



MEETING MINUTES
Friday, February 22, 2008

I. Call to Order and Roll Call

Chair Gayle called the meeting to order and welcomed everyone. He noted that there were no formal actions taken in the closed session meeting that directly preceded this meeting.

Roll call was taken. Present were Commissioners Linford Gayle, Tom Greene, David Pating, Larry Poaster, Andrew Poat, Darlene Prettyman, and Edwardo Vega. Quorum not established.

Absent were Commissioners Wesley Chesbro, Saul Feldman, Beth Gould, Patrick Henning, Larry Trujillo, Mary Hayashi, William Kolender, Mark Ridley-Thomas.

MOTION: Commissioner Poat moved approval of the Motions Summary from last meeting and asked that they defer the vote until a quorum occurs; seconded by Chair Gayle.

II. Mental Health Funding and Policy Implications: CMHDA Perspective

Pat Ryan with CMHDA reported the following:

- The California Mental Health Services Act in 1969 was a national model of mental health legislation that deinstitutionalized mental health services and really started the change from serving people in the state hospitals to serving them in the community.
- The Short-Doyle Act was the funding mechanism and the legislative intent language called for funding to shift from the state hospitals to the communities, however, the money did not really translate.
- There is no entitlement for community mental health services in California unlike the developmental disabilities system. Mental health services, by statute, are provided to the extent resources are available.
- There are major sources of funding.
- Beginning with inadequate funding, state allocations to counties were severely diminished due to inflation throughout the 1970's and 1980's. There were no cost of living or case load adjustments to support community mental health and at the time, the community mental health services were subject to the state budget process.
- In 1990, California faced a \$15 billion state budget shortfall. This is what propelled realignment.
- Realignment was enacted in 1991 with the passage of the (Brawns McCordel Act). Instead of community mental health funding being funded through the state general fund, it was realigned so that revenues flowed directly to counties so certain programs were taken out of the state budget and a revenue source was created and the funding went directly to counties. This represented a major shift in funding for mental health.
- The revenue sources came from a ½ percent increase in sales tax and an increase in the state vehicle license fee, which was about \$2 billion dollars.

- Money was taken out of the state budget and all community mental health programs were funded through the new revenue source: Community mental health services and state hospital services for civil commitments.
- Institutions for mental disease were also transferred to communities.
- Realignment has provided counties many advantages, including a stable funding source, which has made a long term investment in community mental health possible and practical. It also has given the counties the ability to reduce the high cost restrictive settings and place clients more appropriately in the community. It's given greater flexibility and control and has allowed the roll over of funds from one year to the next so that counties were able to build up realignment trust funds. It gave a clear mission and defined target population allowing counties to develop comprehensive, community based systems and institute best practices and focus their scarce resources on recovery.
- Annually realignment revenues are distributed to counties on a monthly basis until each county receives funds equal to the previous year totals. Any funds above that amount are placed into sales tax and vehicle license fee growth accounts for health, social services and mental health.
- The first claim on the sales tax growth account goes to the case load driven, social services entitlement program. Because IHSS has grown, the first growth goes to those accounts and for the last few years has left near nothing left over for health and mental health.
- All VLF growth has been distributed according to a formula developed in statute to all 3 accounts. The only thing that county mental health has gotten over the past years has been VLF growth. VLF growth has averaged less than 3% a year for the past 4 years.
- The costs of services and other demands steadily rise, revenue source remains flat.
- Federal Medicaid dollars currently constitute the second largest revenue source for community mental health after realignment and this is crucial to understanding county mental health financing.
- Medi-Cal programs originally consisted of physical health care benefits with mental health treatment making up only a small part of the program. Mental health services under a fee-for-service system were limited to treatment provided by physicians, psychiatrists and psychologists, hospitals and nursing facilities and were reimbursed through the fee-for-service system directly by DHS. There was no federal funding of the county Short-Doyle Mental Health Program until the 1970's when it was recognized that these programs were treating many Medi-Cal beneficiaries.
- The Short-Doyle Medi-Cal program started as a pilot project in 1971 and counties were able to obtain, for the first time, federal funds to match their own funding to provide certain mental health services to Medi-Cal eligible individuals. They were able then to offer a broader range of mental health services than those that were provided under the original Medi-Cal programs under fee-for-service.
- A Medicaid state plan amendment in 1993 added more services under the Medicaid rehabilitation option to the scope of benefits. The rehab option as opposed to the clinic option which really just paid for hospital and outpatient psychologists and psychiatrist services now allows for all of those services to be reimbursed through the Medicaid program.
- From 1995-1998 the state and counties worked together closely and consolidated their fee-for-service and their Short-Doyle programs into one carved out specialty mental health managed care program. Under the program, they combined the revenues from both. Counties are given the first right of refusal for taking on the new responsibility. Counties are not mandated to manage the Medi-Cal program as it is a

voluntary contract that they enter into with the state. Under this program, all Medi-Cal beneficiaries must receive their specialty mental health services through the county mental health system. Specialty mental health a service means one has to meet medical necessity. General mental health care needs for Medi-Cal beneficiaries remain under the responsibility of the California Department of Health Care Services. DHCS is also responsible for all pharmaceutical costs for carve out beneficiaries. When consolidation occurred the state transferred the funds that it had been spending under the fee-for-service system for inpatient and outpatient psychiatric and psychological services to county mental health plans that agreed to manage the program. It was assumed by counties at that time that mental health plans would receive additional funds yearly beyond the base allocation for increases in Medi-Cal beneficiary case loads and for cost of living adjustments. It was also assumed that any cost beyond the allocation that they received from the state for the services were to come from realignment revenues.

- Since Medi-Cal consolidation, counties have not received COLA's for the Medi-Cal programs since 2000 but have had case load growth.
- This year and next year the Governor proposed an additional 10% reduction in the allocation to counties for the Medi-Cal managed care program, so this base funding had already been reduced once. These reductions, if adopted, would total \$64 million dollars including FFP.
- Cumulatively they estimate over time because of the lack of COLA and the decrease in '03/04, that the reduction between state general fund and FFP is about \$60 to \$80 million dollars since '01.
- The 5% rate reduction in '03/04 to the Medi-Cal consolidation allocation was restored for other providers. So when they took that reduction, they took it for other health plans and other individual providers, all of which were restored except for the mental health plans.
- The early and periodic screening diagnosis in treatment is a part of the federal Medicaid program and it applies to children. When the Medi-Cal program was consolidated and given to counties to manage, it included services to adults and to children. A lawsuit against the state in 1995 resulted in the expansion of Medi-Cal services to beneficiaries less than 21 years of age, who needed specialty mental health services to correct mental health services whether or not those services were covered under the Medicaid plan. Counties were contracted with the state to provide those services and as a result of the settlement, the state agree to provide the state additional state general fund account as a match for the expanded mental health services for children.
- DMH developed an interagency agreement with DHS in which county mental health plans were reimbursed the entire non federal costs for all EPSCT eligible services in excess of the expenditures made by each county for those services at the time that the lawsuit was won.
- In fiscal year '02/03 a 10% county share of cost which includes FFP was imposed by the Administration done in the budget by line item on counties of the growth. Those funds come from realignment.
- The AB 3632 special education services to students – this is another federal entitlement program, it's the Individuals with Disabilities Education Act which entitles all children to a free appropriate public education. In 1984, the state legislature decided that access to services for this entitlement program were not adequate and the legislature passed a bill that mandated that county mental health programs provide the mental health IDEA services to children.

- In the early 2000's, the state failed to reimburse counties for providing the mandating services, which created a severe cash flow issue. While the state since recognized its responsibility to pay counties for the program, the state still owes counties about \$250 to \$300 million dollars. Four counties actually sued the state and won.
- Bottom line is realignment was never fully funded was intended to grow over time, that growth has not occurred as expected, does not keep up with the cost of providing services. Medi-Cal services have not received COLA. Realignment funds must be used to pay for the increased costs, which means there is less money left over to pay people who uninsured.
- It has been estimate that their system serves only about 40% of persons with serious disable and mental illness.
- California still ranks near the bottom nationally in resources available for person receiving Medicaid. Each year the services that can be delivered erode under multiple demands on scarce dollars.

Stephanie Welch reported on MHSA:

- One of the exciting things about MHSA is that the services look very different than what was provided before. The Act was intended to expand services.
- The Act requires maintaining current spending levels, protecting existing entitlement so that MHSA cannot be used to supplant existing services. The MHSA was never intended to provide a funding source to do what was already being done.
- The Act requires the state to continue to provide financial support to mental health programs with not less than the same entitlements, amount of allocations from the general fund and formula distributions of dedicated funds as provided in the last fiscal year which was '03/04 and then prior to the effective date of the Act.
- The state may not make any changes to the structure of the financing of mental health services that increases a counties share of cost or financial risk for mental health services, unless the state includes adequate funding to fully compensate for such increased cost or financial risk.
- There are all sorts of implementation challenges and need to manage expectations because of the new kinds of services that they are providing, the training that is needed, the revving up that's needed and the time that it is taking to get resources to counties not because people are sitting on the man. It's difficult process that takes time.
- Roughly \$3 billion in MHSA revenues has been collected since January 2005, most counties have only received their CSS dollars and their one time planning funds and that totals a little \$750 million for local resources for direct services in communities. Over \$1.3 billion in resources has been committed but not actually been distributed into communities.
- As in LA County, among the state there are large county deficits while there is a MHSA influx and a lot of planning and energy going into designing new programs.
- The proposed budget for '08/09 and while MHSA is a growing a portion of the overall mental health budget, it is still not as significant as sometimes people think.
- The MHSA revenue sources are going to become a bigger part of the mental health system.

Pat Ryan thanked the MHSOAC for allowing CMHDA to present on the topic.

Vice Chair Poat thanked Sheri Whitt and staff for providing reports beforehand so that the Commissioners could review the material. He said the MHSOAC's new practice will be to read

the reports and then have time to ask questions on any of the DMH, OAC or other reports that are submitted.

III. March Strategic Planning Meeting – Proposed Draft Agenda

Ms. Whitt reported on the agenda for the Strategic Planning Meeting in March as follows:

This meeting will not be run as a “typical MHSOAC business meeting”. They will be moving through the agenda items (as provided to Commissioners) and if public does attend the meeting, they will have an opportunity at the very end to make some comments.

- Day One – the original thinking was that as part of the strategic planning it made sense to go back and touch base with what the original vision was both in the Act and the original set of Commissioners who came together as they were thinking about the roles and responsibilities of the Commission.
 - Have a review of 2005 retreat results and brainstorm on what is meant by “oversight and accountability” and “inclusion and transparency”.
 - Review current MHSOAC Workplan with the opportunity to make edits as needed.
 - Review proposed annual calendar for MHSOAC meetings with edits as needed.

- Day Two – Review current rules of procedures
 - MHSOAC Meeting Format including 1) Standing Agenda Items 2) How to select additional agenda items 3) Public Comment 4) Format of Minutes
 - Lessons Learned and Next Steps

She said that she is looking into having a facilitator at the meeting.

Commissioner Questions/Comments

Commissioner Pating expressed concern in regards to the allotted times on the agenda for the retreat. He said they would need some time to brainstorm and suggested looking at evening hours.

Commissioner Trujillo agreed with Commissioner Pating that more time needs to be allotted, but not necessarily evening hours. He noted that the agenda item covering the 2005 retreat results was not an issue of importance to him.

Ms. Whitt clarified that the agenda items rests with the Chair and Vice Chair.

Vice Chair Poat said the point for the agenda item is to get their respective thoughts on the table and then Ms. Whitt and staff would integrate their thoughts into a final agenda.

Chair Gayle expressed that evening hours are not his preference.

Commissioner Prettyman stated that it is important for the Commission to unwind together and brainstorm. Ms. Whitt said that in thinking of a working dinner, there would need to be some sort of arrangement to have a meal brought it.

Ms. Whitt said that she will expand the draft agenda and provide more detail on anticipated topics under each agenda item along with the anticipated outcomes from each of those discussions. She

will add content regarding financial oversight and accountability and how the Commission would like to achieve that.

Commissioner Trujillo suggested a team building experience at the retreat.

Chair Gayle said he and the Vice Chair will work with Ms. Whitt on the Proposed Draft Rules of Procedure.

Public Comment

Carmen Diaz asked why LAX was chosen for the site of the meeting because there had been a problem getting her community people there only because LAX is hard to get to. She said that Commission should go to the community not vice versa. She said that the language is too intense and should be simplified. A list of acronyms should be provided to the public. She said with regards to the OAC retreat the Commission should think very carefully about a working dinner because the meeting will be open to the public.

Zed Null said after he spoke of hoarding at the prior days meeting, he was approached by someone that asked why hoarders can't apply to IHSS for help; specifically their workers are not trained in the sensitivity that is required to deal with the valuation of the items that the hoarder chooses to keep in their environment. He said that whenever there are budget cuts managed care comes up as the program of choice on getting the most for the buck. He stated that managed care may be cost effective, but it limits accessibility to consumers by creating certain restraints as to how often they can get health care. He said that in Los Angeles, the Board of Supervisors had proposed closing all of the public health clinics and replacing them with private clinics. He said under the mental health services program that is state funded, unfortunately consumers that need access to care will identify that they have a mental health concern and use that clinic as an access point to get the services that they want.

Delphine Brody said in regards to the WET Review Tool she hoped that the OAC will add the following two criteria: 1) what specific provisions are included in the county WET plan to value the advocacy and empowerment of consumers after they have become employees of the county mental health system and community based organizations and; 2) does the county WET plan give emphasis to supporting existing consumer run self help organizations and developing capacity for new consumer run programs and organizations.

Vice Chair Poat thanked the Commissioners, staff, and the public.

Meeting adjourned at 12:02pm