$19 Billion Surplus- What Opportunities Might It Present for Behavioral Health?

by Rusty Selix

I am writing this before the governor's budget is released on Wednesday, Jan. 10, but by the time you read it the budget will be out. We already know there is a projected $19 billion surplus between the current year and 2018–19 budget year and the governor is certain to say that it has to be viewed as one-time money with the next economic downturn due to hit soon, and a portion of it will go to increasing the so-called rainy-day reserve.

In doing so, he will be the first governor since his own previous term from 1975-82 to leave the state in good financial shape and that will be a major part of his legacy. Nonetheless, there will be billions of dollars to spend and opportunities in all subject areas as long as they are viewed as one-time costs that do not create ongoing state financial pressures. While our issues are not likely to be priorities in the initial budget that comes out from the governor, there is likely to be legislative support and potential for the governor to also support behavioral health priority investments, which have benefits in helping to reduce other government costs in healthcare and criminal justice. I want to highlight two CBHA priorities that I hope the broader community will also want to support.

Integration with Physical Healthcare for People in Behavioral Health System

The first is bringing better physical healthcare to people receiving significant behavioral health care in the county systems. Everyone knows that integrating physical health and behavioral health produces better outcomes and saves money. But outside of our community most people think of that as something that primary care would manage. There is not much attention for the people that we see whose care is managed, often daily, by behavioral health providers.

When the state was developing its Coordinated Care Initiative for people with both Medi-Cal and Medicare, the plan was to address this issue. It was acknowledged by the Medi-Cal managed care plans that the people seen in the behavioral health system had the worst physical health outcomes. The Department of Health Care Services presented data showing that 70% of the 5% of people who have the highest physical healthcare costs have a mental illness diagnosis. Medi-Cal managed care plans acknowledged that in a managed-care approach to all the people with Medi-Cal and Medicare, the people from whom we would save the most money are those who are in the public behavioral health system. However, that part of the Coordinated Care Initiative was never implemented. The Medi-Cal managed care plans never contacted behavioral health providers to find out what the specific physical health needs were for the people they served and what was the best way to get those needs met. Based on numerous pilot projects mostly funded through the SAMHSA/HRSA integrated care program, we know that in most cases the best way to provide care is to co-locate it at the location of behavioral health providers. The potential to provide better physical healthcare and get those savings still exists not just for the people who are in Medi-Cal and Medicare but for everyone who is seen in the behavioral health care county systems.

Last year, the Department of Finance made a finding that the Coordinated Care Initiative was not generating enough savings to cover the cost of having shifted In-Home Support Services from county to state financing. A big part of last year's budget was the loss of behavioral health funds from 1991 Realignment growth being redirected to In-Home Support Services. At that time, I pointed out the fact that this part of the Coordinated Care Initiative had not been implemented and suggested that the state should make that a new program incentive for the Medi-Cal managed care plans. In addition, I noted that because the county behavioral health system was taking the losses from the shift of realignment funds, any savings realized should primarily go to county behavioral health.

By the time we were able to present this, the 2017–18 budget was largely completed and the decisions related to Medi-Cal and realignment were already done. But there is no reason not to make this a major focus in 2018–19. In fact, this large surplus is a perfect time to offer modest one-time funds to Medi-Cal managed care plans to incentivize them to build the partnerships between behavioral health providers and primary care providers to fully implement this form of physical health behavioral health integration.

All the evidence suggests that this will create significant long-term savings for the state and the health plans. There will be costs for primary care providers and behavioral health providers that should be fully covered in the proposal. Moreover, as incentives for counties to promote this program, and is part of the recoupment of the losses from the redirection of realignment funds, it seems most equitable that county behavioral health should receive most of the savings that the program generates in relationship to what the physical healthcare costs of this population would have been without this new program.

Diversion from the Criminal Justice System

Nearly every year over the past several years, there has been new money to some way address the population of people returning to the community after state prison, as well as a new program not yet well defined under the California Health Facilities Financing Authority for $67.5 million for a broad range of diversion strategies for local government.

What there hasn't been funding for is for counties to partner with their cities to implement a comprehensive program both to keep people from entering the criminal justice system, as well as to keep them from returning after discharge.

We all know the basic two problems: police officers take people with severe behavioral health problems to jails and hospitals because they know these places must take them--not because they are the right place for people to be, and police officers acknowledge that most of these people need treatment and would not likely be committing crimes if that treatment were available. Similarly, when people are discharged from jail or prison (or hospitals), we know that if they have a significant behavioral health problem they need to be in a comprehensive program, but the capacity of those programs is quite limited. Most people wind up just going back to wherever they were before, which is often homelessness or a marginal form of housing with no services.

The recent report by the Mental Health Services Oversight and Accountability Commission documents most of the strategies which we have all supported for many years. The National Association of Counties Stepping Up Initiative outlined the type of comprehensive plans counties across the nation support. When there was a Step-Up Summit in Sacramento last year, 53 out of 58 counties sent teams of people to participate.

If we really want to get these programs taken to scale across the state, the best way to do so is for the state to offer significant incentive funds that would be matched by local efforts. With a large state budget surplus--possibly the largest in history, this is the best year to put forward this type of proposal. It would seem now is the time for the behavioral health community to come together with counties, cities, and other supporters to develop a specific budget proposal.