

# Innovative Financing Models

California Institute for Mental Health

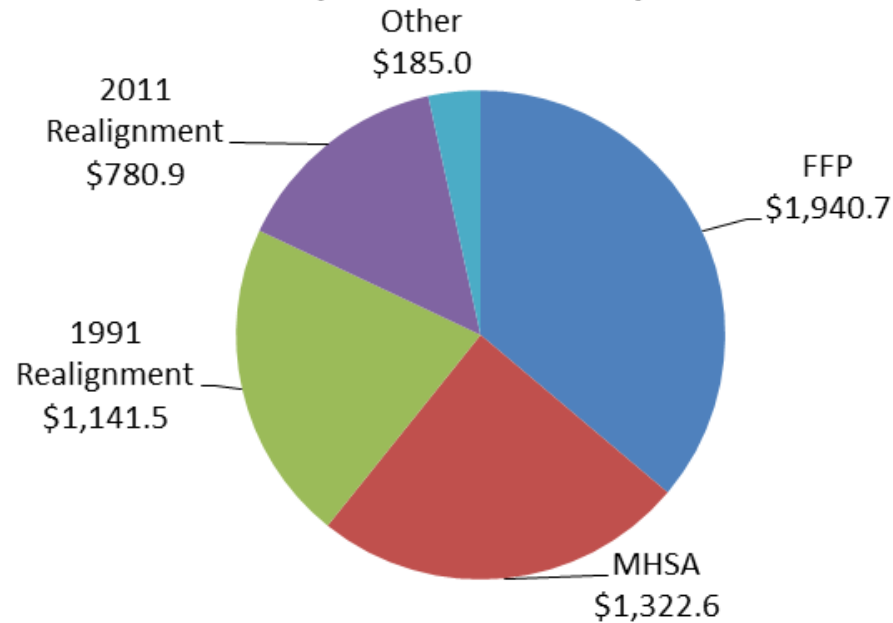
Mental Health Policy Forum

September 13, 2012

# Community Mental Health Services Funding

## Estimated FY12/13 Community Mental Health Funding

(Dollars in Millions)



# 1991 Realignment

- “1991 Realignment” refers to the realigning of the funding and responsibility for mental health services, social services and public health services
  - It represented a major shift of authority from state to counties for mental health programs
- Three revenue sources funded 1991 Realignment
  - ½ Cent of State Sales Tax
  - State Vehicle License Fees
  - State Vehicle License Fee Collections

# 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 amount in FY11/12 (\$1,083.6 million)
    - Guaranteed minimum amount beginning in FY12/13 (\$1,120.5 million)
  - Mental Health will begin to receive growth in 1991 Realignment funds once funding for CalWORKs MOE is equal to the guaranteed minimum amount of Mental Health funding
  - Mental Health will also receive 5% of the annual growth in the 2011 Realignment Support Services Account beginning in FY12/13
    - Does not impact the base funding

# 1991 Mental Health Realignment

## 1991 Mental Health Realignment Estimated Revenues (Dollars in Millions)

	10/11	11/12	12/13	13/14	14/15
<b>Base Amount</b>					
Sales Tax	\$692.6	\$1,067.5	\$1,120.5	\$1,120.5	\$1,120.5
Vehicle License Fees	\$316.5	\$16.1	\$0.0	\$0.0	\$0.0
Vehicle License Fee Collections	\$14.0	\$14.0	\$14.0	\$14.0	\$14.0
<b>Growth in Base</b>					
Sales Tax	\$0.0	\$0.0	\$0.0	\$0.0	\$17.2
Vehicle License Fees	\$0.0	\$0.0	\$0.0	\$0.0	\$6.5
<b>One-Time Growth</b>					
5% of Support Services Account Growth	\$0.0	\$0.0	\$7.0	\$5.2	\$17.3
<b>Total</b>	<b>\$1,023.1</b>	<b>\$1,097.6</b>	<b>\$1,141.5</b>	<b>\$1,139.7</b>	<b>\$1,175.5</b>

# 2011 Realignment

- Additional realignment occurred as part of FY11/12 State Budget
- 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

## 2011 Realignment Behavioral Health Subaccount Estimated Revenues (Dollars in Millions)

	11/12	12/13	13/14	14/15
<b>Base Amount</b>				
EPSDT <sup>a/</sup>	\$579.0	\$584.1	\$584.1	\$584.1
Existing EPSDT	\$579.0	\$540.0	\$540.0	\$540.0
Healthy Families		\$17.3	\$17.3	\$17.3
Katie A. Settlement		\$26.8	\$26.8	\$26.8
Specialty MH Managed Care <sup>b/</sup>	\$183.7	\$196.7	\$196.7	\$196.7
SUD Residential Treatment	\$5.1	\$5.1	\$5.1	\$5.1
Other SUD Services	\$178.5	\$178.5	\$178.5	\$178.5
<b>Growth in Base</b>				
New Growth		\$18.7	\$22.6	\$74.5
Prior Year Growth		\$0.0	\$18.7	\$41.3
<b>Total</b>	<b>\$946.3</b>	<b>\$983.1</b>	<b>\$1,005.7</b>	<b>\$1,080.2</b>
<b>Percent Change</b>		<b>3.9%</b>	<b>2.3%</b>	<b>7.4%</b>

a/ MHSA funds in FY11/12

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

# 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 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)
    - Not just millionaires
  - Annual Adjustment based on actual tax returns
    - Settlement between monthly PIT payments and actual tax returns
- Funds now distributed to counties monthly based on unspent and unreserved monies in State MHS Fund at end of prior month



# Mental Health Services Act

## MHSA Estimated Revenues<sup>a/</sup> (Cash Basis-Millions of Dollars)

	Fiscal Year				
	Actual	Estimated			
	10/11	11/12	12/13	13/14	14/15
Cash Transfers	\$905.0	\$906.0	\$981.0	\$1,030.5	\$1,082.0
Annual Adjustment	\$225.0	(\$64.5)	\$157.0	\$173.0	\$200.0
Interest	\$9.7	\$2.4	\$1.3	\$1.4	\$1.0
<b>Total</b>	<b>\$1,139.7</b>	<b>\$843.9</b>	<b>\$1,139.3</b>	<b>\$1,204.9</b>	<b>\$1,283.0</b>

a/ FY12/13 Governor's May Revised Budget cash transfers and interest through FY12/13 and annual adjustment through 13/14.

# Mental Health Services Act

## MHSA Estimated Component Funding (Millions of Dollars)

	Fiscal Year				
	Actual		Estimated		
	10/11	11/12	12/13	13/14	14/15
CSS	\$783.6	\$741.0	\$1,005.2	\$883.7	\$941.0
PEI	\$216.2	\$185.2	\$251.3	\$220.9	\$235.2
Innovation <sup>a/</sup>	\$119.6	\$48.7	\$66.1	\$58.1	\$61.9
<b>Total</b>	<b>\$1,119.4</b>	<b>\$974.9</b>	<b>\$1,322.6</b>	<b>\$1,162.7</b>	<b>\$1,238.1</b>

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

# 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)
- County MHPs are reimbursed an interim amount throughout the fiscal year based on approved Medi-Cal services and interim billing rates
- 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 Specialty Mental Health Reimbursement

- AB1297
  - Required State to conform to federal requirements
    - Elimination of state-imposed claiming time frames
    - Elimination of state-imposed SMAs
    - Calculation of county specific upper payment limits
- Supplemental Payment State Plan Amendment
  - Allow counties to voluntarily claim for CPE above the SMAs
    - Retroactive to 1/1/09
- Affordable Care Act will provide reimbursement for additional clients
  - Reimbursed initially at 100% FFP

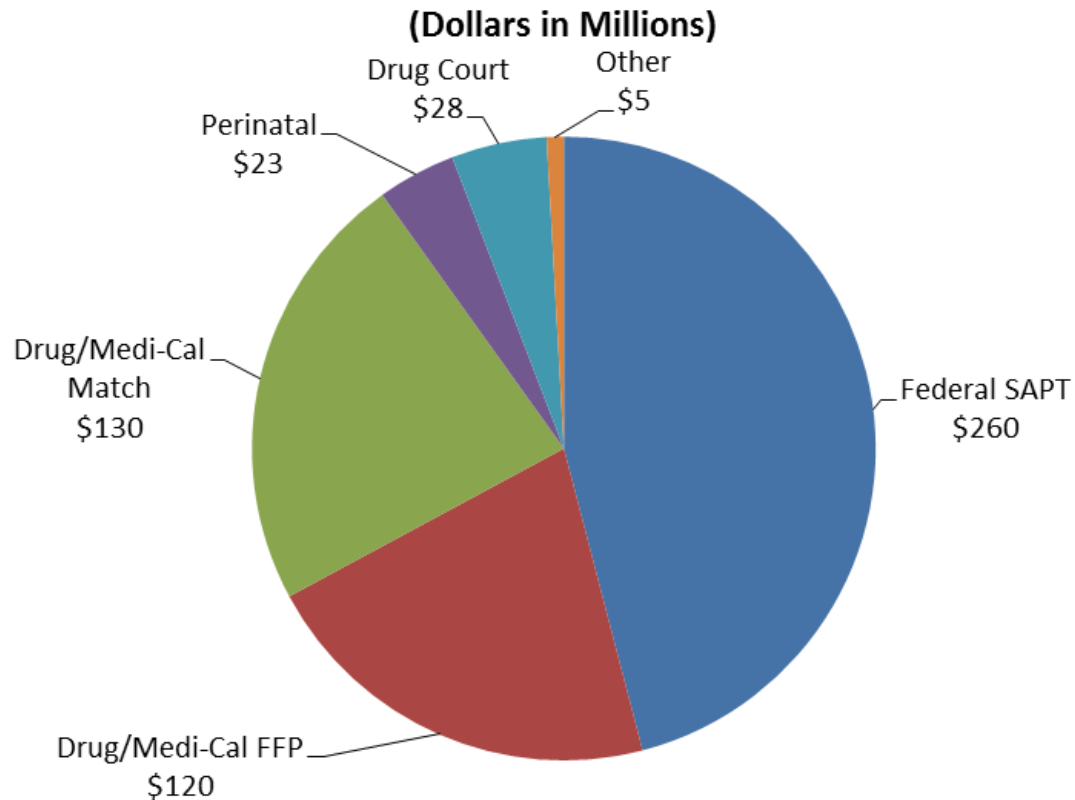
# Medi-Cal Specialty Mental Health Reimbursement

## Medi-Cal Specialty Mental Health Estimated Federal Reimbursement (Dollars in Millions)

	11/12	12/13	13/14	14/15
Existing Specialty Mental Health Services	\$1,456.0	\$1,765.6	\$1,854.9	\$1,948.8
Supplemental Payment SPA		\$175.1	\$114.2	\$117.6
Affordable Care Act			\$153.0	\$321.6
Total Mental Health FFP	\$1,456.0	\$1,940.7	\$2,122.1	\$2,388.0

# Substance Use Disorder Services Funding

## Traditional Public Substance Use Disorder Services Funding



# Background

Traditional sources of funding for public SUD services:

- Federal Substance Abuse Prevention & Treatment Block Grant - \$260 million.
- FFP for Drug Medi-Cal - \$120 million
- State General Fund for:
  - Drug Medi-Cal Match - \$130 million
  - Perinatal Services - \$23 million
  - Drug Court Treatment Programs - \$28 million
  - Discretionary - \$5 million
  - Proposition 36 Treatment – reduced over the past several years from \$140 million to \$0.

# Background (cont.)

- Many SUD treatment facilities lack the administrative and infrastructure support necessary to meet the requirements of mainstream health care financing and management. Current providers are seldom integrated with other health service systems, and make limited use of information technology, even for administrative, claims, and/or billing purposes.
- More than half of all nonprofit facilities do not accept either private insurance or Medicaid, and about half do not have any contracts with managed care plans.
- Only about 40% of adults report that their SUD treatment was paid for by insurance, including Medicaid. About one-third either pay out of pocket or receive services free; the rest rely on other sources of payment.



# Background (cont.)

- More than three-quarters of the funding for SUD treatment services comes from public sources, compared to less than half for all other health care.
- Nationwide, state general fund spending for SUD treatment declined 3.8% between FY 2008 and FY 2009, and an additional 7.3% in FY 2010. In California, state funding for SUD services has been reduced by over 40% over the past 5 years.

# Health Reform Provisions

- The Affordable Care Act, sometimes referred to as “Health Care Reform,” could more accurately be defined as “Health Financing Reform,” or “Health Coverage Reform.”
- The ACA contains provisions that will 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 (cont.)

## 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 (cont.)

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.

## Health Reform Provisions (cont.)

- ❖ Payment systems for SUD providers will be based on equitable reimbursement for services consistent with a medical model framework for levels of care, such as the patient placement criteria offered by the American Society of Addiction Medicine.

# The Impacts of Parity

- The ACA expands the Parity requirements to all private health insurance plans, to Medicaid, and to plans under the state Health Exchanges.
- Opportunities under Parity:
  - Less cost shifting from the private to the public sector.
  - Increased payment from commercial insurance.

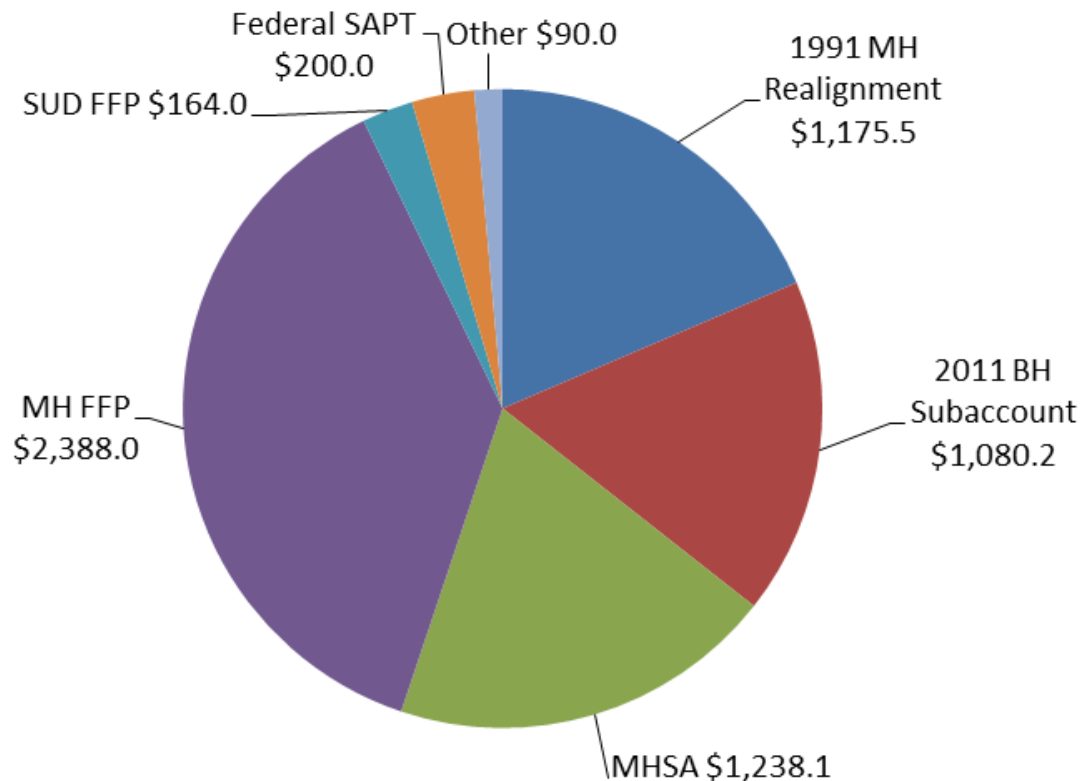
# Behavioral Health Funding

## Behavioral Health Estimated Funding (Dollars in Millions)

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MHSA	\$974.9	\$1,322.6	\$1,162.7	\$1,238.1
MH FFP	\$1,456.0	\$1,940.7	\$2,122.1	\$2,388.0
SUD FFP	\$120.0	\$130.8	\$142.6	\$164.0
Federal SAPT	\$260.0	\$260.0	\$230.0	\$200.0
Other	\$190.0	\$190.0	\$140.0	\$90.0
<b>Total</b>	<b>\$5,044.8</b>	<b>\$5,968.7</b>	<b>\$5,942.8</b>	<b>\$6,335.8</b>

# Behavioral Health Funding

## FY14/15 Estimated Behavioral Health Funding (Dollars in Millions)





# Critical Issues

- Sufficient revenues are necessary in order to incur Certified Public Expenditures (CPE)
  - Non-federal revenues countercyclical to service need
  - Cash flow becomes even more important
- Federal reimbursement process should be aligned with program responsibilities
  - Managed care and realigned program responsibilities with a Fee-for-Service interim reimbursement process settled to actual costs

# Financing Models

- Short Term
  - Eliminate reimbursement elements specific only to California
  - CPE reimbursement focused on County expenditures
- Long Term
  - Intergovernmental Transfers (IGT)
    - Transfer of County revenues to State in order to obtain federal funding
  - Case Rates
    - Payment rate per client that receives services
    - Different rates for different levels of acuity
  - Capitation or Sub-Capitation Rates
    - Payment per member eligible for services
    - Paid through managed care plan (sub-capitation) or directly to mental health plan (capitation)
    - Different rates for different risk factors

# Implications and Discussion

- Maximization of federal and insurance plan coverage of beneficiaries, services and cost is a critical policy goal
- Minimization of administrative requirements preserves dedicated sales and income tax revenues for direct service coverage
- Sales and income tax revenues can be “counter cyclical” to need and thus require the development of reserve strategies at the local level
- Quality management and improvement requirements should be developed with the consideration of opportunities to maximize federal financial participation
- Federal reimbursement structures should be efficient and timely to preserve dedicated tax revenues