MHSOAC

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

1300 17th Street, Suite 1000 Sacramento, CA 95811 (916) 445-8692

AGENDA – Revised

February 27, 2009

California Institute for Mental Health Sequoia Room 2125 19th Street, 2nd Floor
916-556-3480 Sacramento, CA

Call In Number: 877-287-0283; Code: 360768

TIME	TOPIC
8:00 am	**Stakeholder Orientation** *Sheri Whitt, Executive Director Deborah Lee, Consulting Psychologist Darlene Pret*
9:00 am	**Introductions; Roll Call; Adopt Minutes of January 2009 Meeting** *Andrew Poat, Chair Nicole Behler, MHSOAC Staff*
9:15 am	**Mental Health Funding Committee Report – Adopt Fiscal Reporting Template** *Chairs* • Public Comment • Vote
10:15 am	**BREAK**
10:30 am	**Discussion on Current Budget Issues** *Tom Greene and Larry Poaster, Co-Chairs* Panel Discussion *Kiyomi Burchill, Consultant to Senator Darrell Steinberg Patricia Ryan, Executive D* *Executive Director, CCCMHA Stephen W Mayberg, PhD, Director, DMH*

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Mental Health Services Oversight and Accountability Commission Meeting Minutes January 30, 2009

Hyatt Vineyard Creek Hotel 170 Railroad Street Santa Rosa, CA 95401

1. Call to Order

Chair Poat called the meeting to order at 9:08 a.m.

2. Roll Call

Commissioners in attendance: Andrew Poat, Chair; Larry Poaster, Vice Chair. Linford Gayle, Beth Gould, Tom Greene, Patrick Henning, Howard Kahn, Bill Kolender, David Pating, Darlene Prettyman, Eduardo Vega, Richard Van Horn.

7. Mental Health Funding Committee ReportMr. Mark Heilman, DMH Community Services Division, provided an overview of MHSA

funding. Some highlights: …….

- Counties are notified of available cash through planning estimates, which are based on all cash deposits projected to be on hand on July 1st of the planning year. For example, revenues collected in FY 08/09 will fund planning estimates in FY 09/10. Generally, counties received 75% of cash requested when the plans are approved; the remaining 25% of approved cash is released upon receipt of the required fiscal reports. **Commissioner Greene** then commented on some of the emerging policy issues. The first issue is money in the bank. MHSA has generated more than $4.1 billion in additional revenues through the end of FY 07/08. However, just under $2 billion has been distributed through the end of FY 07/08. There will always be a balance in the MHSA Fund because cash accumulates so that counties can receive their funds whenever they request them. In addition, revenue accrues to the Fund throughout the year. However, estimated revenues are declining. Projected revenues for FY 07/08 are $1.5 billion; in 08/09 that drops to $1.3 billion. In 09-10 it remains roughly $1.3 billion, then drops below $1 billion in FY 11/12. Thus, over a five year span the system goes from a roughly $1.5 billion system to roughly a $1 billion system, a loss of a third of the money. How does the Commission want to deal with this reality of declining revenues? The second major policy issue is supplantation. The MHSA, section 15, states that “funding . . . shall be utilized to expand

mental health services . . . [and] . . . shall not be used to supplant existing state or county funds to provide mental health services." However, the current FY 09/10 Governor's Budget proposes to take $226.7 million of these funds. Another issue is Prudent Reserve. Guidelines say that Prudent Reserve should be set at a level of 50% of the most recent annually approved CSS funding level, and this 50% level should be fully funded by July 1, 2010. **The next issue is to clarify the policies in place in order to avoid a two-tiered system; i.e. does someone new to the system get only MHSA funding? Commissioner Vega** asked if the Prudent Reserve is exclusively county funded. **Commissioner Greene** responded that it is a county by county reserve and is not state funded. Counties differ greatly in terms of how much prudent reserve they currently have on hand.

Commissioner Greene further clarified that the numbers presented do not take into account any supplantation decreases. Thus, if the Governor's Budget goes through as proposed, the funds would decrease by $226.7 million.

Mr. Don Kingdon, California Mental Health Director's Association (CMHDA) Deputy Director, then provided a series of slides detailing MHSA funding and how it might change given the changing climate. The overall question to wrestle with is *Do you set policy first and then finance or does finance drive policy?* One of the problems in California is that the state's dependency on federal funding sometimes drives policies that the state may not agree with later on.

He described the "big four" in funding streams that are tracked over time. They include SGF -- the State General Fund (which is now shrinking as an overall proportion of the funding pie, and that may continue); FFP -- Federal Financial Participation (the largest funder by far but there are often significant delays from the time the claim is submitted until the funding arrives); R -- Realignment (transfer of responsibilities from the state to the county through sales taxes and vehicle licensing fees); and the MHSA -- the Mental Health Services Act.

The problem today is cash flow; counties may or may not receive funding in a timely manner. The ultimate financial risk to maintaining services while waiting for cash is the county's not the state, which leads to many of today's problems, as it becomes more difficult for county's to acquire loans to carry them through until funding arrives.

Patricia Ryan, Executive Director, CMHDA, gave a short presentation that detailed some of the policy implications that counties deal with because of these funding streams. As old revenue streams are crumbling and new monies come in from MHSA, how do we make the system funding work effectively?

The ultimate objective is a continuum of care in the community that provides a transformational system for everyone. **The MHSA was written to build upon the existing system of care, not to create a separate program.** It is attempting to prevent the negative outcomes associated with Serious Mental Illness (SMI) and Severely Emotionally Disturbed (SED) and is also equipped to offer individuals the right amount of services at the right time to improve quality of life.

One of the lessons learned from implementation of the MHSA is that we must simplify and streamline requirements and use performance measures and program monitoring to ensure

accountability.

The MHSA provides a roadmap to achieving a continuum of care by adding to and building upon existing statutory requirements in the California Welfare and Institutions Code (WIC) related to community mental health services. There is a need to support timely and efficient implementation of the MHSA by removing any unnecessary barriers to transferring funds from the MHS Fund into local communities for services and interventions. Flexibility must be built

into the system and clarified so that counties fully understand how to obtain funds from the varying sources without violating regulations.

In summary, the two-tiered system (MHSA, non-MHSA) needs to be dismantled; the money needs to get to the local communities; and both needs can begin to be achieved by clarifying and considering more flexibility with Full Service Partnerships (FSP).

Mr. Rusty Selix, Executive Director, California Council of Community Mental Health Agencies (CCCMHA), stated that the real problem is in understanding the range of things that can still be called an FSP. The term Full Service Partnership is not in the Act. The term "Full" means "whatever you need" and has been taken to mean that a huge thing is needed. Some people need less than others. "Services" means the array of services. "Partnership" has two parts -- first is the partnership between the client and family being served and the provider or county being responsible for those services that determine what is needed; second is the original model of an integrated service agency that eventually people realized was not always realistic and what it means now -- a partnership of different entities working together to provide all that's needed, with a single person as a manager trying to put it all together.

Where we want to get to, to eliminate the two-tiered system, is a point where "that's all there is." It's what everybody gets. It starts from who's in the system and what do they need and everybody gets whatever they need. We need to clarify how things are put together, to make things more like an FSP. When something is called an FSP it automatically triggers the evaluation criteria, the outcome measures that we have, and the accountability we need.There is one type of borrowing that the Act does not prohibit. That is borrowing for the purposes of funding the actual services in the Act. If counties have more money they can manage the cash flow for services much better than they currently do.

Dr. Stephen Mayberg, DMH Director, expressed his appreciation for the presentation on mental health funding issues and stated that it underscored how important it is to take all the issues into account as decisions are made.He noted that the regulations do allow for more flexibility than is generally understood. For a person to be eligible for an FSP they need to meet one of two criteria -- first, either they are SMI or SED or have a condition that would contribute to a substantial impairment of function; and second, they need to meet one of the categories of at risk for homelessness, involvement in the criminal justice system, or at risk of institutionalization.

The regulations do say that the priority should be the people who have been unserved, and the Act does talk about increasing the number of people who have access to the mental health system.