



CalMHSAs, CBHDA and CIBHS STRATEGIC PLANNING SESSION

California Mental Health Service Authority
(CalMHSAs)

Executive Committee Meeting Agenda

Friday, March 13, 2015

8:00 a.m. – 3:00 p.m.

Doubletree Sacramento Hotel

2001 Point West Way

Sacramento, CA 95815

(916) 924-4900

(Business Casual Dress)

California Mental Health Services Authority (CalMHSA)

**CalMHSA, CBHDA and CIBHS STRATEGIC PLANNING SESSION
AND EXECUTIVE COMMITTEE MEETING**

Friday, March 13, 2015

7:00 a.m. – 3:00 p.m.

In compliance with the Americans with Disabilities Act, if you are a disabled person and you need a disability-related modification or accommodation to participate in this meeting, please contact Laura Li at (916) 859-4818 (telephone) or (916) 859-4805 (facsimile). Requests must be made as early as possible, and at least one full business day before the start of the meeting.

Materials relating to an item on this agenda submitted to this Board after distribution of the agenda packet are available for public inspection at 3043 Gold Canal Drive, Suite 200, Rancho Cordova, CA, 95670, during normal business hours.

FRIDAY, MARCH 13, 2015

7:00 a.m. – 8:00 a.m.	Full Breakfast
8:00 a.m. – 8:15 a.m.	WELCOME AND PRESIDENTS' MESSAGES (<i>Maureen Bauman, Mary Hale, and Mark Refowitz</i>)
8:15 a.m. – 8:25 a.m.	CALL THE MEETING TO ORDER, ROLE CALL AND OPEN FOR PUBLIC COMMENT
8:25 a.m. – 10:15 a.m.	GOALS FOR THE DAY REPORT ON S.W.O.C. FROM ALL MEMBERS' MEETING AND DISCUSSION
10:15 a.m. – 10:30 a.m.	Break
10:30 a.m. – 12:00 p.m.	IDENTIFY THE ROLES OF EACH ORGANIZATION IN COLLABORATING FOR SUCCESS
12:00 p.m. – 1:00 p.m.	Lunch
1:00 p.m. – 2:00 p.m.	SOLIDIFY AGREEMENT ON THE ROLES AND RESPONSIBILITIES AND IDENTIFY THE PROCESS FOR DECISION-MAKING
2:00 p.m. – 2:45 p.m.	DEVELOP PROPOSED PLAN FOR ACTION AT A LATER MEETING
2:45 p.m. – 3:00 p.m.	WRAP-UP <ul style="list-style-type: none">• Next steps
3:00 p.m.	ADJOURN



California Mental Health Service Authority
(CalMHSA)
Executive Committee Meeting Agenda
Friday, March 13, 2015
8:00 a.m. – 3:00 p.m.

Doubletree Sacramento Hotel
2001 Point West Way
Sacramento, CA 95815
(916) 924-4900
(Business Casual Dress)

In compliance with the Americans with Disabilities Act, if you are a disabled person and you need a disability-related modification or accommodation to participate in this meeting, please contact Laura Li at (916) 859-4818 (telephone) or (916) 859-4805 (facsimile). Requests must be made as early as possible, and at least one full business day before the start of the meeting.

Materials relating to an item on this agenda submitted to this Committee after distribution of the agenda packet are available for public inspection at 3043 Gold Canal Drive, Suite 200, Rancho Cordova, CA, 95670, during normal business hours.

1. CALL TO ORDER

2. ROLL CALL AND INTRODUCTIONS

3. INSTRUCTIONS FOR PUBLIC COMMENT AND STAKEHOLDER INPUT – The Executive Committee welcomes and encourages public participation in its meetings. This time is reserved for members of the public (including Stakeholders) to address the Committee concerning matters on the Agenda, however due to duration and single issue on this agenda time will be limited to two minutes per person and ten minutes total.

For Agenda items, public comment will be invited at the time those items are addressed. Each interested party is to indicate their interest at the request of the Chair upon conclusion of Committee discussion of each item. When it appears there are several members of the public wishing to address the Committee on a specific item, at the outset of the item, the Committee Chair may announce the maximum amount of time that will be allowed for presentation of testimony on that item.

4. STRATEGIC PLANNING SESSION

5. ADJOURNMENT

ORGANIZATION OVERVIEW

Structure Description(s)	CaIMHSA	Purpose	CBHDA	Purpose	CIBHS	Purpose
Organization Type	Joint Powers Authority (JPA), Section 6500 et seq.	A government entity among California Counties to obtain and administer public funds to provide certain community mental health services to persons residing within the same counties and cities. Members jointly develop, fund and implement mental health services, projects, and educational programs at the state, regional and local levels.	501c(4)	Civic leagues or organizations for profit but operated exclusively for the promotion of social welfare and the membership of which is limited to the employees of designated person(s) in a particular municipality, and the net earnings of which are devoted exclusively for the promotion of social welfare.	501c(3)	Non-profit organization approved by IRS as a tax-exempt, charitable organization. "Charitable" is broadly defined as being established for purposes that are religious, educational, charitable, scientific, literary, testing for public safety, fostering of national or international amateur sports, or prevention of cruelty to animals and children.
Funding Source	Program Participation		100% Dues Support		County/CBO/State Contracts and Grants	
Membership	Counties & Cities		County Behavioral/Mental Health Directors & Two Cities		Local Behavioral/Mental Health Directors; Stakeholders; Consumers; Family Members; public	

COLLABORATIVE PROJECTS

PROJECT/ PROGRAM	PURPOSE	POSITIVE COLLABORATION	AREAS OF IMPROVMENT
<p>Statewide Prevention and Early Intervention (PEI) Projects</p>	<ul style="list-style-type: none"> In January 2011, CalMHSAs Work Plan was approved by MHSOAC for the purpose of implementing \$129 million in Prevention and Early Intervention project to reduce suicides, stigma and discrimination, and improve student mental health CalMHSAs contracted with 26 Program Partners to execute the Work Plan 	<ul style="list-style-type: none"> CBHDA Members determined the Statewide PEI county funding would be most effective implemented through a single administrative entity through a Joint Powers Authority CalMHSAs (JPA) was formed in July 2009 CIBHS was the lead in the Subject Matter Expert selection process and convening of review panels for RFP Proposals An expedited RFP and contract process resulted in 25 contracts put in place with clear deliverable. The early indications are that these state wide programs are resulting in positive outcomes 	<ul style="list-style-type: none"> Changing leadership Reaching each county at the Director level Facilitate better coordination with counties local PEI programs and providers. Identification and increased dissemination of specific positive outcomes at the local level Improve understanding of county operation Increased collaboration between CalMHSAs, CBHDA and CIBHS Create briefing on paradigm shift of this public health approach to Mental Health promotion
<p>State Hospital Beds</p>	<ul style="list-style-type: none"> JPA acting on behalf of member counties (and non-member counties via a contractual agreement) in the development of a joint MOU with the Department of State Hospitals (DSH) for a statewide utilization of state hospital beds. This allows for the JPA to collectively negotiate 	<ul style="list-style-type: none"> CBHDA asked for our involvement when DSH went to a three tier rate structure and increased rate dramatically CalMHSAs form a State Hospital Bed Committee which included CBHDA staff and County Staff In collaboration with CBHDA, staff was able to convene many meetings 	<ul style="list-style-type: none"> Joint Contracting Process is Slow Delay in Funding Finalize RFI and RFP process based on extensive work of DSH workgroup. Develop implementation work plan to include selection of vendor, facility financing, and

	term, including bed rates, utilization, flow of funds, and standards of care	with DSH, State Controller's Office, and Department of Finance	county specific process for buy in. <ul style="list-style-type: none"> Address common problem of going from concept to County full commitment.
Short Doyle Modernization Project	<ul style="list-style-type: none"> Transition from Short-Doyle 2 to a new billing system The intent is to migrate from the state-operated Short-Doyle 2 system to HIPAA-compliant, county-based encounter data systems that use certified vendors/systems to collect and store encounter information in a HIPAA-compliant format locally. This solution is intended to simplify the federal reimbursement process for the state and counties, and allow counties and their vendors to fully implement the federal information coding and exchange requirements. 	<ul style="list-style-type: none"> CMHDA took action on May 9, 2013, where members voted to approve the IT Committee's CMHDA/DHCS Short-Doyle 3 Feasibility Study Partnership Proposal CalMHSA Executive Committee took action on July 25, 2013 to authorize its staff to work with CMHDA and DHCS on this project CalMHSA Board took action on August 15, 2013 for approval of the allocation methodology outlined in MHSD Information Notice 13-15 for determining each county's share of the estimated \$300,000 cost for the quality improvement efforts CalMHSA is the fiscal administrator of the project 	<ul style="list-style-type: none"> Joint Contracting Process is Slow Delay in Funding Get clearer proof of concept from the beginning, project has morphed several times, over couple of years. New versions of this project should have complete timeline for completion including milestones and deliverables. Obtain assurances from DHCS that any new project directions have approval of Agency and will continue through completion of project Contact and include in project design, other interested stakeholders such as providers of service, OAC, etc.

DRAFT FOR DISCUSSION PURPOSES ONLY
CONFIDENTIAL
March 14, 2012

**COMMUNITY MENTAL HEALTH IN CALIFORNIA:
A COUNTY BUSINESS PLAN FOR THE FUTURE**

Purpose

The purpose of this document is to identify the critical issues that will impact county mental health departments and the state in the coming years. It also serves to describe and clarify the collaborative relationship that will be necessary to address these issues, both between the state and the three California county mental health-focused organizations: the California Mental Health Directors Association (CMHDA), the California Institute for Mental Health (CIMH), and the California Mental Health Services Authority (CalMHSA) (each described in more detail later in the document). The collaborative relationships necessary to address the issues and priorities raised in this plan will be in addition to those that the organizations maintain as a part of their existing and ongoing operations. Largely due to the severe impact that the economic recession has had on our economy, our national, state and local governmental systems are in the process of intense change and re-structuring, in order to be more efficient with scarce public dollars. As this process occurs, new solutions to solving old problems must and will evolve. One such transformation that focuses specifically on the community mental health system is the evolution of the business relationship that exists between the state and the three organizations noted above. As outdated and often cumbersome governmental administrations and practices change, new paradigms of conducting the business of behavioral health must emerge. Over the past year, the development of CalMHSA and the proposed elimination of the state Departments of Mental Health and Alcohol and Drug Programs has created new possibilities and challenges for the community mental/behavioral health system. The following pages are an attempt to describe this innovative approach, and to articulate what may become a solid vehicle and business plan by which the policy development, administration and technical support of community mental/behavioral health systems will develop in the months and years to come.

Background

Through a combination of legislation, voter initiative and state administrative action, the responsibility and financial risk for the community-based public mental health system in California has progressively been transferred from the state to county mental health departments. The intent of these significant policy decisions is repeatedly stated in legislation

and initiative, but is probably best summarized in the following statement in the Bronzan-McCorquodale Act (1991 Realignment): *“This part is intended to organize and finance community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs.”* Each of these significant mental health policy initiatives also specifies that counties can act jointly through either contract with the state, or under the provisions of a joint powers authority to implement the transferred mental health obligations. This explicit acknowledgement of the potential benefit and efficiency of counties acting jointly, although in current law, has received little attention by counties from a business, programmatic, administrative and fiscal risk management perspective. As a result, counties have, for the most part, absorbed each transfer of statewide obligation and the associated funding independently, emphasizing their jurisdictional authority and geographic boundaries.

The significant Community Mental Health policy initiatives that have been adopted are:

- 1991 Mental Health Realignment
- Medi-Cal Mental Health Inpatient and Outpatient Consolidation (Medi-Cal Specialty Mental Health)
- Mental Health Services Act (Proposition 63)
- California’s Bridge to Health Reform/1115 Demonstration Waiver
- State Mental Health Administrative Reorganization Plans
- 2011 Medi-Cal Specialty Mental Health Realignment

County Opportunities and Challenges (partial list based on current experience and discussions)

1991 Realignment

- Development of a state hospital bed purchase contract and reimbursement process, under the provisions of WIC 5602, that allows Boards of Supervisors to use a JPA to purchase state hospital services from DMH.

Challenge: Currently CMHDA has attempted to facilitate contract discussions between a few counties and the state, but is hampered by a lack of legal staff, and does not have formal status as the counties’ “agent” for contract negotiations. The risk to individual counties is that the rates will be unilaterally set by the state with no fiscal justification; bed utilization is managed by each county separately with no ability to adjust use across counties; the counties do not leverage their collective purchasing power when negotiating the annual contract.

- Development of statewide or regional approaches to promoting and establishing secure Lanterman-Petris-Short (LPS) treatment facilities and alternatives in the community.

Medi-Cal Mental Health Consolidation (Medi-Cal Specialty Mental Health Program)

- Joint county negotiation of the annual Mental Health Plan contract provisions and amendments.

Challenge: CMHDA has attempted to facilitate MHP Contract negotiations using representative counties and the LA county counsel as consultants. These negotiations have been hampered by similar issues that were raised in the above state hospital bed contract negotiations. The risk to counties is that the state represents its interests consistent with its interpretation of statute and/or regulations, and counties are not able to formally exercise their collective legal remedies in a timely manner.

- Development and implementation of the supplemental federal payment structure outlined in WIC 5783, including the reimbursement of state administrative and quality improvement costs.

Challenge: The counties that elect to participate in the supplemental payment structure will be required to reimburse DHCS for their annual administrative costs. If each county needs to implement this provision individually there will be a lost opportunity to pool resources and hold the state accountable for justifying the total claimed costs.

- Development and management of statewide and county Medi-Cal financial risk and federal settlement issues under the provisions of 2011 Realignment.

Challenge: Counties will need to address the CMS requirements to detect and address under- and overutilization, both at a local level and on a statewide basis. Either can result in an individual county having either too much or not enough realignment revenue in its local “behavioral health account, emphasizing the need for reserves to be established by counties to collectively address these types of issues.

- Regional and statewide Medi-Cal resource development opportunities.

MHSA

- Pooled county funding for regional and statewide collaborative approaches to Prevention and Early Intervention (PEI), Workforce, Education and Training (WET), capital projects, technology projects, and Innovation.

Challenge: The state’s interest in having counties “assign” their MHSA funds to the department for statewide projects was covered by the assignment clause in the MHSA Agreement. This practice did not prove to be efficient, and will need to be replaced by counties acting jointly, consistent with the provisions of the Act.

- Development of collective approaches to outcomes measurement, accountability, prevalence determination and financial forecasting.

Challenge: Counties are vulnerable to negative individual and state stakeholder perception without a solid accountability and outcomes base. The need to address accountability and perform fiscal forecasting is a collective county interest that cannot effectively be addressed one county at a time. Each county will be vulnerable to negative perception and continue to defend against such perceptions until a collective story can be developed and told.

Development of collective approaches to practice improvement, implementation of evidence based practices and evaluation of community defined practices

Challenge: Counties are vulnerable to negative perception without visible and transparent methods to address practice improvement, methods of selecting and implementing evidence-based practices that are appropriate to the specific populations, and methods of selecting, implementing and evaluating community defined practices.

State Administrative Reorganization

- Development of shared governance opportunities that replace existing state-only functions, i.e., SAMHSA grant administration, performance outcomes measurement, statewide project administration.

Challenge: Many of these activities require direct contracting with state departments and the transfer of administrative oversight from the state to the counties. This may be seen as a conflict of interest in some circumstances and the financing and contracting arrangements would need to be clear and transparent.

California's Bridge to Health Reform/1115 Demonstration Waiver

- Development of common mental health coverage definitions and certified public expenditure (CPE) claiming and reporting structures.

Challenge: Each county, or counties acting jointly through the County Medical Services Program (CMSP), is designing its behavioral health coverage to meet local needs and the terms and conditions of the 1115 waiver. Once the term of the waiver is complete, the newly covered eligible beneficiaries will need to be assimilated into the existing waiver and state plan coverage provisions in effect at that time. Statewideness and other provisions that were waived during the demonstration will once again apply to these new Medi-Cal eligibles.

- Development of collaborative coverage and pooled risk management strategies, such as the County Medical Services Program (CMSP), or more focused low incidence/high utilizer projects.

Challenge: The Dual Eligibles Pilot, to be conducted by DHCS through contracts with health plans and a county plan, has intensified the focus on the relationship between capitated health plans and county MHPs. Currently, a contract is required in each county between the MHP and the health plans under CCR Title 9. There is little uniformity in the content and administration of these contracts, which hampers the development of consistent policies and procedures between counties and health plans that cross county boundaries.

- Development of shared psychiatric pharmacy risk-management and purchasing strategies.

Challenge: The terms and conditions of the 1115 waiver require that the county cover psychiatric medications for the Medi-Cal expansion population. San Mateo County has had some experience managing Medi-Cal psychiatric pharmacy, and many counties provide some non Medi-Cal pharmacy coverage. Pooled pharmacy purchasing options are available, as are agreements with pharmaceutical companies. The counties have not collectively leveraged their purchasing power thus far, but may find it valuable to explore options as the obligations expand under the 1115 waiver.

- Development of shared programmatic and practice strategies for integration of mental health, substance use disorder services, and general health.

Challenge: Health care reform and the 1115 waiver require that mental health -- and in the near future substance use disorder services -- closely coordinate or integrate with general health care. Collectively leveraging learning and process development would greatly assist counties to address the complexity of these processes.

2011 Realignment

- EPSDT service development, out-of-county placement and growth fiscal risk pools.

Challenge: The counties have not developed an effective fiscal mechanism to account for out of county placement reimbursements. 2011 Realignment will present challenges and opportunities to address statewide and individual county financial risk through the use of set-asides and risk pools that assure that funds are available to meet statewide and local Medi-Cal CPE obligations.

- Development of substance use treatment enhanced service development reserves.

Challenge: The CSAC proposed local account structure creates a blended “behavioral health account” that combines mental health and AOD revenues into one account, to be used to meet the obligations of all transferred MH and AOD programs.

- Development of alternative and additional approaches to the more effective recovery of federal financial participation (FFP).

Challenge: Short Doyle 2 has not proven to be the most effective system for drawing down federal interim CPE reimbursements. Improvements or alternatives may require leveraged investment by counties. DHCS has, for example, indicated that the creation and maintenance of a permanent production test environment may require a county contribution to implement.

- Development of regional approaches to subcontracting for specialized Medi-Cal treatment services to selected high risk populations.

Challenge: Many counties subcontract with the same private providers using separate contracts and rates. There have been successful examples of regional approaches to contracting and rate setting that could form the basis for more comprehensive approaches in the future.

- Collective approach to legal challenges, mandates filings and court actions, should they be necessary to protect county interests.

Challenge: Counties have mutual legal interests that would be best addressed collectively, but there is no current mechanism to exercise these interests other than through individual county counsels or the CSAC county counsel committee. This can hamper timely consideration and filing of legal actions that are in the best interest of all 58 counties.

Governance

Each of these initiatives also emphasizes the need to establish local community planning and input processes to assure that the mental health services provided by the county are relevant to local needs, and that the county utilizes and coordinates local resources effectively. This emphasis on local community planning is included in 1991 Realignment with the statement that the intent is “...to provide a means for participation by local government in the determination of the need for and the allocation of mental health resources under the jurisdiction of the state.” This intent for local planning and shared governance has been difficult to realize due to the significant differences in the structures and “cultures” of county and state government. The state has had difficulty shifting from an oversight and regulatory perspective to collaborative planning and implementation, while the counties have resisted collective resource management and governance, holding on to their independent jurisdictional interests. As a

result, opportunities for administrative efficiency may have been missed for both parties as these policy initiatives were implemented statewide.

- Development of shared processes for local stakeholders, including local boards and commissions, capacity building and input processes.

Challenges: The realigned responsibilities raise significant concerns among stakeholders that counties will not provide for adequate stakeholder input. Shared strategies that are visible and transparent would help to allay these concerns.

Financing/Fiscal Analysis

The financing structures for each of these community mental health policy initiatives have changed over time, but all now have certain characteristics in common. These common characteristics are:

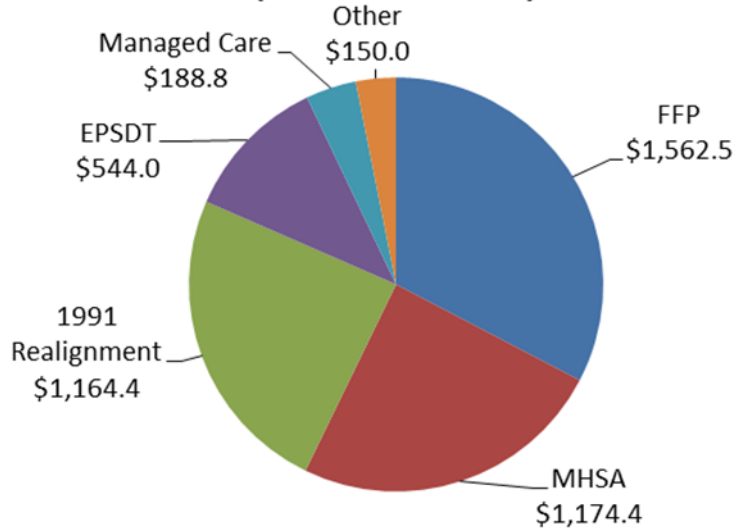
- the use of dedicated sales and income tax revenue sources;
- the ability to leverage federal Medi-Cal funds for covered services and beneficiaries;
- the assumption that counties would implement service utilization efficiencies and absorb risk;
- the requirement that expenditures be accounted for using government accounting standards.

This shift, from the use of state general funds to dedicated tax revenues, has relieved both the state and counties of the uncertainties of the annual legislative appropriations process. It has also replaced the legislative process with continuous appropriation authority, requiring formula-based allocations to be developed for each county to facilitate distribution of the dedicated tax revenues by the State Controller. Since these dedicated tax revenues are considered “counter-cyclical,” in that they tend to increase during times of economic growth and decrease during recessions (when need tends to increase), they require the use of fiscal forecasting, reserve management and other “business “approaches to ensure adequate resources are available, both locally and statewide.

The use of fiscal forecasting as a tool to plan and manage community mental health services in California is critical to developing sustainable programs. Unlike mental health programs in other states, the majority of community mental health funding is not determined based on the need for services, but on the performance of the economy. The chart below shows the estimated community mental health funding available in fiscal year (FY) 2012/13 using data from the Governor’s Proposed FY12/13 Budget.

Estimated FY12/13 Community Mental Health Funding

(Dollars in Millions)



Federal Financial Participation (FFP)

Medi-Cal FFP is one of the few community mental health revenues that are driven by expenditures. Counties are reimbursed based on actual Certified Public Expenditures (CPE) incurred in providing Medi-Cal Specialty Mental Health Services. In California, counties are generally reimbursed 50% of their actual CPE for Medi-Cal Specialty Mental Health Services. The state has imposed artificial limits through a Schedule of Maximum Allowances (SMAs) that will be eliminated in FY12/13 thereby increasing FFP reimbursement by approximately 5% statewide.

Mental Health Services Act (MHSR)

MHSR funding is derived from a one percent tax on personal income in excess of \$1 million. In order to make funding available sooner (rather than having to wait for filing and reconciliation of personal income tax returns), 1.76 percent of all personal income taxes are deposited into the state MHS Fund on a monthly basis. A subsequent reconciliation is then performed between actual tax returns and the amount deposited on a monthly basis. This allows for sufficient time for the state to process income tax returns and determine the actual amount earned by the tax. This reconciliation results in an annual adjustment which, if positive, is deposited into the state MHS Fund on July 1 or, if negative, results in a repayment to the State General Fund during the first part of the fiscal year. Thus, the amount ultimately earned by the tax is driven by the top income earners in the state, but cash flow is driven by overall personal

income tax collections. Additionally, the state MHS Fund earns interest, although the amount is estimated to be relatively immaterial in the future as distributions are made from the state MHS Fund on a monthly basis to counties. The chart below shows actual and projected revenues for the state MHS Fund on a cash basis.

MHSA Estimated Revenues^{a/}
(Cash Basis-Millions of Dollars)

	Fiscal Year									
	Actual				Estimated					
	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	
Cash Transfers	\$983.9	\$797.0	\$799.0	\$905.0	\$945.0	\$1,004.0	\$1,052.2	\$1,094.3	\$1,160.0	
Annual Adjustment	\$423.7	\$438.0	\$581.0	\$225.0	(\$64.5)	\$112.0	\$206.0	\$250.0	\$325.0	
Interest	\$94.4	\$57.6	\$14.9	\$9.7	\$2.4	\$1.3	\$0.0	\$0.0	\$0.0	
Total	\$1,502.0	\$1,292.6	\$1,394.9	\$1,139.7	\$882.9	\$1,117.3	\$1,258.2	\$1,344.3	\$1,485.0	

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

This revenue source is largely driven by capital gains income (i.e., gains from the sales of assets, such as stocks, bonds, and real estate). The revenue projections in the above chart reflect a more conservative forecast of capital gains in FY14/15 and FY15/16 than what the state is projecting as part of the FY12/13 budget. The revenue projections in the above chart are more in line with capital gains projections prepared by the Legislative Analysts' Office.

The revenue projections in the above chart also do not take into account the Facebook Initial Public Offering (IPO) anticipated for later this year. In all likelihood, the earliest the state MHS Fund would see an increase in revenues due to this IPO would be in FY13/14 in the form of higher cash transfers in April 2014 based on increased personal income tax payments for the 2013 tax year and in FY15/16 when the annual adjustment from the 2013 tax year would be posted to the Fund.

The revenue projections in the above chart then form the basis for the amount of funding available to counties for MHSA programs. The chart below shows the actual and estimated available funding for the three on-going MHSA components.

MHSA Estimated Funding for Three On-Going Components
(Millions of Dollars)

	Fiscal Year								
	Actual					Estimated			
	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
CSS	\$518.2	\$650.0	\$900.0	\$783.6	\$741.0	\$892.5	\$922.8	\$985.9	\$1,089.1
PEI	\$115.0	\$232.6	\$330.0	\$216.2	\$185.2	\$223.1	\$230.7	\$246.5	\$272.3
Innovation		\$71.0	\$71.0	\$119.6	\$48.7	\$58.7	\$60.7	\$64.9	\$71.7
Total	\$633.2	\$953.6	\$1,301.0	\$1,119.4	\$974.9	\$1,174.4	\$1,214.2	\$1,297.2	\$1,433.0

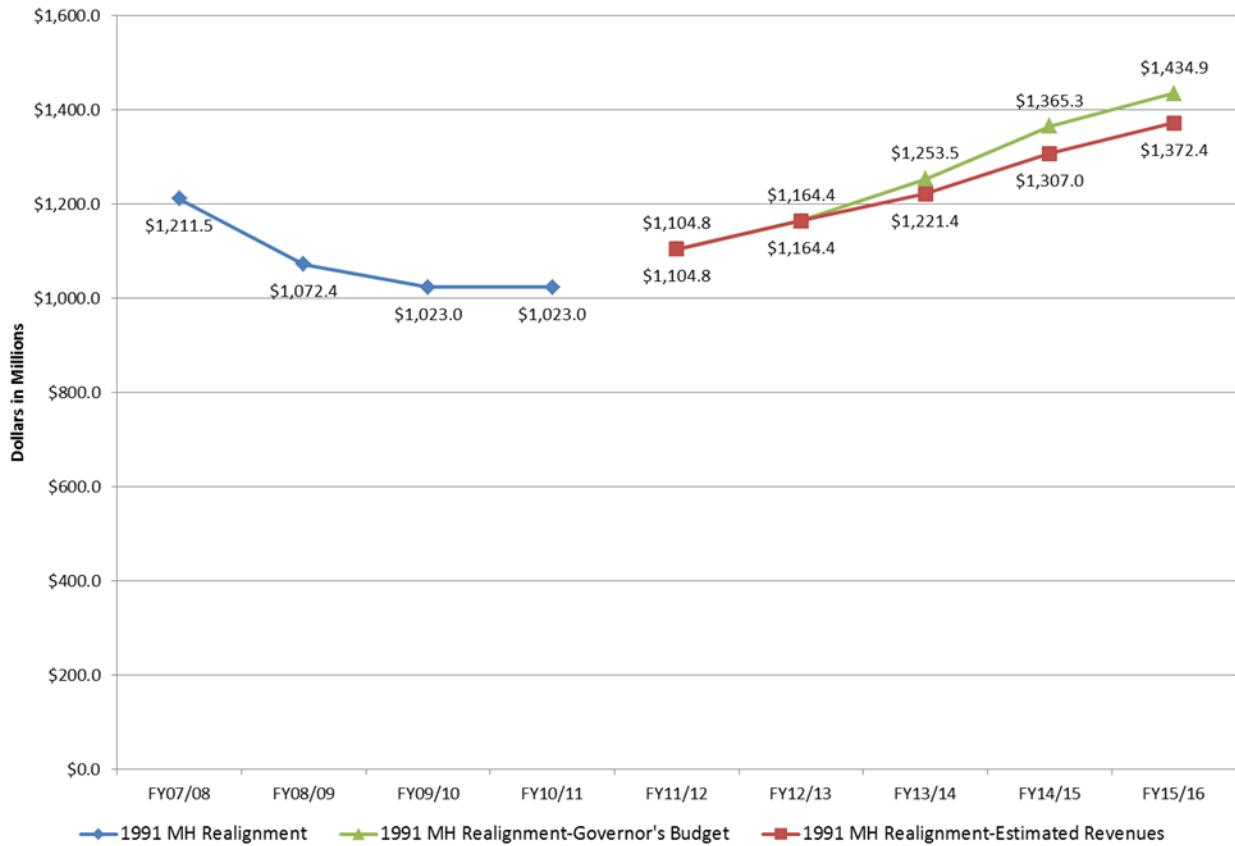
1991 Realignment

Prior to FY11/12, 1991 Realignment funding was derived from sales tax revenue, vehicle license revenue and vehicle license collection revenue. Beginning in FY11/12, 1991 Realignment funding is derived solely from sales tax revenue. This amount was initially set in statute for FY11/12 as \$1,083.6 million, but the Governor's Proposed FY12/13 Budget anticipates additional sales tax revenues and so is projecting \$1,104.8 million in available funding. The FY12/13 Governor's Proposed Budget shows an increase in this funding to \$1,164.4 million in FY12/13 with no growth shown in subsequent years. However, the state does project growth in sales tax revenues, but does not show it allocated to the various programs being realigned.

Sales tax revenues significantly declined during the recession which led to a more than 15% decrease in 1991 Realignment funding from FY07/08 to FY09/10. The proposed amount of funding in FY11/12 represents an 8.0% increase over FY10/11 funding, and the proposed amount of funding in FY12/13 represents a 5.4% increase over FY11/12 funding.

The sales tax revenue estimates in the FY12/13 Governor's Proposed Budget reflect anticipation of fairly significant growth beginning in FY13/14. While this level of growth may not materialize, the overall level of funding appears to be sufficient to fund some level of growth in the realigned programs. It is not known at this point how growth will be distributed, but assuming a proportionate distribution among the programs, actual and estimated 1991 Realignment funding under the FY12/13 Governor's Proposed Budget and a more conservative estimate are shown in the chart below.

1991 Mental Health Realignment Funding

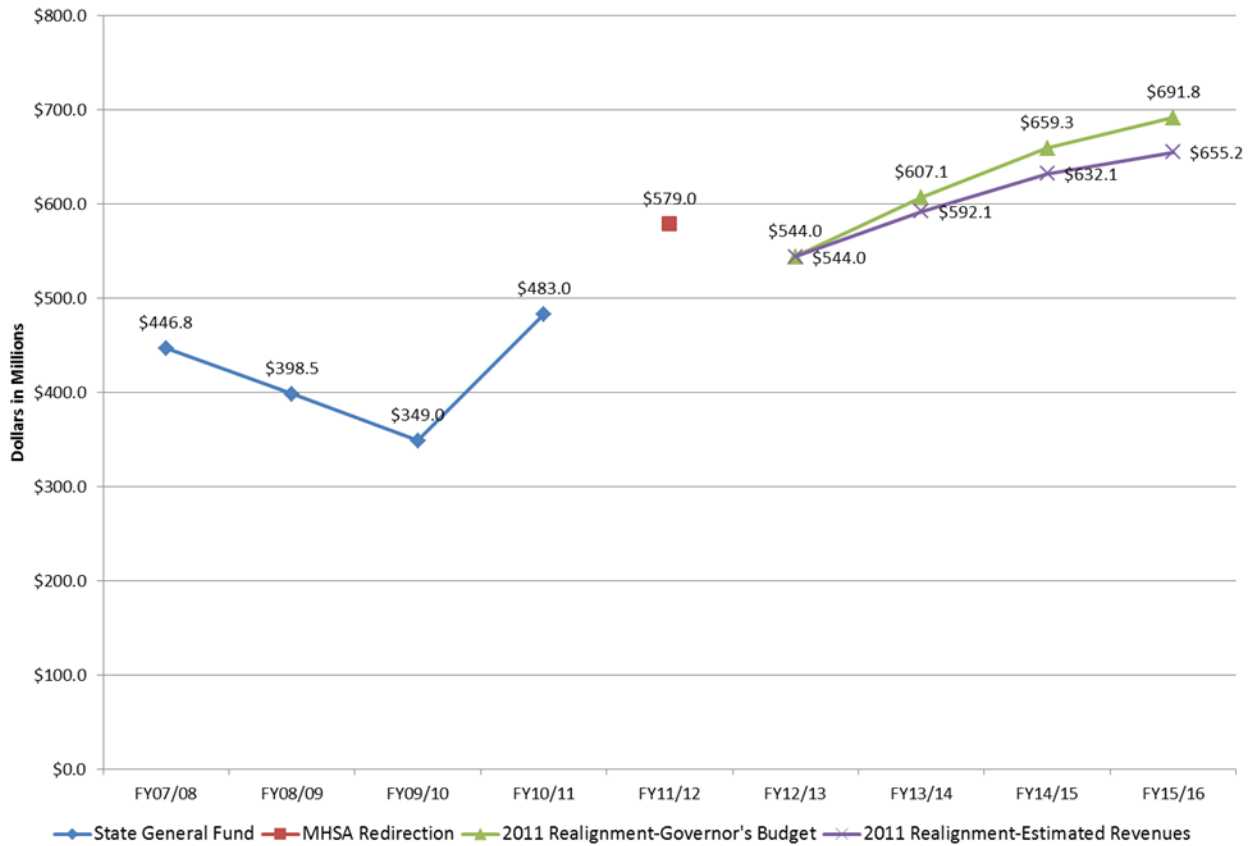


Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Prior to FY11/12, EPSDT services were funded from State General Fund (SGF) monies based on the actual cost of each individual county’s EPSDT program. In FY11/12, EPSDT funding is a fixed amount of funding diverted from the state MHS Fund specifically for EPSDT services. Beginning in FY12/13, EPSDT funding will be part of the 2011 realigned services and will be funded with sales tax revenues.

As with the 1991 Realignment funding, beginning in FY12/13, EPSDT funding is dependent on sales tax revenues, and the sales tax revenue estimates in the FY12/13 Governor’s Proposed Budget reflect anticipation of fairly significant growth beginning in FY13/14. Again, assuming proportionate distribution of growth among the realigned programs, actual and estimated EPSDT funding under the FY12/13 Governor’s Proposed Budget and a more conservative estimate are shown in the chart below.

EPSDT Funding

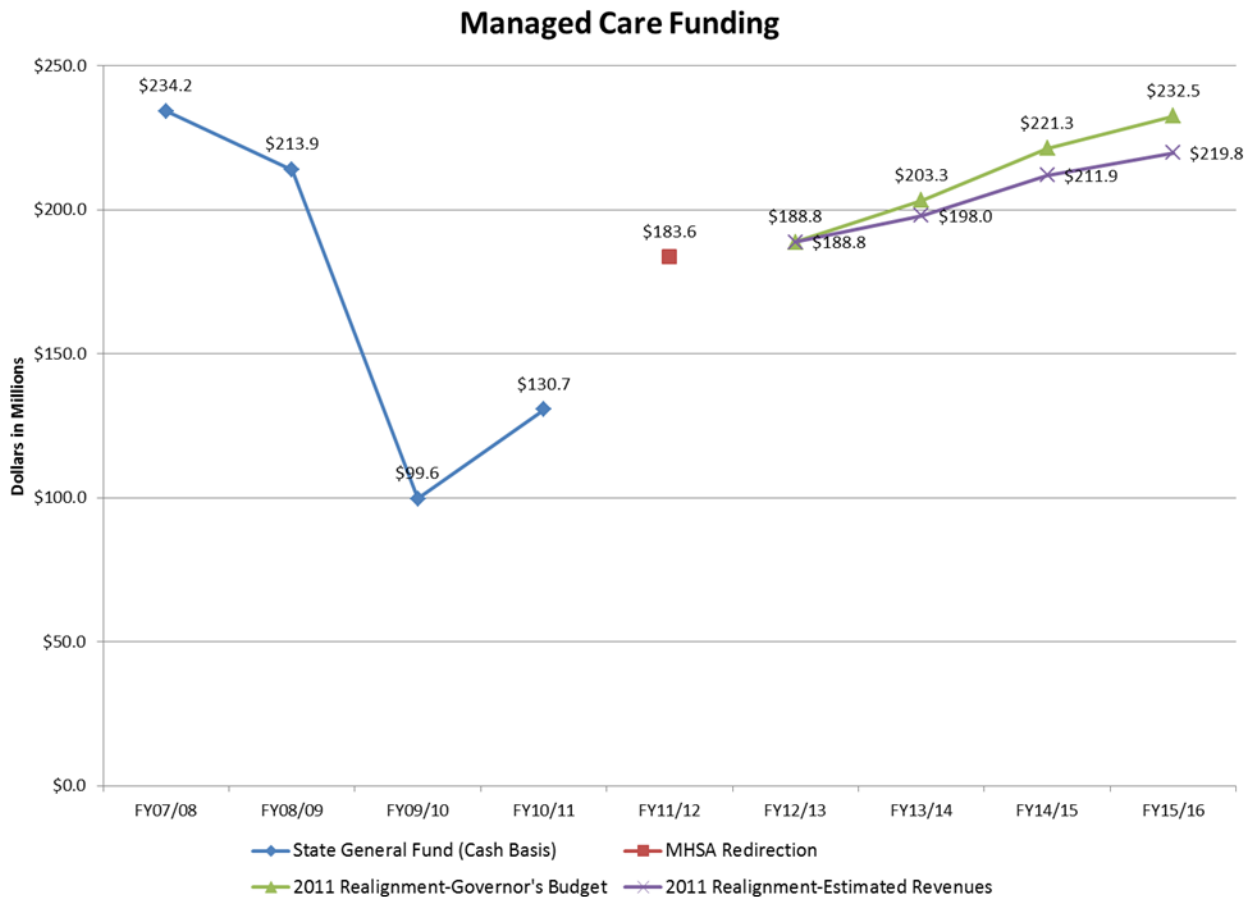


Note that the amounts through FY11/12 include budget balancing adjustments and cost settlement adjustments while the amounts beginning in FY12/13 do not include these figures. Also, the amounts shown beginning in FY12/13 and subsequent years include funding for the Katie A. lawsuit settlement and the Healthy Families Program transition to Medi-Cal. Finally, amounts shown beginning in FY12/13 do not include EPSDT SGF cost settlements and audit settlements through FY10/11 which the state has indicated will be funded through a separate SGF appropriation.

Managed Care

Similar to EPSDT, prior to FY11/12, Managed Care allocations were funded from State General Fund (SGF) monies. The initial amount of Managed Care funding was based on the cost of the program in FY94/95 adjusted for changes in the number of Medi-Cal beneficiaries (the allocation also included an adjustment for inflation which was eliminated in FY00/01). In FY11/12, Managed Care funding is a fixed amount of funding diverted from the state MHS Fund specifically for this purpose. Beginning in FY12/13, Managed Care allocations will be part of the 2011 realigned services and will be funded with sales tax revenues.

As with the 1991 Realignment and EPSDT funding, beginning in FY12/13, Managed Care funding is dependent on sales tax revenues, and the sales tax revenue estimates in the FY12/13 Governor's Proposed Budget reflect anticipation of fairly significant growth beginning in FY13/14. Again, assuming proportionate distribution of growth among the realigned programs, actual and estimated Managed Care funding under the FY12/13 Governor's Proposed Budget and a more conservative estimate are shown in the chart below.



Other

Other funding consists of Medicare and other insurance payments, grants, patient revenues, and county contributions which consist of a local maintenance of effort funding required for Realignment funds and, in a few counties, additional county funding. The state has also previously provided SGF monies for the AB3632 program and redirected MHSA funds to partially fund this program in FY11/12.

Summary

Overall community mental health funding in California is projected to grow approximately 5 percent per year for the next several years driven by projected growth in personal income tax revenues from the wealthy and projected growth in sales tax revenues, which in turn provide sufficient revenues to incur CPE and increase Medi-Cal FFP reimbursement. This comes after several years with little to no growth. The chart below shows overall community mental health funding.

**Summary of Estimated Community Mental Health Funding
(Dollars in Millions)**

Revenue Source	FY09/10	FY10/11	FY11/12	FY12/13	FY13/14	FY14/15	FY15/16
FFP	\$1,477.3	\$1,647.0	\$1,456.0	\$1,562.5	\$1,689.8	\$1,758.1	\$1,829.1
MHSA	\$1,301.0	\$1,119.4	\$974.9	\$1,174.4	\$1,214.2	\$1,297.2	\$1,433.0
1991 Realignment	\$1,023.0	\$1,023.0	\$1,104.8	\$1,164.4	\$1,221.4	\$1,307.0	\$1,372.4
EPSDT	\$349.0	\$483.0	\$579.0	\$544.0	\$592.1	\$632.1	\$655.2
Managed Care	\$99.6	\$130.7	\$183.6	\$188.8	\$198.0	\$211.9	\$219.8
Other	\$230.3	\$139.4	\$238.0	\$150.0	\$150.0	\$150.0	\$150.0
Total	\$4,480.3	\$4,542.5	\$4,536.3	\$4,784.1	\$5,065.5	\$5,356.4	\$5,659.6

Accountability

Another important aspect of these mental health policy initiatives is the measurement and reporting of performance outcomes from a consumer, service quality and community perspective. 1991 Realignment emphasized that accountability is to be measured through the evaluation of client outcomes and cost-effectiveness, as well as compliance with laws and regulations. The legislature declared its intent in Welfare and Institutions Code (WIC) 5879: *“It is the intent of the legislature to increase accountability of mental health and other human service programs whenever feasible by developing and implementing new and useful measures of performance, including client and cost outcomes.”* Here again, we find a clear statement of purpose, but also a possible missed opportunity for implementation. Neither the state nor the counties have come to a clear consensus on how to approach this critical element of the transfer of responsibility for community mental health from the state to the counties. As a result, although some individual counties can clearly summarize local results, no credible statewide story can be told. This statewide accountability vacuum understandably calls into question the promise of these policy initiatives that emphasize local governance and performance.

Oversight

Under 1991 Realignment, the legislature created independent oversight bodies to help both the state and counties to determine the needs, and provide effective and efficient allocation of resources to meet these needs on a local and statewide basis. The promise of this new “realigned” relationship requires that both state and local governments ask themselves and their community stakeholders, “*What am I doing, and what should I be doing to assure efficient and effective access to quality mental health services in my jurisdiction?*” Moving from the perspective of competition for scarce resources, to collaborative solutions, to the achievement of efficiency and effectiveness, requires a shared vision at the state and the local levels. Leaving fights over state general fund and equity behind, counties and the state have been presented with an opportunity to solve problems collaboratively by focusing on results and community engagement at both the statewide and local levels.

County Mental Health Organizational Resources

California Mental Health Directors Association (CMHDA)

The California Mental Health Directors Association (CMHDA) is a nonprofit advocacy association representing the mental health directors appointed by each of California's 58 counties, as well as two cities (Berkeley and Tri-City).

The mission of the California Mental Health Directors Association is to provide leadership, advocacy, expertise and support to California's county and city mental health programs (and their system partners) that will assist them in promoting the recovery of persons with serious mental illness and serious emotional disturbance. The Association's goals are to assist in building a public mental health system that ensures the accessibility of quality, cost-effective mental health care, and to advocate for equity and full inclusion of vulnerable populations and secure social justice as measured by access to necessary quality services that promote mental health, wellness, resiliency and recovery in our communities.

California Mental Health Services Authority (CalMHSA)

The CalMHSA is a Joint Powers Authority (JPA) created by and for counties, to facilitate the ability of counties to act jointly on mutually identified projects, either statewide, regionally or as otherwise deemed beneficial to two or more counties, and is focused on the efficient delivery of California mental health programs. Member counties jointly identify, develop, fund, administer and implement mental health services, projects, and educational programs at the state, regional, and local levels. Each member county has delegated a representative (typically the Mental Health Director or Behavioral Health Director) to a position on the Board of Directors. CalMHSA has the capacity and capability to promote systems and services arising from a shared member commitment to community mental health.

The mission of CalMHSA is to provide member counties a flexible, efficient, and effective administrative/fiscal structure focused on collaborative partnerships and pooling efforts in:

- Development and implementation of common strategies and programs
- Fiscal integrity, protections, and management of collective risk
- Accountability at state, regional, and local levels

California Institute for Mental Health (CiMH)

CiMH is a training, technical assistance, evaluation, research, practice implementation, and professional resource organization originally founded by the California Mental Health Directors Association. The purpose of CiMH is to promote wellness and positive mental health and substance use disorder outcomes through improvements in California's health systems. The vision of CiMH is that California will be the national leader in the provision of mental health services and support systems that successfully advance hope, wellness, resiliency, recovery and full community integration for all adults, children and families across their life spans. In this future, mental health wellness, resiliency and recovery are fully understood by the general public; thus communities and mental health systems partner to promote and support opportunities for people at risk of mental health issues to achieve wellness and/or full recovery. Proven practices, opportunities, and technologies are used to prevent and/or reduce the impacts of mental illness and addiction and to promote the health of individuals and families.

County Mental Health Needs, Strengths and Barriers

Counties have historically relied on CMHDA to represent their interests in Sacramento at the administrative, judicial and legislative policy levels. Increasing demands on CMHDA members and staff have led to a determination that a mechanism is also needed to represent counties' collective needs from fiscal, contracting and legal perspectives. CMHDA has increasingly been filling these "business" roles out of necessity. However, members recently formed a joint powers authority (JPA) to facilitate implementation of community mental health statutes that encourage counties to act jointly. In order to get the JPA "off the ground," CMHDA staff and members initially recommended that it be used to address the needs of counties to more efficiently pool MHSAs funds for already identified but stalled statewide PEI projects. CalMHSA (the JPA) has successfully begun that process.

County mental health directors have also historically relied on CiMH to address their individual, regional and statewide training and technical assistance needs. CiMH was conceptualized and founded by county mental health directors to meet this important need, as well as to provide evaluation, research, practice improvement and implementation of evidence based practices using both state and local funding as leverage to other foundation, federal and state grants.

CMHDA was instrumental in promoting continued state financial support for CiMH, as well as identifying it specifically as the “go to” mental health training entity in California. For example, when CalWORKs was enacted, with an emphasis on treatment of mental health and substance use disorders that interfered with employment, counties each contributed a portion of their funds to CiMH to research, evaluate, and work with counties to implement effective practices. A second example is the development of the evidence based practices initiative which leverages a small state contract with county funds to implement twelve practices in 352 sites. Finally, with the passage of the MHSa, funding for workforce, education and training (WET) became more readily available for individual counties and for regional and statewide projects, and CiMH developed a dedicated staff position, with the support of CMHDA, to address workforce issues on a county, regional and statewide basis. In addition, WET Regional Collaboratives were formed under both county and CiMH direction to plan and implement workforce development projects using the dedicated MHSa WET funding.

State Leadership Changes/Challenges/Opportunities

The community mental health system was originally intended to evolve under the centralized oversight of the state Department of Mental Health (DMH), using its ability to convene interested parties and develop collaborative policy initiatives that support the legislative intent specified in statute. This intent was never fully realized, resulting in fragmentation and often duplicative attempts by CMHDA, CiMH and eventually CalMHSa to fill this centralized planning and implementation void. The community mental health system has thus evolved county by county, suffering from a lack of efficient centralized leadership and guidance, other than that which has been increasingly exercised by CMHDA through its members and their influence within CiMH and CalMHSa. This evolution has resulted in many successes, but it has also suffered from a lack of coordinated planning that has led to redundancy, administrative inefficiencies, and unsustainable efforts to expand successful local programs.

Need for Collaborative Statewide and County Leadership

Counties need to fill this statewide leadership vacuum with a lead entity that can convene counties to identify their collective fiscal, workforce, communication, evaluation, analysis, training and technical assistance needs, and develop concise initiatives to address these needs on an individual, regional and statewide basis. The recommendations and proposed results could then be effectively communicated by this entity to the county, state and federal governments, as well as to interested stakeholders and oversight bodies. Once approved or adopted by the appropriate body, these initiatives would have fiscal, workforce, communication, evaluation, analysis, training and technical assistance components that require implementation on both a local and statewide basis. Efficient implementation will also require

ongoing statewide leadership and support to assure that the efforts don't become fragmented as they are rolled out by counties and their implementation partners.

The weakness in our current structure (CMHDA/CalMHSA/CIMH) is that it lacks the clear identification of such a leadership entity that is charged with assuring effective collaboration between the three. County directors and their staff are pulled in different directions and are being asked to take their "hats" on and off depending on which meeting, workgroup or stakeholder process they are in, devoting time, money and energy to decision-making processes that lack a coordinated vision and purpose. This dilemma is further demonstrated when looking more closely at the executive and Boards of Directors' membership of each and tracking the separate decision-making processes for each organization. Currently, each is conducting multiple workgroups or stakeholder processes that require the attention of directors and/or their staff. This redirection of resources from local needs to the duplicative needs of the support organizations becomes an often unrecognized drain on the scarce resources needed to operate programs and administrative functions at the county level.

Thus, the essential missing element from a collaborative resource management and "business" perspective is a collective county mental health leadership and coordination function. The members of CMHDA have determined that the Association must fulfill this leadership role to assure the following;

- Full participation of all 58 counties
- Equal participation of all counties in policy-related decision making
- Ability to address county and local community interests as a priority
- Credibility with and access to state and federal decision makers
- Ability to address the various statutory references/requirements for consultation from a statewide organization representing counties

CMHDA is the Appropriate Lead Policy Entity

Since the 58 county mental health directors make up the membership of CMHDA, and this body is a well-respected non-profit policy and advocacy organization guided by full time competent staff, it makes sense for CMHDA to assume the lead role for policy development and collaborative county and statewide implementation. CMHDA and its members will rely upon CIMH for technical support, training, data collection, analysis, and other services, and upon CalMHSA to implement agreed upon business strategies, using standard governmental legal, fiscal, and administrative processes so that the vision of county mental/behavioral health directors may be realized. In this manner, with clear identification of leadership that works effectively and collaboratively with state government, the way will be cleared for the county-

based community mental health system to forge forward in this time of exciting but intense change. It is critical that the recovery and person-centered values as established over the years by CMHDA and CiMH be used as the foundation to this new entity. As CalMHSA implements projects within the parameters set forth by CMHDA and CIMH, there is little doubt that real efficiency will be achieved because duplication will be reduced as compared to having each of the three organizations act alone.

Collaborative Functions and Roles to be Addressed

Policy Development

The first step in the process of determining responsibilities between federal, state and local governments is policy development. This occurs in a number of settings, with different “players” depending on the issue to be addressed, the interests of each entity and the desired outcomes. Policy typically has the following components:

- Intent (such as better outcomes for residents)
- Legal
- Fiscal
- Administrative (related to implementation).

CMHDA currently fulfills the policy development and “negotiation” role for county mental health departments with the following governmental bodies:

- State Administrative Agencies/Departments, through regulation, contracts, information notices and letters.
- County Administration and Departments through CSAC, other affiliates, contracts and county budgets.
- State Legislature, through policy and budget trailer bills.
- Judicial, through legal actions, collaboration with the courts and other administrative actions.
- Federal, state and local oversight bodies, including CMS, SAMHSA, DHCS, CHHS, MHSOAC, MHPC, and county mental health boards.
- Mental health advocacy organizations such as NAMI, the Alliance, consumer representatives and health advocacy organizations.

Policy Implementation

The next step in the policy process is implementation of the administrative, practice, fiscal and legal components resulting from the above policy development process. CiMH and CalMHSA were developed by county directors to support the individual and collective needs of county

mental health departments to implement approved policies, and help counties to respond effectively to the requirements outlined in statute, regulation, contracts, state plans/waivers and information notices and letters. Implementation has the following components:

- Administrative. Includes contract development and approval, administration and management procedure development and implementation, information management and data requirements, quality assurance, utilization management and other functions required for successful and efficient implementation.
- Practice. Includes the identification and development of evidenced based clinical, rehabilitative and case management culturally appropriate practice approaches that serve as the basis for the intervention and supportive mental health services delivered during implementation. This element requires ongoing training, technical assistance and supervisory and practice support for the specialists delivering the mental health services and rehabilitative supports.
- Fiscal. Includes the establishment and implementation of approved government accounting practices, account structures, audit procedures, funds distribution procedures, and revenue and expenditure reporting and budgeting procedures.
- Legal and Compliance. Includes promoting adherence to federal and state laws and regulations by all parties as an integral part of the implementation process.

Measurement and Reporting

The final step in the policy process is measurement and reporting of results and outcomes of the policies as they are implemented, for continuous practice and system improvement, as well as for accountability purposes. The federal and state governments play a strong role in development of the measurement and reporting requirements associated with accountability, as do the oversight bodies created in statute and regulation. CMHDA has identified this as a significant area of focus for the coming year from a policy and implementation perspective. Results measurement and accountability has the following components:

- The need for objective third party development and review of the results to be measured.
- The need for development and maintenance of reliable measures and data sources.
- The need for reporting and feedback systems to promote the reliability and validity of the measurement process.
- The need to be able to communicate results in such a way as to be relevant to a broad and diverse cross section of stakeholders.

Case Example

Because outcomes and accountability need significant attention, CMHDA has begun the process of policy analysis related to mental health outcomes and accountability. The Association has published a set of principles that will guide staff and member representatives in this effort. These principles will now be shared and discussed with the oversight bodies and state and community stakeholders to acquire input and feedback from these important constituency groups. It has been determined that the current statutory framework has evolved over time into a fragmented and unclear roadmap to guide accountability and outcome efforts. As a result, legislative leadership will likely be necessary to address the statutory changes needed to clarify the accountability framework for community mental health in California.

As this process unfolds, CMHDA will engage both CiMH and CalMHSA in the accountability and outcome development process. CiMH has demonstrated experience in the development and dissemination of evidence-based practices, as well as the ability to gather critical information and examples of outcomes frameworks that have been successfully implemented in mental health and health care environments. CiMH has developed and implemented processes to collect outcome information on evidence-based practices, analyze the data, and return data dashboards to sites along with benchmarks for comparison. CalMHSA was formed to assure that county fiscal and administrative resources could be pooled to address the infrastructure development needs that are identified. CalMHSA, as a joint powers authority, also has the ability to negotiate the contract and state plan implementation issues with the state and possibly the federal governments that are identified as a result of the policy development and implementation process.

This is an example of the power of the collaborative relationship that was conceptualized in the formation of these collective entities. Once a priority area of focus is identified and agreed upon, each entity may have a role in the successful development and implementation of the final product. The challenges that arise as the process unfolds will require flexibility and negotiation with other interested parties, and the key is to prevent fragmentation within the “county family” as the process unfolds. CMHDA will fulfill this role in this process on behalf of its membership.

Conclusions and Recommendations

Many of the opportunities and challenges identified in this plan require immediate attention, from both a policy and implementation perspective. As a result, these conclusions and recommendations are presented from both a short term and longer term perspective. By short term we mean implementation during FY 11/12 and 12/13, with the longer term focused on FY 13/14 and beyond, including the anticipated changes coming with the implementation of federal health care reform. These conclusions and recommendations are intended by CMHDA to assist in focusing the discussion among county members to arrive at a clear short term plan

for mitigation of county risk, and leveraging of county resources to meet the transferred local and statewide obligations for the community mental health system. The recommendations are prioritized to facilitate the discussion, but are also subject to change at the discretion of the membership.

Many of the priority issues identified in this business plan came to light during its development. The risks and opportunities were subsequently identified and discussed with the current leadership of CalMHSA, CMHDA and CiMH. Opportunities to address these critical issues were presented to all three organizations, and this process was helpful in determining the best approach to the short term needs of counties, in the priority areas identified. For the purposes of addressing the priority areas in the short term, during this and next fiscal year we have concluded that CMHDA is the most appropriate entity to take on these functions, with CiMH and CalMHSA providing support, as needed, based on their current areas of expertise and development. CalMHSA is a very new organization, and is focused on the implementation of PEI statewide projects and determining its role in relation to the state department with which it currently contracts for these projects. CiMH is a mature organization that has existing contracts with the state and counties that can be leveraged in conjunction with CMHDA to address the short term priority areas efficiently and effectively.

Over time, as CalMHSA evolves and counties collectively address the role it may play in the future, there may be opportunities to expand the role of the JPA in the administration of these priority areas. In the short term, the membership of CMHDA may rely on the JPA for some fund deposit and fund management functions, to implement 2011 Realignment and other pooled funding requirements identified as needed to support counties. In contrast, CiMH and counties have a long term business relationship that will need to be clarified and enhanced to address the practice implementation, evaluation, data analysis, technical assistance and training issues that are identified during implementation over the next two years.

To effectively and efficiently address these priority areas, CMHDA will need to both redirect current resources and expand resources in this and next fiscal year. Additional financial resources will likely be needed by CMHDA to prevent escalating pressure on the current fund balance to meet these new and expanded obligations. Since many of these functions have both a policy and an administrative implementation component, the financial support provided to CMHDA by counties may need to be categorized differently. CMHDA has past and current experience with the administration of similar programs, including the small county state hospital bed pool, SCERP and other county support functions that would be helpful as it develops the short term implementation strategies under the direction of its Governing Board and membership. Finally, since the role of CMHDA representing counties is specified in statute and has been tested and proven over these difficult transition months with various state

departments and agencies, it can hit the ground running in the short term, which is of obvious benefit to counties.

The proposed initial priority areas are: (additional priority areas for all three organizations will be provided for consideration on a separate document)

- Support for the IMD ancillary lawsuit
- Medi-Cal MHP contract negotiations
- State hospital bed purchase contract and bed pool development
- 2011 Realignment implementation
- 2012/13 MHSA funds distribution implementation

With the approval of CMHDA membership, staff will develop a plan for implementation of each approved priority area, including estimates of resources and cost for this and next fiscal year. The estimated cost for implementation of the approved priority plans will be included in the CMHDA budget for final membership review and approval. Every effort will be made to minimize cost to the counties through the effective use of collaboration with CiMH and CalMHSA, professional contracts and existing staff resources. The longer term issues and strategies will be addressed by CMHDA through additions to this business plan during the next fiscal year, as more information becomes available.

Attachment A

Proposed County Business Plan Short Term Priorities

3-12-12

CMHDA

- a. Develop CMHDA resources to support legal consultation and support for legal action to be taken by counties, when necessary.
- b. Complete the FY 12/13 Medi-Cal MHP Contract negotiations with DHCS.
- c. Represent county mental health departments' interests in the 2011 Realignment negotiations with CSAC, the administration and the legislature.
- d. Complete the FY 12/13 state hospital bed purchase contract negotiations with DMH/Department of State Hospitals, including consideration of the development and implementation of a bed pool purchasing agreement.
- e. Develop county distribution recommendations for DoF and SCO, as required in statute and agreements.
- f. Participate in the development and implementation of state plans, waivers and demonstration requests that have a mental health component and are submitted by DHCS to CMS for review and approval.
- g. Work with CADPAAC to address the fiscal risk associated with the realignment of drug and alcohol programs.
- h. Participate in the development and implementation of the state's EPSDT Katie A settlement plan.
- i. Participate and provide recommendations to DHCS as it convenes the Med-Cal mental health claims, cost report and audits process improvement workgroups.
- j. Develop financial approaches that support statewide implementation of the Medi-Cal mental health program requirements, and assist counties in the management of local fiscal risk and federal revenue maximization.

CiMH

- a. Disseminate evidence-based practices to support implementation of health and behavioral health care integration.
- b. Continue to develop practice improvement strategies to support implementation of health and behavioral health care integration.
- c. Assist DHCS in the development of its short and long term business plan for the administration of behavioral health services.

- d. Provide technical assistance and support to counties, and capacity building for stakeholders, to implement the local planning and stakeholder processes required by the MHSA.
- e. Continue efforts to engage counties in learning collaboratives that support implementation of 2011 Realignment, health care integration and behavioral health expansion.
- f. Disseminate evidence-based practices to support treatment of mentally ill offenders.
- g. Continue efforts to support counties in reducing disparities.
- h. Work with counties to develop and implement an effective outcomes and accountability structure.

CaIMHSA

- a. Develop and implement a policy that ensures that county funds transferred to the JPA for a specified purpose are considered expended by the county for that purpose.
- b. Develop public information resources for county mental health departments and CMHDA (this was recommended at the Governing Board Retreat 2 years ago)
- c. In collaboration with county and CMHDA staff, develop and implement a short and long term public communication and information program that educates and informs the public and other stakeholders regarding the role of counties in the community mental health system.
- d. Assist in the fiscal management of AB 100 and 2011 Realignment county mental health revenues and risk pools.
- e. Provide financial support for an outcomes and accountability resource to counties for statewide policy and implementation strategy development. This resource would be managed by CMHDA/CiMH and CaIMHSA to facilitate this work.
- f. Continue to implement the funded statewide PEI projects, and develop a sustainability plan for those that prove successful.
- g. Continue to support individual and collective county mental health projects that require expedited implementation and contracting.

**COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
of CALIFORNIA**

STRENGTHS

- **Experience and Knowledge**
- **Diversity Allowing for Flexibility and Focused Response to Community Needs**
- **Focused and Successful Rehabilitation and Recovery**

WEAKNESSES

- **Funding Dependent on Public Support and Limited to Public Resources**
- **Diversity Results in Variable Access, Services and Mixed Messages**
- **Not Well Understood by Others**



**Internal
Factors**

OPPORTUNITIES

- **Whole Health Integration**
- **Communications – Develop Coherent Messages**
- **Experience and Knowledge**

THREATS

- **Lack of Understanding of CBH Benefits/Value by Decision-Makers**
- **Whole Health Integration Dilutes Behavioral Health Care**



**External
Factors**

STRENGTHS

SYSTEM REFORM and ORGANIZATIONAL STRUCTURE

- **Experience and Knowledge**
- **Diversity Allowing for Flexibility and Focused Response to Community Needs**
- **Focused and Successful Rehabilitation and Recovery**
- Integration of MH/S exists – need to build on it
- Counties are somewhat prepared to demonstrate the value of county behavioral health in an ACA world
- Data and information exists that reinforces the value of behavioral health – need to formulate a concise case
- Five regions represent the varied interests across all counties – somewhat neutral

WEAKNESSES

SYSTEM REFORM and ORGANIZATIONAL STRUCTURE

- **Funding dependent on public support and limited to public resources**
- **Diversity results in variable access, services and mixed messages**
- **Not well understood by others**
- The real practical issues at the county level of DMC, integration, parity, EQRO, audits, EMR's, law enforcement issues from jails to OIS, adequately trained staff, etc. are not being addressed in the current governing structure
- Inability to easily act regionally – structurally get out of county shells and work across county lines
- County behavioral health is “unprepared” to provide integrated care when behavioral health is a “carved-out” silo
- Don't have a concise and effective way of making the case for the value of county behavioral health in an ACA world
- Unclear if there is consensus on what the role of counties should be in demonstrating the value of county behavioral health in an ACA world
- Small and rural counties continue to be left out
- Very small counties are under-represented

OPPORTUNITIES

SYSTEM REFORM and ORGANIZATIONAL STRUCTURE

- **Whole health integration**
- **Communications – develop coherent messages**
- **Experience and knowledge**
- Improve relationships with health plans and criminal justice
- Build on integration of MH/S – Need to look for a model to integrate all care for patients
- Lead in preventing mental health problems – work across county lines and with other interested parties
- Innovative community-based whole-person integrated services and funding
- Enhance relevancy of CBHDA to diverse and underserved communities
- Look for pilot project to carve a mental health plan into a general Medi-Cal plan, (through the 1115 waiver) to do away with false dichotomy between mild/moderate and severe
- Integrate to ensure the issue of carve out is a “non-issue”
- Consolidate the approach counties will take with respect to the carve out
- Place funding into the MCP – make them responsible to develop a non-fragmented seamless system of care
- Explore models that allow health plans to provide mental health and SUD prevention and treatment services
- Work collaboratively with health plans in providing mental health and SUD prevention and treatment services
- Clearly demonstrate CMH’s value to the health plans in providing mental health and rehabilitative services
- Get behavioral health prevention and treatment at the forefront of health policy; get the governor’s ear; identify legislative champions
- Engage more with EQRO and MHSOAC regarding outcome and performance measures

Communications

- Develop a regional approach for CBHDA messaging that allows for diversity throughout the state
- Develop a clear, coherent message to address the issue in rural, suburban, and urban counties
- Clearly outline why counties are better at providing these services and will have patients and the public as first priority
- Develop a clear, concise message on the value of CBH in an ACA world that appeals to audiences, including policy makers and the public

THREATS

SYSTEM REFORM and ORGANIZATIONAL STRUCTURE

- **Lack of understanding of CBH benefits/value by decision-makers**
- **Whole health integration could dilute CBH care**
- Waiver renewal/CMS pressure
- Loss of “carve-out”
- “Disconnection” of Medi-Cal auditors from changes happening to counties
- Struggle and work required to get payment from insurance companies – deters interest in taking on new patients
- A mild/moderate benefit in the managed care plans but no financial incentive to cover people with SMI – no incentive to keep people well
- Simplify and de-clutter rhetoric around mental health/behavioral health. Make it easier to understand
- CBHDH’s value proposition is not defined
- Lack of quantifiable outcomes
- Muddles messaging