California HealthCare Foundation

A Complex Case:
Public Mental Health Delivery and Financing in California

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by
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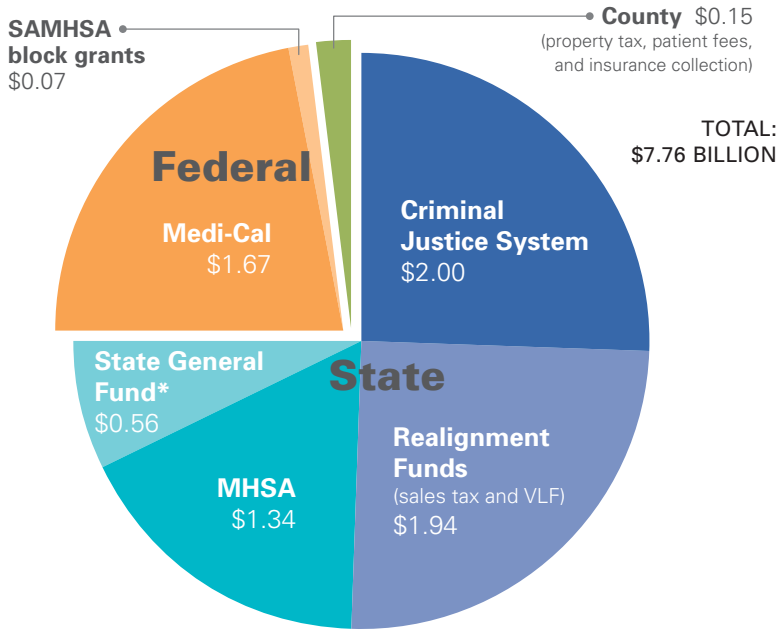
I. Introduction

For individuals with disabling mental health conditions who do not have private health insurance, publicly funded facilities, agencies, and programs are the primary, if not only, source of mental health care.

In California, about 16% of the adult population, more than 4 million people, have mental health care needs. Of those, an estimated 1 million adults have a severe mental illness that impairs their daily functioning. Approximately 714,000 California children have what qualifies as a serious emotional disturbance.[1] For individuals with disabling mental health conditions who do not have private health insurance, publicly funded facilities, agencies, and programs are the primary, if not only, source of mental health care.

Public spending on mental health services in California for Fiscal Year (FY) 2012–13 was estimated to be $7.76 billion, of which $3.34 billion was for Medi-Cal (California's Medicaid program)

Figure 1. Estimated Public Spending on Mental Health Services in California, by Source, FY 2012–13 (in billions)



*Psych Rx drugs and school-based services.

Notes: Data for Medicare spending on mental health services were unavailable. This chart includes spending by the criminal justice system, which is not discussed fully in the report. State General Funds and a portion of MHSA and realignment funds make up $1.67 billion of nonfederal Medi-Cal spending. MHSA and realignment funds are administered by counties. Segments don't add to total due to rounding.

Sources: Mental Health Oversight and Accountabily Commission, *Semi-Annual Report* (January 2013); Medi-Cal Local Assistance Estimate (November 2012); California Department of Finance, *2012–13 Annual Budget Estimate.*

beneficiaries.[2] (See Figure 1.) As the most populous state, California ranked first in the US for total spending on public mental health services but 15th for per capita spending on public mental health services in 2010.[3]

Due to the lack of coverage of mental health services through private insurance, over time, public facilities and programs have played an increasingly important role in the provision and coverage of mental health services. Until the 2008 passage of the federal Mental Health Parity and Addiction Equity (MHPAE) Act, private health insurance coverage for mental health benefits was significantly more limited than its coverage for medical and surgical benefits. Patients faced greater outpatient and inpatient coverage limitations and higher cost sharing.[4] Historically, even Medicare has required higher cost sharing for mental health services than for medical services. Such historical imbalances have meant that the burden of providing mental health services has fallen largely to state and locally funded safety-net systems and to Medicaid, the joint federal-state health coverage program.

California's complex financing and delivery structure for public mental health services developed over the last 60 years in a context of chronic underfunding and stigma toward mental illness.[5] Public mental health services in California are delivered primarily through county systems that operate separately from other publicly funded health care services. These county mental health programs are funded through several dedicated revenue streams that are not subject to the annual state appropriations process. The patchwork nature of these interrelated categorical funding sources and the decentralization of responsibilities complicates discussions about how mental health services fit within overarching health policy goals of improving health outcomes while containing costs.

This report provides an overview of how California's public mental health system services are financed, administered, and delivered.[6] It is offered as background to inform policy discussions about how public mental health services fit within California's overall public health care system.

II. Funding Sources for Mental Health Services in California

Mental health services accounted for 6.1% of all health spending in the United States in 2005.[7] Public payers were responsible for a greater proportion of mental health services spending (58%) than for overall health care spending (46%).[8] In the US, Medicaid was the largest public purchaser of mental health treatment, accounting for 28% of all mental health spending; other state and local government sources paid for 18%; Medicare, 8%; and other federal sources, about 5%. Private health insurance accounted for about 27% of all mental health treatment spending, and out-of-pocket and other private sources purchased the remaining 15%.[9]

In California, public spending on mental health services (outside the criminal justice system and Medicare) was estimated to be $5.7 billion in FY 2012–13.[10] (See Table 1.) Counties administer about 90% of the revenue dedicated to public mental health services in the state.

This section summarizes the revenue sources for public mental health services by each level of government.

Table 1. Estimated Public Spending on Mental Health Services, California, FY 2012–13

		TOTAL	FEDERAL	STATE	COUNTY
Medi-Cal					
County-administered	Adults	$976,498,000	$488,249,000	$0	$488,249,000
	Children	$1,394,890,000	$688,459,987	$0	$686,464,000
	Miscellaneous costs*	$559,002,000	$288,780,013	$1,548,000	$288,640,000
State-administered	Psychiatric pharmacy†	$409,260,000	$204,630,000	$204,630,000	$0
	Medi-Cal Subtotal	**$3,339,650,000**	**$1,670,119,000**	**$206,178,000**	**$1,463,353,000**
Non-Medi-Cal					
County-administered community and institutional‡		$1,971,311,000	$69,606,980	$0	$1,901,704,020
	County-Administered Subtotal	**$4,901,701,000**	**$1,535,095,980**	**$1,548,000**	**$3,365,057,020**
School-based		$420,189,000	$69,000,000	$351,189,000	$0
	Total	**$5,731,150,000**	**$1,808,725,980**	**$557,367,000**	**$3,365,057,020**
	Percentage	**100.0%**	**31.6%**	**9.7%**	**58.7%**

*Includes county administrative costs, anticipated increases in federal payments due to changes in billing processes, and historical cost settlement expenses.
†Includes Medi-Cal prescription drugs carved out of Medi-Cal managed care plans and reflects a 43% rebate from drug manufacturers.
‡Funding sources include MHSA, 1991 realignment, federal SAMHSA grants, and local funds, and includes spending on the Low-Income Health Program.

Note: Estimates for spending on Medicare and primary care–based Medi-Cal mental health services were unavailable for this chart.

Sources: Mental Health Oversight and Accountabily Commission, *Semi-Annual Report* (January 2013), mhsoac.ca.gov; Medi-Cal Local Assistance Estimate, November 2012.

Federal Funding

The majority of federal funding — about $1.7 billion — that California receives for public mental health care is used to reimburse the state and counties for services provided to Medi-Cal beneficiaries. Federal payments match state spending based on the federal Medicaid assistance percentage, which in California is set at 50% for most expenditures. Because Medi-Cal is a federal entitlement program, it has a legal obligation to pay for all medically necessary, covered services for eligible individuals. Thus, the state — or its administering partners, the counties — cannot set predetermined spending limits for Medi-Cal beneficiaries.[11]

Substance Abuse and Mental Health Services Administration (SAMHSA) block grants are an additional source of federal mental health funding in California. Totaling nearly $70 million in FY 2011–12, this block grant funding is awarded by the state to counties based on a legislative formula and application process.[12] While they make up a small percentage of the total public mental health budget, the SAMHSA grants are a flexible funding source for services for adults and children ineligible for Medi-Cal and with no other health coverage.[13]

State Funding

California pays for public mental health services primarily through dedicated revenue sources not directly subject to the annual state appropriations process. A portion of the state's revenues from sales tax and vehicle license fees is directed to California's 58 counties for administration of mental health services. For FY 2012–13, this revenue was estimated to be $1.94 billion.[14]

The state's Mental Health Services Act (MHSA) is another source of state mental health funding that flows directly to counties. Passed through the Proposition 63 state ballot initiative in 2004, the MHSA created a 1% surtax on personal income over $1 million to provide additional revenue for community-based mental health services. Since 2004, the MHSA has generated more than $8.5 billion to fund rehabilitative and preventive mental health services to underserved populations.[15] Estimated MHSA revenue for FY 2012–13 was $1.34 billion.[16] The state may legally keep only 3% of MHSA funding for administrative activities, and the rest must go directly to counties. MHSA revenue fluctuates annually based on economic conditions. (See Figure 2.)

Figure 2. MHSA State Revenue Collected (bars in millions), **FY 2004–05 to FY 2011–12**

Source: Mental Health Oversight and Accountabily Commission, Semi-Annual Report (January 2013).

California spent an estimated $557 million from its General Fund in FY 2012–13 on mental health services outside the criminal justice system, primarily for purchasing psychiatric prescription drugs in the Medi-Cal program ($205 million)[17] and providing school-based mental health services (formerly called AB 3632 services) to students with disabilities ($350 million).[18]

California's Criminal Justice System and Mental Health Services

Mental health services associated with the criminal justice system are not discussed in detail in this paper because of the complexity of how mental health services are provided to this particular client population. The subject warrants a comprehensive discussion of its own.

Mental health services provided to individuals within the criminal justice system do significantly impact the state's budget. California's FY 2012–13 budget projected spending about $1.6 billion on mental health services for 6,100 patients in five state hospitals.[19] About 90% of these patients are transferred to these hospitals from state prisons or county jails because they have severe mental disorders and are incompetent to stand trial or have been found not guilty due to insanity. The California Department of Corrections and Rehabilitation's FY 2012–13 budget includes $420 million for mental health services to prison inmates.[20] Also, California's counties spend significant sums of money providing mental health services to individuals in local jails.[21]

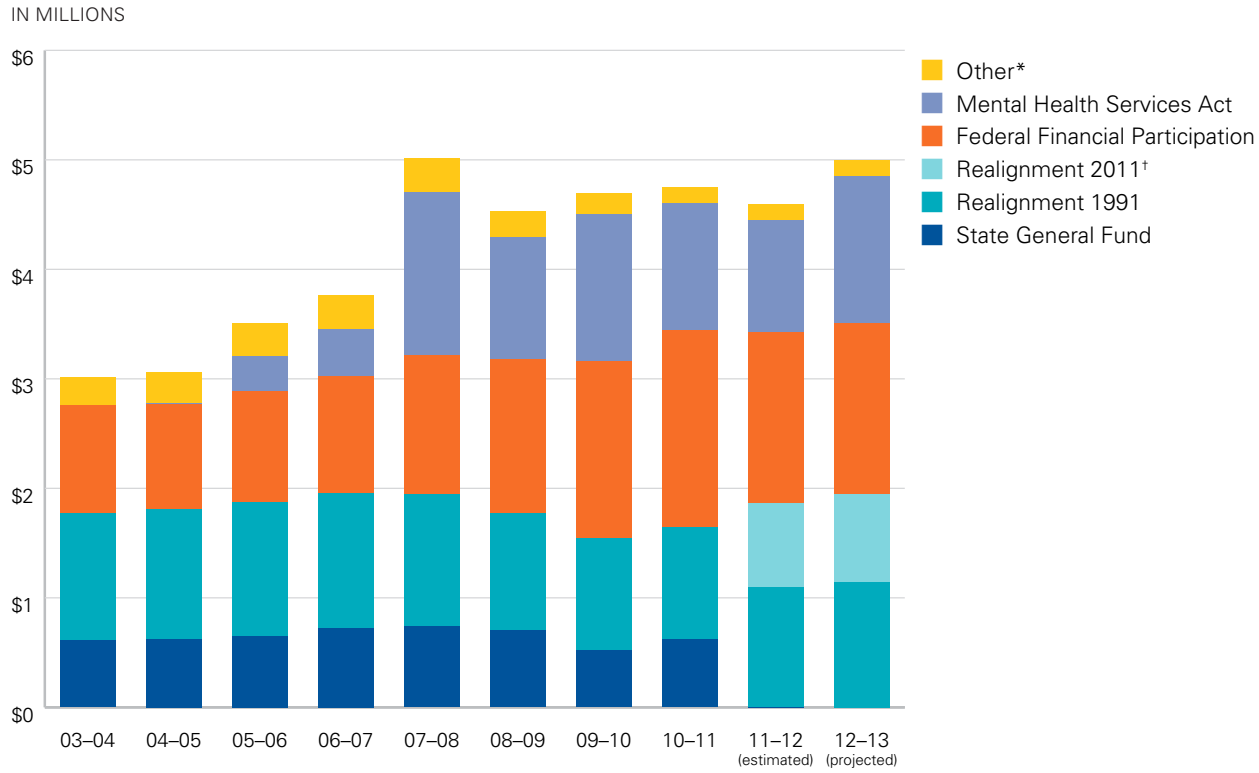
County Funding

In addition to federal and state sources of funding, California's 58 counties use revenue from local property taxes, patient fees, and some payments from private insurance companies to fund mental health services. (See Figure 3 on page 7.) This amount totaled about $150 million in FY 2012–13, roughly 3% of the total funding counties administer to provide mental health services for more than half a million adults and children statewide.[22] Of this locally generated money, $25 million goes toward counties' maintenance-of-effort (MOE) level of spending, the amount required to receive their portion of state sales tax revenue for mental health services. Counties' required MOE ranges from zero in the smallest counties to about $8.5 million in Los Angeles County.[23]

Most of the remaining $125 million in local county funding is discretionary overmatch — local funds above the MOE amount that are used for a variety of mental health services. These funds may go toward Medi-Cal services, thereby allowing the county to draw down additional federal dollars. Counties may also spend overmatch dollars on non-Medi-Cal reimbursable services or on services provided to uninsured adults and children. Because it is discretionary, the overmatch funding fluctuates annually and varies between counties.

While no current analysis comparing each county's total per capita mental health program revenues and expenditures is publicly available, it is widely assumed that the amounts vary greatly between counties. This variation is due to realignment policies (see below) that locked in historical funding levels at the state and county levels, varying local priorities, varying capabilities to leverage local resources to receive federal matching funds, and the discretionary levels of local overmatch funds, among other factors.

Figure 3. Revenue for County-Administered Specialty Mental Health Services, by Source, FY2003–04 to FY2012–13



*Other includes local funds from property tax, insurance and fees, Medicare, and federal grants.
†2011 realignment allocation for EPSDT and Mental Health Managed Care was funded through a one-time fund transfer from MHSA.

Notes: Data excludes pharmacy costs, primary care–based mental health services, and state hospital costs paid by the state general fund.

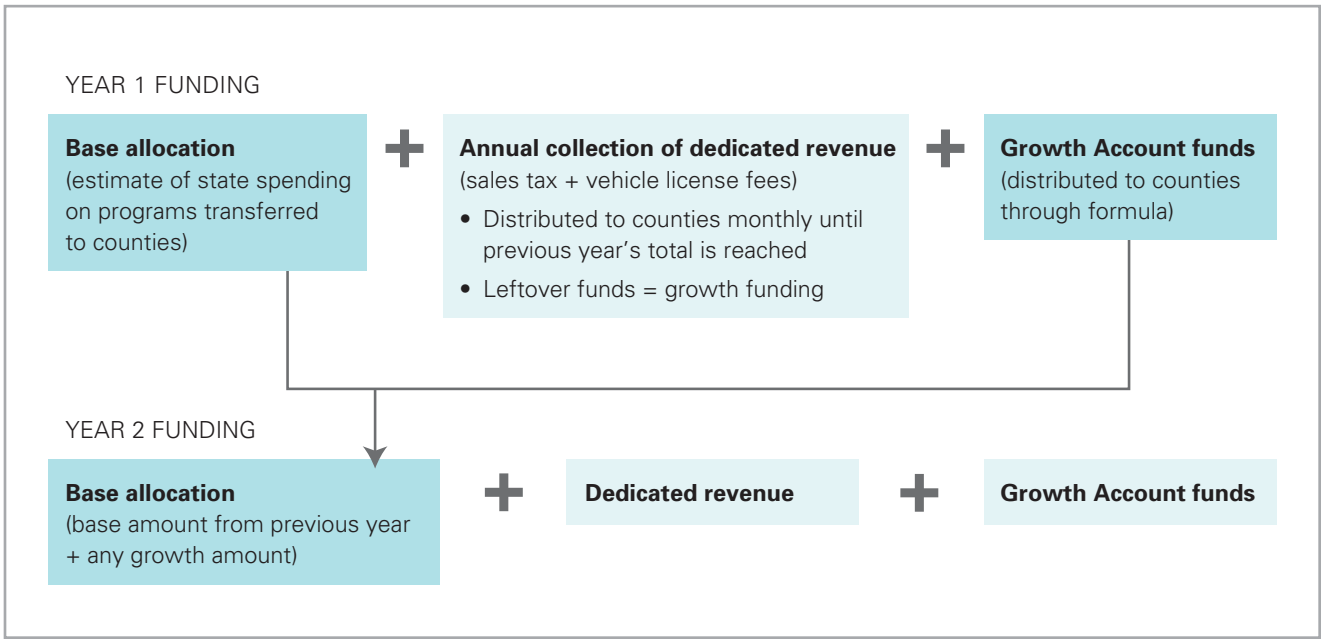
Sources: Mental Health Oversight and Accountabily Commission, *Semi-Annual Report* (January 2013). Source for Realignment 2011 for 2011–12 (estimated) is Mike Geiss, "Realignment Funding Estimates," Presentation at the California Institute for Mental Health Policy Forum, February 14, 2013.

Mental Health Funding Realignment

Realignment — the transfer of administrative and financial control from the state to counties — is unique to California and plays a critical role in the state's mental health financing. California underwent two major realignments, in 1991 and in 2011, that affected mental health program responsibilities. The 1991 and 2011 realignment funds typically are viewed as distinct revenue sources because they were authorized under different statutes and fund different obligations.

Realignment funding starts with a base allocation to counties that is an estimate of the amount the state would have spent on the various programs that were transferred to the counties. Then, the state collects dedicated revenue (sales tax and vehicle license fees), which is distributed monthly by the state controller's office until each county receives a total amount of funds equal to the previous year's total. Leftover dedicated revenue funds are placed into separate, designated growth accounts. At the end of the year, these growth accounts are distributed to county programs based on formulas set in statute. The base amount plus the growth amount equals the next year's base. This concept is known as the "rolling base." (See Figure 4 on page 8.)

Figure 4. Realignment Rolling Base



Realignment in 1991

Prior to 1991, county mental health programs competed for limited funding made available through the annual state budget. The unpredictability of this funding stream made it difficult for counties to set priorities and to plan. Facing a $14 billion state budget shortfall in 1991, California transferred financial and administrative responsibility for several social services and public, indigent, and mental health programs to the counties. To pay for these new obligations, the state provided counties with a portion of the revenue from a new state sales tax and with a portion of the revenue from vehicle license fees.

Policymakers hoped that by providing counties with a dedicated revenue source that did not rely on the annual appropriations process, they would be increasing local administrative flexibility and stabilizing local funding. To track this progress, the 1991 realignment law mandated that the state develop a uniform system for reporting and tracking outcomes. Despite numerous efforts, however, no standardized outcomes reporting system has been established.[24]

Under the 1991 realignment funding structure, a county's previous funding levels determined its base allocation. Counties that had invested more local money in mental health programs received a greater portion of funding going forward.[25] Counties anticipated that realignment revenue would grow over time and that it would keep pace with inflation and an increase in demand for mental health services. However, actual revenues never met these expectations.

A last-minute amendment to the original 1991 realignment growth formula eventually proved detrimental to mental health services funding. The growth formula determined how tax revenue was distributed after annual base allocations were met — this leftover revenue is referred to as growth funding. The sales tax growth funding was distributed first to meet caseload increases in county-operated social services entitlement programs: to In-Home Supportive Services, and

to child welfare. Any remaining sales tax growth funds and all vehicle license growth funds were then allocated proportionately among social services, public health, and mental health accounts. As social services program caseloads increased over the subsequent 20 years, mental health programs received a smaller and smaller share of the growth allocation. Eventually, the mental health program funding base stagnated because inflation in health care costs and increased caseloads exceeded the annual increase to the base allocation for mental health services, and in some years, these revenues actually declined. By 2010, the mental health realignment base revenues roughly equaled the original baseline amounts from 1992, after accounting for inflation.[26]

The 1991 realignment revenue stream was originally intended to fund safety-net, community-based mental health services for people with and without Medi-Cal or other insurance and also to support non-Medi-Cal reimbursable treatment, such as inpatient care in a locked, long term psychiatric facility. Over time, counties used increasing portions of realignment funding as the match for Medi-Cal services, leaving less money for services for the uninsured population.[27]

Realignment in 2011

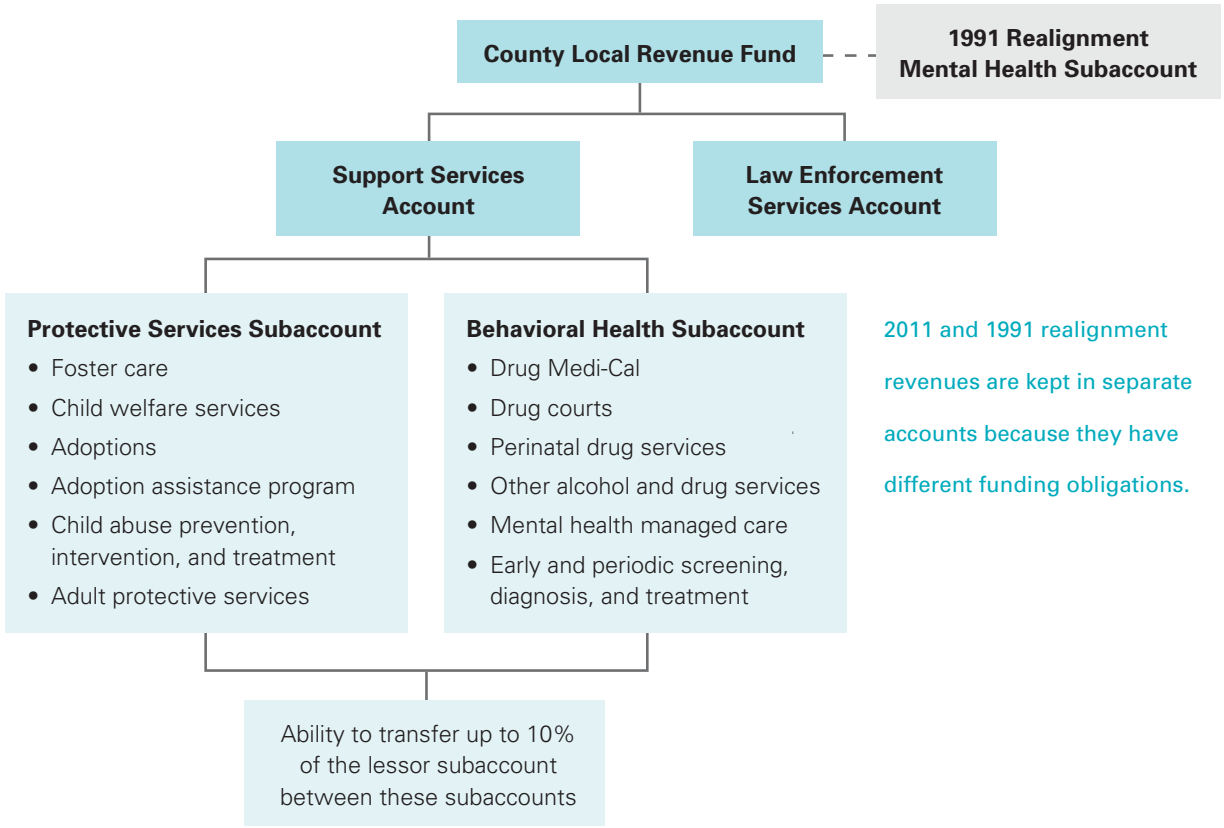
Facing a $20 billion state budget shortfall in 2011, California underwent a second major realignment of programs. Under the policy known as Public Safety Realignment, California transferred $6.3 billion in government program funds from the state to counties. Implemented through a series of bills tied to the State Budget Act, the 2011 realignment package included various criminal justice, mental health, drug and alcohol, and social services programs.

The 2011 realignment completed the transfer of funding and responsibility for public mental health services from the state to counties. The 2011 realignment structure established that a portion of a 1.0625% state sales tax be deposited in each county's behavioral health subaccount, which funds the following: various drug and alcohol treatment programs, the Medi-Cal Mental Health Managed Care Program, and Medi-Cal's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health program for children. Counties were already administering these programs, and with the 2011 realignment, they have become responsible for fully financing them as well.[28] (See Figure 5 on page 10 for a diagram of the realignment account structure.)

The 2011 base allocation for the realignment mental health programs came from a one-time diversion of $860 million in MHSA funds approved by the state. The state Department of Finance, in collaboration with the California Mental Health Directors Association, developed an allocation formula to distribute the revenue between counties.[29] Each county received a proportional share of the diverted MHSA funding based on the amount of program funds that the state otherwise would have distributed to each county in FY 2011–12. The 2011 growth formula called for proportionate distribution of growth funds among programs, except for an initial front-loading of the child welfare account with $200 million. This new formula should allow counties to budget more accurately than they could under the 1991 realignment structure because they will be able to more accurately project expected revenue.

Each county's estimated proportional share for children's mental health services under EPSDT accounted for prior allocations plus adjustments for implementing more intensive services as required by the 2011 lawsuit settlement *Katie A. v. Bontà,* and the transition of the Healthy Families program into

Figure 5. 2011 Realignment Funding Structure



Source: California Department of Finance, *California FY 2011–12 Budget Summary.*

Medi-Cal. (See Table 2 on page 11 for a summary of estimated realignment funding.) Until 2011, counties received a 90% reimbursement for EPSDT services — 50% from the federal government and 40% from the state government. Now, counties are responsible for providing the entire nonfederal share using 2011 realignment allocations. Although counties' EPSDT distribution formulas are to be updated annually based on the previous year's service use, counties and advocates will be watching EPSDT use and revenue under 2011 realignment especially closely, given the experience with the declining base under the 1991 formulas.

As part of the 2011 realignment, the 1991 realignment funding structure was also updated. While the 1991 obligations remain, the funding source changed. Counties' 1991 realignment mental health responsibilities are now funded from the 2011 Local Revenue Fund sales tax revenues rather than the 1991 realignment vehicle license fee and sales tax revenue. In addition, counties now receive a set 5% annual growth increase on the 1991 realignment, plus more future growth funds after funding for social service programs reaches a certain level.

The Proposition 30 ballot measure, which was passed by voters in November 2012, added

constitutional protections to the 2011 realignment funding structure. This is a key difference from the 1991 realignment: Proposition 30 requires the state to provide counties with the redirected funds and gives counties legal grounds to resist new unfunded state mandates or obligations. Proposition 30 also prohibits the state from passing any new laws, regulations, or administrative orders that increase county costs without providing additional funding.

Table 2. Estimated Realignment Revenue, FY 2011–12 to FY 2013–14 (in millions)

	FY 2011–12	FY 2012–13	FY 2013–14
1991 Mental Health Realignment Account			
BASE AMOUNT			
Sales Tax	$1,067.5	$1,120.6	$1,120.6
Vehicle License Fees	$16.1	$0.0	$0.0
Vehicle License Fee Collections	$14.0	$14.0	$14.0
Total	**$1,097.6**	**$1,144.2**	**$1,164.1**
GROWTH IN BASE			
Sales Tax	$0.0	$0.0	$16.6
Vehicle License Fees	$0.0	$0.0	$1.8
One-Time Growth — 5% of Support Services Account Growth	$0.0	$9.6	$11.1
2011 Behavioral Health Realignment Subaccount			
BASE AMOUNT			
EPSDT	$579.00	$584.10	$584.10
Specialty Mental Health Managed Care	$183.70	$196.70	$196.70
Mental Health Subtotal	**$762.70**	**$801.20**	**$801.2 + growth**
Substance Use Disorder Services	$183.60	$183.60	$183.60
Total	**$946.30**	**$989.20**	**$1,063.00**
GROWTH IN BASE			
New Growth		$24.80	$73.80
Prior-Year Growth		$0.00	$24.80

Source: Mike Geiss, "Realignment Funding Estimates" (presented at the California Institute for Mental Health Policy Forum, February 14, 2013).

III. Structure and Governance of California's Mental Health System

This section discusses how California's mental health system is organized, and describes the roles of the federal, state, and county governments.

Federal Role

The federal government approves and oversees California's Medi-Cal program to ensure that it complies with federal laws and regulations. The federal government must approve any changes proposed to the State Medicaid Plan, which lists all covered benefits and services, and any waivers that allow the state to provide services in a manner different than called for by federal Medicaid law. Also, the federal agency SAMHSA monitors California's administration of annual block grant funding for mental health services.

State Role

California's community-based mental health system dates back to 1957, when it was established by the Short-Doyle Act. This act encouraged local governments to deliver community-based mental health services by providing matching state funds for these programs. The relationship between the state and counties in providing mental health services has shifted over the subsequent 50 years, but counties have retained the primary responsibility for delivering services while the state remains primarily responsible for oversight. (See Appendix B for a detailed timeline of the development of California's public mental health system.)

Major State Legislation Governing Public Mental Health Services

Lanterman-Petris-Short Act (1967). Describes treatment standards and procedures for involuntary treatment of persons with psychiatric disabilities and facilitates the use of community-based services rather than state hospital services.[30]

The Bronzan-McCorquodale Act (1991). Describes the state-county relationship for community mental health services. It replaced the original Short-Doyle Act of 1957 that described the community mental health system and target populations, as well as authorized the 1991 realignment that shifted mental health program and funding responsibilities from the state to counties.

The Children's Mental Health Services Act (1992). Outlines a coordinated, goal-directed system of mental health care for children and their families that emphasizes an interagency approach through collaboration by the primary child-serving agencies, such as social services, probation, education, health, and mental health agencies.[31]

The Adult and Older Adult Mental Health Systems of Care Act (1996). Outlines a recovery-oriented, outcome-based mental health treatment for adults with serious mental disorders. Specifies that county participation is voluntary and that the services for non-Medi-Cal adults shall be provided to the extent that funds are made available.[32]

The Mental Health Services Act (2004). Imposes a 1% state surtax on personal income greater than $1 million to create funding to fill gaps in the adult and older adult and children's systems of care, along with new programs to invest in prevention and early intervention, to develop the workforce, and to invest in related capital facilities and technologies.[33]

The California Department of Mental Health (DMH) was the agency in charge of public mental health services until 2012, when it was eliminated and its responsibilities were distributed among other state departments. The responsibility for operating the five state psychiatric hospitals and two psychiatric programs went to the newly formed Department of State Hospitals. Most other duties related to administration of Medi-Cal and community mental health programs went to the Department of Health Care Services (DHCS). Several state mental health statutes govern operations and administration of mental health services. (See sidebar on previous page.)

Most DMH employees were transferred in July 2012 to the DHCS Mental Health and Substance Use Disorders Division. The Division oversees and monitors local Mental Health Plans to ensure that Medi-Cal services are accessible, cost-effective, and high quality. DHCS conducts onsite reviews every three years and audits county cost reports involving Medi-Cal revenues and expenditures annually.[34] As required by federal law, DHCS contracts with an External Quality Review Organization (EQRO) to conduct annual reviews and to provide technical assistance to the Medi-Cal mental health delivery system.[35]

DHCS shares state-level responsibilities for policy development, implementation, and oversight for the broader public mental health system with the California Mental Health Planning Council (planning council) and the Mental Health Services Oversight and Accountability Commission (commission). Federal and state laws mandate that the planning council, located within DHCS, provide a voice in state policy development for people with mental illness. The MHSA established the 16-member commission to oversee the provision of services under the MHSA. With the transfer of responsibilities from DMH to DHCS, the legislature created new requirements for DHCS, the planning council, and the commission to collaboratively develop a comprehensive plan for coordinated oversight and evaluation of outcomes for the public mental health system (see Table 3 on the following page for an overview of responsibilities between the oversight entities).

Medi-Cal Specialty Mental Health

DHCS administers the state's $60 billion Medi-Cal program for about eight million beneficiaries. DHCS is responsible for setting state Medi-Cal policy and for overseeing local administration of Medi-Cal-covered mental health services. Most Medi-Cal mental health services are provided under the state's Medi-Cal Specialty Mental Health Services (SMHS) Consolidation 1915(b) waiver program.[36] Through "waivers" the federal government may grant states exceptions to federal Medicaid rules that require states to offer services comparable in amount, duration, and scope to all beneficiaries.

Through this waiver, which first received federal approval in 1995 and has been renewed about every two years since, California created a managed care program for specialty Medi-Cal mental health services that operates outside the Medi-Cal physical health services delivery system. Commonly referred to as the Medi-Cal mental health carve out, the waiver program requires Medi-Cal beneficiaries to access specified mental health services through a county-operated Mental Health Plan (MHP). (MHPs are discussed in detail in the County Role section on page 16.)

The Medi-Cal specialty mental health services 1915(b) waives beneficiaries' "freedom of choice" to receive care from any willing provider. Instead, they must receive the covered services only through the local MHPs. While the state developed this county-

Table 3. State Governance of Public Mental Health Services Delivery

	RESPONSIBILITY	ORGANIZATIONAL COMPOSITION
Department of Health Care Services	DHCS oversees the Medi-Cal program, including the 1915(b) Specialty Mental Health Services Medicaid waiver. DHCS contracts with local Mental Health Plans to provide specialty mental health services to Medi-Cal beneficiaries. DHCS also is required to collaborate with the planning council and the commission on oversight of delivery of MHSA services and other non-Medi-Cal, community mental health programs.	The DHCS director reports to the secretary of the California Health and Human Services Agency, within which DHCS is located.
California Mental Health Planning Council	Each state must have a mental health planning council in order to receive SAMHSA block grant funding. Federal law (PL 106-310) requires the planning council to perform the following functions: • Review the state Mental Health Plan and recommend modifications • Review the annual implementation report on the state Mental Health Plan required by federal law (and submit any comments to the state advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems) • Monitor, review, and evaluate annually the allocation and adequacy of mental health services within the state State law requires that the planning council provide oversight of the mental health system and advocate for people with mental illness.[37]	The planning council has 32 members appointed by the director of the DHCS, plus eight representatives from state departments, for a total of 40 members. Members are appointed to three-year terms and may reapply for appointment. Staff for the council are located within DHCS. The members consist of: • Twenty appointees made up of consumers of mental health services, family members, or advocates • Twelve appointees who are providers and/or representatives of mental health professional organizations • Eight members who are representatives of state departments that serve mental health clients
Mental Health Oversight and Accountability Commission	Established by the MHSA, the commission's role is to oversee implementation of the MHSA and to develop strategies to overcome stigma. The commission advises the governor or the legislature on mental health policy. The commission also evaluates MHSA-funded programs throughout the state. The commission receives all county three-year MHSA plans, annual updates, and annual revenue and expenditure reports. Prior to passage of AB 100 in March 2011, the county plans for prevention and early intervention required commission review and approval. AB 100 shifted the commission's role to training and technical assistance for county mental health planning, as needed. The commission still reviews and approves county innovation plans.	The commission is an independent entity created by the MHSA. A staff with an executive director supports 16 voting members, consisting of: • The attorney general or designee • The superintendent of public instruction or designee • State Senate representative • State Assembly representative The governor appoints 12 board members representing consumers with severe mental illness, family members, providers, law enforcement, educators, employers, labor, and health plans.

operated managed care structure for Medi-Cal mental health services, it simultaneously implemented a major expansion of the Medi-Cal managed care program for physical health services delivered through commercial or local nonprofit insurance organizations. As a result, California's policies ensured that Medi-Cal beneficiaries with mental health needs would continue to navigate two separate health care delivery systems.

Medi-Cal specialty mental health services are defined as "services provided under the waiver to Medi-Cal beneficiaries who meet specified medical necessity criteria."[38] Essentially, these are Medi-Cal covered mental health services that cannot be provided through primary care. These services are not covered through the Medi-Cal managed care plans for physical health or in Medi-Cal fee-for-service. They include a range of interventions to assist beneficiaries with serious emotional and behavioral challenges, including acute psychiatric inpatient care, treatment from psychiatrists and psychologists, and a host of rehabilitation services. They also include specialized EPSDT mental health services for children and youth with serious emotional disturbances.

Under the 1915(b) waiver, California defined the Medi-Cal population that qualifies for specialty mental health services to individuals who meet specific medical necessity criteria as determined by local MHPs during patient assessments.[39] Medi-Cal beneficiaries with mental health conditions who do not meet these medical necessity criteria have access to the limited scope of primary care–based mental health services provided by Medi-Cal managed care plans or the original Medi-Cal fee-for-service program.

County Role

Counties are responsible for administering nearly 90% of public mental health services funding in California. County boards of supervisors are required by law to oversee these local mental health programs with input from local mental health advisory boards.

Counties are required to have two contracts with DHCS detailing how they provide mental health services:

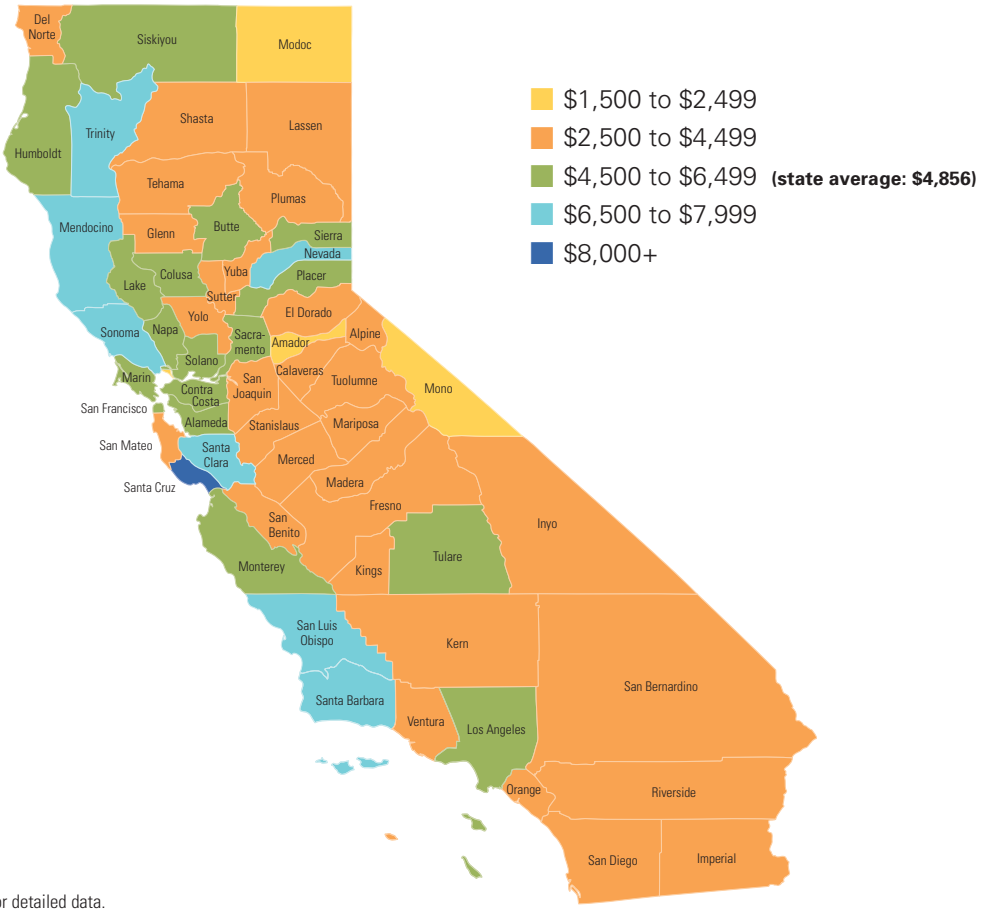
1. **Medi-Cal Mental Health Managed Care Contracts** guide the coverage and provision of Medi-Cal specialty mental health services under the 1915(b) waiver program.

2. **Mental Health Performance Contracts** guide the provision of non-Medi-Cal mental health services.[40]

Counties are required to deliver mental health services to people with and without Medi-Cal in line with the approach described in the California Welfare and Institutions Code sections Mental Health Adult and Older Adult System of Care and Children's System of Care.[41,42] Core elements of this approach include consumer- and family-focused services, a personal service plan, a coordinated services delivery system, case management, and the delivery of services that are measurable and accountable. The MHSA created additional funding to support counties' efforts to strengthen these systems of care, which historically have suffered from underfunding.

Within state and federal parameters, counties have broad discretion in how they fund and provide mental health services to target populations, including determining program budgets and priorities. They deliver services either directly through physicians and staff employed at county-owned and county-operated facilities or by contracting with outside hospitals, clinics,

Figure 6. Medi-Cal Specialty Mental Health Services, Average Payment per Client, by County, CY 2011



Note: See Appendix C for detailed data.

Sources: APS Healthcare, California External Quality Review Organization, www.caeqro.com/webx.

community-based organizations, and private practitioners. As with many aspects of local mental health programs, there is wide variation among counties in the proportion of services that are provided by contractors versus by the county directly.

Each county mental health system looks different. For example, the Los Angeles County Department of Mental Health, the nation's largest public mental health system, serves about one-third of all people receiving public mental health services in California and accounts for about one-third of the state's total mental health costs. In contrast, the 15 smallest, rural California counties combined served about 1% of all people who received public mental health services in 2011.[43] Counties differ in the numbers of people without Medi-Cal served, spending per individual, and availability of services. (See Appendix C for tables showing variation among counties.)

County Mental Health Plans

When California initiated the managed care program for Medi-Cal specialty mental health services between 1995 and 1998, counties were given the right of first refusal to become the local MHP. All but two counties elected to become the local MHP (Yuba and Sutter Counties joined forces to become one MHP,

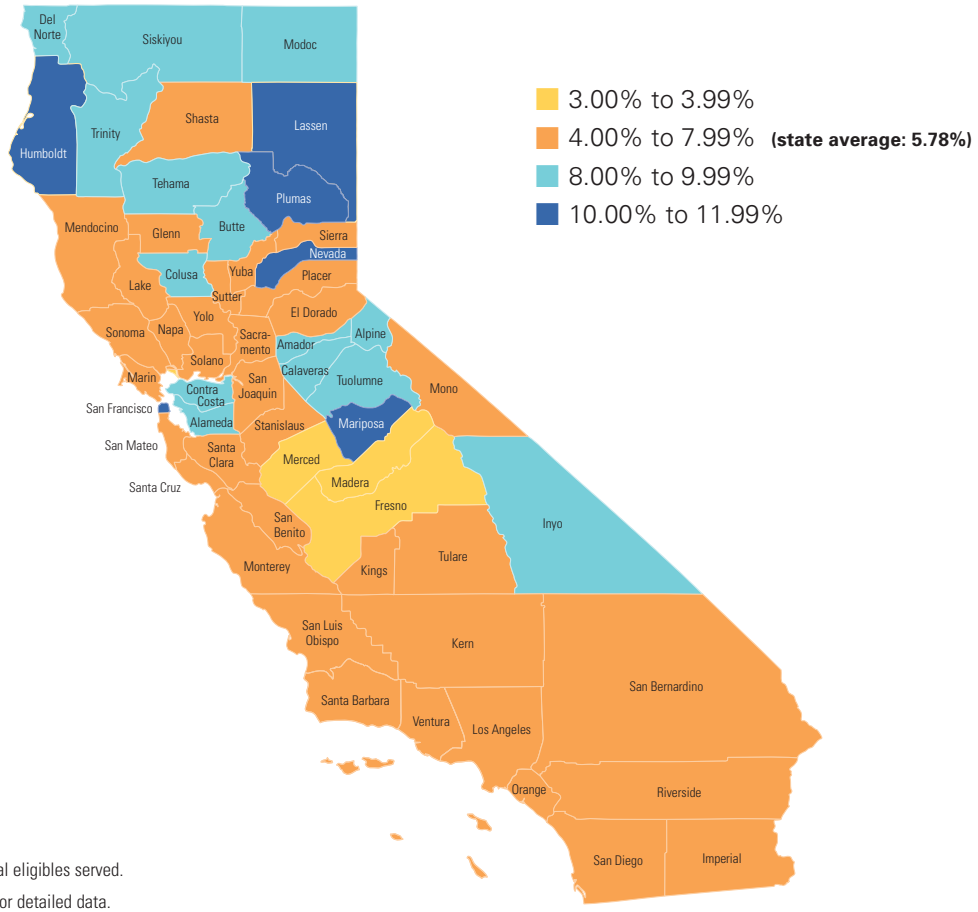
as did Placer and Sierra Counties). Today, 56 county-operated MHPs operate under contract with DHCS. The MHPs select and credential their Medi-Cal provider network, negotiate rates, authorize services, and pay the state's share for Medi-Cal services.[44]

The county MHPs are classified by federal regulation as prepaid inpatient health plans (PIHP) since they meet the following criteria:

- Provide medical services to enrollees under contract with the state agency
- Have responsibility for the provision of any inpatient hospital or institutional services for their enrollees
- Do not have comprehensive risk contracts, meaning they are not fully capitated to provide inpatient and outpatient medically necessary services[45]

Counties must also meet other federal requirements for PIHPs, including undergoing annual reviews by the EQRO and implementing electronic health records systems that comply with federal electronic records requirements.

Figure 7. Medi-Cal Specialty Mental Health Services, Penetration Rate,* by County, CY 2011



*Percentage of Medi-Cal eligibles served.

Note: See Appendix C for detailed data.

Sources: APS Healthcare, California External Quality Review Organization, www.caeqro.com/webx.

MHPs are not paid on a capitated basis like the Medi-Cal managed care plans for physical health services. Instead, MHPs operate under a hybrid managed fee-for-service financial arrangement. They pay providers for care at the time of service using realignment, MHSA, and other local money. By paying for specialty mental health services, MHPs incur certified public expenditures (CPEs). MHPs submit these CPEs to DHCS, which uses them to claim federal reimbursement for Medi-Cal specialty mental health services.[46] DHCS, in turn, pays MHPs the federal Medi-Cal reimbursement on an interim basis throughout the year. After the close of the state fiscal year, the state and counties complete a final cost settlement process.

The federal reimbursement that counties receive to provide Medi-Cal specialty mental health services to any qualifying recipient is not capped. However, a county's annual allocation of realignment revenue that can be used as the nonfederal Medi-Cal payment is capped. Therefore, any costs for the Medi-Cal program that exceed the counties' realignment revenue must be paid for using county funds or MHSA funds, to the extent allowable under law.[47] This is called local "overmatch."

All counties' 2011 realignment funding is for Medi-Cal specialty mental health services. Increasingly, counties have used their 1991 realignment funding as the nonfederal portion for funding Medi-Cal services. In FY 2012–13, counties were projected to spend about 60% of their $1.16 billion in 1991 realignment revenue on Medi-Cal services.[48] Similarly, counties increasingly are using MHSA dollars as the nonfederal portion to pay for Medi-Cal specialty mental health services and to draw down federal funding. In FY 2008–09, about 20% of MHSA expenditures went toward Medi-Cal-reimbursable services, about twice the percentage two years prior.[49]

Counties as Providers of Safety-Net Mental Health Services, Including MHSA Services

State law requires counties to be the safety-net providers of mental health services to target populations: adults with serious mental disorders, children with serious emotional disturbance, and people in acute psychiatric crisis (see sidebar on page 19).[50] Legally, counties can and do limit access to mental health services for individuals ineligible for Medi-Cal (for example, medically indigent adults) to the extent that the counties have funds remaining after serving Medi-Cal-eligible clients. The ratio of Medi-Cal to non-Medi-Cal services provided varies among counties.

County mental health programs provide some services that are ineligible for federal Medicaid reimbursement due to the following factors:

- The recipient is not a Medi-Cal beneficiary.
- The service is not covered by Medi-Cal.
- The service is provided at a site that is ineligible for Medi-Cal reimbursement, such as an institution for mental disease (IMD).

The MHSA now serves as the largest funding source for counties to provide non-Medi-Cal community mental health services. MHSA annual revenue —more than $1 billion — represents about one-quarter of all counties' mental health funding combined. Between 2006 and 2012, county-administered mental health funding increased by about 30%, but without the MHSA, it would have increased by only 6%.[53] (In comparison, the total Medi-Cal budget grew at an average rate of about 7% over the same period, almost doubling from $34.4 million in FY 2005–06 to about $60 billion in FY 2012–13.)[54]

The proportion of MHSA revenue each county receives is based on a formula that takes into account

Priority Populations for Mental Health Services

To the extent counties have resources available after serving Medi-Cal beneficiaries, counties must use realigned state funds to provide services to these groups:

Adults with serious mental illness. Adults are considered to have a serious mental illness (SMI) if they have a clinically identified mental disorder that meets the following criteria:

- Severe
- Persistent
- Interferes substantially with primary activities of daily living
- May result in an inability to maintain independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time

Examples of SMIs include schizophrenia, bipolar disorder, and post-traumatic stress disorder.[51]

Children and adolescents with serious emotional disturbance. Children or adolescents with the following characteristics are considered to have a serious emotional disturbance (SED):

- Have an identified mental disorder that results in age-inappropriate behavior
- Are substantially impaired in at least two areas among self-care, school functioning, family relationships, and ability to function in the community
- Are at risk of removal from the home or have already been removed

Children are also considered to have an SED if the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment, and if, as a result, the child or adolescent presents psychotic features, risk of suicide, or risk of violence.[52]

each county's total population, proportion of households with incomes below 200% of the federal poverty level, proportion of uninsured residents, and prevalence of mental illness. The result is adjusted based on cost of living and available resources. Small counties with fewer than 200,000 residents each receive a set minimum payment per county.[55]

The MHSA mandated that each county involve consumers, families, and other stakeholders in a multiyear planning process to set community priorities for how to spend MHSA funds.[56] Counties must create three-year program and expenditure plans that reflect local priorities. As a result of this emphasis on local priorities, MHSA programs vary greatly among counties. According to statutory changes adopted in 2011, counties no longer need the state's approval for their three-year MHSA planning and expenditure plans. The only approval required is by the locally elected county board of supervisors. Counties must submit to the state a signed letter from the local mental health director and county auditor-controller certifying that the county is administering the MHSA funds in accordance with state laws and regulations.[57]

A central aim of the MHSA was to expand the types of services offered by counties and to serve new populations. It included a MOE clause that required the state to maintain funding for existing community mental health services. In 2008, community mental health providers sued the state for violating this clause when it cut a $55 million mental health program for 4,700 homeless adults. The resulting appeals court decision found that while the state cannot reduce total funding for mental health services below the amount spent in FY 2003–04 ($577 million), the MHSA MOE clause does not protect individual programs from elimination.[58]

IV. Delivery of Public Mental Health Services

Mental illness can have a major impact on an individual's overall health status and quality of life. It is estimated that, on average, people with serious mental illness die 25 years earlier than the general population.[59] Unaddressed mental illness also impacts overall health care costs. Among Medicaid beneficiaries with chronic conditions, health care costs are up to 75% higher if they have a mental illness.[60] One analysis estimated that 11% of beneficiaries in fee-for-service Medi-Cal in 2007 had SMI, and spending for these individuals was 3.7 times greater than for the general Medi-Cal population ($14,365 per person versus $3,914).[61] For Medicare, costs are estimated to be five times higher for beneficiaries with SMI or a substance use disorder than for similar beneficiaries without these diagnoses.[62]

An estimated 16% of California adults have some degree of mental illness. Of those, about 4% have conditions that are severely disabling. Among all California children, an estimated 7% are seriously emotionally disturbed (see Table 4).[63]

A large proportion of Californians lack access to mental health services.[64] According to the 2009 California Health Interview Survey, less than half of California adults with mental health needs received treatment. Of those who did receive treatment, less than one-quarter reported that the treatment met their needs. Of the respondents with mental health needs who were uninsured, 69% received no treatment.[65]

Table 4. Prevalence of Mental Illness Among Californians, 2009

	NUMBER (percentage)	HOUSEHOLDS BELOW 200% OF FPL
Children with severe emotional disturbance (age 0–17)	714,431 (7.6%)	367,257 (8.9%)
Adults with serious mental illness	1.18 million (4.3%)	615,555 (7.7%)
Adults with any mental health needs (broadly defined)	4.36 million (15.9%)	1.89 million (23.6%)

Note: FPL is federal poverty level.

Source: Technical Assistance Collaborative and Human Services Research Institute, *California Mental Health and Substance Use Needs Assessment* (February 2012)

Access to publicly funded mental health services in California depends on many factors:

- Age (whether the patient is an adult or a child)
- Insurance status (whether the patient has Medi-Cal or other insurance)
- Illness severity
- County of residence

This section describes the publicly funded mental health services available to California's adults and children.

Medi-Cal Specialty Mental Health Services

Counties provide mental health services to Medi-Cal beneficiaries who seek mental health services on their own, to patients in a psychiatric crisis held involuntarily, and to those referred by third parties, such as physical health care providers, schools, county welfare departments, family members, and law enforcement agencies. An initial assessment is conducted of each individual referred to the county for services. Through the assessment, the MHP determines if the individual's illness meets medical necessity criteria defined in state regulation. An individual must meet these criteria to receive Medi-Cal specialty mental health services. Any Medi-Cal beneficiary who meets these criteria, regardless of age, is entitled to receive Medi-Cal specialty mental health services covered by the MHP under the 1915(b) waiver. Beneficiaries who are deemed not to meet these criteria are referred to a Medi-Cal managed care plan or Medi-Cal fee-for-service program for limited primary care–based mental health services.

The criteria for receiving outpatient Medi-Cal specialty mental health services include the following:[66]

Diagnosis. The patient must have one or more of 18 specified diagnoses.[67]

Impairment. The mental disorder must result in one of the following:

- Significant impairment or probability of significant deterioration in an important area of life functioning
- For those under 21, a probability that the patient will not progress developmentally as appropriate, or when specialty mental health services are necessary to ameliorate the patient's mental illness or condition

Intervention. The services must address the impairment and be expected to significantly improve the condition, which would not be responsive to physical health care–based treatment.

Types of Services

Under the Specialty Mental Health Services 1915(b) Waiver program, a number of services are available to beneficiaries who meet the medical necessity criteria. MHPs may provide these services through the Rehabilitation Option, a Medi-Cal state plan amendment that allows counties to receive federal reimbursement for services delivered in nontraditional settings and by nontraditional providers. (See sidebar.)

Medi-Cal Rehabilitation Option

The Medi-Cal Rehabilitation Option allows for expanded coverage:

Locations. Services may be delivered in a variety of community settings, such as at a client's home or via telephone.

Providers. A wider variety of provider types, including paraprofessionals and peer support specialists, may be reimbursed for services. This promotes matching of cultural, ethnic, and service needs across a diverse population.

Services. Community-based services covered under this option include assessments, rehabilitation, crisis intervention and stabilization, medication support, service plan development, therapy, and training or counseling for family members.

The specialty mental health services covered under the waiver include:

- Mental health outpatient services, including assessment, service plan development, therapy (individual or group), rehabilitation (individual or group), and collateral contact (such as training or counseling for family members)
- Targeted case management
- Medication support
- Day treatment intensive programs
- Day rehabilitation
- Crisis intervention
- Crisis stabilization
- Adult residential treatment services
- Adult crisis residential services
- Psychiatric hospitalization

Individuals age 21 and under receive all of these services plus expanded mental health services available through the EPSDT program.

MHPs are contractually required to provide a toll-free phone number that is staffed around the clock to inform callers about available services. MHPs also are obligated to ensure access to services by having adequate numbers of qualified providers, institutional facilities, and service sites. Service availability varies among counties. Some counties with few in-county inpatient and residential treatment providers rely significantly on out-of-county providers. For example, 25 California counties have no inpatient psychiatric hospital beds for adults, and 45 counties have no pediatric inpatient psychiatric hospital beds.[68] Rural counties have more difficulty hiring qualified mental health workers to meet the needs of their target populations. Increasing use of telemedicine has been identified as one way for MHPs to improve access to care — for example, for psychiatric consultations in both English and Spanish.[69]

Use and Penetration

Local MHPs provided Medi-Cal specialty mental health services to 456,260 people in 2011. Of those, 263,500 (58%) were adults (age 18 and older).[70] (See Table 5.)

Table 5. Trends in Medi-Cal Specialty Mental Health Service Delivery, 2005–2011

	BENEFICIARIES		SPENDING	
	Number Served	Penetration Rate*	TOTAL (in billions)	Average per Beneficiary
2005	426,978	6.27%	$1.711	$4,007
2006	426,158	6.28%	$1.841	$4,320
2007	423,037	6.19%	$1.883	$4,451
2008	445,651	6.38%	$2.085	$4,679
2009	453,590	6.15%	$2.196	$4,841
2010	438,230	5.86%	$2.053	$4,685
2011	457,264	5.78%	$2.221	$4,856

*Percentage of total Medi-Cal beneficiaries.

Source: APS Health Care, California EQRO.

The penetration rate, defined as the proportion of Medi-Cal beneficiaries receiving specialty mental health services, is commonly used to assess access to services when compared against the estimated need for services within that population.[71] In 2011, the statewide specialty mental health service penetration rate for adults age 18 to 59 was 7.4%, ranging from 3.5% in Solano County to 16% in Lassen County.[72]

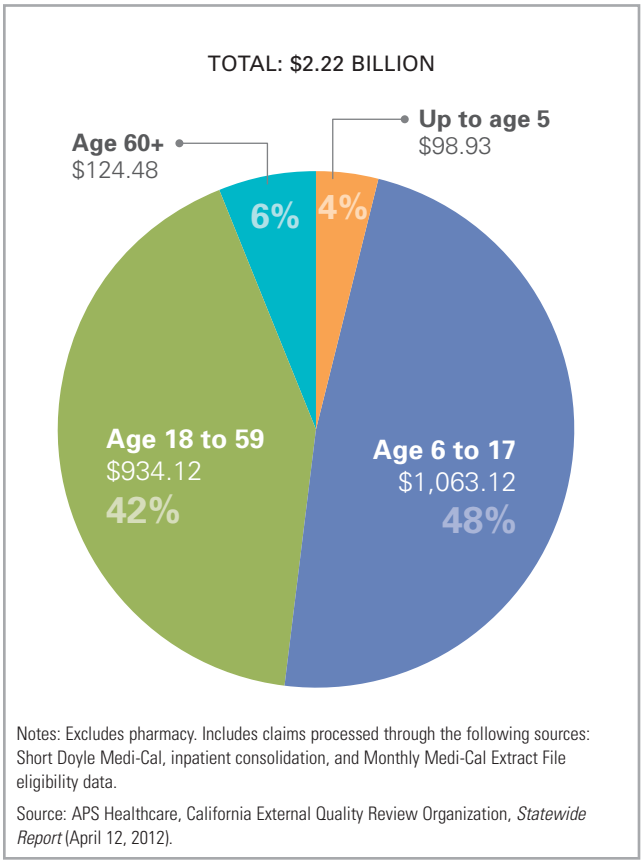
Use of specialty mental health services tends to decline as Medi-Cal beneficiaries age. The statewide penetration rate for adults age 60 and older in 2011 was 3.4%.[73] Penetration rates also vary by race. In 2011, the statewide penetration rate was 10.5% for Whites and African Americans, 4% for Asians, and 3.8% for Latinos.[74]

Average Spending

Spending on county-administered Medi-Cal specialty mental health services in FY 2011–12 was estimated at $2.2 billion, which was split roughly evenly between adults and children (see Figure 8). Medi-Cal spending on mental health services is concentrated among a small population. In 2011, 2.5% of beneficiaries accounted for 25% of spending.[75] The average amount spent on Medi-Cal specialty mental health services per beneficiary across all age groups in 2011 was $4,856, while the median amount spent was $1,755.[76]

Spending varied among counties. At the low end, Modoc County spent $1,817 per beneficiary in 2011; in contrast, Santa Cruz spent $10,216 per beneficiary.[77] Average spending per beneficiary also varied by age: Children ages 6 to 17 had the highest per capita spending at $6,340; for beneficiaries age 18 to 59, average spending was $4,200; for those age 60 and older, average spending was $3,170.[78]

Figure 8. Medi-Cal Specialty Mental Health Spending by Age Group, 2011 (in millions)



Notes: Excludes pharmacy. Includes claims processed through the following sources: Short Doyle Medi-Cal, inpatient consolidation, and Monthly Medi-Cal Extract File eligibility data.

Source: APS Healthcare, California External Quality Review Organization, *Statewide Report* (April 12, 2012).

Children's Specialty Mental Health Services

The Medi-Cal program covers approximately 90% of children with SED served by counties. The majority of services provided are referred to as "EPSDT enhanced mental health services." Youth with SED and their families almost always need coordination of services received from the school, child welfare agency, juvenile justice system, and other community organizations. Thus, under the children's system of care in the California Welfare and Institutions Code, counties are required to coordinate a child's mental health care with these other entities. (A diagnosis of autism spectrum disorder does not qualify a child for Medi-Cal specialty mental health services.)

Early and Periodic Screening, Diagnosis, and Treatment Program

EPSDT is a comprehensive health program for individuals under age 21. It has been a required benefit of the Medicaid program since its inception in 1966. Federal EPSDT rules require that states provide people under 21 with access to all necessary services to "correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services," regardless of whether these

services are covered under the state's Medicaid plan.[79] The program is aimed at correcting or improving conditions that could be more expensive to treat later in life.

Starting in 1995, in response to legal actions, California expanded the mental health services offered through EPSDT. (See sidebar.) EPSDT mental health services now include all of the specialty mental health services covered under the 1915(b) waiver, plus more intensive therapeutic behavioral services for children at risk of psychiatric inpatient hospitalization.[80] Local MHPs provide EPSDT mental health services under the specialty mental health services waiver program to children with SED who meet the medical necessity criteria. MHPs receive referrals from physical health providers and managed care plans, which are responsible for the screening function of EPSDT.

Litigation Affecting EPSDT Services

Lawsuits affecting the provision of EPSDT specialty mental health services in California:

TL v. Belshe, settled in 1995, resulted in California's implementation of an expanded EPSDT mental health services benefit. Counties assumed responsibility for providing these services, given their historic role as providers of mental health services to children and youth with SED.

Emily Q. v. Belshe, settled in 2001, resulted in the creation of a new type of intensive EPSDT service called therapeutic behavioral services.

Katie A. v. Bontà, settled in 2011, required statewide implementation of more intensive, individualized mental health services to youth in foster care.

Children in Foster Care

In 2011, about 63,000 California children lived in foster care.[81] Children in foster care have high rates of mental health, substance use, and physical health care issues. Estimates of mental health and/or substance use disorders are as high as 80% for youth in foster care.[82] Children automatically become eligible for Medi-Cal, and thus EPSDT, when they enter the foster care system.

Starting January 2013, all MHPs must provide expanded mental health services to children in foster care, as required by the *Katie A. v. Bontà* lawsuit settlement agreement. These new services include intensive care coordination and intensive home-based services. An estimated 11,130 children are expected to qualify for these expanded specialty mental health services upon full implementation of the settlement agreement at an average cost per person, per year of $10,400.[83]

California's county-based mental health system is particularly complicated for the 12,800 foster care children who are placed outside of their home county, or county of jurisdiction, because the responsibility to provide and fund mental health services for these children remains with their county of origin. Research commissioned by the California Child Welfare Council found that foster children placed outside their county of origin tended to receive fewer and less intensive mental health services.[84] MHPs often have difficulty finding and contracting providers for services, authorizing treatment, and coordinating and monitoring care for foster children living in other counties. To address this gap in services for this population of children in foster care, the Child Welfare Council recommended that California adopt a policy of "presumptive transfer" so that the responsibility for providing mental health services for a foster child would fall on the county in which the child lives.[85]

Service Use and Penetration

Youth access to specialty mental health services increased significantly after 1995, when counties were required to provide enhanced EPSDT mental health services. In 2011, California counties provided EPSDT mental health services to 223,200 children statewide, almost quadruple the number treated in 1995. The statewide EPSDT penetration rate in 2011 was 6%; the rate ranged from 2.2% in Merced County to 12.6% in Nevada County.[86] Statewide penetration rates of EPSDT services among youth in foster care are also rising as MHPs increase their focus on this population; in 2011, the statewide penetration rate average for foster care youth was 56%.[87]

Average Spending per Child Beneficiary

In 2011, combined county and federal spending on EPSDT mental health services totaled $1.25 billion, a ten-fold increase from the $100 million in combined spending in 1995.[88] The average amount spent on EPSDT mental health services in 2011 was $5,600 per beneficiary, with the average varying considerably among counties: In Modoc County, for example, the average spent per beneficiary was $1,270, while it was $9,930 in Santa Clara County. Average EPSDT mental health services spending per foster care beneficiary was $6,980, ranging from zero in Alpine County, which had no foster care beneficiaries, to a high of $20,939 in Santa Clara County.[89]

School-Based Mental Health Services

Schools are a main provider of mental health services for children in California. The federal Individuals with Disabilities Education Act (IDEA) was adopted in 1975 to guarantee children with disabilities a right to public education in the least restrictive setting. In California, the federal IDEA mandate to provide special education services is administered by local school districts and local education agencies. Special education students may be eligible for health care services, including mental health services, in specific IDEA disability categories. Mental health services provided to special education students include counseling and guidance, psychological services, parental counseling and training, and residential placement, among others.

Prior to 2011, special education students who had an SED condition documented in their individual education plans were referred by their schools to county mental health agencies for treatment, as called for under AB 3632 passed in 1984. Funding for AB 3632-mandated services became an ongoing financial struggle between the state and counties, with counties accusing the state of not fully reimbursing them for costs associated with providing these services.[90] In 2011, the California Legislature repealed the state mandate on county mental health agencies to provide IDEA-related mental health services and shifted this financial responsibility to the California Department of Education.[91] The Department of Education's projected budget for these services in FY 2012–13 was $420 million, of which about $69 million was federal money. The remainder was state Proposition 98 funding. Local education agencies and local MHPs were required to develop new agreements defining agency responsibilities that reflected the changes in state law. MHPs remain responsible for providing EPSDT services for students who are Medi-Cal beneficiaries with IDEA-related individualized education, if they meet medical necessity criteria.

Between 1991 and 2011, the state Department of Mental Health also operated the Early Mental Health Initiative, which provided schools with approximately $15 million annually to serve children in kindergarten through third grade with mild and moderate mental health problems. With the transfer of responsibilities from the DMH to DHCS in 2012, this program was shifted to local education departments. Many counties also fund on-campus mental health services to non–special education students through EPSDT- and MHSA-funded early prevention programs.

Non-County-Administered Medi-Cal Mental Health Services

While counties are responsible for providing most public mental health services, there are some important exceptions. Counties do not pay for psychiatric care in nursing facilities or at Indian Health Centers, which are not county-run entities. Counties also do not fund or provide psychotherapeutic prescription drugs to Medi-Cal beneficiaries; DHCS handles this responsibility for all prescriptions written outside of primary care. Compared to Medi-Cal covered drugs, this class of drugs had the highest expenditures, and the fastest rate of growth between 2004 and 2007.[92] In FY 2011–12, estimated combined state and federal spending for 1.97 million prescriptions filled for 40 commonly prescribed psychotherapeutic drugs was $409 million.[93]

Medical Necessity Coverage Gap

Counties do not provide mental health services for people who do not meet the county's medical necessity criteria. MHPs assess all Medi-Cal beneficiaries who are referred for services, but not everyone is deemed sufficiently functionally impaired to qualify for specialty services. A recent statewide behavioral health needs assessment described these individuals, who are symptomatic but not yet considered disabled by their illness, as falling into a major coverage gap.[94]

Counties vary in their interpretation of medical necessity.[95] Advocates have asserted that some counties ration services to adults, in particular, through overly stringent application of the medical necessity criteria.[96] A new mother with postpartum depression or someone with bipolar disorder but who continues to function in daily life are examples of people who may fall into the coverage gap and have more limited Medi-Cal treatment options. These patients may receive medications from primary care doctors, but they may not receive case management, therapy, or other rehabilitative services that are available as mental health benefits but often not from physical health plans or Medi-Cal fee-for-service plans.

In each county, the MHP and physical Medi-Cal managed care plans are required in their respective contracts with DHCS to have a memorandum of understanding specifying roles and responsibilities for coordinating the delivery of medically necessary mental health services. However, this coordination has been limited. Operating under different payers and through separate service delivery infrastructures, physical health and mental health providers struggle to share basic information to coordinate care for their patients. DHCS management of the psychiatric pharmacy benefit at the state level without sharing data with health plans and counties, due to patient privacy laws, has further hindered effective treatment coordination.

Community Health Centers

Federally qualified health centers (FQHCs) and rural health centers (RHCs) provide mental health services for many Medi-Cal beneficiaries and uninsured people, particularly those whose illnesses are not severe enough to meet county medical necessity criteria. California's roughly 800 FQHC sites serve about 2.3 million people annually and are required by federal law to provide behavioral health services.[97] The total number of FQHC visits for mental health and substance use in 2007 was greater than the total number of visits for diabetes and hypertension.[98] FQHCs in many counties have become leaders in providing integrated physical and mental health services at the same location, despite the disincentive of a California law prohibiting FQHCs from billing

for visits to a physical health and a mental health provider on the same day.[99]

FQHCs are paid through an all-inclusive, per-visit, prospective payment system (PPS) rate set by the federal government. Many FQHCs contract with physical Medi-Cal health plans at a set rate and are paid by DHCS the difference between that contracted rate and their PPS rate. Some MHPs also contract with FQHCs for services. Medi-Cal payments made up 41% ($597 million) of FQHC financing for all services in 2007.[100] The amount of FQHC financing for mental health services was not available for this study.

Safety-Net Mental Health Services

California's health care safety net is a complex web of programs and providers that serve low-income, uninsured residents, with counties being the safety-net providers of mental health services.[101] In 2010, counties served a total of 560,700 people, of whom between 20% and 30% were ineligible for Medi-Cal. (The proportion of non-Medi-Cal beneficiaries served varies significantly between counties.)[102] Counties are required to provide uninsured adults and children with services in line with the systems of care outlined in state statutes, but only to the extent that resources are available after serving Medi-Cal beneficiaries. The available services resemble Medi-Cal specialty mental health services. Counties also are the safety-net providers for crisis mental health services regardless of a person's insurance status.

Mental Health Services in the Low-Income Health Program

California's Bridge to Reform, a Section 1115 Medicaid waiver approved in 2010, provided a new source of federal matching funds to California counties for providing health care services to uninsured adults. Bridge to Reform created the Low-Income Health Program (LIHP) to expand county coverage to adult residents — age 19 to 64 — who are ineligible for Medi-Cal and who have incomes at or below 200% of the federal poverty level (FPL).[103] Previously, these individuals were covered under county indigent programs, and they had more limited access to health care services. Bridge to Reform was designed to prepare for the 2014 Medi-Cal expansion authorized by the Affordable Care Act (ACA).

As of August 2012, 50 counties operated LIHPs, with a total enrollment of 487,000.[104] Under the state's anticipated Medi-Cal expansion under the federal ACA, most individuals covered by the LIHPs would transfer to the full Medi-Cal program.[105] To qualify for federal matching funds through the LIHP, counties must provide coverage for a standard set of benefits, including certain mental health services. The minimum level of mental health services counties are required to provide include up to 10 days per year of acute psychiatric inpatient care, psychiatric medications, and up to 12 outpatient encounters per year. At least a dozen counties used additional local dollars to expand their LIHP mental health benefits to match those offered under the Medi-Cal specialty mental health services waiver program.[106] For the most part, counties pay for LIHP mental health services with money they would have spent on the medically indigent population.[107] Federal reimbursement for these services will help offset this indigent care obligation.

Institutions for Mental Disease

The federal definition of an institution for mental disease (IMD) is "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."[108]

California has 60 such facilities with about 6,200 acute psychiatric and long term care beds (not including state hospitals) that meet this definition.[109]

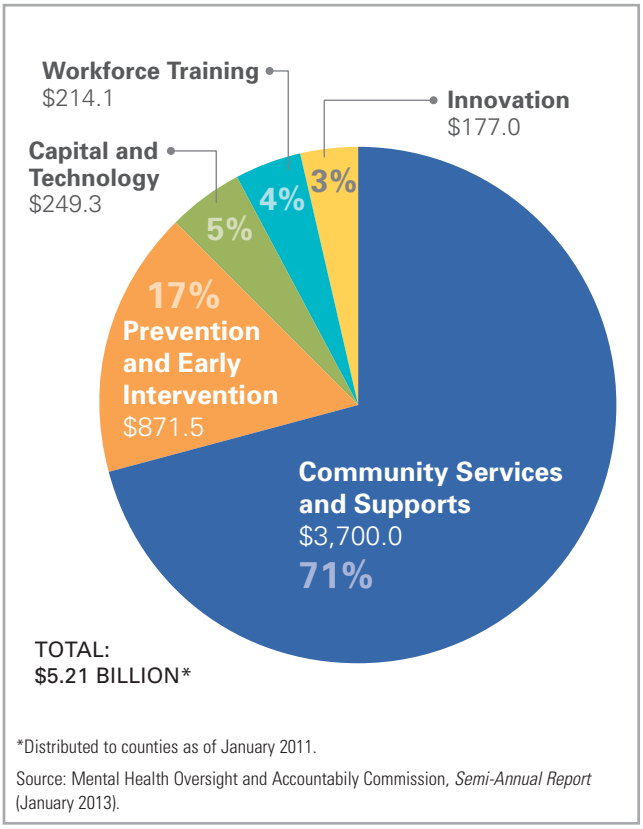
IMDs are ineligible for federal Medicaid reimbursement, and thus Medi-Cal coverage, for beneficiaries age 22 to 64. Congress created this exclusion to discourage institutionalized care and to promote the provision of care in smaller, community-based settings.[110,111] Counties use 1991 realignment revenue to provide medically necessary services in IMDs. The IMD exclusion from Medi-Cal means that counties pay for 100% of the costs associated with care in IMDs for people age 22 to 64. Most IMDs are private providers that contract with counties. Statewide, in FY 2011–12, counties spent an estimated $330 million on non-Medicaid reimbursable treatment in IMDs, according to analysis from the California Mental Health Directors Association.[113]

California is participating in a federal three-year Medicaid Emergency Psychiatric Demonstration starting in July 2012 allowing federal reimbursement for freestanding IMD psychiatric hospitals.[112] The intent of the project is to test whether this coverage increases timely access to care for patients needing acute short-term emergency psychiatric treatment and reduces the time patients wait in hospital emergency departments for psychiatric beds to become available.[114] The demonstration project is estimated to bring in an additional $6 million in federal funding to the participating counties for treating 1,850 beneficiaries in specific freestanding psychiatric hospitals.[115]

Mental Health Services Act

California's MHSA is the largest non-Medi-Cal service program for counties. The MHSA intended to transform the public mental health system from one that provides crisis care to one that focuses on consumer wellness, recovery, and resilience. The MHSA is intended to serve children with SED and adults with SMI, as defined in state law, and specifically mentions adults and transition-age youth who are "unserved, underserved, or inappropriately served," such as people who are homeless, frequent users of hospitals, or have a criminal justice history. The MHSA has been recognized nationally as a unique approach to both funding and delivering recovery-focused mental health services. (For distribution of MHSA funds by category, see Figure 9.)

Figure 9. MHSA Allocations by Category, 2004–2011
(segments in millions)



*Distributed to counties as of January 2011.

Source: Mental Health Oversight and Accountabily Commission, *Semi-Annual Report* (January 2013).

MHSA services are divided into five broad categories. Some of the services provided through MHSA programs are eligible for federal Medicaid reimbursement and some are not. Consumer, family, and stakeholder engagement is a required component of all services, which are described below:

1. **Community services and supports.** By law, at least 51% of MHSA funds must provide community services and supports, including full-service partnerships, and other services that cover gaps in the systems of care, such as transportation, vocational training, outreach and engagement, and crisis intervention. The disproportionate allocation (see Figure 9) for this service category reflected the estimated need of underserved people with severe mental illnesses who were homeless or at risk of homelessness, incarceration, or hospitalization.

   An estimated 27,000 Californians — Medi-Cal beneficiaries as well as non-Medi-Cal beneficiaries — receive treatment under the intensive full-service partnership model.

   In the full-service partnership model, county mental health programs contract with community-based organizations to provide a "whatever it takes" approach to helping clients, including outreach, care coordination, housing, food, and other nontreatment services.[116] The estimated annual cost per client served in a full-service partnership is about $20,000, which includes some housing costs.[117] A 2012 UCLA analysis found that across all age groups, 75% and 88% of full-service partnership program costs for new enrollees in FY 2008–09 and FY 2009–10 (respectively) were offset by savings to the public mental health, health, and criminal justice systems.[118]

2. **Prevention and early intervention (PEI).** MHSA funding is also used by counties to develop prevention and early intervention programs for people at risk of, or showing early signs of, a mental illness. The aim is to provide services, including brief treatment, in a timely manner before the illness develops or becomes more severe. A central goal of PEI is making mental health a socially accepted aspect of community wellness, and diminishing stigma and discrimination against those identified as having a mental illness. The majority of spending in this category goes toward children's services. About $140 million in PEI money pays for an ongoing county-based suicide reduction campaign.[119]

3. **Innovation.** Funding is provided for counties to develop and test innovative ways to improve access to mental health services, including increasing access for underserved groups, improving program quality and outcomes, and promoting interagency collaboration in the delivery of services.

4. **Capital facilities and technology needs.** MHSA funds allow counties to invest in technology improvements and capital facilities needed to provide mental health services. This funding has enabled adoption of electronic health records in some counties and has supported overall health information technology improvements essential to helping counties meet federal requirements.

5. **Workforce education and training.** To address the shortage of qualified individuals providing MHSA services to target populations, funding can be used to promote employment of mental health consumers and family members as

peer-level providers, to increase the cultural competency of county mental health staff, and to develop new workforce programs.

Not part of the original MHSA, in 2006 the governor issued an executive order directing $400 million in MHSA funding to create up to 10,000 additional units of supportive housing for individuals with mental illness and their families.[120]

MHSA Focus on Children

The MHSA provided additional funding for programs targeting children with SED, such as the Early Mental Health Initiative, that had been eliminated through budget cuts over the years.[121] The MHSA mandates that funding also target transitional-age youth, age 16 to 25, in recognition of this group's unique mental health needs, particularly for those aging out of foster care. A majority of the prevention and early intervention funding must be spent on services targeting youth, including youth in stressed families, those who have been exposed to trauma, and those at risk for school failure or who have been involved with the juvenile justice system. This mandate is based on studies showing that 50% of all mental illnesses manifest by age 14, and 75% by age 25.[122] Through programs funded by the community services and supports component of MHSA, counties are expanding screening programs for children and youth, and promoting outreach and engagement in schools, on college campuses, and in primary care sites.

Mental Health Services for People in State and County Locked Institutions

Mental health services are provided to individuals in locked facilities, when needed. These individuals include adults or juveniles in the criminal justice system and some adults under mental health conservatorship, meaning the court has deemed them gravely disabled and assigned someone else (a conservator) to make decisions on their behalf.[123]

Generally, federal Medicaid law prohibits reimbursement by Medi-Cal for services provided in incarceration centers. One exception is when an incarcerated individual is taken off the grounds of the correctional facility for psychiatric inpatient hospital services. These services are eligible for federal reimbursement if the individual is Medi-Cal eligible.[124]

Institutions for Mental Disease

Some gravely disabled individuals are placed in IMDs that are locked, long term care skilled nursing facilities. Under IMD rules, counties are responsible for 100% of the costs provided in these facilities for uninsured adults and for Medi-Cal beneficiaries age 22 to 64.

State Hospitals

Counties pay for about 600 beds in state hospitals to provide services to adults with serious mental disorders who no longer can safely live in the community. The daily bed rate is between $620 and $775, depending on acuity.[125] The state sets the rates for these beds. The remaining 90% of the 6,100 state hospital beds are for patients transferred there from prisons and jails — an increase from 1986, when only half of state hospital beds were used for criminal offenders. California budgeted $1.6 billion for the state hospital system in FY 2012–13.

Prisons, Jails, and Juvenile Detention Centers

An estimated 31,400 inmates (24% of the total state prison population) in state prisons have mental illnesses, for which the State Department of Corrections and Rehabilitation budgeted $300 million for mental health treatment.[126] Under 2011 realignment policies, county jails and probation departments statewide received additional low-level offenders with mental illness transferred to the county level from state prisons. Particularly impacted by this realignment, the Los Angeles County Jail has been called "the largest mental institution in the country" based on its estimated daily census of 1,400 mentally ill inmates.[127] The 2011 Public Safety Realignment included provisions to encourage collaboration between county mental health and criminal justice systems, such as an option for counties to fund mental health and alcohol and drug treatment as an alternative to incarceration. A recent proposal calls for construction of a new Integrated Inmate Treatment Center in Los Angeles County designed to serve inmates with mental illness, comorbid substance abuse, and specified medical conditions.[128]

Juvenile Justice

The estimated 225,000 youths who are involved with California's juvenile justice system each year are estimated to be two to four times more likely to need mental health care than other youth in the state.[129] About 30% of these youths become wards of the court, and of the wards of the court, about 10% are placed in facilities.[130] Youth involved in the juvenile justice system may be placed in a variety of settings, depending on the severity of the crime and the needs of the individual. California law provides for regional or community locked facilities specifically for delinquent youth with SED, but few such facilities exist.[131] Under certain conditions set in state statute, youth with SED can be involuntary detained and may be placed in foster care, licensed group homes, and community treatment facilities, some of which may be out of state.

Counties manage supervision of the vast majority of juvenile offenders, and are responsible for providing services, such as mental health assessments and counseling, anger management, gang intervention, and drug and alcohol education, family mentoring, and life skills counseling. Many county mental health agencies provide services to youths in county detention centers, although available funding tends to be limited.[132] Additionally, several counties are using MHSA funds to expand mental health services to youth in the juvenile justice system and to add additional case management responsibilities to probation officers' duties.[133]

Services for Medicare Beneficiaries

About 5 million people with Medicare live in California; about 1.2 million of them are eligible for both Medicare and Medi-Cal ("dual eligibles").[134] An analysis of dual eligibles enrolled in fee-for-service Medi-Cal in eight California counties estimated that about 20% had a mood disorder, such as bipolar disorder, and 10% had schizophrenia or another psychotic condition. Of all health conditions among the dual-eligible population in these counties in 2010, mood disorder was the 12th most common and 6th most costly, with combined per capita Medicare and Medi-Cal annual spending of $50,000. Schizophrenia was the 15th most common and 5th most costly condition, with combined per capita annual program spending of $59,000.[135]

Medicare finances about 7% of mental health care spending nationally, less than half its share of financing for total health care spending (18%).[136] Until 2008, Medicare required a 50% copayment for outpatient mental health services, even though

the copayment for medical and surgical services was 20%. Since the parity law passed in 2008, this disparity is being phased out. By 2014, the copayment for mental health services will also be 20%.

Modeled after private coverage, Medicare mental health coverage tends to emphasize a more "medical model" compared to Medi-Cal's social rehabilitation model. Older adults in original Medicare often do not have access to mental health case management or rehabilitation programs. Even for dual eligibles, access to this type of mental health care can be limited, particularly for people with Alzheimer's disease or other dementia, which are not diagnoses included in medical necessity requirements for county specialty mental health services.

V. Future Considerations

This section highlights opportunities and challenges the public mental health system may face over the next five years.

Monitoring and Oversight

As with many county-based health and social service programs, county-by-county comparisons in spending, outcomes, and programs are difficult due to a lack of a statewide standardized reporting and outcome measurement system that spans payers and programs. The 1991 realignment law mandated the creation of a statewide system for measuring and tracking community mental health system performance toward client outcome goals and cost effectiveness. Despite numerous efforts over decades, however, no such standardized framework for an outcome and performance measurement or accountability system has been adopted.[137]

This is not to say, however, that no significant county data is available. County mental health programs must submit to the state detailed cost reports that track all of their services for all clients served regardless of payer. Stored in the electronic Client and Service Information (CSI) system, these data could provide a comprehensive picture of mental health service delivery across the state. While inconsistent quality and timeliness of the county-reported data are barriers, the CSI is a rich database that could be more fully used.

In 2012, the legislature mandated that the state implement several efforts to promote standardized reporting systems and to increase performance monitoring.[138] Among these efforts are the following:

- DHCS is developing state regulation regarding parts of the MHSA for which no regulation currently exists, such as prevention and early intervention, and innovation programs.
- DHCS is developing new county performance contracts that will include MHSA requirements and are expected to go into effect July 1, 2013. These updated performance contracts will outline county roles and responsibilities for all mental health programs described in state statute and funded by federal block grants.[139]
- DHCS and the Mental Health Oversight Commission are required to draft a plan for implementing an EPSDT performance outcome system by January 2014. The aim of this system is to "improve outcomes at the individual and system levels and inform fiscal decisionmaking related to the purchase of services."[140]
- In March 2013, the commission adopted a comprehensive master plan to provide a complete evaluation of the community mental health system, including core indicators for uniform, statewide evaluation.[141]

Implementing Health Reform and Federal Parity

Implementation of federal health reform under the ACA presents opportunities and challenges related to mental health service delivery. For now, many uncertainties exist, including the future relationship between the state and counties regarding funding financial obligations.[142] Starting in 2014, an

estimated 1.5 million to 2 million childless adults with incomes below 133% of the FPL will become eligible for Medi-Cal under the expansion allowed for by the ACA. Of these newly eligible adults, between 279,000 and 373,200 are estimated to have mental health needs.[143]

Under the Medi-Cal expansion beginning in 2014, counties may receive 100% federal reimbursement for three years to provide health services, including mental health, to individuals who are newly eligible for Medi-Cal. The federal government's share of funding will decline to 90% by 2020. This additional federal support may enable counties to reallocate some realignment, federal block grant, and local funds to efforts focused on covering the residually uninsured, broadening coverage to people with less severe illness, and providing additional support services that are not Medi-Cal reimbursable. Even with additional funding, however, there are concerns about some counties' capacity to serve an expanded population, particularly those counties that already face workforce shortages.

Under the ACA in 2014, health plans participating in California's Health Benefit Exchange must cover 10 Essential Health Benefit categories, including mental health and substance use disorder services. These services must be provided at parity with medical and surgical benefits, in accordance with the 2008 federal Mental Health Parity and Addiction Equity Act.[144] The benefit package offered to the Medi-Cal expansion population also must conform to these requirements. Whether California's current Medi-Cal mental health and substance use benefits meet federal parity law requirements remains an open question. Counties' 2011 realignment allocations were based on the existing benefit structure, and how and by whom any required benefit expansions would be funded is unclear.

Improving Coordination of Physical and Mental Health Services

Ensuring access to coordinated mental health and physical health services is imperative to improving population health outcomes. A central theme of federal health reform is promoting such coordination by aligning financial incentives. California is expanding coordinated care throughout its health systems, with many pilot projects being implemented across the state to increase integration of primary care and mental health services at the service delivery level. (See sidebar.)

Projects in California Promoting Behavioral Health Integration

California's Coordinated Care Initiative was adopted in 2012 to be implemented in 2014 to promote integration of medical, long-term services and supports, and behavioral health care.

County Medical Services Plan (CMSP) Behavioral Health Pilot Project was a three-year project implemented from 2008 to 2011 in 15 of 34 rural CMSP counties. The project enhanced covered behavioral health services and saw a decrease in hospitalization and emergency department use.[145]

Frequent Users of Health Services Initiative was a $10 million project from 2003 to 2008, funded by The California Endowment and the California HealthCare Foundation, focused on improving health outcomes for frequent users of health services and avoiding unnecessary use of emergency departments.[146]

Integrated Behavioral Health Project is a statewide initiative started in 2006 with funding from The California Endowment and the Tides Center to focus on advancing the goal of integrating mental health, substance use, and physical health services.[147]

SAMHSA Primary and Behavioral Health Care Integration Grants are funding ongoing projects in at least seven counties that support the integration of primary care prevention and services into behavioral health settings.[148]

One example of promoting coordination at the payer level is California's proposed "shared accountability framework" for the state's planned Cal MediConnect program, a federal demonstration project in eight counties to improve coordination of care for Medicare/Medi-Cal dual eligibles. Under the proposed model, dual eligibles could enroll in a single health plan in their county that would cover all their Medicare and Medi-Cal services, except for Medi-Cal specialty mental health services, which will remain carved out of each plan's benefit packages. To ensure that enrollees have seamless access to all needed mental health services, the state made a portion of the health plans' capitation payment contingent upon meeting certain quality measures related to coordination with the MHPs.[149]

Another potential opportunity to promote coordination of physical and mental health care under the ACA is a financing option for states to design health homes for Medi-Cal beneficiaries with chronic conditions. Under this option, the state could receive a two-year enhanced (90%) federal match for health home services that today are not reimbursable under Medi-Cal, such as joint care plan development, interdisciplinary care team meetings, and colocation of services.[150]

VI. Conclusion

Public programs and agencies are the primary payers for and providers of mental health services across the nation and in California. California has an expansive Medi-Cal mental health services package and a robust, community-based delivery system compared to many other states. For people with severe mental illness, the California public mental health system offers rehabilitative, recovery-focused care. However, many Medi-Cal beneficiaries and uninsured adults with less severe mental health conditions face significant gaps both in coverage and in access to services.[151]

State law and regulation in California shape the public mental health delivery structure, but nearly all financial and administrative responsibility for delivering mental health services has been transferred to the 58 counties. This means that decisions about program design and operations are made closer to the point of service, which may offer the ability to match services to local needs. But this decentralization also leads to wide variation from county to county in program operations, quality, and service availability. Tracking and comparing county performance is difficult due to the lack of uniform statewide performance metrics and a comprehensive, transparent reporting system.

Each year the state transfers dedicated mental health funding to counties based on a set amount of tax revenue. Counties use these funds to pay directly for mental health services and to draw down federal Medicaid reimbursement. Counties must provide specialty mental health services to all Medi-Cal beneficiaries who meet the medical necessity criteria. They provide mental health services to non-Medi-Cal beneficiaries with any remaining resources. Over time, counties have used increasing portions of their realignment money (funds shifted from the state to the counties) as the nonfederal match for Medi-Cal services, leaving MHSA revenue as the primary funding source for non-Medi-Cal services.

As in many other states, funding for California's public mental health system is "carved out," or disconnected, from the rest of public health care system funding. As a result, people with mental health needs often must navigate two systems for care. There is increasing emphasis, driven by federal, state and local policymakers, to improve coordination of these systems and to increase integration of physical and mental health services. Understanding how public mental health services are financed and administered in California will be essential to move these discussions forward.

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Appendix A. Matrix of California's Public Mental Health Programs, Services, and Funding

	FUNDING SOURCE(S)	SUMMARY	SERVICES	ELIGIBLE POPULATION
Medi-Cal Specialty Mental Health Services	• 2011 realignment • MHSA • 1991 realignment • Federal matching reimbursement	Starting in 2012–13, dedicated sales tax revenues were established under the 2011 realignment. These funds cover counties' federal certified public expenditure match obligations for services specified under the state's 1915(b) waiver and the Rehabilitation Services and Targeted Case Management state plans. Counties incur the full expenditure and then claim federal reimbursement, subject to final cost settlement. The Federal Medical Assistance Percentage determines the amount of federal reimbursement per category of service. Generally, services are reimbursed at a 50% rate. Services for youths 18 and younger who qualify under the State Children's Health Insurance Program (SCHIP, formerly Healthy Families) receive a 65% matching rate.	Medically necessary services as specified in the state's Medicaid Plan under the Rehabilitation Option and Targeted Case Management, and subject to the conditions of the 1915(b) Medi-Cal Specialty Mental Health Services waiver. These include: • Rehabilitative outpatient mental health services • Psychiatric inpatient hospital services • Targeted case management services • EPSDT services, including therapeutic behavioral services for beneficiaries under 21 years of age	Adults enrolled in Medi-Cal who meet clinical eligibility criteria in regulation: 9 CCR §§ 1805.210 and 1830.205 *Diagnosis*. The person must have one or more of 18 specified diagnoses. *Impairment*. The mental disorder must result in significant impairment or probability of significant deterioration in an important area of life functioning. *Intervention*. The services must address the impairment, be expected to significantly improve the condition, and a physical health care–based treatment would not work. For youths under 21, a probability that the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated or when specialty mental health services are necessary to correct or ameliorate a defect, mental illness, or condition of a child.
Medi-Cal psychotherapeutic pharmacy	• State General Fund • Federal matching reimbursement	DHCS maintains responsibility for managing prescription drug services, partially to take advantage of bulk purchasing and available rebates.	Prescription drugs	Medi-Cal beneficiaries (For indigent clients, counties provide pharmacy several ways, including drug company patient assistance programs and direct contracts with pharmacies using 1991 realignment and local funds.)

	FUNDING SOURCE(S)	SUMMARY	SERVICES	ELIGIBLE POPULATION
Medi-Cal primary-case based mental health services	• State General Fund • Federal matching reimbursement	Limited services are available for individuals who do not meet medical necessity criteria for Medi-Cal specialty mental health services.	Outpatient services in primary care Federally Qualified Health Center services (psychiatrist, nurse practitioner, LCSW, psychologist)	Medi-Cal beneficiaries
Safety-net services to medically indigent population and non-reimbursable services to Medi-Cal beneficiaries	• 1991 realignment • County general fund	Under the 1991 Bronzan-McCorquodale Act, dedicated revenues are deposited directly into local fund accounts for mental health services. The base and growth allocations are determined by formula set in statute. The base allocation and growth distribution amounts and formulas were updated during the 2011 realignment. County responsibilities for 1991 realignment are set in statute. Generally, 1991 realignment is a very flexible funding source. This is counties' primary funding source for caring for the indigent. In order to receive the 1991 realignment funding, counties must provide a set amount of services, known as "maintenance of effort." Counties may use 1991 realignment as the local match for federal Medicaid reimbursement. Thus, the budgeted allocation overlaps some with the budget for Medi-Cal specialty mental health services.	To the extent resources are available, counties provide the following services to target populations: • Crisis care • Assessments • Medication support • Case management • Vocational rehabilitation • Long term nursing care • 24-hour care in state hospitals, institutes for mental disease, and community-based acute hospitals	Target populations for 1991 realignment funded services include: • Children and adolescents with SED* • Adults with SMI†

	FUNDING SOURCE(S)	SUMMARY	SERVICES	ELIGIBLE POPULATION
Mental Health Services Act (Prop. 63)	1% state tax on incomes greater than $1 million	Revenues are distributed directly to counties, with no more than 3.5% used for state-level administration. County allocations are based on total population, households with incomes below 200% FPL, percentage uninsured, and prevalence of mental illness. This is adjusted based on cost of living and existing resources. Counties with fewer than 200,000 residents receive a set amount. MHSA funds are intended to be the payer of last resort, and law requires maintenance of effort toward existing entitlements. MHSA funds may be used as the certified public expenditure to draw down federal Medicaid reimbursement. Thus, it overlaps with the Medi-Cal specialty mental health service budget.	MHSA service categories: • Community services and supports, including full-service partnerships • Prevention and early intervention • Capital facilities and technology needs • Workforce education and training • Innovation	• Children and adolescents with SED* • Adults with SMI† • Children, transition-age youth, and adults who are unserved, underserved, or inappropriately served (e.g., homeless, frequent users of hospitals, individuals with criminal justice history)
Low-Income Health Program	• 1991 realignment • County general funds • Federal matching reimbursement	Under the Sec. 1115 Bridge to Reform Medi-Cal waiver, counties may elect to operate a LIHP to expand health coverage. Participation requires a minimum mental health benefit. As of May 2012, 50 counties operated LIHPs, and 383,000 low-income adults were enrolled in county LIHPs.	Benefits vary by county. Minimum required benefits: • Up to 10 days per year of acute psychiatric inpatient care • Psychiatric medications • Up to 12 outpatient encounters per year (assessment, therapy, crisis intervention, and medication support)	Early Medi-Cal expansion population, primarily childless adults earning up to 133% of the FPL who are otherwise receiving services through county indigent programs
School-based mental health services (formerly AB 3632 services)	• Proposition 98 state education funding • Federal special education funding	Starting in 2012, responsibility for providing mental health services under the federal Individuals with Disabilities Education Act (IDEA) became the responsibility of schools.	• Individual or group psychotherapy • Medication monitoring • Intensive day treatment • Case management • Day rehabilitation • Residential placement	Students with disabilities who have a current individualized education program (IEP) on file

	FUNDING SOURCE(S)	SUMMARY	SERVICES	ELIGIBLE POPULATION
Medicare	Federal funds	*Medicare Part A* applies to inpatient psychiatric hospitalization. *Medicare Part B* applies to physician visits and outpatient services. *Medicare Part C* includes Parts A and B benefits delivered through Medicare Advantage health plans. *Medicare Part D* applies to prescription pharmacy.	Medicare's benefits are more medical and less rehab-focused than Medi-Cal. Medicare can cover inpatient psychiatric hospitalization, pharmacy, and treatment by a psychiatrist or psychologist in an office setting.	People with Medicare, including people who have both Medicare and Medi-Cal (dual eligibles)

*Serious Emotional Disturbance: A child or adolescent is considered to have a serious emotional disturbance if he or she has an identified mental disorder that results in behavior inappropriate to the child's age, has substantial impairment in at least two areas (self-care, school functioning, family relationships, ability to function in the community), is either at risk of removal from the home or has already been removed, the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment, and presents psychotic features, risk of suicide, or risk of violence due to the mental disorder.

†Serious Mental Illness: Adults are considered to have a serious mental illness if they have an identified mental disorder that is severe, persistent, and interferes substantially with the primary activities of daily living, and may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time.

Appendix B. California Public Mental Health Service Funding Timeline

1950s and 1960s: The Launch of California's Community Mental Health System

Pre-1957. *State Hospitals.* State funding for mental health services was concentrated on eight state hospitals that served roughly 36,000 mental health patients.

1957. *Short-Doyle Act.* Created a delivery system for community mental health services managed by counties to replace large, state-run institutions. The state provides matching funds to counties and cities for delivering mental health services.

1966. *Medi-Cal.* The state-run Medi-Cal program was created under the federal Title XIX Medicaid amendment to the Social Security Act. Medi-Cal covers minimal mental health services.

1968. *Lanterman-Petris-Short Act.* A milestone in protecting rights of people with mental illness and moving toward deinstitutionalization. The act requires counties with more than 100,000 residents to provide mental health services and increases the Short-Doyle funding ratio to 90% state funds and 10% county funds.

1970s and 1980s: Increasing State Requirements, Declining State Funding

1971. *Expanded Medi-Cal.* Some Short-Doyle community mental health services were added as Medi-Cal benefits, enabling counties to obtain additional federal reimbursement for costs of treating Medi-Cal beneficiaries. The fee-for-service Medi-Cal program still covered psychiatric inpatient hospital services, psychiatrist and psychologist professional services, and nursing facility services.

1974. *Mandatory County Programs.* Legislature required all counties to have mental health programs.

1976. *Equity Distribution of Funding.* Legislature adopted an "equity distribution" formula for three years to allocate new funds to counties as a result of the underfunding of some counties. Los Angeles, San Diego, Riverside, and San Bernardino Counties received about half the funds.

1984. *Equity Distribution of Funding Revisited.* State Department of Mental Hygiene developed a "poverty/population model" to allocate funds to counties.

1984. *AB 3632.* The state created a new program to fulfill the federal Individuals with Disabilities Education Act requirements for youth with mental health needs. Counties were responsible for providing these services funded by the state allocations.

1988. *Wright-McCorquodale-Bronzan Mental Health Act.* Demonstration projects were established to test the effectiveness of community-based, integrated service systems of care for adults with serious mental illness.

1989. *Targeted Case Management SPA.* California expanded Medi-Cal mental health services by adding a state plan amendment (SPA) for targeted case management.

1989–90. *State Budget Shortfalls.* State was in a period of economic recession, and counties received no new state General Fund allocations for mental health.

1990s: Realignment and Consolidation

1991. *Bronzan-McCoquodale Act.* Facing a $14 billion state budget shortfall, the legislature "realigned" administrative and funding responsibilities for several programs, including mental health, to the counties. This new law replaced Short-Doyle, changed state-county cost sharing ratios in health and social service programs, and created a dedicated revenue stream of a new sales tax and vehicle license fees.

1993. *Rehabilitation Option SPA.* California again increased covered Medi-Cal mental health services through a state plan amendment to include the "Rehabilitation Option." The Rehab Option added Medi-Cal benefits and expanded the range of personnel who could provide services and the locations at which Medi-Cal services could be delivered. The SPA also enhanced counties' ability to get federal Medicaid reimbursement.

1995. *Enhanced EPSDT Mental Health Services.* In response to legal action, California expanded mental health services delivered through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program by providing state matching funds to counties.

1995–1998. *Medi-Cal Specialty Mental Health Services Consolidation.* Through a 1915(b) "freedom of choice" Medicaid waiver, the state consolidated the two mental health funding streams — community-based Short-Doyle/Medi-Cal and the state-administered fee-for-service Medi-Cal — into one Medi-Cal Mental Health Managed Care Program. Under the waiver, Medi-Cal specialty mental health services were available only through Mental Health Plans (MHPs) under contract with the state Department of Health Services. Counties had the "first right of refusal" to become a Mental Health Plan. Two counties each joined with another county, so there were 56 MHPs across the state.

1999. *Assembly Bill 34.* The Legislature authorized grants totaling $9.5 million for pilot programs in Los Angeles, Sacramento, and Stanislaus Counties to provide services for severely mentally ill adults who are homeless, recently released from jail or prison, or at risk of being homeless or incarcerated in the absence of services. The program was expanded to all counties the next year.

2000–2010: Mental Health Services Act and Multibillion-Dollar Budget Deficits

2000. *Assembly Bill 88.* California's mental health parity law required health plans to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age and for the serious emotional disturbances of a child under the same terms and conditions applied to all other covered medical conditions.

2001. *Assembly Bill 1424.* The Lanterman-Petris-Short Act of 1968 was modified, and now mandated that mental health departments, law enforcement agencies, and court systems consider a patient's psychiatric history.

2003. *Assembly Bill 1421 "Laura's Law".* Court-ordered, assisted outpatient treatment permitted for people with severe mental illness.

2004. *Mental Health Services Act.* The voters of California passed Proposition 63, the Mental Health Services Act (MHSA). The MHSA is funded through a 1% state income tax on personal income in excess of $1 million. The MHSA addresses a broad continuum of prevention, early intervention, and service needs, plus necessary infrastructure, technology, and training elements.

2007–2010. *State Budget Shortfalls.* The nation and state were in a period of economic recession. Counties experienced cuts in state General Fund allocations, and their 1991 realignment base allocation stagnated.

FY 2007–08. *Budget Cuts.* Governor Schwarzenegger vetoed all $55 million in state funding for the AB 2034 Integrated Services for Homeless Adults, the highly successful program on which the MHSA was based.

2008. *Mental Health Parity and Addiction Equity Act of 2008.* This federal law ensures access to health care for those with behavioral health problems equal to those with physical health problems.

2010. *Patient Protection and Affordable Care Act (ACA).* Congress passed and President Obama signed into law the most significant government expansion and regulatory overhaul of the United States health care system since the creation of Medicare and Medicaid in 1965.

2011–2013: Realignment Revisited

2011. *Realignment II.* The state realigned to the counties all remaining General Fund obligations for community mental health services. Representing a roughly $1 billion transfer of financial responsibility, the EPSDT and Medi-Cal managed care programs now would be funded through sales tax revenue distributed directly to counties. The transition relied on a one-time use of $760 million in MHSA funds.

2011–2013. *Implementation of the Low-Income Health Program (LIHP).* 54 counties chose to implement the LIHP, increasing coverage of mental health services to low-income, childless adults.

2011. *Elimination of the Department of Mental Health.* The legislature eliminated the Department of Mental Health, created a new Department of State Hospitals, and transitioned responsibility for managing community mental health services to the Department of Health Care Services (DHCS), which oversees the Medi-Cal program.

2011. *AB 114.* The legislature repealed the mandate, dating back to 1984, requiring county mental health agencies to provide mental health services to special education students. These responsibilities were permanently shifted from county mental health to the schools.

2011–12. *"SPD" Transition.* As part of its 2010 Section 1115 Medicaid waiver, California mandatorily transitioned more than 300,000 Medi-Cal seniors and persons with disabilities into Medi-Cal managed care. Now, most Medi-Cal beneficiaries who receive county mental health services receive their health care through a Medi-Cal managed care health plan, enhancing the need for coordination with carved-out specialty mental health services.

2013. *Dual Eligibles Demonstration.* The DHCS signed a memorandum of understanding with the federal Centers for Medicare and Medicaid Services to implement a new program integrating care for people with both Medicare and Medi-Cal — dual eligibles — through managed care health plans. Medi-Cal specialty mental health services remain carved out of the new program, but closer collaboration with demonstration health plans is required.

Appendix C. County Comparison of Medi-Cal Specialty Mental Health Services (SMHS) Expenditures and Penetration Rates, 2011

	BENEFICIARIES		SPENDING			
	Number Served	Penetration Rate*	Approved Total	Average per Client	Median per Client	Average Standard Deviation
STATEWIDE	457,264	5.78%	$2,220,644,513	$4,856	$1,755	$9,375
Alameda	23,414	8.85%	$148,608,630	$6,347	$2,044	$11,698
Alpine	19	8.92%	$62,608	$3,295	$2,364	$3,348
Amador	433	8.94%	$917,135	$2,118	$1,087	$3,390
Butte	5,456	9.87%	$28,934,810	$5,303	$2,241	$10,071
Calaveras	578	8.03%	$1,683,517	$2,913	$1,178	$5,733
Colusa	443	8.55%	$2,560,994	$5,781	$2,036	$11,932
Contra Costa	12,203	8.20%	$63,177,418	$5,177	$1,398	$10,815
Del Norte	695	8.07%	$2,248,036	$3,235	$1,055	$5,586
El Dorado	1,452	7.14%	$5,444,145	$3,749	$1,592	$7,606
Fresno	11,115	3.44%	$44,545,888	$4,008	$1,505	$7,930
Glenn	563	7.42%	$2,261,228	$4,016	$1,766	$7,422
Humboldt	2,924	10.26%	$15,737,529	$5,382	$1,868	$11,855
Imperial	3,869	6.36%	$14,303,180	$3,697	$1,508	$5,789
Inyo	357	8.99%	$987,676	$2,767	$1,194	$4,247
Kern	12,834	5.17%	$44,365,586	$3,457	$1,676	$6,088
Kings	1,847	4.82%	$5,644,318	$3,056	$1,410	$5,862
Lake	884	4.60%	$5,522,131	$6,247	$1,262	$12,885
Lassen	597	11.12%	$2,062,150	$3,454	$1,550	$5,126
Los Angeles	147,637	5.87%	$849,893,926	$5,757	$2,310	$10,236
Madera	1,722	3.65%	$6,136,929	$3,564	$1,197	$7,269
Marin	1,777	7.36%	$9,787,456	$5,508	$1,900	$8,754
Mariposa	344	11.42%	$1,453,767	$4,226	$1,965	$6,421
Mendocino	1,544	6.34%	$12,267,150	$7,945	$2,687	$12,764
Merced	3,018	3.47%	$9,498,649	$3,147	$1,052	$6,999
Modoc	179	8.10%	$325,207	$1,817	$700	$2,817
Mono	85	5.69%	$193,097	$2,272	$1,057	$3,141
Monterey	4,440	4.45%	$28,268,446	$6,367	$2,132	$11,464
Napa	1,199	6.55%	$7,237,936	$6,037	$2,610	$10,004

	BENEFICIARIES		SPENDING			
	Number Served	Penetration Rate*	Approved Total	Average per Client	Median per Client	Average Standard Deviation
Nevada	1,361	11.07%	$9,809,513	$7,208	$2,015	$13,863
Orange	21,319	4.50%	$64,350,157	$3,018	$1,073	$6,464
Placer/Sierra	1,704	5.15%	$7,778,391	$4,565	$1,611	$8,101
Plumas	371	10.97%	$1,623,166	$4,375	$1,357	$8,460
Riverside	20,901	4.98%	$62,665,183	$2,998	$976	$6,789
Sacramento	18,094	5.46%	$84,591,160	$4,675	$2,240	$7,349
San Benito	803	7.35%	$2,235,490	$2,784	$1,384	$5,042
San Bernardino	25,791	5.21%	$79,600,858	$3,086	$1,152	$5,764
San Diego	31,509	6.91%	$101,091,773	$3,208	$919	$6,803
San Francisco	14,812	10.48%	$82,619,371	$5,578	$1,989	$10,666
San Joaquin	9,341	4.99%	$26,003,073	$2,784	$1,152	$5,167
San Luis Obispo	2,754	7.72%	$13,451,651	$4,884	$1,723	$10,741
San Mateo	5,950	7.50%	$23,821,898	$4,004	$1,271	$8,373
Santa Barbara	4,584	5.40%	$30,991,284	$6,761	$2,437	$11,985
Santa Clara	15,172	5.55%	$116,785,021	$7,697	$2,757	$14,823
Santa Cruz	2,852	6.41%	$29,136,602	$10,216	$5,138	$14,073
Shasta	2,997	6.83%	$11,479,123	$3,830	$1,414	$7,057
Siskiyou	1,078	9.73%	$6,124,705	$5,682	$1,811	$10,866
Solano	2,657	3.66%	$14,008,839	$5,272	$2,105	$8,889
Sonoma	2,963	4.47%	$19,508,516	$6,584	$2,556	$9,974
Stanislaus	7,057	4.94%	$27,006,147	$3,827	$1,795	$6,204
Sutter/Yuba	3,272	7.07%	$11,935,422	$3,648	$1,060	$7,026
Tehama	1,706	8.94%	$5,198,370	$3,047	$1,054	$7,178
Trinity	271	8.98%	$1,898,871	$7,007	$3,589	$13,682
Tulare	7,264	4.16%	$35,900,942	$4,942	$2,379	$8,064
Tuolumne	738	8.42%	$2,726,180	$3,694	$1,295	$7,280
Ventura	6,289	4.72%	$26,146,708	$4,158	$1,958	$7,002
Yolo	2,026	6.22%	$8,026,557	$3,962	$1,218	$8,381

*The penetration rate, defined as the proportion of Medi-Cal beneficiaries receiving specialty mental health services, is commonly used to assess access to services when compared against the estimated need for services within that population.

Notes: Includes claims processed through the following dates: Short Doyle Medi-Cal, December 10, 2012; Inpatient Consolidation (IPC), August 21, 2012; and Monthly Medi-Cal Extract File (MMEF) eligibility data, April 2, 2012. Total costs do not reflect psychiatric pharmacy costs, nor costs associated with physical health care needs, such as nonpsychiatric emergency department or inpatient hospital admissions.

Sources: APS Healthcare, California External Quality Review Organization, www.caeqro.com/webx.

Appendix D. County Comparison of Medi-Cal Specialty Mental Health Services (SMHS) Expenditures and Penetration Rates, by Age Group 2011

	AGE 0–5			AGE 6–17			AGE 18–59			AGE 60+		
	Number Served	Penetration Rate*	Average Payment	Number Served	Penetration Rate*	Average Payment	Number Served	Penetration Rate*	Average Payment	Number Served	Penetration Rate*	Average Payment
STATEWIDE	26,051	1.75%	$3,797	167,626	7.52%	$6,342	224,317	7.37%	$4,164	39,270	3.42%	$3,170
Alameda	1,387	3.17%	$7,740	7,966	12.33%	$8,433	12,058	11.43%	$5,195	2,003	3.95%	$4,020
Alpine	0	0.00%	$0	6	9.84%	$3,455	12	13.04%	$2,561	1	2.94%	$11,141
Amador	5	0.64%	$2,753	103	8.35%	$2,785	296	13.47%	$1,932	29	4.57%	$1,539
Butte	307	3.52%	$2,608	1,908	13.85%	$7,248	2,857	11.20%	$4,377	384	5.29%	$4,686
Calaveras	11	0.99%	$770	137	7.35%	$4,144	387	11.61%	$2,553	43	4.78%	$2,776
Colusa	23	1.93%	$2,109	157	10.36%	$8,183	234	12.74%	$4,414	29	4.55%	$6,717
Contra Costa	600	2.25%	$6,777	3,974	10.05%	$7,652	6,653	11.05%	$3,872	976	4.37%	$3,015
Del Norte	49	3.62%	$1,713	277	13.06%	$4,355	333	8.14%	$2,559	36	3.43%	$2,932
El Dorado	70	1.97%	$2,216	661	13.05%	$4,213	648	7.12%	$3,640	73	2.79%	$1,994
Fresno	618	0.95%	$2,401	4,162	4.24%	$4,539	5,611	4.37%	$3,975	724	2.30%	$2,579
Glenn	16	1.02%	$1,144	203	9.51%	$3,448	304	10.17%	$4,697	40	4.42%	$2,880
Humboldt	165	3.39%	$2,855	931	14.31%	$6,010	1,628	11.85%	$5,261	200	5.90%	$5,528
Imperial	112	1.07%	$2,237	1,719	10.62%	$4,581	1,794	7.83%	$3,154	244	2.16%	$2,127
Inyo	9	1.29%	$1,031	105	10.16%	$4,419	198	12.28%	$2,234	45	7.13%	$1,600
Kern	908	1.71%	$1,341	5,876	7.71%	$3,366	5,558	5.68%	$3,839	492	2.31%	$4,134
Kings	30	0.37%	$1,173	637	5.47%	$2,926	1,056	7.04%	$3,241	124	3.52%	$2,607
Lake	20	0.69%	$3,264	222	4.92%	$7,907	544	6.13%	$5,824	98	3.36%	$5,442
Lassen	9	0.97%	$1,285	165	12.42%	$4,281	397	16.06%	$3,195	26	4.08%	$2,912
Los Angeles	10,260	2.32%	$4,056	58,337	8.14%	$8,049	65,124	6.85%	$4,583	13,916	3.41%	$2,892
Madera	60	0.61%	$3,004	595	4.17%	$3,893	940	4.96%	$3,497	127	3.06%	$2,784
Marin	77	1.81%	$1,031	438	8.25%	$5,169	964	8.99%	$5,961	298	7.72%	$5,699
Mariposa	6	1.29%	$2,168	120	15.54%	$5,070	195	14.56%	$3,626	23	5.26%	$5,451
Mendocino	71	1.66%	$3,168	811	12.82%	$11,281	599	5.64%	$4,578	63	2.02%	$2,404
Merced	39	0.23%	$2,363	756	2.85%	$5,059	2,021	5.74%	$2,579	202	2.45%	$1,831
Modoc	2	0.57%	$227	39	7.34%	$2,326	125	12.95%	$1,599	13	3.53%	$2,625
Mono	0	0.00%	$0	30	6.45%	$1,795	48	8.68%	$2,380	7	6.31%	$3,571
Monterey	401	1.74%	$5,811	1,412	5.15%	$6,289	2,346	5.88%	$6,464	281	3.00%	$6,738
Napa	56	1.52%	$3,613	504	10.97%	$6,781	557	7.69%	$5,623	82	2.94%	$5,928

	AGE 0–5			AGE 6–17			AGE 18–59			AGE 60+		
	Number Served	Penetration Rate*	Average Payment	Number Served	Penetration Rate*	Average Payment	Number Served	Penetration Rate*	Average Payment	Number Served	Penetration Rate*	Average Payment
Nevada	77	3.98%	$4,859	493	16.60%	$8,242	703	12.54%	$6,577	88	4.92%	$8,505
Orange	1,196	1.26%	$1,842	8,475	6.28%	$3,594	9,913	5.96%	$2,832	1,735	2.25%	$2,083
Placer/Sierra	35	0.58%	$2,378	579	6.83%	$4,782	988	7.25%	$4,604	102	2.07%	$3,708
Plumas	5	0.93%	$1,543	125	15.92%	$5,477	213	13.91%	$3,488	28	5.30%	$6,713
Riverside	585	0.63%	$2,897	7,160	5.43%	$3,283	11,653	7.92%	$2,839	1,503	3.14%	$2,915
Sacramento	1,106	1.84%	$3,611	7,428	8.13%	$6,201	8,486	6.10%	$3,597	1,074	2.61%	$3,736
San Benito	25	1.07%	$1,931	275	8.88%	$2,856	448	10.53%	$2,749	55	4.47%	$3,092
San Bernardino	1,169	1.13%	$2,738	9,679	6.18%	$3,663	13,592	7.39%	$2,802	1,351	2.67%	$2,115
San Diego	1,795	2.01%	$1,676	11,141	8.70%	$4,347	16,045	9.67%	$2,756	2,528	3.50%	$2,149
San Francisco	262	1.68%	$4,784	2,611	10.96%	$8,246	8,787	15.66%	$5,633	3,152	6.88%	$3,279
San Joaquin	383	1.04%	$2,694	2,387	4.44%	$3,191	5,619	7.35%	$2,666	952	4.70%	$2,492
San Luis Obispo	176	2.56%	$5,348	1,021	10.76%	$7,358	1,408	9.41%	$3,200	149	3.42%	$3,300
San Mateo	247	1.64%	$2,060	1,407	7.32%	$4,032	3,333	11.93%	$4,491	963	5.62%	$2,774
Santa Barbara	463	2.36%	$2,890	1,464	6.24%	$6,279	2,256	6.81%	$7,457	401	4.62%	$9,074
Santa Clara	1,224	2.62%	$6,626	4,477	6.61%	$11,684	7,595	7.43%	$6,555	1,876	3.31%	$3,506
Santa Cruz	193	2.11%	$6,973	1,219	10.70%	$9,172	1,236	6.69%	$11,689	204	3.74%	$10,602
Shasta	104	1.47%	$2,809	1,130	10.70%	$5,335	1,569	7.62%	$3,026	194	3.41%	$2,116
Siskiyou	40	2.32%	$4,580	351	13.14%	$9,447	603	11.88%	$3,914	84	5.22%	$3,162
Solano	353	2.70%	$4,541	1,103	5.65%	$6,956	1,086	3.51%	$3,950	115	1.25%	$3,865
Sonoma	63	0.47%	$3,047	1,069	6.31%	$6,446	1,536	5.76%	$7,101	295	3.18%	$5,148
Stanislaus	388	1.43%	$1,660	3,200	7.85%	$3,469	3,097	5.31%	$4,415	372	2.24%	$4,268
Sutter/Yuba	59	0.69%	$2,752	1,039	8.21%	$5,542	1,850	9.48%	$2,752	324	5.78%	$2,854
Tehama	32	0.92%	$1,355	468	9.03%	$3,453	1,070	13.02%	$2,756	136	6.18%	$4,342
Trinity	11	2.69%	$1,709	96	13.41%	$6,719	150	10.69%	$6,969	14	2.85%	$13,556
Tulare	293	0.81%	$2,969	3,978	7.35%	$5,654	2,699	3.90%	$4,289	294	1.95%	$3,273
Tuolumne	14	1.12%	$3,574	200	9.24%	$3,642	462	11.51%	$3,793	62	4.65%	$3,152
Ventura	371	1.25%	$3,577	2,231	5.97%	$5,107	3,245	6.61%	$3,702	442	2.58%	$3,199
Yolo	71	1.19%	$2,617	569	6.36%	$5,113	1,188	9.11%	$3,733	198	4.26%	$2,507

*The penetration rate, defined as the proportion of Medi-Cal beneficiaries receiving specialty mental health services, is commonly used to assess access to services when compared against the estimated need for services within that population.

Notes: Includes claims processed through the following dates: Short Doyle Medi-Cal, December 10, 2012; Inpatient Consolidation (IPC), August 21, 2012; and Monthly Medi-Cal Extract File (MMEF) eligibility data, April 2, 2012. Total costs do not reflect psychiatric pharmacy costs, nor costs associated with physical health care needs, such as nonpsychiatric emergency department or inpatient hospital admissions.

Sources: APS Healthcare, California External Quality Review Organization, www.caeqro.com/webx.

Appendix E. County Comparison of Medi-Cal Specialty Mental Health Services (SMHS) Expenditures on High-Cost* Beneficiaries, 2011

Statewide, high-cost beneficiaries constituted less than 2.5 percent of beneficiaries served in 2011, but accounted for more than one quarter of spending. Inpatient services costs significantly drive the disproportionate service dollars attributable to the highest-cost beneficiaries.

	HIGH-COST BENEFICIARIES			
	Number Served	% Served with SMHS	% of SMHS Costs	Average Payment
STATEWIDE	11,570	2.53%	25.59%	$49,117
Alameda	1,063	4.54%	34.97%	$48,895
Alpine	0	0.00%	0.00%	$0
Amador	1	0.23%	4.01%	$36,764
Butte	168	3.08%	29.03%	$49,999
Calaveras	7	1.21%	16.68%	$40,109
Colusa	18	4.06%	38.65%	$54,992
Contra Costa	441	3.61%	34.85%	$49,928
Del Norte	4	0.58%	7.38%	$41,474
El Dorado	24	1.65%	22.10%	$50,130
Fresno	217	1.95%	22.82%	$46,841
Glenn	10	1.78%	20.60%	$46,577
Humboldt	92	3.15%	33.34%	$57,038
Imperial	32	0.83%	8.89%	$39,716
Inyo	2	0.56%	6.70%	$33,079
Kern	135	1.05%	13.69%	$45,003
Kings	20	1.08%	15.34%	$43,290
Lake	51	5.77%	46.53%	$50,380
Lassen	5	0.84%	8.48%	$34,960
Los Angeles	4,385	2.97%	25.76%	$49,918
Madera	25	1.45%	19.44%	$47,727
Marin	48	2.70%	20.62%	$42,053
Mariposa	6	1.74%	14.33%	$34,725
Mendocino	109	7.06%	39.70%	$44,683
Merced	47	1.56%	21.78%	$44,011
Modoc	0	0.00%	0.00%	$0
Mono	0	0.00%	0.00%	$0
Monterey	195	4.39%	33.99%	$49,271
Napa	40	3.34%	26.70%	$48,321

	HIGH-COST BENEFICIARIES			
	Number Served	% Served with SMHS	% of SMHS Costs	Average Payment
Nevada	69	5.07%	38.69%	$55,003
Orange	225	1.06%	17.30%	$49,484
Placer/Sierra	40	2.35%	21.84%	$42,477
Plumas	5	1.35%	15.42%	$50,064
Riverside	267	1.28%	20.34%	$47,732
Sacramento	291	1.61%	15.60%	$45,337
San Benito	4	0.50%	9.19%	$51,345
San Bernardino	228	0.88%	12.35%	$43,101
San Diego	442	1.40%	19.15%	$43,808
San Francisco	523	3.53%	31.43%	$49,649
San Joaquin	67	0.72%	10.84%	$42,071
San Luis Obispo	82	2.98%	33.22%	$54,500
San Mateo	139	2.34%	27.00%	$46,272
Santa Barbara	232	5.06%	36.43%	$48,662
Santa Clara	895	5.90%	42.48%	$55,425
Santa Cruz	217	7.61%	36.72%	$49,302
Shasta	38	1.27%	16.00%	$48,321
Siskiyou	34	3.15%	29.52%	$53,169
Solano	66	2.48%	22.05%	$46,798
Sonoma	130	4.39%	27.53%	$41,308
Stanislaus	84	1.19%	13.14%	$42,240
Sutter/Yuba	44	1.34%	16.90%	$45,854
Tehama	18	1.06%	18.41%	$53,160
Trinity	10	3.69%	29.46%	$55,940
Tulare	128	1.76%	17.05%	$47,821
Tuolumne	14	1.90%	22.13%	$43,094
Ventura	89	1.42%	15.46%	$45,413
Yolo	44	2.17%	25.94%	$47,315

*Annual SMHS costs greater than $30,000. Total costs do not reflect psychiatric pharmacy costs, nor costs associated with physical health care needs, such as nonpsychiatric emergency department or inpatient hospital admissions.

Sources: APS Healthcare, California External Quality Review Organization, www.caeqro.com/webx.

Appendix F. County Comparison of Provision of EPSDT Mental Health Services, 2011

	EPSDT BENEFICIARIES				EPSDT FOSTER CARE BENEFICIARIES		
	Number Served	Penetration Rate*	Approved Claims	Average Spending / Claim	Number Served	Penetration Rate*	Average Spending / Claim
STATEWIDE	223,166	5.98%	$1,250,767,437	$5,605	35,189	55.88%	$6,977
Alameda	10,986	9.99%	$85,995,903	$7,828	1,423.00	67.38%	$11,352
Alpine	6	6.38%	$20,731	$3,455	0	0.00%	$0
Amador	132	6.35%	$331,409	$2,511	20.00	47.62%	$5,058
Butte	2,581	10.90%	$16,139,480	$6,253	434.00	64.58%	$6,148
Calaveras	184	5.83%	$593,799	$3,227	26.00	30.23%	$3,841
Colusa	221	8.45%	$1,522,988	$6,891	21.00	56.76%	$10,966
Contra Costa	5,318	8.03%	$36,190,659	$6,805	658.00	58.28%	$10,571
Del Norte	374	10.24%	$1,358,260	$3,632	59.00	57.84%	$4,396
El Dorado	824	9.46%	$3,132,555	$3,802	148.00	55.43%	$6,176
Fresno	5,469	3.23%	$22,103,069	$4,042	1,250.00	54.42%	$5,143
Glenn	267	7.36%	$881,285	$3,301	32.00	41.03%	$3,434
Humboldt	1,293	11.14%	$6,743,926	$5,216	170.00	55.37%	$11,354
Imperial	2,135	7.52%	$9,120,560	$4,272	112.00	36.13%	$5,538
Inyo	147	8.30%	$548,656	$3,732	16.00	57.14%	$5,312
Kern	7,634	5.95%	$22,631,349	$2,965	1,086.00	47.26%	$3,962
Kings	790	3.95%	$2,038,286	$2,580	125.00	30.41%	$3,262
Lake	291	3.82%	$1,798,013	$6,179	66.00	36.07%	$9,402
Lassen	231	9.73%	$895,294	$3,876	37.00	47.44%	$3,322
Los Angeles	77,919	6.68%	$546,224,082	$7,010	13,173.00	61.41%	$6,263
Madera	792	3.30%	$2,635,381	$3,328	103.00	46.82%	$7,017
Marin	592	6.40%	$2,564,549	$4,332	48.00	50.00%	$5,725
Mariposa	144	11.27%	$683,250	$4,745	27.00	64.29%	$5,362
Mendocino	1,048	9.83%	$10,391,654	$9,916	189.00	64.07%	$17,617
Merced	1,013	2.24%	$4,082,843	$4,030	128.00	20.35%	$10,558
Modoc	64	7.03%	$81,338	$1,271	3.00	25.00%	$1,258
Mono	39	5.14%	$74,024	$1,898	4.00	33.33%	$1,730
Monterey	2,131	4.35%	$12,701,754	$5,960	379.00	101.90%	$11,879
Napa	676	8.27%	$4,028,999	$5,960	108.00	66.26%	$8,985

	EPSDT BENEFICIARIES				EPSDT FOSTER CARE BENEFICIARIES		
	Number Served	Penetration Rate*	Approved Claims	Average Spending / Claim	Number Served	Penetration Rate*	Average Spending / Claim
Nevada	635	12.61%	$4,575,136	$7,205	107.00	81.68%	$9,806
Orange	11,200	4.96%	$35,246,595	$3,147	1,129.00	54.07%	$4,471
Placer/Sierra	730	4.98%	$3,040,476	$4,165	182.00	59.67%	$5,307
Plumas	159	12.07%	$744,674	$4,683	46.00	70.77%	$3,643
Riverside	9,198	4.22%	$27,044,967	$2,940	1,720.00	38.64%	$3,202
Sacramento	9,790	6.25%	$54,549,557	$5,572	1,712.00	52.77%	$8,273
San Benito	342	6.52%	$899,312	$2,630	32.00	36.36%	$6,149
San Bernardino	12,660	4.81%	$38,623,603	$3,051	2,210.00	45.65%	$4,176
San Diego	14,794	6.99%	$55,019,671	$3,719	2,175.00	65.10%	$6,689
San Francisco	3,432	8.48%	$25,115,697	$7,318	818.00	60.77%	$12,835
San Joaquin	3,366	3.68%	$9,290,095	$2,760	612.00	47.19%	$2,969
San Luis Obispo	1,355	8.52%	$8,686,179	$6,410	257.00	72.19%	$9,662
San Mateo	2,016	6.10%	$7,268,202	$3,605	261.00	79.82%	$5,934
Santa Barbara	2,141	5.16%	$11,835,939	$5,528	364.00	62.54%	$5,800
Santa Clara	6,659	5.75%	$66,140,188	$9,932	861.00	63.45%	$20,939
Santa Cruz	1,664	8.16%	$14,668,722	$8,815	291.00	93.87%	$14,229
Shasta	1,428	7.84%	$6,532,871	$4,575	257.00	46.14%	$6,663
Siskiyou	461	10.51%	$3,949,382	$8,567	74.00	67.27%	$8,862
Solano	1,660	4.89%	$10,484,251	$6,316	256.00	61.39%	$8,204
Sonoma	1,335	4.52%	$7,816,545	$5,855	214.00	39.93%	$8,294
Stanislaus	4,078	5.77%	$12,660,084	$3,104	373.00	56.52%	$5,224
Sutter/Yuba	1,269	5.84%	$6,140,341	$4,839	124.00	43.21%	$8,068
Tehama	624	7.08%	$1,886,006	$3,022	104.00	47.06%	$3,734
Trinity	125	10.66%	$726,200	$5,810	28.00	63.64%	$3,827
Tulare	4,727	5.19%	$24,424,055	$5,167	501.00	45.59%	$7,256
Tuolumne	261	7.39%	$838,424	$3,212	29.00	25.66%	$4,430
Ventura	3,006	4.55%	$13,750,078	$4,574	493.00	60.20%	$8,196
Yolo	750	5.15%	$3,296,090	$4,395	114.00	40.71%	$5,989

*The penetration rate, defined as the proportion of Medi-Cal beneficiaries receiving specialty mental health services, is commonly used to assess access to services when compared against the estimated need for services within that population.

Notes: Includes claims processed through the following dates: Short Doyle Medi-Cal, December 10, 2012; Inpatient Consolidation (IPC), August 21, 2012; and Monthly Medi-Cal Extract File (MMEF) eligibility data, April 2, 2012. Claims do not reflect psychiatric pharmacy costs, nor costs associated with physical health care needs, such as nonpsychiatric emergency department or inpatient hospital admissions.

Sources: APS Healthcare, California External Quality Review Organization, www.caeqro.com/webx.

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