AGENDA

1. Refresher: BH funding sources, mandates, and entitlements
2. Post COVID-19 state budget and fiscal forecasting
3. CBHDA fiscal and budget advocacy
4. Local landscape and decision-making
### HISTORY & TIMELINE:
**CA’S PUBLIC BEHAVIORAL HEALTH SYSTEM**

#### State Control
- 1950s: State Hospitals/Institutional Care

#### Move Towards Local Control
- 1957: Short-Doyle Act
- 1963: Community Mental Health Act
- 1967: Lanterman-Petris-Short Act
- 1989: Targeted Case Management SPA
- 1993: Rehabilitation Option SPA
- 1995-97: 1915(b) Waiver/Mental Health Managed Care
- 2004: Mental Health Services Act
- 2011: Public Safety Realignment /AB 100 (Changes to MHSA)

#### Increasing Partnerships/Broader Healthcare System Integration
- 2010: Affordable Care Act/CA’s Bridge to Reform 1115 Waiver
- 2014: Expanded Outpatient Mental Health Benefits (“Mild/Mod”)
- 2015: Medi-Cal 2020 Waiver/DMC-ODS Pilot Approval
- 2016: Medicaid Managed Care Final Rule
ORIGINS OF THE COMMUNITY MENTAL HEALTH SYSTEM

- The Short-Doyle Act - 1957
  - Funding mechanism intended to build the community mental health system
  - Shift from state hospitals to community programs
  - Full savings from closures of state hospitals were not distributed to the community mental health system
  - The public mental health system was never conceived of as an “entitlement”
  - County mental health services provided “to the extent resources are available”

- This essential difference created the illusion of a broad mandate, but built rationing of services into the framework of mental health service delivery.
EVOLUTION OF PUBLIC SUD TREATMENT & DRUG MEDI-CAL

- **Drug Medi-Cal – 1980 - 2010**
  - Limited benefits supported by state GF and federal funds
  - Counties contracted with the CA Dept. of Alcohol and Drug Programs (ADP) to administer SUD services and received state GF and FFP from the state
  - The state also contracted directly with SUD providers

- **Substance Abuse Prevention and Treatment Block Grant - 1993**
  - Established by Congress and was a primary funding source for SUD treatment
  - Focus on pregnant women and mothers, IV drug users, TB services, HIV/AIDS early intervention, primary prevention

- **Sobky v. Smoley - 1994**
  - Led to expansion of NTP services
  - Court ruled counties’ use of caps and wait lists for methadone maintenance to Medi-Cal enrollees violated the compatibility provisions of Medicaid
  - State established direct contracting with any willing certified provider of the service in a county if that county was unwilling

- **Realignment - 2011 Realignment**
  - Codified the role of counties and provided dedicated funding
COUNTY BEHAVIORAL HEALTH SOURCES OF FUNDING

1991 Realignment

2011 Realignment

Mental Health Services Act (MHSA)

Federal Financial Participation (Medicaid aka Medi-Cal in California)

Other local funds (variable) and grants
1991 REALIGNMENT
1991 MENTAL HEALTH REALIGNMENT

- Bronzan-McCorquodale Act of 1990/"1991 Realignment"
  - Recasts Short-Doyle financing and obligations as part of 1991 Realignment
  - Requires counties to serve the mental health needs of children with serious emotional disturbance and adults with serious mental illness
  - County mental health agencies responsible for serving the needs of specified target populations, *to the extent resources are available*

- Mental health programs realigned from the state to counties:
  - All community-based mental health services
  - State hospital services for civil commitments
  - "Institutions for Mental Disease" which provided long-term nursing facility care

- Funds may be used as match to federal Medi-Cal claim when services are provided to Medi-Cal beneficiaries
1991 REALIGNMENT REVENUE STRUCTURE

Three revenue sources:
- ½ Cent of State Sales Tax
- State Vehicle License Fees
- State Vehicle License Fee Collections

County Maintenance of Effort (MOE) Required
1991 REALIGNMENT GROWTH FUNDS DISTRIBUTED BY FORMULA

- Base funds were distributed to individual counties based on prior State General Fund county allocations.

- The distribution of growth funds is complex. However, the first claim on the Sales Tax Growth Account goes to caseload-driven social services entitlement programs (IHSS and child welfare).

- Any remaining growth from the Sales Tax Account and all VLF growth are then distributed according to a formula developed in statute.

- Growth distributed in the year after it is collected
  - Increases the base for that year

- Decrease applied proportionally to all programs
  - Lowers the base for that year and subsequent year
• Swap of CalWORKs MOE with Mental Health Realignment beginning in FY11/12
  • *CalWORKs MOE funded with Realignment revenues that would have gone to Mental Health*
• Mental Health services funded with 2011 Realignment sales tax revenue
  • *Guaranteed minimum amount beginning in FY12/13 ($1.12 billion)*
• Mental Health began receiving growth in 1991 Realignment funds once funding for CalWORKs MOE equaled the guaranteed minimum amount of Mental Health funding in FY13/14
• Mental Health also receives 5% of the annual growth in the 2011 Realignment Support Services Account
CURRENT STRUCTURE OF 1991 MENTAL HEALTH REALIGNMENT

- Realignment revenues are distributed to counties on a monthly basis as funds are collected until each county receives funds equal to previous year’s total.
  - Separate distributions for:
    - Mental Health (fixed, guaranteed amount)
    - Mental Health Sales Tax Base
    - Mental Health VLF Base
    - Mental Health VLF Collections

- CalWORKs MOE is funded prior to the funding of Mental Health Sales Tax Base and Mental Health VLF Base.
  - Mental Health Sales Tax and VLF base are not funded if the CalWORKs MOE base funding is not met.

- Revenues above that amount are placed into growth accounts
  - Sales Tax
  - VLF
CURRENT STRUCTURE OF 1991 MENTAL HEALTH REALIGNMENT-KEY POINTS

- 1991 mental health realignment funding *not* tied to demand for services
- Mental Health is guaranteed a minimum level of funding regardless of revenues
- Individual county allocations are fairly predictable based on current allocation percentages
- No limitations on when funds need to be expended
Decrease in FY19/20 revenues due to COVID-19 economic and policy implications

Anticipate growth in revenue as economy recovers

- No mental health distributions from growth in Sales Tax revenue due to IHSS caseload cost increases
- No mental health distributions from growth in VLF revenue due to CalWORKS MOE base

CURRENT STRUCTURE OF 1991 MENTAL HEALTH REALIGNMENT - KEY POINTS
2011 REALIGNMENT
Additional realignment occurred in FY11/12 that shifted funding and service responsibility from the state to the counties for:
- Law Enforcement, Social Services, Behavioral Health

Driven by state budget crisis, not counties

Goals:
- Protect California’s essential public services
- Assign program and fiscal responsibility to the level of government that can best provide the service
- Provide dedicated revenues to fund these programs
- Avoid Proposition 98 Education Funding Guarantee call on state general fund
Dedicated a specific revenue to fund realigned services

VLF Transferred to fund law enforcement programs

MHSA funds used to fund realigned mental health services in FY11/12

1.0625% of Sales Tax

Realigned services previously funded with State General Fund
State transferred financing responsibility to counties for:
- Medi-Cal Mental Health Managed Care
- Medi-Cal Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Substance use disorder services, including:
  - FFS/State plan Drug Medi-Cal benefits for eligible adults
  - Drug Courts
  - Perinatal Drug Services
  - Non-Drug Medi-Cal Substance Use Services

If DHCS determines that a county is failing or at risk of failing to perform the functions of a Behavioral Health Subaccount program to the extent federal funds are at risk, DHCS may determine amount needed and divert dollars from the county to operate the service directly.
State must fund any new laws that increase costs of local services mandated by 2011 Realignment as follows:

- New laws (after 9/30/12)
- New regulations, executive orders, administrative directives (after 10/9/11)

Unless the state provides funding, state cannot submit federal plans/waivers/SPAs that increase local costs

State provides 50% of needed funds for changes to federal statutes/regulations or federal judicial or administrative proceedings
2011 REALIGNMENT DISTRIBUTIONS

- FY16/17 individual county allocations established each county’s base
  - Information Notice 16-052

- Subsequent fiscal year allocations based on rolling base concept
  - Current year base equals prior year base plus prior year growth

- Behavioral Health Subaccount growth
  - Growth distributed based on a formula driven by actual claims and population
    - 50% of growth distributed based on actual claims from two entitlement programs
    - Balance distributed based on percentage of average monthly Medi-Cal enrollment
Funding *not* tied to enrollment/demand despite Medi-Cal/EPSDT entitlements

Statute provides flexibility on use of the funds between behavioral health programs, but state monitors *as if the funding was categorical*

No limitations on when funds need to be expended
2011 REALIGNMENT - COVID-19

- Decrease in FY19/20 revenues due to COVID-19 economic and policy implications
- Anticipate growth in revenue as economy recovers
- Individual county allocations should be more predictable over the next several years as revenues are used to restore base funding levels
MENTAL HEALTH SERVICES ACT
The MHSA created a 1% tax on income in excess of $1 million to expand mental health services.

Approximately 1/10 of one percent of taxpayers are impacted by tax.

Two primary sources of deposits into State MHS Fund:
- 1.76% of all monthly personal income tax (PIT) payments (Cash Transfers)
- Annual Adjustment based on actual tax returns
  - Settlement between monthly PIT payments and actual tax returns

Other deposits:
- Interest income (posted quarterly)
- Excess State Administration (unauthorized and unexpended)
- Reverted funds
MENTAL HEALTH SERVICES ACT
REVENUES

- Cash Transfers are largest in months with quarterly tax payments and year end tax payments
  - January, April, June and September

- Annual Adjustments are incredibly volatile
  - Two-year lag
  - Known by March 15th
  - Deposited on July 1st
MHSA COUNTY FUNDING

- Funds distributed on a monthly basis (W&I Code Section 5892(j)(5))
- Unexpended and unreserved funds on deposit in the State MHS Fund at the end of the month are distributed by the 15th of the next month
- Up to 5% is reserved for State Administration

- Counties receive one warrant (check) from the state
  - County responsible for ensuring compliance with W&I Code Section 5892(a) and State guidance
    - 5% for Innovative programs
    - 19% for Prevention and Early Intervention programs
    - 76% for Community Services and Supports (System of Care)

- Each county required to have a local Mental Health Services fund in which interest earned remains in the fund to be used for MHSA expenditures

- Individual county allocation percentages are based on:
  - Estimated need for services
  - Self-sufficiency and resources
  - Small county minimum allocations
  - Information Notice 19-043 describes methodology
**MHSA COUNTY EXPENDITURES**

**Requirements:**
- Prepare a Three-Year Program and Expenditure Plan
- Gain approval of Plan through annual stakeholder process
- Spend in accordance with an approved Plan
- Prepare and submit MHSA Annual Revenue and Expenditure Reports

**Restrictions:**
- Cannot be used to supplant existing resources
  - *Based on FY04/05 programs and expenditures*
- Generally cannot be used for involuntary services
  - *Exception is short-term acute care for Full-Service Partners*
- Generally cannot be used for services to individuals incarcerated in state or federal prisons
Income taxes on very few high-income earners fund MHSA regardless of demands

Revenues are volatile

Large decrease in FY19/20 and subsequent increase in FY20/21 due to delay of tax filing and payment deadlines

Large decrease in FY22/23 due to economic conditions in 2020

Amount of county funding is not guaranteed

More risk to counties
MHSA-KEY POINTS (CONT.)

- Cash flow varies significantly during the fiscal year
  - 40% of MHSA cash transfers received in last three months of fiscal year

- MHSA provides tools to manage funding
  - Local prudent reserve
  - Three-year reversion period for unspent CSS, PEI and Innovation funds

- All expenditures must be consistent with an approved MHSA Plan

- Funds must be spent within specified time frame (generally, three years)

- State recalculates allocation percentages each fiscal year making it difficult to predict individual county allocations
OTHER FUNDING
MEDI-CAL BEHAVIORAL HEALTH REIMBURSEMENT

- Revenues are based on Certified Public Expenditures incurred by the County
- Requires county to have sufficient revenue available to incur full funds expenditure prior to obtaining reimbursement
- Percent reimbursement is generally based on the Medi-Cal beneficiary’s aid code
- Final entitlement amounts are not known until after audit and appeals, which is currently at least six years after provision of services
  - Requires counties to establish reserves in case of audit recoupment
- Incentive is to maximize volume of services, not quality of care
STATE GENERAL FUNDS

- Proposition 30 obligations for post-2011 Medi-Cal Specialty Mental Health mandates
  - ACA expansion population, state-only undocumented immigrant enrollment
  - EPSDT Performance Outcome System
  - Federal Managed Care Rule implementation
  - Continuum of Care Reform responsibilities

- Recent grant programs (2018 Budget Act)
  - $100 million over 3 years for counties to contract with Department of State Hospitals for services that reduce referrals of felony Incompetent to Stand Trial
  - $50 million to DHCS for county multi-disciplinary teams for homeless outreach and treatment.
  - $10 million for the Homeless Youth and Exploitation Program through the Office of Emergency Services to provide grants to up to six counties.
MISC. FUNDING

- Counties contribute additional county funds (overmatch) based on the availability of local revenues and local priorities
  - Varies significantly by county – counties with public hospitals tend to have higher county contributions

- SAMHSA funds the Mental Health Block grant:
  - $88.1 million

- Other third-party revenues:
  - Insurance
  - Medicare
FUNDING: KEY TAKEAWAYS
Majority of funding driven by on economic conditions, not demand for services

- Need for services is often countercyclical to health of the economy

1991 Realignment is the most flexible funding, followed by 2011 Behavioral Health Subaccount and MHSA

- Each funding source is used for somewhat unique services and population groups
- The funding sources increase at different rates which results in disparities among services and population groups

Need to maximize Medi-Cal revenue with fewer resources available to incur CPE

- Most treatment services should be Medi-Cal eligible
- Make sure MHSA treatment services are documented and claimed if covered by Medi-Cal
ATYPICAL BUDGET PROCESS FOR FY 20-21

- Due to COVID-19, Governor’s May Revise very different from January proposal
- Deadline for legislature to pass budget: Midnight, June 15
- Governor has until July 1 to sign or veto. May also use “blue pencil” authority for line-item vetoes.
- This year: Two phases to account for delay in tax filing deadline
  - Re-visit in August, compare actual revenues to projections, adjust as needed
- Budget will include trigger mechanisms based on availability of federal funding
January Budget Proposal

$222 billion state general fund
Historically low unemployment at 3.9%
CalAIM proposal for Medi-Cal
Proposed coverage expansion to include undocumented older adults
Medi-Cal estimated $99.5 billion ($22.7 b GF)

May Revision

$203 billion state general fund
Historically high unemployment projected at 18%
Proposed elimination of existing 13 optional benefits (e.g. audiology)
Project Medi-Cal caseload to grow by 2 million Californians in 2020 (14.5 million)
Medi-Cal estimated $112.1 billion ($23.2 b GF)
Delayed negotiations for federal 1915(b) and 1115 waivers for a year requested

Contained significant behavioral health reforms, including payment reform and changes to medical necessity

Estimated savings: $695 million ($347 million GF)

Eliminates proposed Behavioral Health Quality Improvement Program (QIP) which had been ($87 million) for county behavioral health
Increase in Federal Match
- COVID-19 related increase in FMAP results in $5.1 billion in GF savings

Proposition 56 Tobacco Tax
- 2016 voter approved initiative to fund provider rate increases in Medi-Cal
- Shift $1.2 billion from rates to fund Medi-Cal

Medi-Cal Managed Care
- CMS approval of MCO tax in April augments GF budget by $1.7 billion
- Proposal to cut rates by 1.5% ($182 million GF in 2020-21)
- “Efficiency Cuts” savings of $91.6 million in 2020-21 and $179 million in 2021-22
CARES Act – March 2020
$2 trillion relief package passed by Congress
California received $15.3 billion based on population estimates
• $9.5 billion paid directly to the state
• Remaining $5.8 billion distributed directly from the U.S. Treasury to cities and counties with populations > 500,000

May Revise Proposal
$450 million to expand funding to all cities for homelessness and public safety; and,
$1.3 billion shifted from the state to counties, “for public health, behavioral health, and other health and human services”
FEDERAL CARES ACT FUNDING (CONT)

- Funding Restrictions:
  - Must be used for actions taken to respond to the pandemic
  - May not be used to backfill/supplant existing budgeted services
  - Cannot be used as non-federal share of Medicaid payments

- Examples of eligible uses (partial):
  - PPE
  - Hazard Pay
  - Medical treatment related to COVID-19
  - Public health communication and enforcement
  - Payroll expenses for essential workers directly involved in pandemic response
  - Public safety response to COVID-19
  - Sanitation efforts
  - Distance learning
FY20/21 Estimated Behavioral Health Funding

(Dollars in Millions)

- Mental Health Services Act: $2,032.4
- 2011 Realignment: $1,401.9
- 1991 Realignment: $1,242.8
- Mental Health FFP: $2,747.8
- SUD FFP: $396.7
- Federal SABG: $233.7
- MH SGF: $157.5
- SUD SGF: $65.3
- Other Mental Health: $187.5
## Estimated Community Behavioral Health Funding
(Dollars in Millions)

<table>
<thead>
<tr>
<th></th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
<th>21/22</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991 Realignment</td>
<td>$1,270.7</td>
<td>$1,134.6</td>
<td>$1,242.8</td>
<td>$1,134.6</td>
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<tr>
<td>2011 Realignment</td>
<td>$1,483.2</td>
<td>$1,250.2</td>
<td>$1,401.9</td>
<td>$1,322.9</td>
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<tr>
<td>Mental Health Services Act</td>
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<td>$1,645.3</td>
<td>$2,032.4</td>
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<td>Mental Health FFP</td>
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<td>SUD FFP</td>
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<td>$333.9</td>
<td>$396.7</td>
<td>$408.6</td>
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<tr>
<td>Federal SABG</td>
<td>$231.4</td>
<td>$233.7</td>
<td>$233.7</td>
<td>$233.7</td>
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<tr>
<td>Other Mental Health</td>
<td>$244.7</td>
<td>$217.4</td>
<td>$187.5</td>
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<tr>
<td>MH SGF</td>
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<td>$127.6</td>
<td>$157.5</td>
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<tr>
<td>SUD SGF</td>
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<td><strong>Total</strong></td>
<td><strong>$8,567.4</strong></td>
<td><strong>$7,811.0</strong></td>
<td><strong>$8,465.6</strong></td>
<td><strong>$8,291.7</strong></td>
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</table>
Suspension of all but essential business operations is anticipated to significantly reduce sales tax and vehicle license fees.

Overall decline in FY19/20 1991 Realignment revenue of 5% to 10% compared to FY18/19 revenues.

Deferral of small business sales and use taxes by up to 12 months is estimated to impact 1991 Realignment by approximately $300 million in FY19/20.

FY19/20 distributions will become new base.

Anticipated increase in FY20/21 revenues will be used to fund FY19/20 and FY20/21 social services caseload costs.

Don’t anticipate fully meeting social service caseload costs and CalWORKs MOE until FY24/25.

Mental Health will not receive any Sales Tax or VLF growth.


$200 million of State General Funds distributed in August.

$300 million of federal funds (if received) distributed in October.
## 1991 Mental Health Realignment Estimated Revenues
(Dollars in Millions)

<table>
<thead>
<tr>
<th></th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
<th>21/22</th>
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</thead>
<tbody>
<tr>
<td><strong>Base Amount</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Mental Health (CalWORKS MOE Swap)</td>
<td>$1,120.6</td>
<td>$1,120.6</td>
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<tr>
<td>Mental Health Sales Tax Base</td>
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<td>Mental Health Vehicle License Fee Base</td>
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<tr>
<td>Mental Health Vehicle License Fee Collections</td>
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<tr>
<td><strong>Total Base</strong></td>
<td><strong>$1,263.9</strong></td>
<td><strong>$1,134.6</strong></td>
<td><strong>$1,134.6</strong></td>
<td><strong>$1,134.6</strong></td>
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<td><strong>Growth in Base</strong></td>
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<tr>
<td>Sales Tax</td>
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<tr>
<td>Vehicle License Fees</td>
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<td>State Funds</td>
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<td>Federal Funds</td>
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<td><strong>One-Time Growth</strong></td>
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<tr>
<td>5% of Support Services Account Growth</td>
<td>$6.8</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$1,270.7</strong></td>
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<td><strong>$1,134.6</strong></td>
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Suspension of all but essential business operations is anticipated to significantly reduce sales tax and vehicle license fees.

- Overall decline in FY19/20 2011 Realignment revenue of 5% to 10% compared to FY18/19 revenues.

- Deferral of small business sales and use taxes by up to 12 months is estimated to impact 2011 Realignment by approximately $628 million in FY19/20.

- The highest fiscal year distribution establishes the base.
  - FY18/19 base plus FY18/19 growth will most likely represent the base due to lower FY19/20 revenue.
  - Growth in revenues will be used to restore funding to the base level.

- Don’t anticipate fully restored base until FY24/25.

- State Budget proposal would backfill $500 million of 2011 Realignment in FY20/21.
  - $200 million of State General Funds distributed in August.
  - $300 million of federal funds (if received) distributed in October.
### 2011 Realignment Behavioral Health Subaccount Estimated Revenues

(Dollars in Millions)

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<td><strong>Base Amount</strong></td>
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<tr>
<td>Total Base</td>
<td>$1,415.4</td>
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<tr>
<td><strong>Growth in Base</strong></td>
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<tr>
<td>New Growth</td>
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<td><strong>One-Time Realignment Backfill</strong></td>
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<td>State Funds</td>
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<td>Federal Funds</td>
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<td>Total</td>
<td>$1,483.2</td>
<td>$1,250.2</td>
<td>$1,401.9</td>
<td>$1,322.9</td>
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<tr>
<td><strong>Percent Change</strong></td>
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<td></td>
<td>4.8%</td>
<td>-15.7%</td>
<td>12.1%</td>
<td>-5.6%</td>
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</table>

Excluding Women and Children's Residential Treatment Services Special Account which is a fixed amount.
IMPACT OF COVID-19 ON MHSA REVENUES

- Estimate 5% to 10% decrease in FY19/20 cash transfers due to lower revenues
- Estimate additional 15% to 20% decrease in cash transfers in FY20/21 due to lower revenues
- Estimate $300 million in deferred revenue from FY19/20 to FY20/21
  - Deadline for 2019 tax filing and 2020 first and second quarter estimated tax payments until July 15, 2020
- Estimate significantly lower annual adjustment ($172.9 million) in FY22/23 due to capital gains from calendar year 2020
  - State estimated $511.4 million annual adjustment prior to COVID-19 crisis
- Total decline in estimated revenues is comparable to revenues during the Great Recession
- State is estimating the Annual Adjustment that will post in FY21/22 to be over $1 billion
  - State estimated $572.8 million annual adjustment prior to COVID-19 crisis
  - Almost double the largest historical Annual Adjustment
### MHSA Statewide Estimated Revenues
(Cash Basis-Millions of Dollars)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Estimated</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>18/19</td>
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<tr>
<td>Cash Transfers</td>
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<tr>
<td>Annual Adjustment</td>
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<td>$2,105.3</td>
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</tbody>
</table>
MHSA COMPONENT FUNDING

- Funds distributed to counties are considered component funding
  - Excludes funds expended and reserved
- Funding for No Place Like Home debt service is excluded from component funding
  - $53.7 million in FY19/20
  - $92.0 million in FY20/21
  - $114.0 million in FY21/22
  - $130.0 million in FY22/23
  - Up to $140 million
- Anticipate large fluctuations in funding
  - Decrease in FY18/19 due to lower annual adjustment
  - Expect large annual adjustments in FY20/21 and FY21/22 due to capital gains spike in 2018 and 2019
  - Expect significantly lower annual adjustment in FY22/23 due to COVID-19 impact on 2020 economy
- Estimated component funding does not include redistributed funds based on reversion
## MHSA Estimated Component Funding
(Cash Basis-Millions of Dollars)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Actual</th>
<th>Estimated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18/19</td>
<td>19/20</td>
</tr>
<tr>
<td>CSS</td>
<td>$1,501.4</td>
<td>$1,250.4</td>
</tr>
<tr>
<td>PEI</td>
<td>$375.3</td>
<td>$312.6</td>
</tr>
<tr>
<td>Innovation</td>
<td>$98.8</td>
<td>$82.3</td>
</tr>
<tr>
<td>Total</td>
<td>$1,975.5</td>
<td>$1,645.3</td>
</tr>
</tbody>
</table>
1. **Lower federal Medi-Cal payments**: Lower Medi-Cal billable services means fewer federal dollars and a significant negative impact overall.
   - COVID-19 lowered volume due to: Cancelled appointments, provider staffing challenges, illness, digital divide, etc.

2. **Loss of core funding**: Main sources of funding (MHSA and Realignment) are drawn from millionaire’s tax, sales tax, and vehicle licensing fees.
   - *All are projected to decrease significantly* over the next 1-5 years as the U.S. and California face economic recession.

3. **Increase in Medi-Cal beneficiaries**: More Californians will qualify for Medi-Cal Behavioral Health due to job loss and increases in mental illness and substance use disorders.
   - New beneficiaries will not come with new funding (though state will continue to provide non-federal share for ACA expansion population).
4. **Increased community need for emergency crisis supports:** Broad community reliance on public behavioral health safety net due to anxiety and stress of the global pandemic and related economic and other impacts.

5. **Migration to telehealth and phone-based services:** County behavioral health has undergone a complete shift to phone and telehealth-based services where possible with no new funding invested.

6. **Alternative sites for new and existing clients:** County behavioral health must self-finance alternative settings to help with isolation, new populations, and alternatives to residential and congregate care settings.

7. **Support for providers:** Counties have invested more in trying to ensure contracted providers can weather the crisis financially so that we maintain access to services.
CBHDA
FISCAL ADVOCACY
COVID-19 FISCAL ADVOCACY (PENDING AS OF JUNE 1)

State Budget/Legislative Advocacy
- Realignment “backfill”
- MHSA flexibilities
- Other BH items

COVID-19 Emergency Funding
- State and federal proposals pending
- Available federal relief funds

Emergency Fiscal Flexibility – Medi-Cal
- CPE protocol/cost report and settlement changes
• Request to Backfill Realignment
  • Anticipated losses of $3.3 billion over two years for 1991 and 2011
  • Impacts all realignment funded services: public safety, social services, public health, and behavioral health
  • Estimated $710 million loss for county behavioral health for current year and budget year
  • Joint request with CSAC and affiliates for $1 billion (even split between 2011 and 1991)
  • $600 million contingent on availability of federal funds

• No Place Like Home Technical Assistance Deadline Extension

• Elimination of the Integrated Services for Mentally Ill Parolees Program and funding for parolee outpatient clinics

• FURS Funding Restoration

• OIG Recoupment

• MHSA
ACCESS TO PRUDENT RESERVES
EXTEND DEADLINES FOR 3-YEAR PLANS, PLAN EXTENSIONS, ARER SUBMISSIONS
MOVING FUNDS BETWEEN COMPONENTS (WITH LIMITATIONS)
AVOID REVERSION

MHSA FLEXIBILITIES (BH COALITION PROPOSAL, MAY 2020)
TWO-PHASE BUDGET ACTION ON MHSA
(*PLANNED STATUS AS OF JUNE 15)

**JUNE**
- Prudent reserves
- 3-year plan deadlines
- Reversion (Part 1)

**AUGUST**
- INN flexibility
- Transfers to WET, capital, prudent reserves
- Reversion (Part 2)
# Advocacy for COVID-19 Emergency Funding (Status as of June 15)

<table>
<thead>
<tr>
<th>1115(a) Waiver Board &amp; Cares (federal - NOT ADVANCING)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Proposal to bring in FFP to support COVID-19 expenses and response for Board &amp; Care providers</td>
</tr>
<tr>
<td>• $60 million non-federal share ask</td>
</tr>
<tr>
<td>• Temporary IMD waiver proposal also pending, per DHCS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SB 89 Funds (state - PENDING)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Digital divide and county, provider, client technology needs</td>
</tr>
<tr>
<td>• $100 million requested</td>
</tr>
<tr>
<td>• $30 million updated request for technology needs</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>FEMA Grant (federal - PENDING)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Proposal for $84.6 million grant</td>
</tr>
<tr>
<td>• Partnership with CalMHSA</td>
</tr>
<tr>
<td>• Statewide crisis counseling “virtual EAP” with referrals to county behavioral health</td>
</tr>
<tr>
<td>• Targeted Media Campaign</td>
</tr>
<tr>
<td>• Support for schools</td>
</tr>
</tbody>
</table>
OTHER FEDERAL COVID-19 FUNDING

6.2 percent FMAP increase - federal Families First Coronavirus Response Act

CARES Act funds - distributed to each county via the state budget

CARES Act funds - NEW: $15B available to Medicaid providers

Federal Paycheck Protection Program loans - direct to small businesses, including BH CBOs
DHCS FISCAL ADVOCACY: MEDI-CAL & CPE PROTOCOLS

- **Flexibilities proposed:**
  - Waive interim rate-setting methodologies
  - Allow settlement to cost (rather than lowest of cost or customary charge)
  - Increase maximum administrative reimbursement from 15-30 percent of direct costs

- **Status as of June 15, 2020: APPROVED**
  - Administrative reimbursement increase enacted via Governor’s executive order
  - Interim rate and cost settlement proposals for DMC state plan, SMH, and DMC-ODS approved by CMS
  - See: DHCS Information Notices 20-024, 20-023, and 20-031

- **Effective March 1, 2020, until state of emergency is lifted**
LOCAL DECISION-MAKING
CONSIDERATIONS FOR DECISION-MAKERS

- **Prioritize entitlement obligations**
  - Required to provide all Medi-Cal entitlement services
  - Required to provide acute psychiatric inpatient services in IMDs

- **Maximize revenue**
  - Maximize Medi-Cal FFP
  - CARES Act and other federal funds

- **Use revenue strategically**
  - Blend funding to greatest extent possible
  - Know requirements for each funding source and understand spending hierarchy

- **Reduce or eliminate programs that are optional or not cost-effective**
  - Non-required programs likely funded exclusively by MHSA
  - Evaluate cost effectiveness: E.g., crisis stabilization units in small-to-medium counties
BREAK WITH OPEN CHAT