers. We need to be integrated into personnel in the mental health system from top to bottom.

Other Questions and Comments

CFM Comment: These forms are not transformative. They are the same old forms. List support and expenditures first. In the personnel section, list consumer and family member positions first.

DMH Response (MG): DMH cannot transform financial reporting forms the same way counties can transform the system. However, the Department should be able to change the order the information is requested.

III. Financing Workgroup (1:00 – 4:00 p.m.)

One hundred twenty-nine (129) stakeholders participated in the workgroup session, Part III on the Financing for CSS DRAFT Plan Requirements on March 30, 2005, from 1:00 – 4:00 p.m. This was the third in a series of three workgroup sessions on the CSS DRAFT Plan Requirements.

Bobbie Wunsch, Pacific Health Consulting Group and facilitator of the MHSA stakeholder process, welcomed the participants by reminding them that this was the sixth workgroup meeting since the end of February. She reviewed the agenda and the anticipated outcomes. Ms. Wunsch reminded everyone that the varied format of the workgroups was to ensure that as many voices could be heard as possible because every participant has something valuable to add to the process.

A. Discussion of Feedback on Principles Regarding Distribution of Funds

Carol Hood, DMH Deputy Director, provided a brief overview of how the CSS DRAFT *Principles Regarding the Distribution of Funds* was created. The challenge for DMH is to determine the basis upon which each county receives a portion of \$350 million dedicated to CSS. The Department has found in the past that once actual funding amounts are assigned, the discussion cannot remain on a broad level about principles. DMH also recognizes that while the MHSA is an infusion of much-needed funding, each county can certainly use more money than MHSA will provide. DMH wants participant input on the principles, from which Department staff will derive the distribution amounts.

There are two aspects to the funding. The first is a planning estimate to each county, a maximum that will be set aside for that county. The planning estimate will take into account county population, need, and a minimum level of funding for small counties.

The need will be derived using measures including poverty, uninsured population who are most likely to use public sector services and resources, resources in a given county, and prevalence, which is a statistical formula based on independent research.

The second part is a set-aside, which is not included in the planning estimate. This might be used for expansion in counties with programs running and ready to implement expansion; reserves for the possibility that tax receipts may be lower than the estimate in a given year; statewide or regional strategies for low incidence populations, such as deaf or hard-of-hearing or the developmentally disabled population with severe mental illness and behavioral issues; and other critical needs. DMH is seeking input on ways to use the set-aside most effectively. It is also seeking input on what additions and changes should be made to the principles, as well as what issues are missing.

Participants sitting in small groups at their tables were asked to discuss the following questions:

What additions to the CSS DRAFT Principles Regarding Distribution of Funds would make them more useful to counties and local stakeholder participants?

What questions do you still have about CSS financing?

The groups met for about 45 minutes. A summary of their additions, changes and questions follows.

What additions to the CSS DRAFT Principles Regarding Distribution of Funds would make them more useful to counties and local stakeholder participants?

Available Resources

- The allocation method should take into account stable funding versus variable funding, i.e., short-term funding such as SAMHSA grants.
- “Available resource” issue seems to try to address existing equity issues in realignment. If DMH is going to do this, do it overtly.
- Consideration of “available resources” is not appropriate as the use of these resources to describe need is redundant. Prevalence and unserved data will produce a more reliable indication. Use of available resources would be punitive to counties that have been successful at capturing these revenues. Available resources are not equally available to all target populations, i.e. EPSDT for children. It should not reduce MHSA funding which is flexible and usable for all target populations. Eliminate this as a factor.
- Outcomes should be included in the calculation of available resources so counties doing well will not be penalized.
- Consider a county’s available resources.

Population

- Overall county population: may allocate more monies to larger counties. Should be less weighted. Put more weight on other factors or on a per capita basis.
- Homeless are not counted.
- The overall population of counties is taken into account, but not the actual size of the county. It is difficult to get access to services for those not near the center of a county.
- In addition to overall population, look at age and ethnicity of that population.
- Set guidelines for the distribution of funding among the age groups in each county, unless that county can justify why not to provide this funding. There must be criteria for this.
- Population should include remoteness and geographical barriers.
- DMH should consider which are most unserved populations in the counties before approving funding for specific populations. Look at demographics by age.
- Reduce homelessness and imprisonment.

- Have separate funding pools for each age range based on an index of relative need.
- Population size should be a major factor.

Uninsured and Poverty

- The degree of uninsured and level of poverty factors are important factors in counties with large indigent populations.
- Consideration of underinsured population. Might consider increasing poverty level to 300% or 400% based on other cost-of-living factors.
- Incidence of uninsured: include underinsured.
- Include issue of underinsured for mental health coverage as part of uninsured populations.
- Raise the income limits applying to those who are Medi-Cal recipients.
- In defining the impoverished population, include homeless and institutionalized, for children and adults.
- Rate of poverty: use the federal standard of 200%.
- Provide guidelines on definition of poverty and poverty level.

Small Counties Issues

- Minimum funding for small counties is essential.
- Take into account small county staffing issues, for example, one person doing seven jobs.
- Geographically isolated areas have difficulty counting population, knowing what services are available and accessing them.
- Minimum funding level for small counties should be based on county infrastructure, geographical area, inaccessibility and human resources. Small counties have additional issues with expansion of current infrastructure and creating satellite offices to reach consumers and do not have the ability to redirect staff. Cost for expansion of facilities and staff for small counties is equal to the cost for medium and large counties.
- Especially in small counties, ensure that underserved ethnic communities that do not meet the threshold language still get served. Counties need to identify these people and how they intend to spend this funding.
- There is a concern over the amount that small counties will actually get.
- Small counties must be held accountable to all the same criteria as larger counties.
- Provide financial consideration for counties to meet a baseline infrastructure for MHSA.
- There is concern about the minimum funding for small counties, which have more logistical, geographical, transportation issues to solve or take into consideration.

Prevalence

- Need more clarification on how the “prevalence of mental illness” is determined.
- Prevalence has not even been touched yet. They are soft numbers. So it is hard to define unserved and underserved.
- Clarify whether prevalence will be correlated with those already receiving services to determine unmet need.

- Do not limit prevalence to SED; include all individuals whose mental health conditions could be ameliorated.
- As part of prevalence, penetration should be a consideration.
- Separate prevalence among age groups from ethnic populations.

Set-Aside

- In set-aside, be cautious that funding set aside for expansion of existing programs does not penalize those counties that have not developed programs already.
- Set-aside should be for demonstrating effective program practices that eventually become part of the county plan.
- If there is a requirement for counties to have a reserve, specify percentage.
- If the purpose of set-aside is to protect against deficits in tax receipts only, then the funds need to be held at the state level only. They are not necessary at the county level as well.
- Set-aside funding should be thought of as savings or a reserve fund only. The other criteria should be put in a separate category.
- State-level reserve funding should also be available for unusual situations, such as higher incidence of PTSD after 9/11.
- Set-aside: agree with use for reserves and statewide or regional approaches, but put expansion based on demonstrated capacity as part of innovation.
- In set-aside, be cautious with regional approaches. This language should not be a disincentive for regional approaches within the regular allocation.
- If DMH intends to distribute set-aside funding on a competitive basis, group does not support that. These funds should be distributed to all counties based on principles established for the primary allocation.
- Planning estimate should be larger than set-aside. It promotes greater sharing of money to counties.
- Agree with subgroups with critical need, i.e., developmentally disabled with mental illness. Add persons with dementia with co-occurring mental illness.

Additions to Principles

- Include cost-of-living factor as an allocation factor.
- In distribution of funds, use a standard, such as “Self-Sufficiency for California” (2003, National Economic Development and Law Center) which outlines, county by county, how much money it takes to sustain a decent standard of living.
- Add principle about using MHSA as a leverage for other funding, such as Medi-Cal, criminal justice, education, tobacco funds, EPSDT, etc.
- Principles of the planning estimates should be cross-referenced to the CSS DRAFT Plan Requirements and vice versa if there are specific definitions or methodology associated with terms.
- There is a concern about how performance will be considered. Most counties will pick things to show their program is working. Also if a county is having trouble it should get assistance, not a penalty.

- When DMH determines how to distribute funds, they should give weight to those counties who have done a good job of including consumers, family members and caregivers in the planning process.
- Give credit to counties who are able to leverage resources, including staff, from other collaborative partners.
- There should be a statement in the principles that money should support programs that reduce higher-end cost programs, such as crisis homes, mobile crisis units and teams.
- Add a principle that states that if counties use MHSA funds, DMH should require counties to specify or explain how they are not supplanting.

Allocation Method

- Formula for funding: the method for determining need should be balanced so large counties do not end up with a disproportionate amount of the funding.
- The need for mental health services should be weighted more heavily than population or available resources.
- DMH should develop guidelines around funding proportions that factor in other money, unmet need and current capacity.
- Funding should be used to expand mental health services, provided these are cost-effective.

Data

- Clarify data sources to give counties some direction.
- Accuracy of data source for overall population, prevalence, etc.

Other Concerns and Issues

- Give large counties better guidelines and criteria on how to divide among age groups and ethnic groups.
- Require stronger safeguards to ensure county funding is not lost in the bureaucracy but does what is called for in MHSA. Make sure that those laid off from cuts to the present mental health system are not simply rehired under MHSA so the spirit of transformation is truly maintained.
- Three months to start program is not okay, it is too long.
- Enrollee-based and cost-per-client is an artificially imposed number because there are no numbers initially.
- Include line items for:
 - Medications for mental illness.
 - Transportation for medical appointments.
 - Personal attendants or counselors.
 - Family education and anti-stigma campaigns.
 - Client and family member seminars with guest speakers and roundtable discussions.
 - The means to have more interventions before problems escalate to hospitalization or other emergency.
 - Medicare co-pays for those transitioning from Medi-Cal/Medicare in 2006.
 - Warm line.

What questions do you still have about CSS financing?

Set-Aside

- How much money or what percentage will be allocated for set-aside? What is the purpose?
- Will counties need to follow the same planning process as for CSS for accessing set-aside funding?
- What is meant by the phrase “demonstrated capacity to expand and achieve outcomes?”
- Define “other critical need” for set-aside uses of funding.
- Is there going to be a cap or percentage on the reserve?
- Why does there need to be additional set-aside of funds designated for the counties?
- Contingency reserve is already occurring at the county level. Why also reduce at state level? It is redundant.
- How are reserves protected with regard to rollover and a county’s general fund money?
- Is DMH considering regional or statewide initiatives? Is there a strategy to bring in other state agencies’ funding?
- Agree with statewide/regional strategies for low incidence populations. Who is included in these populations?
- What percentage of set-aside for capital facilities and workforce development should be done at the same time as CSS? For example, can counties use it for consumer training?
- Is the set-aside happening at the state or county level or both? Both would be best.
- Set-aside uses: is this competitive among counties? Is it part of a county’s plan or a separate plan for services? Do Boards of Supervisors have control over discretionary funds or set-asides of MHSA?
- Must the set-aside be competitive?

Process Timing

- Define procedures for redistribution of future unspent county MHSA funds as soon as possible.
- Is there going to be a three-year planning estimate? Can funds be rolled over?
- How to keep the process going between the submitting of the plan to DMH including the inevitable disappointments of unfulfilled raised expectations; how to keep the community engaged to more smoothly go into program implementation, maintain and build community support.
- Is there any provision for county plans to be reviewed annually or more often, if needed, i.e., if funding is lost?
- When is the beginning of the three-year limit? For example, when does the clock start to run on services, which have three years to be spent? What happens if red tape prevents spending of the money?

- At what point will funding formulas be reconsidered after they are established?
- Would DMH consider releasing some MHSA funds soon for AB 2034-like programs and then allow counties to submit their three-year plans later?

Allocation Methodology

- How will DMH determine the weighting of the various factors in determining funding methodology: poverty, prevalence, uninsured, etc.?
- Initiative indicates DMH shall give additional weight to underserved counties. How do these principles address this?
- Are there other state formulas to determine funding levels for small counties, such as Prop. 36?
- How will this formula relate to existing funding under realignment?
- How to weight or value the various factors?

Measuring Need

- Define uninsured and solicit stakeholder input on the definition.
- Race and ethnicity: this is a problem because many of these populations are not counted. They do not show up in poverty numbers and are not counted in the census. How can we ensure that these unserved communities are counted and will be recognized?
- How are the floating populations (homeless, migrant workers, etc.) going to be counted, particularly because some of the databases often undercount them.
- Should ethnic disparities have a greater weight than other factors?
- How do counties gather the data for measuring need of the planning estimate?
- How does the distribution formula address future changes in population, including demographic changes?
- Should the subpopulations of persons with disabilities, or elderly with complex medical problems be considered as a factor that should be included regarding allocation? For example, look at the self-sufficiency index as a possible tool to weight the allocation.
- How does DMH define poverty? Need to account for affordability issue related to poverty, and cost of living considerations. Need to include homeless.
- How will DMH determine uninsured populations?

Prevalence

- If there is a difference of opinion between DMH and the county about prevalence and the incidence of uninsured persons, how does the county appeal the decision?
- How does DMH define mental illness regarding determination of prevalence? How does DMH define SMI and SED? Are the definitions of mental illness concerning SMI and SED that are used for purposes of funding applications the same as what is used for service eligibility criteria in MHSA?
- Is the method to calculate prevalence the same for every county?
- How is “prevalence of mental illness” going to be decided and by whom?
- What about consideration for “underserved” and “difficult to serve”? Do not just base need on prevalence (need vs. demand).

Available Resources

- “Available services” under need: is this penalizing counties with more resources or just trying to estimate need through resources used to serve need?
- Why are “available resources” considered in the amount of MHSA funding a county can receive?
- How is DMH going to take into consideration “the available resources provided” in FY 2003-04?
- How are cultural populations being considered? How are these and other underserved populations being reached and involved?
- Is the term “available resources” the only benchmark for how many services are already being provided?
- How do you take into account the difference in the resources available in large and small counties? For example, small counties do not have the large number of non-profits or senior centers that large counties have. How do you measure the ratio between these other available resources and mental health?

Data

- What sources are used for the data: prevalence in the general population or prevalence in the population below 200% FPL?
- What is the source of data for the uninsured?
- Infrastructure information is needed now to accurately plan program expansion.
- What data are used to determine incidence of uninsured?
- In terms of the “incidence of uninsured persons”: how do you assure the validity of the data?

Enrollment

- Enrollment is confusing.
- Please clarify enrollee as used with the budget worksheet forms.

Medications

- Is it legitimate to fund medications not on the Medi-Cal formulary?
- How will counties pay for clients without insurance? MHSA money cannot pay for medicines.

Funding Questions

- Will all counties get pre-implementation money?
- Please clarify the prorated amount of planning estimate to be provided based on date of plan approval. Include this on draft of funding principles, page 2.

Other Questions

- What are counties required to report to show services are expanded?
- How is DMH including caregivers in distribution of local funds? Caregivers know the need for services and need to be heard by counties on estimating need.

- What guidance will counties receive from DMH and from other stakeholders in deciding how to spend the money? Concerns of service providers are not being included.
- How closely linked are program planning and funding? Needs assessments should drive spending.
- Must a county have two or three projects in each age group?
- Please clarify what you mean by “redirection” of staff.
- How is medical necessity applied to new clients?
- Is there flexibility with the three-year plans? If the counties wish to make a change, what is the process to change the plans? If this is possible, how will changes affect the financing portion? What would be the process to change the financing portion?

B. Review of Pre-Implementation Funds and Funding Limitations

1. Pre-Implementation Funds

The initial planning funding is supposed to last until the county’s CSS plan is submitted to DMH. DMH will approve the county’s plan approximately three months after submission. Pre-implementation funding is provided for the interim period between plan submission and approval, to continue to plan and to begin pre-implementation activities, as long as these do not include providing services.

Stakeholder Questions

Stakeholder Question: Is pre-implementation funding the same as planning money?

DMH Response (MG): It is separate from the planning money. DMH has allocated implementation funding for this fiscal year to fund the period between plan submission and approval. Pre-implementation is in addition to what counties have received already for developing the plan.

Stakeholder Question: For example, say a county gets an allocation of \$50,000 per month for planning, until June 30, 2005. Does this mean they get new money after June 30?

DMH Response (CH): It is hard to think of initial planning money on a per-month basis. If a county received \$100,000 for planning money, it is to cover the entire period until they submit their plan, whether they do so in May or December. The funding is not by month; it is until they submit the county plan. This pre-implementation money is for the period while DMH is reviewing the submission. It is up to the initial planning amount per county. It can be used for the early work of implementing, without starting any services. It can be used to start the hiring process, obtain addition space, start the RFP process for what a county reasonably expects to receive approval for.

Stakeholder Question: This assumes there will be a gap between when plan is approved and started.

DMH Response (CH): If a county uses this money for pre-implementation, it will be subtracted from the CSS allocation later, but it will be used to get the implementation started. The process for review of pre-implementation funding will be quick. DMH will find a way to split this review apart from the plan submission.

Stakeholder Question: How far can you go with pre-implementation? If the program has not been approved by the State, would it not be presumptuous to start things like RFP processes and hiring? Can we have some idea of how to do it?

DMH Response (CH): DMH expects that there will be ongoing discussion during the review process, not just a final decision at the end of three months. The process has not been determined yet. It would be cleaner if everything could happen sequentially. However, that would take years before the money could be released. Suggestions for improving this process are welcome.

Stakeholder Question: Many MHSAs services will be provided by providers. Will pre-implementation funds be available to these providers for their pre-implementation activities?

DMH Response (CH): Yes.

Stakeholder Comment: It is very important for DMH to practice transformation. When the Department is in the three-month review period and talking to the counties, the information should be shared with the stakeholders as well as the county.

Stakeholder Question: Why does pre-implementation funding have to go through an approval process?

DMH Response (CH): DMH has a responsibility to ensure that the money is spent in a manner consistent with the vision of the MHSAs. There will be an abbreviated process for approval.

Stakeholder Question: Please define what are and are not pre-implementation activities.

DMH Response (CH): Examples include: starting an RFP process; starting to establish positions, recruit, maybe even hire, while recognizing that there may be some risk; starting to get facilities; working with consumer organizations.

2. Funding Limitations

Mr. Geiss reviewed the PowerPoint presentation, currently posted on the DMH website.

Stakeholder Questions

Medi-Cal Match

Stakeholder Comment: In terms of the Medi-Cal match: place a caveat that this is not an invitation to underserve the uninsured. It should be an exception.

Stakeholder Comment: In the statewide clients' eyes, using MHSA for Medi-Cal match would be a violation of MHSA mission and vision. This money is to be used for programs for clients who do not qualify for Medi-Cal. Please remove it.

DMH Response (CH): Many Medi-Cal services are consistent with Children's System of Care, consumer-run programs, etc. If half of those services can be paid for by Medi-Cal, then it extends the reach of MHSA. Crisis intervention teams comprised of a police officer and mental health worker are Medi-Cal reimbursable, for example. DMH is trying to put the Medi-Cal match into the context of transformation, not as a driver of MHSA.

Stakeholder Comment: If a county has 100 clients and half are Medi-Cal eligible and half are not, clients and family members want to make sure the half who are not Medi-cal eligible are cared for.

Stakeholder Comment: If Medi-Cal can be used to leverage the program, we should use it. However, clients and family members are concerned about what counties will end up doing, given this opportunity. Create a footnote that is longer than the statement which reiterates that MHSA funding is especially for those who are not eligible for Medi-Cal.

Other Questions

Stakeholder Question: What is the allocation for a reserve? Who is handling that reserve: state or county?

DMH Response (MG): MHSA is specific that counties can maintain a reserve, although the size or percentage is unclear. People gave feedback earlier today about whether DMH should also have a reserve.

Stakeholder Comment: What if stakeholders do not think their county is using funding for expansion and transformation?

DMH Response (CH): We do not have the answer yet.

Stakeholder Question: Will the cost report be able to reflect more than Medi-Cal funds?

DMH Response (MG): Yes. It will be modified for MHSA funds. There was already a minor modification for the planning money. DMH will start working on a new design for FY 2004-5.

C. Small Group Discussions

Group One: Budget Worksheet Forms and Worksheets

Grace Boda, Pacific Health Consulting Group, introduced Mike Geiss, who stated that the purpose of this session was to obtain feedback on the proposed budget worksheet forms. He noted that it is the CSS DRAFT Plan Requirements that drive the budget worksheet forms and not the other way around. Any changes to the CSS DRAFT Plan Requirements may require changes in these forms.

All counties will be required to complete these budget worksheet forms as well as a budget narrative, which describes the approach used to estimate costs and revenues and anything else that will help DMH understand what counties are requesting and how that ties back to CSS Plan.

There is a separate budget worksheet and narrative required for each program. DMH needs a separate budget for each of three fiscal years, at the same time realizing that budgeting two to three years out requires estimates with little information. DMH is required to have the three-year budget. The budget worksheet has been divided into three categories or columns: the county department, other government agencies and community-based organizations.

Stakeholder Comment: In the personnel section's client and family positions, add caregivers.

DMH Response (MG): Issues about separating clients and family members were raised this morning and will be redesigned.

Mr. Geiss then described the information needed to complete the top of the budget worksheet. He clarified that collaboration among counties was encouraged. The type of funding refers to enrolled member services or system capacity. The CSS DRAFT Plan Requirements goes into more detail about what these are. The focal populations refer to the age groups of children and youth, transition-age youth (16 – 25), adults and older adults. The program name should match the county CSS Plan. The budget should identify whether it is for program expansion or additional clients or both. If it is expansion, DMH wants to know what current revenues are spent.

Stakeholder Question: Please explain the difference between enrolled member services and system capacity.

DMH Response (MG): Enrolled member services are those in which you are enrolling members and providing them with services; systems capacity is new programs that provide support to everyone. Less than 50 percent can go to systems capacity. See CSS DRAFT Plan Requirements for more detail.

Stakeholder Question: In terms of expansion: right now is our entire county mental health budget to be included?

DMH Response (MG): Do it by program. You may have a current level of funding for a specific program and a proposed increased staffing, etc. You have the number of existing clients and proposed new clients. You have revenues by program as well.

Stakeholder Question: It is important to define the individual program. For example, what if a county has a clinic-based crisis team that it wants to expand by making it mobile? Is that an expansion or a new program?

DMH Response (MG): It is expansion. The program has to tie back to the county plan and what the county plans to do. Maybe a county has a mobile crisis unit in one part of the county and wants to expand it to other regions; it could go either way. It depends on

how the county captures the program at the county level financial system. If there will be a new cost center, that would correlate to a new program.

Stakeholder Question: We are not set up to structure our budget and accounting by age groups. What are we to do?

DMH Response (MG): It is the Department's intent to understand how the monies are used. DMH is asking for the county's best estimate. Counties will not be held to the amounts line by line.

Stakeholder Comment: While we understand that MHSA is an opportunity to do things differently, this absolutely does not fit into standard government practices. Finance offices will have to go back and categorize things differently, like FTEs by clients and family members. Many counties do not ask staff if they are clients or family members. The desire to model program change is admirable, but what kind of fiscal accounting are you trying to do? My fiscal office does not distinguish between vouchers and subsidies. Clothing is not a line item our county uses. It is under support expenditures. Some do not distinguish bilingual pay supplement.

DMH Response (MG): Bilingual pay came from an attempt to highlight cultural competence. These are good comments. DMH needs to hear them.

Stakeholder Comment: The categories are not going to fit well into any county's accounting. Fiscal offices will not be able to find expenditures or level of staffing by program. For example, it will be hard to make distinctions between old and new clients or programs. It will make accounting nearly impossible. We do not do things this way.

DMH Response (MG): The MHSA requires us to get cost-per-client. Are there any AB 2034 counties that fill out these budgets that can discuss accounting for support expenditures?

Stakeholder Comment: We are an AB 2034 county. We maintain a separate set of records for this.

Stakeholder Question: In terms of budgeting as it relates to county and contracting: we contract out our services. How does this relate to submitting a plan? We do not know what the contract will cost when submitting the plan.

DMH Response (MG): Take your best estimate when you design the plan. The purpose is not to hold you to a specific line item, but how it fits with your plan.

Stakeholder Comment: The difference in costs between client and family member programs and others is huge. We need to figure out how to adjust for this.

DMH Response (MG): It can be revised. We need an estimate.

Stakeholder Comment: Many counties have to issue RFPs for services. They will not know in advance who the contractor will be. In this process, it would be helpful to be able to propose an amount to be spent in RFPs rather than detail.

Stakeholder Comment: We are dealing with budget cuts locally. We are dealing with mayors, Boards of Supervisors, who are looking for ways to cut. This raises a concern about redirected positions: counties may feel that they can lay staff off here and rehire them there. Look at the larger state and county budget picture and how expenditures are done in prisons, schools, home service providers, within ten-year plans. Advocates for mental health need to be in these discussions.

Stakeholder Comment: In the broader perspective, mental health directors are concerned about the approach DMH is taking. While talking about transformation, DMH is approaching this from a micromanagement position. Take a broader view and ask counties to paint a picture: what are you planning to do, what outcomes do you expect? This approach seems contrary to transformation. It would be better to use a categorical approach asking about ideas and programs. DMH should ask counties to tell them how much these ideas and programs will cost. Then after a year, counties can be more specific. This is unbelievably minute detail. This is a major concern of mental health directors, even before we move ahead with planning.

DMH Response (MG): DMH debated this quite a bit, which level of detail to use. The approach selected was enough specificity to relate to the CSS Plan. DMH will take this back and see if it is still the approach the Department wants to pursue.

Stakeholder Comment: We keep hearing “it cannot be done, it cannot be done.” When I first I heard about MHSA, I thought it was about transformation, clients and family members involvement. Now clients and family members are often county and contractor staff. They need to be doing that job of providing services, not advocacy. But clients and family members cannot go back to giving most of the control to the directors. This is about transformation. Then what is MHSA about and now I worry that it cannot be done.

Stakeholder Comment: The mental health directors are not saying it cannot be done. The plan is being created by the community. It is the budget part that is problematic, not the plan part. Mental health directors are not saying it cannot be done.

Stakeholder Comment: This is the first time I as a person responsible for completing the budget have been able to come to these meetings. The budget instructions must discuss flexibility. If there is flexibility on line items, note it on the document, so that when the county department reports to the Board of Supervisors or other stakeholders, it can note this flexibility.

Stakeholder Comment: In terms of our job as bean counters, county fiscal staff need to have definitions of enrollee and system capacity so that they can re-program computers to stay with the curve.

Stakeholder Comment: Counties want to have individually-based services and budgets. There is a significant lack of guidance about what is reimbursable or not. AB 2034 is defined; CSOC is not; EPSDT is not, etc. Fiscal staff must look at each of the different kinds of things the money will be spent on.

Stakeholder Comment: For enrollee based services: in AB 2034, you can count those clients and follow their outcomes. For system capacity programs, such as crisis teams: who counts? Everyone being served? New clients? What about outcomes? In addition, drop-in centers often do not collect statistics on whom they serve.

DMH Response (MG): Outcomes have not been developed yet. DMH is working on them, but does not yet know this. At the same time, the Department will hold counties accountable for performance measures and process measures. This balancing act is very difficult: DMH must be responsible to voters about what we are spending money on.

DMH Response (Holly Johnson): There may be confusion about what needs to be tracked for system capacity and how an enrollee can be tracked. Enrollee is defined as a contract with CMHS and participant about doing whatever it will take to appropriately serve the client. A certain amount will be set aside for programs in which anyone will benefit. There will be a differentiation between enrollee and system capacity. Enrollee outcomes will be tracked. Drop-in centers are system capacity.

Stakeholder Comment: When looking at expenditures, it is important to understand how poverty relates to mental illness. People experience a lack of food, do not know how to prepare healthy food, or have eating disorders. People have an inability to get around: often they do not have cars while public transportation is usually inadequate. Housing is a major issue. Oftentimes, providers have to provide physical services before they can help with mental health issues. Our community has a program to wash people's feet. People need showers and bathrooms. The budget needs to reflect these concerns.

DMH Response (MG): DMH is providing for administrative costs to county mental health departments only. However, the Department is questioning why only to county mental health and not to contractors who are incurring the same expenses. DMH wants to match the cost report. The Department is open to suggestions about administrative costs for contractors, but keep administration only for counties for the purposes of the cost report.

Stakeholder Comment: Most community-based organizations track overhead, both direct and indirect. Most grants and contracts include funding for this for contractors.

DMH Response (MG): Section 7 asks for the estimated number of participants to be enrolled or served. DMH will work to better define that term. We discussed issues about "Per-Member Per-Month" (PMPM) this morning. There was confusion about whether this would be a case rate; it is not. It is a comparative figure to ascertain the difference in costs across counties.

Stakeholder Comment: I am concerned about those not being served, those with unmet need and the underserved population. There is nothing on these sheets to ask for how much money will be spent on those who are underserved or those whose needs are not met.

DMH Response (MG): The assumption is the people you will be serving are those people.

Stakeholder Comment: I do not think so. San Francisco has 14,000 people who are being served. In my estimation, 8,000 are homeless whose needs are not being met; they are an underserved population. No door is open to them to get services. The enrolled population that serves as a baseline does not address underserved or unserved population.

DMH Response (MG): Enrollees are not necessarily those who are currently in the program. DMH hopes enrollees will be those people your county described in its plan. There is not enough money to serve all the unmet need in the state. It is an attempt to move in that direction.

Stakeholder Question: It seems DMH wants us to use prevalence and those in services. If someone is in the system now but the services are inadequate to their needs and now the transformed system can meet their needs, are they a new person?

DMH Response (MG): If they are getting a service they were not getting before, this is a new person. If an existing client gets more services than s/he was getting before, this is considered an expansion, not a new person. DMH will not hold counties to a line item.

Stakeholder Comment: For small counties, having to do a budget like this for every program will eat up the whole grant, just in the budgeting process. In a small county use this type of worksheet for the whole program, not an individual one.

DMH Response (MG): We have heard this loud and clear today.

Stakeholder Comment: The first year of administrative money is focused on training, with education and reeducation of administrators. Clients and family members want people who can listen in those positions, people who can deal with their own recovery issues. Alternative therapies may be helpful to promote health for them.

Stakeholder Question: Can we look at cost-per-unit methodology?

DMH Response (MG): Support expenditures are a problem, most of which are not Medi-Cal eligible costs and will not be claimable in the cost report.

Stakeholder Question: That is true, however, is there a way to break out the mental health services, just for budget purposes?

DMH Response (MG): To the extent there are services that are Medi-Cal, they will be broken out this way. DMH wants to see the detail on personnel, operating and support expenditures.

Stakeholder Question: I know the pressure you are under to act. However, it would be best to move this level of detail to the budget narrative. If this worksheet does not clarify how it ties to a cost report, how are you going to hold us accountable to the cost report? Give us the first year to get into transformation and then let us look at more specific costs.

DMH Response (MG): You must look at transformation and redirected staff in narrative. Thank you for this feedback. These forms are in draft.

Stakeholder Question: Can we use percentages for indirect costs, etc?

DMH Response (MG): Yes, they are definitely allowable.

Group Two Financial Issues and Transformation

Carol Hood presented *Fiscal Issues for Stakeholders* along with Dee Lemonds (DL), Chief, Adult Policy Section, DMH. Ms. Hood posed the question, “What should advocates and stakeholders know about the budget process to use it as a tool for transformation?” Money is a powerful tool to achieve program objectives and budgets should reflect values and objectives. A primary purpose of this small group discussion is to provide tips to enable budgeting as a programmatic tool and to enable participants to review budgets with that in mind.

Ms. Lemonds stated that steps involved in the community planning process should precede any budget building. Ms. Hood said that sometimes counties budget before they establish a vision. It is important to be clear on what the initial strategies and opportunities are before building a budget. DMH will look to see if the budget supports the narrative. The planning estimate provides a maximum; but not every county will receive the maximum. DMH will use the county plans to establish levels of funding. The budgets provide one tool to better understand what is going on at the county level. When Medi-Cal funds are used, the federal government has a very prescribed process and forms into which budget requests must fit and a clear accounting for how money was actually spent.

Stakeholder Question: Will counties have to provide DMH three-year budgets? Will there be an opportunity for modification?

DMH Response (CH): DMH expects that the first year or two will be much more solid. Yes, modifications can be made.

Stakeholder Question: Is there room to make adjustments for rolling over funds?

DMH Response (CH): You can think in much broader ways. MHSA funds do not have the same kind of restrictions that past funds have had, like needing to be spent in a fiscal year.

Stakeholder Question: Are flexibility and update requirements built in?

DMH Response (CH): Yes, at least on a yearly basis, but a county can do it more often.

Stakeholder Question: If counties do not receive the maximum funding they apply for, is it set aside in some way if they make modifications to their plan? If it is set aside, how long will it be held?

DMH Response (CH): This has not yet been determined. How long should DMH set aside funding if a county cannot develop a plan to sufficiently utilize funds, if another county could use it more efficiently?

Stakeholder Comment: Do not accept the issue of withholding money from counties. Clients and family members are so desperate for funding. It is not acceptable that some counties will not get all their funding because they are not sufficiently organized.

Stakeholder Comment: Please commit to figuring out what those counties need, otherwise the consumers and the families in those counties are being punished. Stewardship is the responsibility of the State; those counties need help and support.

Stakeholder Comment: There is concern about lack of technical assistance for the counties having more trouble with their plans. Otherwise, the rich get richer and the poor get poorer.

Stakeholder Question: I do not understand about set-aside funding and contingency planning. Why is the State empowered with this in the legislation and implementation?

DMH Response: The legislation was not written to allocate all money to counties, but to hold some funds back to fund things that DMH cannot possibly anticipate regarding the appropriate formula for allocating funds. DMH needs to incentivize counties to spend as wisely as possible to meet as many unmet needs as possible. Counties need to set targets initially, but some of the funding will be outside of those targets.

Stakeholder Question: How often are audits? Who will pay?

DMH Response (CH): Typically, the audit is done on an annual basis. DMH has been late in the past. Typically, auditors are not needed until services have started. The Department is not sure yet how they will be paid for.

Stakeholder Comment: Regarding staffing, there is a resource crisis and we really need to look at the wage situation, particularly for clients and family staff across different levels of classification.

Stakeholder Comment: It is very important when staffing to look at a range of ways to pay consumers and their family support people for their expertise using a range of compensation options: stipends, part-time wages, etc. Anyone involved in planning needs to look at emerging practices that employ consumers.

Stakeholder Comment: It is more cost-effective to use consumer services. And clients and family members are always at the bottom of the list.

DMH Response (CH): What is being said has great validity. But be certain to specify, regardless of who is providing the service, what needs to be done to meet needs.

Stakeholder Question: I appreciate the guideline on staffing and planning. But why is there a separation between existing staff and client and family member staffing? These should be united if we are really talking about transforming the system.

DMH Response (CH): DMH is asking by classification, because little is learned by aggregate. DMH staff was trying to be responsive in emphasizing the importance of having consumers highlighted throughout the budget documents. The feedback seems to show this has missed the mark. DMH staff are not sure how to do this in another way.

Stakeholder Question: What about indicators of program impact on quality of life: food, clothing, transportation?

DMH Response: It is difficult to draw conclusions about which program or service is responsible for what outcome. DMH has managed this by making sure that the quality of life indicators are included in the narrative.

Stakeholder Question: The cost report is based on units of service. Is this unit-of-service-driven or needs-driven? The budget worksheet forms are very specific; a county must almost complete the RFP process before they have received them back from potential providers. How does a county construct a budget for the provider RFP process before it is done?

DMH Response (CH): DMH is looking for an estimated budget, trying to get a sense that the budget request is reasonably linked to need and proposed service. Suggestions for another way to get back-up for the request are welcome. All of the Medi-Cal rules apply for Medi-Cal clients when using MHSA funds. Not all services on the cost report are units of service.

Stakeholder Question: How will counties get money for operating costs and overhead? Private providers have lower overhead than counties: will there be a suggested limit?

DMH Response (CH): Medi-Cal recommendations are 15% for counties. Counties have responsibility for bringing the whole thing together. Private providers do not have the additional overhead responsibility for oversight. The administration for providing a service is built in, but we have not imposed limitations.

Stakeholder Question: How will the oversight committee measure progress?

DMH Response (CH): After services begin, that kind of outcome assessment needs to occur.

Ms. Hood turned the discussion to questions and ideas about requirements and input on the revenue side.

Stakeholder Comment: Can you show the percentage of MHSA funds matched against the full funding for community services?

DMH Response (CH): It is currently matched in this document against overall community costs for 2001-2002. DMH is trying to provide an overall context to demonstrate how MHSA funds fit into a much larger system.

Stakeholder Question: What is the proportion that MHSA represents of the funds available for county mental health services? This document identifies the proportion relative to the entire universe of mental health expenses, including things like IMDs, hospitalization. It would be more helpful to look at just the picture of what is being expanded, just in the context of mental health services, so we can compare apples to apples.

DMH Response (CH): DMH will look at this in the future.

Stakeholder Comment: This might be a nice opportunity to transform UMDAP: it is very old and not very useful.

Stakeholder Question: What does “realignment” mean?

DMH Response (CH): There was a change in 1991. Instead of providing state general fund monies, a dedicated proportion of sales tax and vehicle license fees were provided to County Mental Health and County Health Departments to prevent significant fluctuations from year to year. Realignment funding gives counties more control. It is about \$1-1.2 billion and the largest revenue for mental health: about 35% of total funds. MHSA would be about 15%.

Stakeholder Question: There is concern about the \$100 million in federal funds. About one-third of total funding will be Medi-Cal match?

DMH Response (CH): This is just an estimate. Until DMH receives plans from counties, it is unknown.

Stakeholder Question: Given that MHSA is only a small portion, is DMH also looking at transformation in other parts of the budget?

DMH Response (CH): That is the core issue. DMH is not looking at categorical funds, and is hoping that the MHSA funds help to transform the system. But it is important to look at the whole. DMH has authority over MHSA funds, not realignment funds.

Stakeholder Question: Our county has projects for which mental health funding was cut in prior years and we secured one-time funding. If our planning process determines that a de-funded service is what we want to do, do we need to worry about supplanting to maintain level of funding we had before?

DMH Response (CH): The issue remains under review. DMH staff do not have clarity yet about the definition of supplantation. It will be provided no later than May 1 (CSS requirements); the plan is to issue it in final form and not solicit review.

Stakeholder Comment: It would be helpful if you would explain supplantation relative to the restoration of previous cuts and to the provision of new services for old clients.

DMH Response (CH): Currently, review of supplantation policies is not on the table, but DMH staff present at this workgroup will bring stakeholder concerns back to administration.

Stakeholder Question: In the suggestions for revenue, given the transformational nature of MHSA and the interaction with other funds, where is the intention to leverage other funding sources to maximize MHSA?

DMH Response (CH): This is very similar to Medi-Cal issue. Sometimes when one pursues a revenue source, one does not necessarily do what is most needed, but what is easiest to fund.

Ms. Lemonds next discussed accountability and transformation, in which the budget is “where the rubber hits the road.” The budget, cost report and state audit are the accountability tools to show how county will operationalize goals. Ms. Hood discussed that money is typically seen as the driver. In this case, DMH wants the money to be a tool to transform the system. MHSA pulled off a lot of the typical constraints. For example, funding is not even tied to a fiscal year. DMH needs to make sure that the money keeps its place, and the vision drives plans and proposals. Be clear about goals and priorities.

Stakeholder Comment: We need to transform communities. This vision gets messed up when talking about budgets.

Stakeholder Comment: Those of us living with mental health issues got this measure passed. We were told that these funds would not be used for involuntary treatment and hospitalization, but for access and early intervention. If funds are allowed to be used for these purposes, it will destroy the community support that passed the measure.

Stakeholder Comment: Speaking as a social worker in the system for 30 years, it is extremely difficult to provide services to non-English speaking clients. Engagement services are the most critical services for these clients – but there is essentially no funding. SAMSHA-funded “community organizing” initiatives are critically transformative. Budgets should reflect deliverables that are not driven by units of service.

Stakeholder Comment: Endorse concept of determining best programs, rather than chasing the money. My fear is that we will continue to pursue the money, not provide the services we need. Budgets are mission statements. Please keep that in mind. Client and family member advocates will look more at your budgets than your narratives. This is an opportunity; please take care and remember that this discussion is not just about jobs, but about issues of life and death for clients and family members.

Stakeholder Comment: Budget should reflect new outcomes.

Stakeholder Comment: Think about client need. I cannot accept the notion that involuntary services are not part of the continuum of care. We should set a goal to reduce it, but work at improving the relevance and efficacy of this type of care.

D. Next Steps

Sylvia Rodriguez, DMH staff in Group One, and Carol Hood in Group Two summarized the next steps in the stakeholder process:

- DMH will prepare a summary to highlight what the Department has heard from the workgroup meetings, emails, letters and telephone calls.
- It will present those findings at the general stakeholder meetings on April 5 and 6.
- Additional input on CSS DRAFT Plan Requirements will be taken until April 11.
- The current target date for release of the final CSS Plan Requirements is May 15.