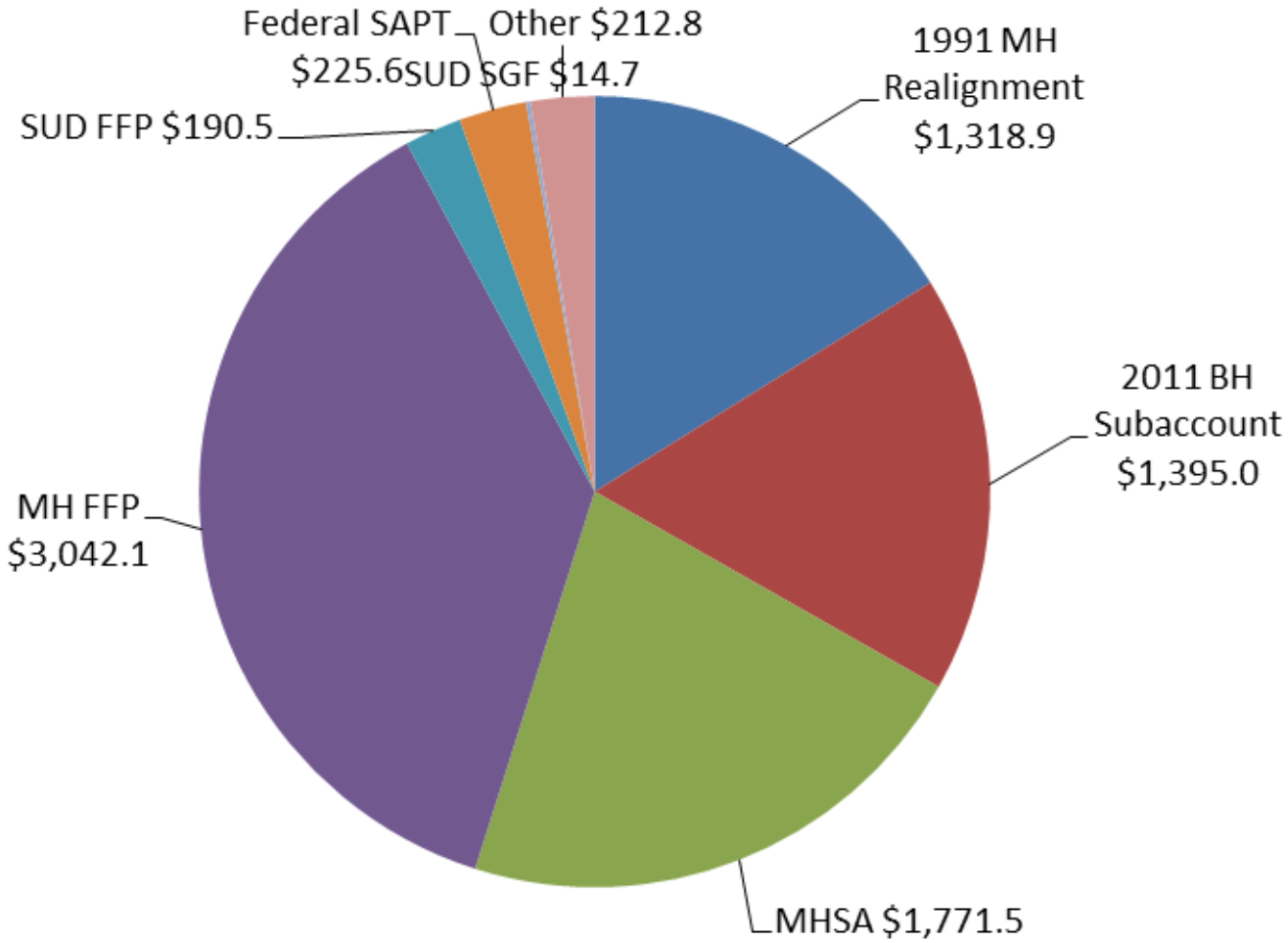
California Behavioral Health Revenue Update

California Institute for Behavioral Health Solutions

May 24, 2016

FY16/17 Estimated Behavioral Health Funding

(Dollars in Millions)



1991 REALIGNMENT

1991 Mental Health Realignment

- 1991 Realignment was enacted with passage of the Bronzan-McCorquodale Act
- The funds are used to serve individuals targeted in the Bronzan-McCorquodale Act
  - County mental health agencies responsible for serving individuals who meet the target population, based on availability of resources
- 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
- These 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 fund 1991 Realignment
  - ½ Cent of State Sales Tax
  - State Vehicle License Fees
  - State Vehicle License Fee Collections
- County's must provide a Maintenance of Effort (MOE)

Benefits of 1991 Realignment

- 1991 Realignment has generally provided counties with many advantages, including:
  - A stable funding source for programs, which has made a long-term investment in mental health infrastructure financially practical.
  - The ability to use funds to reduce high-cost restrictive placements, and to place clients appropriately.
- Greater fiscal flexibility, discretion and control, including the ability to “roll-over” funds from one year to the next, enabling long-term planning and multi-year funding of projects.
- Emphasis on a clear mission and defined target populations, allowing counties to develop comprehensive community-based systems of care, institute best practices and focus scarce resources on supporting recovery.

1991 Realignment Growth Funds Distributed by Formula

- Base funds 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

Current Structure of 1991 Mental Health Realignment

- Swap of CalWORKs Maintenance of Effort (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 ($1,120.5M)
  - Mental Health receives growth in 1991 Realignment funds once funding for CalWORKs MOE is equal to the guaranteed minimum amount of Mental Health funding
  - 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 funded prior to the funding of Mental Health Sales Tax Base and Mental Health VLF Base
- Revenues above that amount are placed into growth accounts
  - Sales Tax
  - VLF

1991 Mental Health Realignment Estimated Revenues

(Dollars in Millions)

	12/13	13/14	14/15	15/16	16/17
Base Amount					
Mental Health (CalWORKS MOE Swap)	$1,120.6	$1,120.6	$1,120.6	$1,120.6	$1,120.6
Mental Health Sales Tax Base	$0.0	$0.0	$11.6	$33.9	$55.9
Mental Health Vehicle License Fee Base	$0.0	$0.0	$11.2	$48.8	$66.8
Mental Health Vehicle License Fee Collections	$14.0	$14.0	$14.0	$14.0	$14.0
Total Base	$1,134.6	$1,134.6	$1,157.4	$1,217.3	$1,257.3
Growth in Base					
Sales Tax	$0.0	$15.7	$22.3	$22.0	$28.0
Vehicle License Fees	$0.0	$16.0	$37.6	$18.0	$21.0
One-Time Growth					
5% of Support Services Account Growth	$10.7	$9.1	$13.4	$10.5	$12.6
Sales Tax Adjustment					
Sales Tax		$10.0			
5% of Support Services Account		$0.3			
Total	$1,145.3	$1,185.7	$1,230.7	$1,267.8	$1,318.9

Current Structure of 1991 Mental Health Realignment-Key Points

- Sales tax and vehicle license fees continue to fund 1991 mental health realignment irrespective of the demand or need for services
- Mental Health is guaranteed a minimum level of funding regardless of revenues
  - More than 90% of base funding guaranteed
- Anticipate continued growth in revenue as economy continues to slowly grow
- Individual county allocations are fairly predicable based on current allocation percentages
  - Counties generally budget prior year base amount and then adjust budget mid-year once growth amounts are known
- No limitations on when funds need to be expended
  - Counties can create reserves

2011 REALIGNMENT

Public Safety 2011 Realignment

- Additional realignment occurred in FY11/12 that shifted funding and service responsibility from the state to the counties
  - Law Enforcement, Social Services, Behavioral Health
- Driven by state budget not counties
- Goals:
  - Protect California's essential public services
  - Create a government structure that meets public needs in the most effective and efficient manner
  - Have government focus its resources on core functions
  - Assign program and fiscal responsibility to the level of government that can best provide the service
  - Have interconnected services provided at a single level of government
  - Provide dedicated revenues to fund these programs
  - Provide as much flexibility as possible to the level of government providing the service
  - Reduce duplication and minimize overhead costs

Public Safety 2011 Realignment

- Dedicated a specific revenue to fund realigned services
  - 1.0625% of Sales Tax
  - Motor Vehicle License Fee Transfer to fund law enforcement program
  - Realigned services previously funded with State General Fund monies
  - MHSA funds were used to fund realigned mental health services in FY11/12

2011 Realignment Behavioral Health Subaccount

- Medi-Cal Specialty Mental Health Managed Care, including:
  - MH Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children and youth
- Drug Medi-Cal, including EPSDT
- Drug Courts
- Perinatal Drug Services
- Non Drug Medi-Cal Services
- Substance Use Early and Periodic Screening, Diagnosis and Treatment

Realignment 2011 and Medi-Cal Specialty Mental Health

- Counties must fund Medi-Cal Specialty Mental Health Services, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), from moneys received from:
  - The 2011 Behavioral Health Subaccount and the Behavioral Health Growth Special Account
  - The 1991 Realignment Mental Health Subaccount
  - MHSA funds, to the extent permissible under the Act
- 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:
  - It notifies the State Controller, Department of Finance, and the county
  - Determines the amount needed from the subaccount to perform the function
  - Controller deposits county's allocation attributable to program into the "County Intervention Support Services Subaccount" (for access by DHCS for the program). DHCS determines when this may cease.

Proposition 30 Constitutional Protections

- State must provide funds for new laws (after 9/30/12) or new regulations, executive orders, administrative directives (after 10/9/11) that increase costs of local services mandated by 2011 Realignment legislation
- 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

- FY12/13 individual county allocation percentages were intended to replicate State General Fund amounts to individual counties
  - Also included estimates of funding for Katie A. settlement and shift of Healthy Families to Medi-Cal
- FY13/14 individual county allocation percentages were updated with more recent data and did not include special treatment for Katie A. settlement or Health Families
- FY14/15 individual county base allocation percentages were again updated with more recent data and included $100,000 minimum Drug/Medi-Cal allocation
- FY15/16 individual county base allocation percentages are currently the same as FY14/15,
- Behavioral Health Subaccount growth
  - Fund two entitlement programs at amounts funded prior to realignment
  - Balance distributed based on percentage of average monthly Medi-Cal enrollment

2011 Realignment Behavioral Health Subaccount Estimated Revenues[c/]

(Dollars in Millions)

	12/13	13/14	14/15	15/16	16/17
Base Amount					
EPSDT[a/]	$584.1				
Existing EPSDT	$540.0				
Healthy Families	$17.3				
Katie A. Settlement	$26.8				
Specialty MH Managed Care[b/]	$196.7				
SUD Services[c/]	$178.5				
Total Base	$959.3	$987.1	$1,046.3	$1,163.3	$1,268.6
Growth in Base					
New Growth	$27.8	$60.0	$117.0	$105.3	$126.4
Total	$987.1	$1,047.1	$1,163.3	$1,268.6	$1,395.0
Percent Change	4.9%	6.1%	11.2%	9.1%	10.0%

a/ MHSA funds in FY11/12

b/ MHSA funds ($183.6M) and State General Fund monies ($148,000) in FY11/12

c/ Excluding SUD Residential Treatment which is a fixed amount per statute.

2011 Realignment-Key Points

- Sales tax funds 2011 mental health realignment irrespective of the demand or need for services
- Behavioral Health growth has increased as $200 million Child Welfare restoration has been fully funded
- Anticipate continued growth in revenue as economy continues to slowly grow
- Individual county allocations are not predicable
  - State continues to modify base allocation percentages making it difficult for counties to budget
- Individual county growth allocations are intended to make counties “whole” but end up lagging expenditures by two years
- Statute provides flexibility on use of the funds between behavioral health programs but state has continued to monitor as if the funding was categorical
- No limitations on when funds need to be expended
  - Counties can create reserves

MENTAL HEALTH SERVICES ACT

Mental Health Services Act Revenues

- 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 tax payers 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
- Counties receive one warrant (check) from the state
  - County responsible for ensuring compliance with W&I Code Section 5892(a)
    - 20% for Prevention and Early Intervention programs
    - Balance for Community Services and Supports (System of Care)
    - 5% of total funding shall be utilized for Innovative programs
- 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

MHSA County Funding

- Beginning in FY 08/09, counties can annually dedicated up to 20% of the average of their 5-year total of MHSA funds to the Prudent Reserve, Cap/Tech, or WET programs/projects
- Counties may use up to 5% of their total annual MHSA revenues for planning and supporting consumers, family members, stakeholder and contractors in local planning processes

MHSA County Expenditures

- Counties are required to prepare a Three Year Program and Expenditure Plan
  - Estimated funding by component
  - Estimated expenditures by component
- Gain approval of Plan through annual stakeholder process
- All MHSA expenditures are required to be in accordance with an approved Plan
- MHSA funds cannot be used to supplant existing resources
- Counties required to prepare and submit MHSA Annual Revenue and Expenditure Reports

Prudent Reserve

- Counties are required to establish and maintain a prudent reserve to ensure the county can continue services in years in which revenues are below recent averages (W&I Code Section 5847(b)(7))
- Counties can include an allocation of funds from their prudent reserve in years in which there is not adequate funding to continue to serve the same number of individuals as in the prior year (W&I Code Section 5847(f))
- In any year after FY07/08, CSS programs may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years (W&I Code Section 5892(b))
  - Limited to 20% of the average amount of funds allocated to a county for the previous five years

MHSA Reversion

- Welfare and Institutions Code specifies that funds must be spent within a certain time period or returned to the state
  - CSS, PEI and Innovation must be spent within three years
  - WET and CFTN must be spent within 10 years
  - Funds dedicated to Prudent Reserve are exempt from reversion
- Reversion period starts at beginning of fiscal year in which funds are available

Projecting Revenues

- Very difficult to estimate the annual adjustment
  - State's estimate is typically 50% or more off from actual
- Personal income tax receipts are impacted by changes in fiscal policies not related to MHSA
  - January, 2013 total Personal Income Tax Collections were significantly higher than anticipated
    - Due to primarily higher than anticipated 2012 estimated tax payments
    - Proposition 30 created three higher income tax brackets for families with taxable income above $500,000 retroactive to 2012
    - Reduced Federal tax rates expired at the end of 2012 increasing taxes for dividend income and capital gains in 2013
  - State tax law change does not impact amount earned in State MHS Fund
    - Increases cash transfers but decreases annual adjustment
  - Federal tax law change may marginally impact amount earned in State MHS Fund

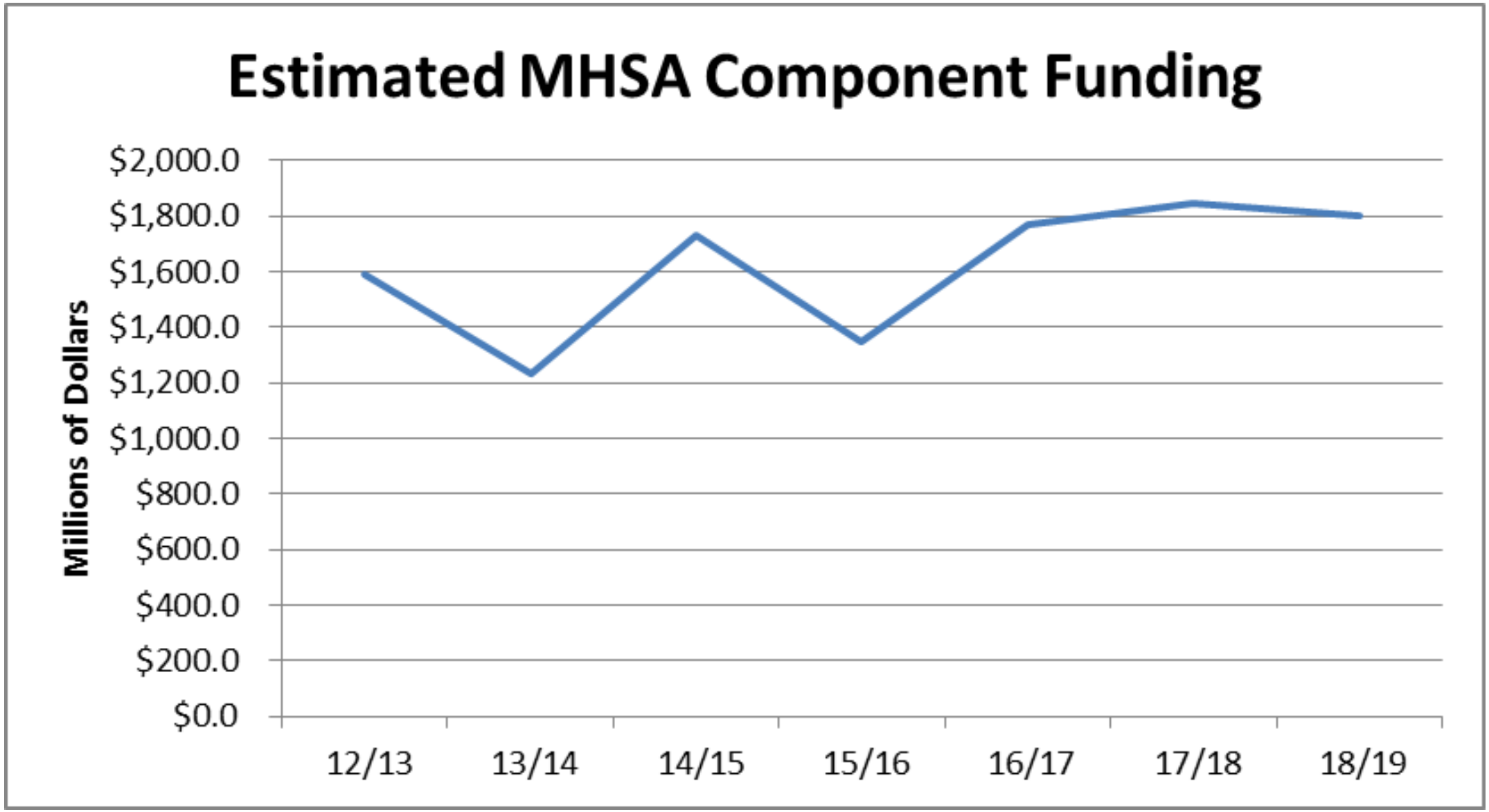
MHSA Estimated Revenues
(Cash Basis-Millions of Dollars)

	Fiscal Year						
	Actual		Estimated				
	12/13	13/14	14/15	15/16	16/17	17/18	18/19
Cash Transfers	$1,204.0	$1,189.0	$1,355.0	$1,350.0	$1,400.0	$1,455.0	$1,440.0
Annual Adjustment	$157.0	$153.5	$479.8	$94.3	$464.1	$490.0	$458.0
Interest	$0.7	$1.2	$0.6	$0.6	$0.6	$0.6	$0.6
Total	$1,361.7	$1,343.7	$1,835.4	$1,444.9	$1,864.7	$1,945.6	$1,898.6

MHSA Estimated Component Funding
(Millions of Dollars)

	Fiscal Year						
	Actual			Estimated			
	12/13	13/14	14/15	15/16	16/17	17/18	18/19
CSS	$1,208.1	$939.2	$1,314.6	$1,026.1	$1,346.3	$1,404.7	$1,370.8
PEI	$302.0	$234.8	$328.7	$256.5	$336.6	$351.2	$342.7
Innovation[a/]	$79.5	$61.8	$86.5	$67.5	$88.6	$92.4	$90.2
Total	$1,589.6	$1,235.8	$1,729.8	$1,350.2	$1,771.5	$1,848.3	$1,803.7

a/ 5% of the total funding must be utilized for innovative programs (W&I Code Section 5892(a)(6)).


Estimated MHSA Component Funding
Millions of Dollars
$2,000.0
$1,800.0
$1,600.0
$1,400.0
$1,200.0
$1,000.0
$800.0
$600.0
$400.0
$200.0
$0.0
12/13
13/14
14/15
15/16
16/17
17/18
18/19

MHSA Future Funding

- Increased personal income tax rates from Proposition 30 set to expire at end of 2018
  - Impacts timing of revenues to State MHS Fund
- Potential proposals to redirect MHSA Funds for statewide activities
  - Steinberg Institute proposing $130 million per year
  - CalMHSA looking for on-going funding
- Long term economic forecasts

Expenditures

- Prudent reserve and unspent funds should equal approximately one year of expenditures to fund status quo through economic downturn
  - Prudent reserve less flexible but more protected than unspent funds
- Need to factor continuation of components that no longer have dedicated funding
  - WET and Cap/Tech funded with CSS

MHSA-Key Points

- Income taxes on very few high income earners fund MHSA irrespective of the demand or need for services
  - Revenues are volatile
- Amount of county funding is not guaranteed
  - More risk to counties
- 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)

MEDI-CAL SPECIALTY MENTAL HEALTH

Medi-Cal Specialty Mental Health Reimbursement

- County Mental Health Plans (MHP) are reimbursed a percentage of their actual expenditures (Certified Public Expenditures-CPE) based on the Federal Medical Assistance Percentage (FMAP)
  - Same for all Medi-Cal Specialty Mental Health services except FFS/MC inpatient hospital services
- County MHPs are reimbursed an interim amount throughout the fiscal year based on approved Medi-Cal services and interim billing rates
  - Interim rates for contract providers represent amount paid by MHP to provider
  - Interim rates for county-operated providers should approximate actual costs
- County MHPs and DHCS reconcile the interim amounts to actual expenditures through the year end cost report settlement process
- DHCS audits the cost reports to determine final Medi-Cal entitlement
- Medi-Cal MHP Administrative costs and Utilization Review costs are reimbursed through quarterly claims and the cost report process

Medi-Cal Specialty Mental Health Reimbursement

- MHP reimbursement was limited to no more than the Schedule of Maximum Allowances (SMAs) prior to the implementation of AB1497 in FY12/13
  - Now generally based on lowest of actual costs and usual and customary charges
- Medi-Cal MHP Administrative costs are limited to 15% of direct service reimbursement
- 1915(b) Waiver limits reimbursement to an Upper Payment Limit (UPL) for each MHP
  - Based on actual CPE incurred by MHP
  - UPL changes up until audit (and any appeals) are completely settled

Medi-Cal Specialty Mental Health Estimated Federal Reimbursement

(Dollars in Millions)

	12/13	13/14	14/15	15/16	16/17
Existing Specialty Mental Health Services	$1,654.6	$1,777.5	$2,153.4	$2,403.7	$2,634.3
Supplemental Payment SPA					$407.8
Total Mental Health FFP	$1,654.6	$1,777.5	$2,153.4	$2,403.7	$3,042.1

Medi-Cal Specialty Mental Health Reimbursement-Key Points

- Revenues are based on Certified Public Expenditures incurred by the County Medi-Cal Specialty Mental Health Plan
  - Requires County MHP 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 FUND

State General Fund Overview

- State General Fund (SGF) revenues are derived from:
  - Personal Income Taxes
  - Sales and Use Taxes
  - Corporation Tax
  - Other Revenues and Transfers
- SGF revenues were provided to counties for various community behavioral health programs
  - Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
  - Medi-Cal Managed Care
  - AB3632-Individualized Education Plan (IEP) services
  - AB2034-Homeless grants
- Proposition 30 provides for additional SGF funding for new requirements
  - Katie A. Progress Reporting - $215,000 in FY16/17
  - Continuum of Care Reform - $6.8 million in FY16/17

EPSDT Overview

- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements established by the federal Omnibus Budget Reconciliation Act of 1989
- EPSDT required services include:
  - Informing individuals of the availability of screening and treatment services
  - Providing screening services to identify health/mental health needs
  - Providing diagnostic and treatment services to correct or ameliorate illness conditions, whether or not such services are covered under the state's Medicaid plan

Prior State EPSDT Funding

- Mental Health Plans were initially reimbursed the entire non-federal share of cost for all EPSDT eligible services in excess of expenditures made in the baseline year (1994-95)
  - Reimbursement for the state share of expanded EPSDT services was from the State General Fund
- Later, Mental Health Plans became responsible for a county match of 10% of the growth of the state/local match above a second baseline year (2001-02) cost settled amounts

State EPSDT Funding

- Services provided by the county or their agents to full scope Medi-Cal beneficiaries 0-21, above the EPSDT "baseline" were eligible for state EPSDT funding
  - Baseline 1 was based on the cost of care provided to eligible recipients in fiscal year 1994-95
  - Baseline was adjusted annually based on cost of living and other factors
  - 10% match on state/local match above baseline 2 cost settled amounts for fiscal year 2001-02
- State reimbursement was a portion of the actual cost of care for direct services (not administrative costs)
- State now trying to replicate statewide calculation through 2011 Realignment Behavioral Health Subaccount allocations

SUBSTANCE USE DISORDER SERVICES

Substance Use Disorder Services Funding

- Traditional sources of funding for public SUD services:
  - Federal Substance Abuse Prevention & Treatment Block Grant
  - FFP for Drug Medi-Cal
- Previously provided State General Fund for:
  - Drug Medi-Cal Match
  - Perinatal Services
  - Drug Court Treatment Programs
  - Discretionary
  - Proposition 36 Treatment
- Two major changes
  - Health Care Reform
  - Drug Medi-Cal Organized Delivery System Waiver

Federal Substance Abuse Prevention & Treatment Block Grant

- The federal government, through SAMHSA, provides the SAPT BG
- Majority of funds (63%) are discretionary, but there are some categorical allocations
  - Prevention
  - Friday Night Live/Club Live
  - Perinatal
  - Adolescent and Youth Treatment Program
- Grant funds are intended to supplement, and not supplant, existing resources
  - Statewide MOE requirement to support that funds supplement existing resources
  - DHCS has translated the statewide MOE to estimated county-specific MOE amounts

Health Reform Provisions

- The Affordable Care Act (ACA) contains provisions that affect the financing and delivery of public SUD treatment services. Generally these provisions are designed to increase service delivery through various types of integrated systems (i.e. health homes), often based on more comprehensive primary care.
- Along with the expansion of Medicaid eligibility, the ACA will greatly increase public support of SUD treatment services. These and other changes will have a significant impact on the types and relative importance of funding sources.

Health Reform Provisions

- Sources of Funding:
  - Under health reform, Medicaid's share of total public funding for SUD treatment will increase, while the share from SGF spending will probably continue to decline.
  - The major source of non-Medicaid funding, the federal Substance Abuse Prevention & Treatment (SAPT) Block Grant, is likely to decline in relative importance, or be repurposed to cover non-treatment services, such as recovery support and prevention.
  - New funding mechanisms will increase opportunities for larger, better-operated programs to expand through the acquisition of smaller, independent providers.

Health Reform Provisions

- These funding changes will have at least four major consequences:
  - Overall public spending for SUD treatment should greatly expand as a result of increased Medicaid enrollment and new benefit and parity requirements.
  - Expansion of Medicaid coverage will increase the proportion of federal spending for SUD treatment services in comparison to other funding sources.
  - The model in which public SUD treatment services are now organized will be fundamentally transformed. Rather than these services being administered by a single state authority that funds designated providers through a system of grants and contracts supporting a specified number of treatment slots, Medicaid will increasingly displace this model with a medical model payment system more characteristic of health plan managed care.

Drug Medi-Cal Organized Delivery System Waiver

- DHCS received approval from CMS to implement the Drug Medi-Cal Organized Delivery System (ODS) pilot
- Counties can opt to participate
  - Required to complete County Implementation Plan
  - Required to prepare County Fiscal Plan
    - Includes developing proposed reimbursement rates
- DHCS reviews and approves Plans
- Overall DHCS 1115 Waiver must be cost neutral
  - Provides opportunities to test different rate structures in different counties

OTHER FUNDING

Other Funding

- Counties are required to provide a county maintenance of effort in order to receive 1991 Realignment funds
  - $48.6 million per year and not indexed for inflation
- Counties contribute additional county funds (overmatch) based on the availability of local revenues and local priorities
  - Amount of overmatch varies significantly by county
  - Counties with public hospitals tend to have high county contributions
- SAMHSA funds the Mental Health Block grant
  - $57.4 million
- Other third party revenues
  - Insurance
  - Medicare
- Uniform Method of Determining Ability to Pay (UMDAP)
  - Patient fees

TOTAL BEHAVIORAL HEALTH FUNDING

Behavioral Health Estimated Funding

(Dollars in Millions)

	12/13	13/14	14/15	15/16	16/17
1991 MH Realignment	$1,145.3	$1,185.7	$1,230.7	$1,267.8	$1,318.9
2011 BH Subaccount	$987.1	$1,047.1	$1,163.3	$1,268.6	$1,395.0
MHSA	$1,589.6	$1,235.8	$1,729.8	$1,350.2	$1,771.5
MH FFP	$1,654.6	$1,777.5	$2,153.4	$2,403.7	$3,042.1
SUD FFP	$130.8	$128.1	$157.1	$141.3	$190.5
Federal SAPT	$214.3	$222.9	$227.0	$225.6	$225.6
SUD SGF	$0.0	$7.3	$10.9	$1.2	$14.7
Other	$190.0	$206.0	$206.0	$206.0	$212.8
Total	$5,911.7	$5,810.5	$6,878.2	$6,864.4	$8,171.1

Key Points

- Majority of funding driven by on economic conditions and is not based on need for services
  - Need for services is often countercyclical to health of the economy
- There is a desire to integrate mental health and substance abuse services but funding remains independent
- Individual county allocations often determined through political process making it difficult for counties to budget
- Much of funding is categorical
  - Counties sometimes given flexibility but monitored at more discrete level