WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

August 25, 2016
PowerPoint Presentations and Handouts

Tab 2:	•	**Handouts:**	**Presenter Bios, Written Responses and Invitation Letters**
Tab 3:	•	**PowerPoint:**	**El Dorado County Innovation Plan**
	•	**Handout:**	**County Innovation Summary, Community Based Engagement and Support Services**
	•	**Handout:**	**County Innovation Summary, Restoration of Competency in an Outpatient Setting**
Tab 4:	•	**PowerPoint:**	**Nevada County Innovation Plan**
Tab 5:	•	**PowerPoint:**	**Additional Funding for Stakeholder Contracts**
Tab 6:	•	**PowerPoint:**	**Request for Proposals for Stakeholder Contracts**

DISCUSSION OF THE MENTAL HEALTH SERVICES ACT POLICY ON REVERSION

> Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the fund. Welfare and Institutions Code, (WIC) § 5892(h)

INTRODUCTION:

The Mental Health Services Act (MHSA) includes an incentive for counties to spend MHSA funds to address community mental health needs. This incentive, known as reversion, requires each county to spend MHSA funds within three years of receipt or risk the return of unspent dollars to the Mental Health Services Fund (MHSF), which is administered by the State. Reverted funds that accrue to the state fund are then redistributed among all counties. For certain program funds, namely workforce training dollars and technology and infrastructure investment funds, the law allows ten years for reversion.

The concept of reverting unspent funds is not unique to the MHSA. Federal, state and local budgets often are designed to be spent in a fiscal year or across a limited timeframe. For example, most General Fund allocations to California State agencies are annual appropriations that must be spent, encumbered or otherwise committed by the end of the Fiscal Year in which they were allocated. Like the MHSA reversion policy, State agencies can encumber money in the initial year, and then have two additional years to spend those dollars. After the third year, the authority to use unspent funds expires. Although those funds do not technically leave the General Fund, the authority to use them expires, which is comparable to the MHSA reversion policy.

Despite the reversion requirements of the MHSA, media and other reports indicate that some counties are currently retaining unspent, unreserved MHSA funds for more than three years. According to the California Department of Health Care services, no county funds have been reverted to the state Mental Health Services Fund for several years.

This briefing paper provides an overview of the issues surrounding MHSA fiscal reversion and is organized into three sections.

Section 1 includes a brief discussion of the status of reversion policy and the challenges associated with implementing that policy.

Section 2 provides a historical overview of the efforts of the Department of Mental Health (DMH) to implement the Act and establish reversion policies and practices.

DISCUSSION OF THE MENTAL HEALTH SERVICES ACT POLICY ON REVERSION

Section 3 provides a review of the legislative changes that have modified the Mental Health Services Act, and how those changes relate to that state's reversion requirements.

SECTION 1: 2016 Status of Reversion and Related Challenges.

As indicated above, there are two timeframes for reversion under the MHSA. Funding for capital facilities, technology, and work force development revert after ten years. Funding for service related or programmatic funds revert after three years.

Data suggests that since the initial passage of the MHSA in 2004, only a handful of counties have been required to revert their MHSA funding back to the state-level Mental Health Services Fund. Implementing reversion has been complicated by the lack of clarity regarding how and when to compute reversion, as well as what method to use to collect reverted funds.

The Department of Mental Health struggled to develop a process for reversion before it was eliminated in 2012. At that time, policymakers shifted responsibility for implementing a reversion policy to the Department of Health Care Services.

Implementing the MHSA reversion policy is difficult because of how MHSA funds are collected, distributed and allocated. The MHSA is funded through a one percent tax on income of more than a million dollars in a given tax year. As MHSA tax revenues are received by the state they are placed into the State Mental Health Services Fund. The Act allows up to five percent of those funds to be set aside for state administration, with the balance – 95 percent – dedicated to funding local mental health programs and services.

Legislation directs the California Department of Health Care Services, in consultation with others, to establish a formula for distributing MHSA funds among the counties. With that distribution formula in hand, the State Controller's Office (SCO) distributes MHSA funds to each county on a monthly basis. The amount of funds distributed statewide ranges significantly from month to month, from as low as $49 million to well over $400 million in a given month.

Counties are required to allocate their MHSA funds based on mandates in the Act:

- 80 percent of local MHSA funds must be dedicated to Community Services and Supports (CSS).
- 20 percent of MHSA funds must be dedicated to Prevention and Early Intervention Programs (PEI).
- And the counties must set aside 5 percent of their CSS and PEI funds for Innovative Programs (INN).

DISCUSSION OF THE MENTAL HEALTH SERVICES ACT POLICY ON REVERSION

Although many parts of the original Act have been amended and administrative functions have been redistributed, the fiscal requirements of the Act have, in large part, remained intact, including most notably and for purposes of this discussion, the Act's requirements for reversion of unspent MHSA funds. The Act required that funds not spent for their authorized purpose by the end of three years after distribution (or 10 years after distribution for funds reserved for capital facilities, technology and workforce education and training), would be returned to the state fund. The Act did, however, qualify that funds put in a local "prudent reserve" would not revert. (WIC § 5892(h)).

The rationale for a prudent reserve is derived from the recognition that MHSA revenues are highly volatile, year over year or across an economic cycle. A prudent reserve allows the counties to set aside a portion of their MHSA funds in anticipation of an economic downturn when MHSA revenues would fall. Thus funds committed to a prudent reserve are not subject to reversion.

While the rationale for having a reversion policy seems clear – creating incentives to dedicate MHSA funds to meet needs, a number of challenges have been raised:

- **Fiscal Reversion may create unintended fiscal shifting.**

Under the statute, reverted funds are redistributed among all counties through a formula that dedicates the largest share of MHSA funds to the most populous counties. As a result, reverted funds would primarily benefit California's largest counties. Similarly, because MHSA funds are distributed among service (80 percent), and prevention and early intervention (20 percent), along with the set aside for Innovation (5 percent), the bulk of reverted funds also would be dedicated to the service component of the Act, rather than the prevention, early intervention or innovation components.

County officials have suggested that Innovation Funds can be at greatest risk for reversion, because of the nature of these programs and the required planning, review and approval process. Thus they point out that small county innovation programs, through reversion, can be subsidizing large county service components, which may not be consistent with the intent of the Act, which calls for transformational change with a focus on prevention, early intervention and innovation.

- **It is unclear when the three-year reversion clock starts.**

The Mental Health Services Act states that funds allocated to a county that have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years. The Act does not clarify if the three-year timeframe begins when funds are distributed to the counties, or when an approved expenditure plan has been put into place. For instance, it is not clear if county innovation funds must be spent within three years of receipt, or three years after the Commission approves an innovation plan.

- **It is unclear what mechanism the state would use to revert unspent MHSA funds.**

Initially, upon passage of the MHSA, the associated tax revenue was held by the state and distributed to the counties upon state approval of a county MHSA plan. Statutory changes altered how MHSA funds flow to the counties, and they now receive monthly allocations based on MHSA revenues. Some have suggested that the greater level of state control over MHSA revenues allowed the state to calculate how much money was subject to reversion and to hold back those revenue amounts from future payments. However, because MHSA revenues are distributed to the counties independent of any plan review or fiscal monitoring, the state would need to establish a procedure to either require the counties to return unspent funds, or to reduce a county's monthly allocation based on the fund amount subject to reversion.

SECTION 2: The Department of Mental Health's (DMH) efforts to implement the Act

California voters passed Proposition 63, the Mental Health Services Act (MHSA) in November 2004. The Act imposed a one percent tax on annual income above $1 million for the purpose of funding mental health systems and services in California. Modeled after AB 2034 (Steinberg, Chapter 518, Statutes of 2000)[1], the Act created a broad continuum of prevention, early intervention, innovative programs, services and infrastructure, technology and training elements to effectively support the mental health system. The Act also divided the administrative responsibilities of overseeing and administering the Act between various state entities—the Department of Mental Health (DMH), the California Mental Health Planning Council (CMHPC) and created the Mental Health Oversight and Accountability Commission (MHSOAC) to perform additional oversight functions.

Funding requirements and restrictions were and continue to be a large part of the MHSA narrative and statute. In 2004, the Act identified annual percentages of funds for certain programs, funds required to be set aside for community planning processes, training, personnel, administration, establishment of a local prudent reserve, interest and reversion of funds not spent. It also reserved amounts in subsequent fiscal years in a trust fund for education and training programs, capital facilities and technological needs. This became the "seed" money for counties to use in addressing some of their personnel and facility needs.

As early as January 2005, DMH[2] began providing instructions to counties on how to make funding requests, how to access funds, how to use startup funds and in general, provided clarification on the funding resources available to each county so that they could avoid the non-supplantation clause of the MHSA[3].

DISCUSSION OF THE MENTAL HEALTH SERVICES ACT POLICY ON REVERSION

By the August 2006, DMH provided instructions to the counties regarding implementation of required three year program and expenditure plans, including explaining how counties could request funds in conformity with new statutory requirements.

In February 2007, the Department issued regulations for the Community Services and Supports (CSS) Component of the Act and provided clarity and specificity to the use of MHSA funds which were being distributed to the Counties. These regulations did not, however, provide any specificity as to reversion or the computation of reversion, although they did provide some reporting requirements related to the fiscal and programmatic elements of the MHSA. The regulations defined MHSA program and fiscal terms, including defining community planning processes, some general and fiscal reporting requirements, as well as report due dates and elements of CSS programs (i.e. full service partnerships, general system delivery, outreach and engagement).

By December of 2007, DMH followed those regulations with Information Notice 07-25, wherein fiscal elements of the MHSA were more comprehensively addressed. At that time, DMH distributed MHSA funds on a quarterly basis to each county, submitting funds 30 days prior to the start of each quarter. Recognizing that this fiscal practice created significant cash flow challenges for counties, DMH determined that annual MHSA revenues would first accumulate in the state Mental Health Services Fund for 12 months prior to distribution. The state would then distribute 75 percent of available MHSA revenues to a county at the beginning of a fiscal year, based on an approved county plan. The remaining 25 percent would be distributed upon submission of required reports, including the semi-annual Local MHS Fund Cash Flow Statement and the Annual MHSA Revenue and Expenditure Report.

This 75:25 distribution strategy was intended to address county cash flow challenges yet retain state-level fiscal control to ensure counties submitted their required financial reports.

This Information Notice also clarified and defined requirements in law related to interest earned on the Mental Health Services Fund, established local prudent reserve requirements, defined component allocations, explained what was meant by unexpended funds, and identified program sustainability, one time funding, cash management, parameters for a state-county MHSA agreement and payments to counties.

DMH's efforts to implement reversion

A few months after the release of that fiscal policy Information Notice, DMH also issued Information Notice 08-07, clarifying the MHSA reversion policy mandated the Act.

DISCUSSION OF THE MENTAL HEALTH SERVICES ACT POLICY ON REVERSION

This Information Notice provided guidance to the counties as to how the Department would compute the amounts subject to reversion, since there had not been an actual start date for the distribution of MHSA funds. Rather, the department had distributed funds for one time startups, community planning processes, etc. The law's mandate was silent on exactly which date would serve as the time from which reversion computations could be made. The Department determined, based on the language in the Act that reversion would occur:

- When a county did not gain approval of its Three-Year Program and Expenditure Plan or Annual Update for all of the funds that were available on the Planning Estimate during the time period; or

- When a county's total expenditures over the reversion period, in a specific category identified in the MHSA Agreement, were less than the amount distributed to a county for that specific category for the year in question.

DMH maintained that a county could not be held to the reversion consequences for funds that DMH had not distributed, despite the three-year deadline included in the law. Instead, DMH determined that three events had to occur before counties could be held accountable for reverting MHSA funds.

- DMH released planning estimates to advise the counties what funds were available to them for a given year;

- DMH released instructions to the counties to advise them how to apply for the funds (Proposed Guidelines and Annual Update instruction); and

- The fiscal year to which the funds applied had started.

DMH practice was to recalibrate the reversion period in the event that the Department was late in its performance of any of these releases. Below are the scenarios DMH developed to compensate for any release delays:

- Prior to the start of the Fiscal Year, funds would be "allocated" at the start of the Fiscal Year to which the Planning Estimate applies;

- In the first quarter of the Fiscal Year to which the funds apply, funds would be considered allocated at the start of that Fiscal Year;

- After the end of the first quarter of the FY to which the funds apply, funds will be considered allocated, for the purposes of calculating reversion, at the beginning of the following FY.

DISCUSSION OF THE MENTAL HEALTH SERVICES ACT POLICY ON REVERSION

To facilitate counties' reversion calculations, the following table was sent as an Enclosure to the Reversion Information Notice (08-07):

Enclosure I

Reversion Period for Previously Released Funds

Component/Source Document	Funding From Fiscal Year	Planning Estimates and Proposed Guidelines Released	Reversion Period	
			Start	End
Community Program Planning				
DMH Letter 05-01	FY04/05	1/18/2005	FY05/06	FY07/08
Community Services and Supports				
DMH Letters 05-02 and 05-05	FY05/06	8/1/2005	FY05/06	6/30/2008
DMH Letter 06-03	FY06/07	2/3/2006	FY06/07	6/30/2009
DMH Letter 06-09	FY07/08	11/29/2006	FY07/08	6/30/2010
DMH Info Notice 07-21	FY07/08 Augmentation	10/18/2007	FY08/09	6/30/2011
MHSA Housing Program-DMH Letter 07-06*	FY07/08	5/14/2007	FY08/09	6/30/2011
Workforce Education and Training				
DMH Info Notices 07-06 and 07-14	FY 06/07	7/24/2007	FY07/08	6/30/2017
Prevention and Early Intervention				
DMH Info Notices 07-17 and 07-19	FY 07/08	9/25/2007	FY07/08	6/30/2010
DMH Info Notices 07-17 and 07-19	FY 08/09	9/25/2007	FY08/09	6/30/2011

* Application was not released until 8/6/2007.

DMH Information Notice 08-07 also clarified some of the terminology (Funds Allocated to a County and Years for the Purpose of Reversion, Funds Spent, Authorized Purpose, and Local Prudent Reserve), the Act used when establishing its reversion mandate.

As indicted by the table, the Department established a complicated process for determining when the reversion "clock" would start, based on its ability to inform the counties of their projected revenues, to provide clear guidance on how funds should be used and to ensure they had sufficient time to spend those revenues within the three-year window. As outlined in Section 3, subsequent changes to the Act modified the state-county relationship and thus the need for new reversion guidelines.

SECTION 3: Legislative changes to the Act since its inception.

The reversion policy, alone, was not the only complication to the implementation of fiscal issues related to the MHSA. DMH was backlogged on reviewing and approving county plans, resulting in delayed funding distributions to the counties. By March 2009, AB 5 (Chapter 20, Statutes of 2009-10 3rd Ex. Sess.) amended the Act. Enacted as

urgency legislation, this law clarified that the Mental Health Services Oversight and Accountability Commission (MHSOAC) would administer its operations separate and apart from the Department of Mental Health (DMH), streamlined the approval process for county plans and updates, and provided timeframes for DMH and MHSOAC to review and/or approve plans.

For the next two years, additional MHSA programs rolled out (Prevention and Early Intervention, the MHSA Housing Program, Workforce Education and Training). Planning Estimates were published, counties submitted Revenue and Expenditure reports, annual updates, three year program and expenditure plans and DMH distributed funds based upon the 75:25 methodology developed in December 2007.

By March 2011 Governor Brown signed into law AB 100 (Chapter 5, Statutes of 2011) which further amended the MHSA. This bill dedicated FY 2011-12 MHSA funds on a one-time, emergency basis to non-MHSA programs such as Early, Periodic, Screening, Treatment and Diagnosis (EPSDT), Medi-Cal Mental Health Managed Care, and mental health services provided for special education pupils. In addition to distributions to these non-MHSA entities, AB 100 directed the State Controller's office to distribute to counties the remainder of their 2011-12 component allocations.

This bill also reduced the administrative role of DMH. Among other changes, the bill eliminated the requirement for counties to submit plans to DMH and for DMH to review and approve these plans prior to implementation. To assist counties in accessing MHSA funds without delay, the bill directed the State Controller to continuously distribute, on a monthly basis, MHSA funds to each county's Local Mental Health Services Fund beginning in April 2012.

With those statutory changes, neither the MHSOAC nor DMH[4] had responsibility for reviewing and approving plans or annual updates, and since AB 100 changed the reporting requirements for the Revenue and Expenditure Report, counties were not required to submit any of these reports, nor were state entities required to collect them. However, some 18 months later, legislation again changed the rules and the counties were again required to submit Revenue and Expenditure Reports to the state.

Statutory changes have altered the state's fiscal role, but reversion requirements have not changed.

While the fiscal relationship between the state and the counties, with regard to MHSA funds, has evolved significantly, reversion requirements in the MHSA have not changed. But as the fiscal relationship changed, the rules that DMH had put in place for reversion lost relevance. Concurrently, responsibility for fiscal policy shifted from the Department of Mental Health as it was eliminated, to the Department of Health Care Services, which has recently begun the process of developing new fiscal rules and regulations for the MHSA.

DISCUSSION OF THE MENTAL HEALTH SERVICES ACT POLICY ON REVERSION

In June of this year, the Department of Health Care Services issued a new Information Notice to the counties to clarify whether Innovation Funds are subject to reversion. The Notice, which is included in this packet, states that MHSA funds received as far back as Fiscal Year 2008-09 are not subject to reversion until July 1, 2019. It is not clear how this information notice is aligned with the statutory direction for a three-year reversion window.

This evolution of state fiscal policy – including reversion requirements – is significant, because it may indicate that the reversion requirements facing the counties are different for portions of the fiscal years between 2008-09 and 2015/16 as the state modified the requirements for the counties across those years. Untangling the requirements for reversion for each county, across each of those years, as the rules evolved, would likely be prohibitively difficult relative to the goals of reversion policy.

---

[1] The AB 2034 initiative provided funding for 53 mental health programs operating in 34 counties and cities throughout California. The programs provided services to a target population, whose needs previously went largely unmet, individuals with a mental illness who had been previously homeless or incarcerated. At the height of the AB 2034 initiative, these programs were serving almost 5,000 individuals through recovery oriented mental health services that followed a harm reduction mode and provided supportive housing. See http://www.casra.org/docs/ab2034.pdf

[2] For purposes of this discussion on the chronology of the fiscal requirements of the Act, the term DMH will be used although the Department, itself was eliminated in FY 2011-12 and fiscal management and authority over the funds related to the Act are currently divided between the Department of Health Care Services, The State Controller's Office, the Mental Health Services Act Oversight and Accountability Commission and the Office of Statewide Health Planning and Development.

[3] DMH Letters 05-02 and 05-04 were the first documents that began to track funds available to the counties, as well as the principle of non-supplantation, which requires that MHSA funds were not be used to fund existing programs. Planning Estimates, which included MHSA funds available for distribution for all components, were later developed and sent in future DMH Information Notices.

[4] At this juncture, AB 102 was also written and passed at essentially the same time. It eliminated the Department of Mental Health and required the department to develop a Transition Plan, based on input from stakeholders reporting the process for transferring its staff and program, and financing to other state departments. For a complete copy of the Plan see http://www.dsh.ca.gov.Publicaations/docs/Transitions_Plan/DMHTransitionPlan.pdf

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2309

December 5, 2011

DMH INFORMATION NOTICE NO.: 11-15

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: CALCULATION OF REVERSION OF MENTAL HEALTH SERVICES ACT (MHSA) INNOVATION (INN) COMPONENT FUNDS

REFERENCE IMPLEMENTATION OF THE MHSA, WELFARE AND INSTITUTIONS CODE (WIC) SECTIONS 5830, 5892(a)(6), and 5892(h)

Section 5892(h) of the WIC requires the reversion of funds which have not been spent for their authorized purpose within specified timeframes to the state Mental Health Services Fund. This Department of Mental Health (DMH) Information Notice provides clarification to Counties regarding the calculation of reversion of MHSA INN component funds.

In calculating reversion of unexpended funds Counties should consider Innovation funds that have been expended as part of their CSS and PEI expenditures, with 20 percent of the Innovation expenditures associated with PEI and 80 percent associated with CSS. To determine the amounts of funds subject to reversion, Counties are instructed to total their expenditures and subtract these expenditures from the distribution for the year for which funds are reverting separately for PEI and CSS. If the total expenditures for CSS or PEI (including Innovation funds) are greater than the amount distributed for CSS or PEI (including Innovation funds), no funds will revert. If expenditures are less than the amount distributed, the difference is the amount of funds that will revert to the State Mental Health Services Fund.

Any funds reverting from these combined totals shall be from each component in proportion to the component allocation in the combined totals for PEI and Innovation, and in proportion to the component allocation in the combined totals for CSS and Innovation. If the combined PEI and Innovation expenditure amount is subject to reversion, the

amount reverted from PEI shall be equal to the reversion amount times the proportion of PEI from the combined component allocation (PEI/INN), and the balance would be from Innovation. Similarly, if the combined CSS and Innovation amount is subject to reversion, the amount reverted from CSS shall be equal to the reversion amount times the proportion of CSS from the combined component allocation (CSS/INN), and the balance would be from Innovation.

Counties should continue to comply with all requirements in the Act, including sections 5892 and 5830.

If you have any questions regarding this Information Notice or the calculation for reversion of Innovation funds, please contact Clark Marshall at Clark.Marshall@mhsoac.ca.gov, telephone (916) 445-8788 or Kevin Hoffman at Kevin.Hoffman@mhsoac.ca.gov, telephone (916) 445-8740.

Sincerely,

Original signed by

CLIFF ALLENBY
Acting Director

Enclosure

cc: California Mental Health Planning Council
California Mental Health Directors Association
Mental Health Services Oversight and Accountability Commission
Acting Deputy Director, Office of Community Services

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 23, 2016

MHSUDS INFORMATION NOTICE NO.: 16-026

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES

SUBJECT: RESCINDED – Department of Mental Health (DMH) INFORMATION NOTICE 11-15

Effective July 1, 2016, DMH Information Notice 11-15, Calculation of Reversion of Mental Health Services Act Innovation (INN) Component Funds, is rescinded.

Any INN funds received in FY 2008-09 through FY 2015-16 that were not spent or reverted will be subject to reversion if not spent within three fiscal years, from July 1, 2016.

Should you have any questions regarding this Information Notice, please contact Donna Ures at donna.ures@dhcs.ca.gov or (916) 324-0401.

Sincerely,

Karen Baylor, Ph.D., LMFT, Deputy Director
Mental Health & Substance Use Disorder Services

Ben Johnson is a Fiscal and Policy Analyst at California's Legislative Analyst's Office (LAO), where he covers the state's Medi-Cal program, behavioral health services, and child welfare services. Before coming to the LAO, Ben attended graduate school at the University of Michigan, where he received his Master of Public Policy degree and conducted research on variation in state welfare policies under the Temporary Assistance for Needy Families block grant program, the effect of income and benefits policies on population health, and the financial regulation of U.S. housing markets. Prior to pursuing his graduate education, Ben helped administer an independent living program for individuals with developmental disabilities and worked for a law firm in the area of immigration law.

Please provide an overview of the California's MHSA reversion policies, including information on the role of the Department of Health Care Services, other state agencies where appropriate, and the role of the counties with regard to implementing reversion.

The Mental Health Services Act (MHSA) was approved by voters in 2004 and enacted a one percent tax on incomes over $1 million, with revenues going toward expanded mental health services and prevention activities. Until 2012, the distribution of local MHSA funds was contingent upon state approval of counties' local MHSA spending plans. Since 2012, MHSA funds have been continuously allocated to counties on a monthly basis according to a formula. The MHSA directs counties to spend MHSA funds on three general classes of activities: Community Services and Supports (CSS), which comprises direct mental health services (often in combination with supportive social services); Prevention and Early Intervention (PEI), which comprises such activities as awareness campaigns and early intervention strategies; and Innovation (INN), which allows counties to experiment with new models and programming to combat mental illness.

The MHSA lays out the broad parameters of the state's MHSA reversion policy, requiring that any funds not spent in accordance with counties' approved MHSA spending plans within three years revert to the Mental Health Services Fund (MHSF), for use by other counties. There are, however, two exemptions within the MHSA that allow counties to legally retain MHSA funds for a period longer than three years. The first exemption allows funds placed in counties' prudent reserves, as established in the MHSA and identified in counties' spending plans, to not revert after three years—these funds are meant to be accessible in years when funding does not keep up with the service needs in a county, for example, in an economic downturn. Given the volatility of the MHSA revenue stream, a provision of prudent reserves to address this volatility

is a sound budgeting practice. The second exemption allows funds designated to be spent on capital facilities, technological needs, or education and training to be retained for 10 years before reverting to the MHSF if unspent.

Since 2012, the Department of Health Care Services (DHCS) has been the state entity with principal responsibility for overseeing county MHSA funding that would include implementation of the MHSA reversion policy. (Prior to 2012, the Department of Mental Health (DMH) had this authority. In 2012, the authorities and responsibilities of DMH with respect to state oversight of the bulk of mental health programs were transferred to DHCS.) The MHSA grants DHCS authority, in *consultation* with the Mental Health Services Oversight and Accountability Commission, to issue regulations to implement the act, which would include the guidelines needed to operationalize the MHSA's reversion requirements. To this day, regulations implementing reversion have yet to be promulgated by DHCS, which, according to DHCS, is a prerequisite for implementation of a reversion policy. DHCS is currently in the process of drafting MHSA regulations, which will include reversion guidelines. Draft regulations are expected to be made public in early 2017 and final regulations are expected to be fully promulgated by mid-2018. In the absence of MHSA regulations, DHCS has *not* implemented an MHSA reversion policy. Thus, unspent county funds are not currently subject to reversion.

DHCS did recently issue guidance in the form of an Information Notice rescinding a previous Information Notice put out by DMH that outlined how reversion with respect to INN funds would be calculated. It is our understanding that the policy laid out in the DHCS notice represents a signal of intent rather than a binding rule that counties are currently subject to. The new, prospective policy outlined in the Information Notice treats INN separately, declaring that funds designated for INN projects will be identified apart from CSS and PEI funds and reverted

if unspent with the three-year time allowance. Moreover, the notice communicates that INN funds allocated during the entire period from fiscal years 2008-09 to 2015-16 will be subject to reversion if unspent by July 1, 2019. This represents a potential policy shift that could change county practices.

Counties are subject to existing regulation that makes them responsible for submitting their Annual Revenue and Expenditure Reports (ARERs) in a timely fashion. ARERs are important because they outline county revenues and expenditures, and thus are expected to serve as the state's tool for determining what county funds are subject to reversion once DHCS has fully promulgated regulations for an MHSA reversion policy.

Reversion policy under the MHSA is intended to create an incentive for counties to spend MHSA revenues to address urgent mental health needs. Please comment on the role of fiscal incentives, such as reversion, and lessons learned from the perspective of the LAO on how to make fiscal incentives effective.

The reversion of unspent funds is a budget policy that is common across California state government. Whether a reversion policy applies, however, tends to depend on the fund source in question. For example, General Fund dollars typically revert back to the General Fund if not encumbered within one year, or expended within two years following the year of encumbrance. The broad parameters for MHSA reversion are thus generally consistent with state budgeting practices for the General Fund. On the other hand, unspent realignment funds generally do not revert, but are instead retained by counties to expand services or hold as reserves. (As with MHSA funding allocated to counties, realignment funds are generally continuously appropriated outside of the annual budget process.) Thus, precedent exists within California state government for both reverting unspent funds and allowing unspent funds to be retained.

When it comes to the state financing of local agencies, the reversion of unspent funds provides an incentive for local entities to be proactive in spending down their funding. Moreover, in cases where funding outpaces the service needs in a particular community, excess funding in one area can be reclaimed and redistributed to areas of greater need. Reversion policies have their potential tradeoffs. One potential tradeoff of a reversion policy is that it can encourage spending for spending's sake, and therefore may not always ensure effective allocation of funding to areas of greatest need. In addition, it can take resources away from entities that have unmet needs but lack the operational capacity to efficiently and effectively deliver services in accordance with state requirements. Taking away unspent funds from entities that lack capacity can have the effect of further impairing these entities' ability to achieve the state's objectives. (Such capacity constraints raise other issues that should be addressed by the state. For example, there may be role for state-provided technical assistance to counties.) Balancing these tradeoffs represents a major challenge when it comes to the state financing of local entities—how to establish fiscal incentives that effectively encourage achievement of the state's objectives without in effect imposing financial penalties that result in some local entities having to relinquish the resources needed to carry out their mission? To appropriately balance such tradeoffs, careful consideration ought to be given to the potential incentive/disincentive impact of any fiscal penalties (or rewards) that are imposed upon local administering agencies.

Overall, variations on fiscal incentives to influence local spending behavior can serve different goals. Accordingly, such fiscal incentives—whether a reversion policy or otherwise—should be tailored to help achieve the goals policymakers have in mind. An example from education policy illustrates that a fiscal incentive need not be based solely on a simple accounting of funds received and expended through time, as with the traditional reversion policy.

Under the state's After School Education and Safety (ASES) Program, which funds local after school education and enrichment programs, local grants are determined by a formula that apportions funding based on community needs. If local grantees fail to meet their *performance target* (in this case, after school program attendance) over multiple, consecutive years, their grant is *reduced* in subsequent years by an amount determined at the discretion of the California Department of Education (CDE). The funds reduced from the grant are then redistributed to other eligible after school programs. The use of fiscal incentives under the ASES program may be worth exploring should a broader evaluation of MHSA reversion policy, in light of the goals that the policy is intended to achieve, be deemed worthwhile.

In general, share your comments on the strengths, challenges, and uncertainties with regard to existing reversion policies and practices and share any guidance you believe the Commission should consider in our efforts to improve reversion policies.

Delay in adopting regulations to implement an MHSA reversion policy has been key to the lack of implementation of a reversion policy. This delay may have stemmed, in part, from historical changes around MHSA implementation and oversight. The legislative changes that made MHSA funding continuously flow to counties beginning in 2012 required a reevaluation of how the state would carry out reversion policy in practice. Soon thereafter, DMH was eliminated with a number of its responsibilities transferring to DHCS—a change in oversight that may have contributed to the delay in the implementation of an MHSA reversion policy.

The identification of the actual amount of county funds subject to reversion remains an outstanding issue that needs to be addressed before a reversion policy can be effectively implemented. Understanding (1) the amount of MHSA funds that counties have on hand, (2) the amount of MHSA funds on hand that counties have encumbered for upcoming projects, and (3)

year-by-year county expenditures (cash spending and encumbrances) are all preconditions to accurately identifying county funds potentially subject to reversion. The state currently does not have this county financial data reported in a form that is up-to-date, comprehensive, and consistent across counties.

While DHCS intends to identify funds subject to reversion through counties' ARERs, this could be problematic since counties currently utilize different accounting methodologies to generate the financial information they report in the ARERs. For example, some counties separate federal funds from MHSA dollars while other counties aggregate the funds and report them together. Therefore, it will be important for DHCS' regulations to provide clear standards for how financial data are reported from the counties.

Challenges also exist that are specific to county financing of MHSA activities. The most commonly cited challenge is that the window for final reconciliation of Medicaid claims is longer than the reversion period. Disallowances from billing Medicaid for ineligible mental health service claims can take as long as seven years, while the MHSA reversion period is generally three years. It is our understanding that counties may be accumulating large financial balances in anticipation of having to return federal Medicaid funds for service claims that have been disallowed at the final federal audit. If this is in fact a primary reason behind counties' accumulation of financial reserves (which are on top of and apart from the "prudent reserves" that the MHSA allows counties to keep), executing an MHSA reversion policy may in practice take away funds that counties had set aside to pay for anticipated federal disallowances. If additional exploration reveals that planning for Medicaid disallowances is in fact a primary factor behind unspent county MHSA funds, it could be beneficial for the state to look into whether this is a legitimate reason for counties to build up reserve balances, and thus whether

laws or regulations should be adopted that expressly allow county reserves for this purpose and provide parameters for their use.

In closing, it should be noted that county-specific challenges when it comes to the unspent funds potentially subject to reversion likely vary from county to county. A more comprehensive understanding of what is preventing counties from spending their MHSA allotments in full would constitute a useful first step before finalizing the state's MHSA reversion policy.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

VICTOR CARRION, M.D.
Chair
TINA WOOTON
Vice Chair
TOBY EWING
Executive Director

August 11, 2016

Ben Johnson, Fiscal & Policy Analyst
Office of the Legislative Analyst
925 L Street, Suite 1000
Sacramento, CA 95814

Dear Mr. Johnson,

Thank you for agreeing to participate in the Commission's public meeting on August 25th. As you know, the Commission is exploring the State's policy for fiscal reversion under the Mental Health Services Act (MHSA). Mental health stakeholders and county representatives have raised concerns that the State's reversion policies and practices may not be clear or implemented in a way that are aligned with the goals of the MHSA. The Commission is working to understand the current legal and regulatory requirements for reversion, how well they are working and strategies for improvement.

With those goals in mind, the Commission has invited a range of subject matter experts to serve on panels to provide guidance and help the Commission explore the State's reversion policies. Those panels will present during the Commission's August 25th meeting beginning at 9 a.m. in the Commission's offices at 1325 J Street, Suite 1700, in Sacramento.

To facilitate discussion for the meeting, we ask you to please respond to the following:

- Please provide an overview of the California's MHSA reversion policies, including information on the role of the Department of Health Care Services, other state agencies where appropriate, and the role of the counties with regard to implementing reversion.
- Reversion policy under the MHSA is intended to create an incentive for counties to spend MHSA revenues to address urgent mental health needs. Please comment on the role of fiscal incentives, such as reversion, and lessons learned from the perspective of the LAO on how to make fiscal incentives effective.
- In general, share your comments on the strengths, challenges, and uncertainties with regard to existing reversion policies and practices and share any guidance you believe the Commission should consider in our efforts to improve reversion policies.

In addition to responding to these issues, please feel free to share with the Commission any information you believe can help the Commission understand fiscal reversion policies and practices under the MHSA and improve the effectiveness of those policies and practices.

To support the Commission's discussions, we ask that you provide written responses and a brief bio, if possible, prior to the Commission meeting. Written responses allow us to share your comments with Commissioners and others who may not be able to attend the meeting on the 25th. Please note that your materials will be shared as public documents.

To facilitate a dialogue with the Commission and other panelists, please be prepared to provide brief oral comments (5-7 minutes) and to follow-up in question/answer format with the Commission.

Thank you again for agreeing to participate in this meeting. If you have any questions or comments, or if you plan to provide a PowerPoint or similar presentation, please let me know. I can be reached at toby.ewing@mhsoac.ca.gov or 916-445-8729.

Respectfully,

Toby Ewing

Toby Ewing
Executive Director

Cynthia Burt

Cynthia Burt is currently on staff at the MHSOAC as a retired annuitant. Prior to retiring she was employed with the MHSOAC and before that with the Departments of Mental Health (DMH) and Rehabilitation. While at the DMH, Cynthia worked on the MHSA regulations team and served as the Manager of the MHSA Housing program for two years. She also managed all the other MHSA programs, components and staff during the transition before the elimination of the Department. She has over 30 years working as a counselor in mental health and rehabilitation, in both the private and public sectors. She earned a Master's of Science in Rehabilitation Counseling from CSU, Sacramento.

Mental Health Services
Oversight & Accountability Commission

POLICY on REVERSION
Mental Health Services Act (MHSA)

Presentation to MHSOAC
August 2016
Cynthia Burt, MS

WELLNESS • RECOVERY • RESILIENCE

MHSA Reversion

- Other than funds placed in a reserve in accordance with an ***approved plan***, any ***funds allocated*** to a county that have not been spent for their ***authorized purpose*** within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the fund. Welfare and Institutions Code, (WIC) § 5892(h)

Sections

- Introduction
- Discussion of the 2016 status of reversion
- Historical backdrop of the Department of Mental Health's (DMH) efforts to implement the Act and Reversion
- Legislative Changes
- Future Challenges

Introduction:
The History of the MHSA Suggests

- The reversion policy was developed to incentivize counties to spend MHSA funds.
- Specific programmatic elements for the use of these funds were intended to “transform” the mental health system.
- In its oversight capacity, MHSOAC should facilitate a discussion, if not a resolution, to the challenges in implementing the goal of the MHSA reversion policy.

Section 1:
Status of Reversion

- Reversion policy has two deadlines
- Only a handful of Counties have had funds revert
- MHSA funds are distributed by the State Controllers Office (SCO)
- What happens to reverted funds?

Section 2:
DMH efforts to implement The Act

- 2007 Final regulations for Community Services and Supports
- Dec 2007 Information Notice 07-25 explanation of fiscal elements
  - Cash Flow Statement
  - Changes to distribution

Section 2…continued: DMH efforts to implement Reversion

- DMH Information Notice 08-07
- Calibration of Reversion period
- Clarification of terminology

Section 3:
Legislative changes made to The Act

- Three major changes
  - AB5
  - AB100
    - Changes to fiscal and programmatic reporting structure
  - AB1467
    - New WIC Section (5899) added for Revenue and Expenditure Reports
    - Reporting Gaps resolved
- No changes to Reversion

Section 4:
Future Challenges

- DHCS Information Notice 16-026 (Reversion for Innovation Funds)
- What are the key challenges with implementing the MHSA policy on reversion?
- What are the legal requirements for reversion?
- Has the State provided enough clarity on the policy? If not, what else is needed?

Section 4…continued: Future Challenges

- DHCS Information Notice 16-026, issued June 23, 2016, rescinded the previous DMH Information Notice on Innovative Program funds reversion. Is there another way to address this so that counties do not lose INN funds to reversion and have them folded into other counties' CSS allocation?
- Why has DHCS issued this Innovation reversion Information Notice at this juncture, and what authority does it have to extend the reversion trigger from three years to up to 11 years (2008 through 2019)?
- Can or should the MHSA be amended to clarify reversion, including the principles, processes and reallocation of funds?
- Are there any intermediary steps the counties and the State can take to implement the policy of reversion in order to be in compliance with the law?

Questions???

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

VICTOR CARRION, M.D.
Chair
TINA WOOTON
Vice Chair
TOBY EWING
Executive Director

August 11, 2016

Cynthia Burt
MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Ms. Burt,

Thank you for agreeing to participate in the Commission's public meeting on August 25th. As you know, the Commission is exploring the State's policy for fiscal reversion under the Mental Health Services Act (MHSA). Mental health stakeholders and county representatives have raised concerns that the State's reversion policies and practices may not be clear or implemented in a way that are aligned with the goals of the MHSA. The Commission is working to understand the current legal and regulatory requirements for reversion, how well they are working and strategies for improvement.

With those goals in mind, the Commission has invited a range of subject matter experts to serve on panels to provide guidance and help the Commission explore the State's reversion policies. Those panels will present during the Commission's August 25th meeting beginning at 9 a.m. in the Commission's offices at 1325 J Street, Suite 1700, in Sacramento.

To facilitate discussion for the meeting, we ask you to please respond to the following:

- Please provide an overview of the process used by the former Department of Mental Health to establish rules and regulations regarding reversion and related fiscal practices that may have impacted reversion.
- Please share additional information that you believe would help the Commission understand the evolution of the state's fiscal reversion policies and how they are understood today.

In addition to responding to these issues, please feel free to share with the Commission any information you believe can help the Commission understand fiscal reversion policies and practices under the MHSA and improve the effectiveness of those policies and practices.

To support the Commission's discussions, we ask that you provide written responses and a brief bio, if possible, prior to the Commission meeting. Written responses allow us to share your comments with Commissioners and others who may not be able to attend the meeting on the 25th. Please note that your materials will be shared as public documents.

To facilitate a dialogue with the Commission and other panelists, please be prepared to provide brief oral comments (5-7 minutes) and to follow-up in question/answer format with the Commission.

Thank you again for agreeing to participate in this meeting. If you have any questions or comments, or if you plan to provide a PowerPoint or similar presentation, please let me know. I can be reached at toby.ewing@mhsoac.ca.gov or 916-445-8729.

Respectfully,

Toby Ewing

Toby Ewing
Executive Director

Brenda Grealish was appointed Assistant Deputy Director for Mental Health and Substance Use Disorder Services within the California Department of Health Care Services in November 2014. As Assistant Deputy Director, Ms. Grealish is responsible for assisting the Deputy Director with the work under all of the mental health and substance use disorder divisions. Ms. Grealish began her state career with the Office of Statewide Health Planning and Development. She then worked at the Department of Mental Health for almost ten years in increasingly responsible positions. She has four years of management experience with the Department of Corrections and Rehabilitation during which she advanced from a Research Manager II to a Research Manager III, then to Deputy Director (Exempt) position within a less than three year period. Prior to her appointment as Assistant Deputy Director, Ms. Grealish was the Chief, Mental Health Services Division. Ms. Grealish has a Bachelor's and Master's Degree in Psychology.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

VICTOR CARRION, M.D.
Chair
TINA WOOTON
Vice Chair
TOBY EWING
Executive Director

August 11, 2016

Karen Baylor
Deputy Director, Mental Health and Substance Use Disorder Services
California Department of Health Care Services
1501 Capitol Avenue, MS 4050
Sacramento, CA 95899-7413

Dear Ms. Baylor,

Thank you for agreeing to participate in the Commission's public meeting on August 25th. As you know, the Commission is exploring the State's policy for fiscal reversion under the Mental Health Services Act (MHSA). Mental health stakeholders and county representatives have raised concerns that the State's reversion policies and practices may not be clear or implemented in a way that are aligned with the goals of the MHSA. The Commission is working to understand the current legal and regulatory requirements for reversion, how well they are working and strategies for improvement.

With those goals in mind, the Commission has invited a range of subject matter experts to serve on panels to provide guidance and help the Commission explore the State's reversion policies. Those panels will present during the Commission's August 25th meeting beginning at 9 a.m. in the Commission's offices at 1325 J Street, Suite 1700, in Sacramento.

To facilitate discussion for the meeting, we ask you to please respond to the following:

- Please outline the role of the Department of Health Care Services (DHCS) with regard to establishing policies and procedures relating to reversion under the MHSA and the strategies the Department has in place to implement those policies and procedures.
- Please share with the Commission information on any challenges or opportunities for improvement the department has identified with regard to implementing reversion and what efforts are underway to address those challenges or opportunities.
- DHCS recently released an Information Notice extending the reversion timeframe to funds released as far back as 2008. Recognizing the law calls for reversion after three years for most MHSA funds, please share with the Commission the rationale for the policy established with that Information Notice.

In addition to responding to these issues, please feel free to share with the Commission any information you believe can help the Commission understand fiscal reversion policies and practices under the MHSA and improve the effectiveness of those policies and practices.

To support the Commission's discussions, we ask that you provide written responses and a brief bio, if possible, prior to the Commission meeting. Written responses allow us to share your comments with Commissioners and others who may not be able to attend the meeting on the 25th. Please note that your materials will be shared as public documents.

To facilitate a dialogue with the Commission and other panelists, please be prepared to provide brief oral comments (5-7 minutes) and to follow-up in question/answer format with the Commission.

Thank you again for agreeing to participate in this meeting. If you have any questions or comments, or if you plan to provide a PowerPoint or similar presentation, please let me know. I can be reached at toby.ewing@mhsoac.ca.gov or 916-445-8729.

Respectfully,

Toby Ewing

Toby Ewing
Executive Director

Kimberly Danner has served as the Napa County Deputy Chief Fiscal Officer for the Divisions of Mental Health, Alcohol & Drug and Public Health for four years of the ten years she has been employed with Napa County Health and Human Services. Some of her responsibilities include the preparation and oversight of division budgets, compliance and claiming for various Federal and State grants and the proper accounting of governmental funds.

Prior to working for Napa County, Kimberly held several audit positions with the State of California, including California Department of Transportation, the California State Controller's Office, and the California Employment Development Department. Kimberly has a bachelor's degree in accounting and a master's degree in business administration. She is also in the process of completing the requirement to become a Certified Public Accountant.

A Tradition of Stewardship
A Commitment to Service

Health & Human Services Agency
Fiscal Administration

2751 Napa Valley Corporate Drive
Building B
Napa, CA 94559

Main: (707) 253-4279
Fax: (707) 259-8335

Howard K. Himes
Agency Director

August 24, 2016

Toby Ewing
Executive Director
Mental Health Services Oversight & Accountability Commission
1325 J Street, Ste 1700
Sacramento, CA 95814

Mr. Ewing:

Thank you for this opportunity to share some of the challenges Counties are facing in administering the Mental Health Services Act (MHSA). The responses below are the views of Napa County and include input from discussions we have had with other Counties via CBHDA's Financial Services Committee.

- Counties have come under criticism from State level stakeholders regarding the variability of programs, outcomes and processes. While it is incumbent upon the Counties to come together in efforts such as CBHDA's Measurements, Outcomes and Quality Assessment (MOQA) initiative to develop approaches that address these concerns. The variety of requirements, approaches and structures imposed upon Counties by the MHSOAC and DHCS create a level of complication that significantly contribute to the issues as well.

- Policy miscommunications involving innovation reversion has set Napa County back considerably in the project development, community input, RFP and contracting processes because of the uncertainty around whether those funds were still available for County use. The recent issuance of DHCS Notice 16-023 has provided some clarification, but the delay in communication to counties has had a negative effect on our ability to properly plan and spend these funds within the 3 year timeframe.

- Counties also require guidance around prudent reserve. For example, in FY 2007-2008, the State Department of Mental Health allowed Counties to put PEI funds into their prudent reserve, but remained silent about the years that followed. Some Counties placed PEI funds into the prudent reserve believing this was an allowable practice based on past experience, the lack of prohibition against it in the Act and subsequent regulations, but we are now being told informally that this is not an allowed practice and the PEI funds from FY 08-09 and subsequent

years may revert. If the purpose of a prudent reserve is to continue funding programs when revenues drop, why would this **not** apply to PEI funds as well?

- The Revenue and Expense Report (RER) has changed over time becoming increasingly more complex. The inclusion of Short-Doyle Medi-Cal (SDMC) revenue offset is a change that has proven to be particularly difficult. California's Short-Doyle Medi-Cal reimbursement is a very complicated system that is organized much differently than MHSA funding and the final reimbursement takes years to determine, as a result it is not feasible to accurately report the two funding streams side by side. For example, many counties are currently completing their FY2010-2011 cost report audit, which will determine the final reimbursement and the final impact to our MHSA programs. In addition, the current RER form is not compatible with Notice 16-023 because it does not allow entry of expenditures for MHSA funds that are older than three years.

- We would also like to direct the attention of the commission to the issues submitted by the California Behavioral Health Director's Associations' Financial Services' subgroup committee for a list of additional challenges.

It is our hope that Counties can work with MHSOAC and DHCS to jointly design processes that meet the needs of Counties, the State and stakeholders while achieving the purpose and intent of the Mental Health Services Act. It is important to establish clear reversion and prudent reserve guidelines in order to assist Counties in administering this program more effectively. This should be a forward looking policy that takes Counties and stakeholders interests into consideration.

Recommendations that we would suggest to improve the MHSA program would include forming a workgroup with participation from Counties, the State and CBHDA to work through complicated issues such as SDMC revenue offset. We also feel it is important to have greater technical assistance provided to Counties when issues arise in both the programmatic and financing side of the MHSA program.

Sincerely,

Kimberly Danner
Deputy Chief Fiscal Officer
Napa County Health and Human Services
Phone: (707) 253-4426
Email: Kimberly.Danner@countyofnapa.org

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

VICTOR CARRION, M.D.
Chair
TINA WOOTON
Vice Chair
TOBY EWING
Executive Director

August 17, 2016

Kimberly Danner, MBA
Deputy Chief Fiscal Officer
Napa County HHSA - Fiscal Division
2751 Napa Valley Corporate Drive, Building B
Napa, CA 94558

Dear Ms. Danner,

Thank you for agreeing to participate in the Commission's public meeting on August 25th. As you know, the Commission is exploring the State's policy for fiscal reversion under the Mental Health Services Act (MHSA). Mental health stakeholders and county representatives have raised concerns that the State's reversion policies and practices may not be clear or implemented in a way that are aligned with the goals of the MHSA. The Commission is working to understand the current legal and regulatory requirements for reversion, how well they are working and strategies for improvement.

With those goals in mind, the Commission has invited a range of subject matter experts to serve on panels to provide guidance and help the Commission explore the State's reversion policies. Those panels will present during the Commission's August 25th meeting beginning at 9 a.m. in the Commission's offices at 1325 J Street, Suite 1700, in Sacramento.

To facilitate discussion for the meeting, we ask you to please respond to the following:

- Please share with the Commission your views on the challenges facing the counties regarding fiscal reversion under the MHSA.
- Please comment on reforms or strategies the state should consider to address the needs of counties, and the goals of the MHSA, regarding implementing and complying with the rules and regulations associated with reversion.
- More specifically, comment on whether the state has provided clarity and consistency in its implementation of reversion policy and what steps the state might take, if any, to improve the clarity and consistency of its rules.

In addition to responding to these issues, please feel free to share with the Commission any information you believe can help the Commission understand fiscal reversion policies and practices under the MHSA and improve the effectiveness of those policies and practices.

To support the Commission's discussions, we ask that you provide written responses and a brief bio, if possible, prior to the Commission meeting. Written responses allow us to share your comments with Commissioners and others who may not be able to attend the meeting on the 25th. Please note that your materials will be shared as public documents.

To facilitate a dialogue with the Commission and other panelists, please be prepared to provide brief oral comments (5-7 minutes) and to follow-up in question/answer format with the Commission.

Thank you again for agreeing to participate in this meeting. If you have any questions or comments, or if you plan to provide a PowerPoint or similar presentation, please let me know. I can be reached at toby.ewing@mhsoac.ca.gov or 916-445-8729.

Respectfully,

Toby Ewing
Executive Director

Melissa Chilton, Budget Specialist for Humboldt County Department of Health and Human Services has 15 years of financial management expertise in county Behavioral Health. Melissa is co-chair of the California Behavioral Health Directors Association Financial Analysis and Review Subcommittee (CBHDA-FARS). This subcommittee of CBHDA Financial Services advises on matters that directly concern county behavioral health programs.

Katy Eckert, MBA, Deputy Director
Yolo County Health & Human Services Agency

County concerns regarding MHSA Reversion:

- There is a misalignment between Medi-cal FFP earnings and the MHSA reversion period. Counties are paid at estimated Medi-cal rates that are not final for 5+ years. Currently, in FY 2016-17 counties are finishing up with FY 2009-10 Medi-cal audits/final settlements, 7 years after the services were provided.

- When counties invest Medi-cal dollars in current year operations it is always just an estimate of how much revenue will be available, and counties want to reinvest Medi-cal funds into MHSA programs without waiting for 5-7 years to identify the amount available.

- Many counties do not have other sources of funding to cover MHSA program costs apart from MHSA itself and the estimated federal Medi-cal dollars. If the Medi-cal estimate is off, then MHSA is affected.

- Counties have no way of re-opening their financial books for a year already closed, to increase or decrease MHSA expense based on the changing Medi-cal revenues estimates that continue for the 5-7 years until the federal revenue is finalized.

- The MHSA Revenue & Expenditure Report only provides estimated information on Medi-Cal revenue, and the corresponding MHSA expenses as this continues to settle out for 5-7 years.

- Besides the federal portion of Medi-Cal revenues, counties are also still getting adjustments to State General fund (EPSDT) revenues for prior years children services, so everywhere Medi-cal is discussed it may apply to both federal and state revenue streams. Accordingly, if EPSDT revenue estimates are off, then MHSA is affected.

- There has not been clear guidance on reversion policy, so each county has implemented different accounting practices. Counties all want to know how to calculate, especially going forward. Counties also have concerns that developing retroactively applied reversion guidelines may be difficult or impossible to calculate.

- Counties are unclear about how to account for audit exceptions between county and contractors when counties have to take money back from a contractor due to an audit for a prior year. Are recoupments subject to reversion? If so, what is the starting date on the reversion clock? And, how would this be accounted for on the MHSA Revenue & Expenditure Report?

- Counties are unclear about the starting date for the reversion period.

- Counties are unclear about how to treat encumbered funds and accruals.

- Counties are unclear on what the basis is to calculate dollars subject to reversion, as the MHSA Revenue & Expenditure reports submitted historically will not reflect accurate amounts due to the factors listed here.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

VICTOR CARRION, M.D.
Chair
TINA WOOTON
Vice Chair
TOBY EWING
Executive Director

August 11, 2016

Melissa Chilton, Budget Specialist
Humboldt County Department of Health and Human Services
507 F Street
Eureka, CA 95501

Dear Ms. Chilton,

Thank you for agreeing to participate in the Commission's public meeting on August 25th. As you know, the Commission is exploring the State's policy for fiscal reversion under the Mental Health Services Act (MHSA). Mental health stakeholders and county representatives have raised concerns that the State's reversion policies and practices may not be clear or implemented in a way that are aligned with the goals of the MHSA. The Commission is working to understand the current legal and regulatory requirements for reversion, how well they are working and strategies for improvement.

With those goals in mind, the Commission has invited a range of subject matter experts to serve on panels to provide guidance and help the Commission explore the State's reversion policies. Those panels will present during the Commission's August 25th meeting beginning at 9 a.m. in the Commission's offices at 1325 J Street, Suite 1700, in Sacramento.

To facilitate discussion for the meeting, we ask you to please respond to the following:

- Please share with the Commission your views on the challenges facing the counties regarding fiscal reversion under the MHSA.
- Please comment on reforms or strategies the state should consider to address the needs of counties, and the goals of the MHSA, regarding implementing and complying with the rules and regulations associated with reversion.
- More specifically, comment on whether the state has provided clarity and consistency in its implementation of reversion policy and what steps the state might take, if any, to improve the clarity and consistency of its rules.

In addition to responding to these issues, please feel free to share with the Commission any information you believe can help the Commission understand fiscal reversion policies and practices under the MHSA and improve the effectiveness of those policies and practices.

To support the Commission's discussions, we ask that you provide written responses and a brief bio, if possible, prior to the Commission meeting. Written responses allow us to share your comments with Commissioners and others who may not be able to attend the meeting on the 25th. Please note that your materials will be shared as public documents.

To facilitate a dialogue with the Commission and other panelists, please be prepared to provide brief oral comments (5-7 minutes) and to follow-up in question/answer format with the Commission.

Thank you again for agreeing to participate in this meeting. If you have any questions or comments, or if you plan to provide a PowerPoint or similar presentation, please let me know. I can be reached at toby.ewing@mhsoac.ca.gov or 916-445-8729.

Respectfully,

Toby Ewing
Executive Director

Michael R. Geiss
President, Geiss Consulting

Mr. Geiss is the founder of Geiss Consulting, a Sacramento-based management consulting firm. He has over twenty-nine years' experience providing services to public sector agencies. Prior to establishing Geiss Consulting, he had over nine years management consulting experience with NewPoint Group and seven years with Ernst & Young. He specializes in financial and economic analyses, business process improvement and operations analyses. Mr. Geiss has managed and participated in over one-hundred separate engagements for various State of California and other government entities, including more than twenty projects for the California Department of Mental Health, numerous projects for more than 25 county mental health agencies in California, and various projects for the California Behavioral Health Directors' Association and the California Institute for Behavioral Health Solutions.

Mr. Geiss provided fiscal consulting services to the California Department of Mental Health for most of his career. A sample of projects he completed for the Department include:

- Development of a revised Medi-Cal cost reporting system and rate setting methodology to meet federal Medicaid and Medicaid standards.
- Development of distribution strategies for the Mental Health Services Act funds, budget formats for counties to use in requesting MHSA funds, and maintenance of effort and non-supplanting issues related to the Act.
- Preparation of cost effectiveness demonstration calculations for the Department's two federal Freedom of Choice Waivers.
- Assisting the Department with preparation of a legislatively mandated analysis of the impact of the Health and Welfare Realignment Program on mental health services and funding.
- Development of a rate setting methodology for psychiatric hospital inpatient services.
- Evaluation of San Mateo County Mental Health Plan (MHP) pharmacy and laboratory costs under a federal Freedom of Choice Waiver in order to determine (1) whether the risk corridor should apply to historical expenditures and (2) what future year pharmacy and laboratory costs are estimated to be.
- Analysis of the case rate reimbursement system for the San Mateo County Mental Health Field Test Waiver.

MHSA Reversion Policy Considerations

Mental Health Services Act Oversight and Accountability Commission

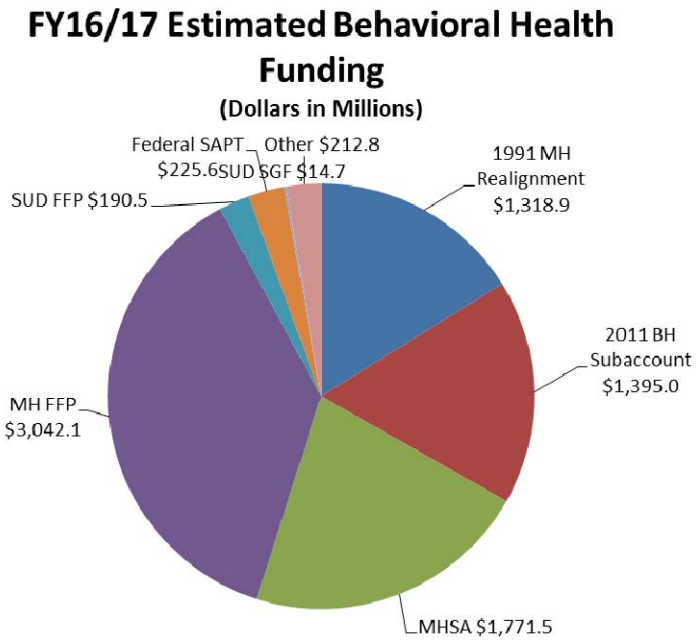
August 25, 2016

Mike Geiss

Geiss Consulting

Reversion Policy

- Reversion and other MHSA fiscal policies should be thought of in the context of overall community behavioral health funding
- MHSA fiscal policies and reporting should be applied consistently from year to year and county to county
- MHSA fiscal policies should be vetted through the regulatory process
- Policy makers need to be thoughtful about how they want to utilize the reversion mechanism



Reversion Considerations

- Goal of fiscal reversion
  - Provide an incentive for counties to implement and expand services
    - Don’t want counties to accumulate large amounts of funding
- Challenges with fiscal reversion
  - “Use it or lose it” approach doesn’t necessarily result in best use of funds
  - Volatile revenue source makes planning difficult
  - Local Boards tend to be conservative
  - Local government policies

Reversion Opportunities

- Develop understanding as to why there are unspent funds
- Clarify outstanding issues through regulatory process
  - Should “spent” be gross or net expenditures?
  - Should “authorized purpose” be each component?
  - Is three years the appropriate time period?
  - How should reverted funds be returned to the state?
- Consider other mechanisms to address unspent funds
  - Counties self-report funds they don’t have the capacity to spend
  - Adjust annual MHSA county allocations to reflect the expenditure capacity of each county
  - Allow counties to request an extension on the use of funds

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

VICTOR CARRION, M.D.
Chair
TINA WOOTON
Vice Chair
TOBY EWING
Executive Director

August 11, 2016

Mike Geiss
Geiss Consulting
2148 Campton Circle
Gold River, California 95670

Dear Mr. Geiss,

Thank you for agreeing to participate in the Commission's public meeting on August 25th. As you know, the Commission is exploring the State's policy for fiscal reversion under the Mental Health Services Act (MHSA). Mental health stakeholders and county representatives have raised concerns that the State's reversion policies and practices may not be clear or implemented in a way that are aligned with the goals of the MHSA. The Commission is working to understand the current legal and regulatory requirements for reversion, how well they are working and strategies for improvement.

With those goals in mind, the Commission has invited a range of subject matter experts to serve on panels to provide guidance and help the Commission explore the State's reversion policies. Those panels will present during the Commission's August 25th meeting beginning at 9 a.m. in the Commission's offices at 1325 J Street, Suite 1700, in Sacramento.

To facilitate discussion for the meeting, we ask you to please respond to the following:

- Please outline your perspective on the goals of fiscal reversion policies in the MHSA and the key challenges facing the state and the counties both to implement the existing requirements and to meet the goals of the act.
- Please comment on opportunities you see to improve how California implements reversion under the MHSA, in terms of strategies and opportunities the state should pursue, as well as strategies and opportunities that the counties should pursue to effectively meet the goals of reversion under the MHSA.
- With those opportunities in mind, please comment on whether there should be changes in the Act, to fully pursue the goals associated with reversion, or if changes in regulation, other policies or practices are more suited to improving the effectiveness of reversion policies.

In addition to responding to these issues, please feel free to share with the Commission any information you believe can help the Commission understand fiscal reversion policies and practices under the MHSA and improve the effectiveness of those policies and practices.

To support the Commission's discussions, we ask that you provide written responses and a brief bio, if possible, prior to the Commission meeting. Written responses allow us to share your comments with Commissioners and others who may not be able to attend the meeting on the 25th. Please note that your materials will be shared as public documents.

To facilitate a dialogue with the Commission and other panelists, please be prepared to provide brief oral comments (5-7 minutes) and to follow-up in question/answer format with the Commission.

Thank you again for agreeing to participate in this meeting. If you have any questions or comments, or if you plan to provide a PowerPoint or similar presentation, please let me know. I can be reached at toby.ewing@mhsoac.ca.gov or 916-445-8729.

Respectfully,

Toby Ewing

Toby Ewing
Executive Director

Mental Health Services
Oversight & Accountability Commission

EL DORADO COUNTY INNOVATION PLAN

August 25, 2016

WELLNESS • RECOVERY • RESILIENCE

Outline

- Summary
- Materials
- Regulatory Criteria
- What OAC staff Look for
- El Dorado County Presentation
- Motion

Summary

- El Dorado seeks approval for two innovation projects.
- Restoration of Competence in an Outpatient Setting. Total INN amount sought: $727,010.
  - Primary purpose is to increase access to services by creating an outpatient restoration of competency program.
  - Amount: $727,010. Project duration: 2 years.
- Community Based Engagement and Support Services. Total INN amount sought: $2,760,021.
  - Primary purpose is to promote interagency collaboration by staffing service “hubs” in local libraries in cooperation with Public Health and the First 5 Commission.
  - Amount: $2,760,021. Project duration: 4 years.
- Staff recommends that El Dorado’s two proposals have met or exceeded minimum program requirements

Materials

- The following materials were included in the meeting packets and are posted on our website:
  - Staff Innovation Summary, Community Based Engagement;
  - Staff Innovation Summary, Restoration of Competency
- The following materials were distributed as handouts and are posted on our website:
  - County Innovation Brief, Community-Based Engagement and Support Services;
  - County Innovation Brief, Restoration of Competency in an Outpatient Setting

Regulatory Criteria

- **Funds exploration of new and/or locally adapted mental health approach/practices**
  - Adaptation of an existing mental health program
  - Promising approach from another system adapted to mental health
- **One of four allowable primary purposes:**
  - Increase access to services
  - Increase access to services to underserved groups
  - Increase the quality of services, including measurable outcomes
  - Promote interagency and community collaboration
- **Addresses a barrier other than not enough money**
- **Cannot merely replicate programs in other similar jurisdictions**
- **Must align with core MHSA principles (e.g. client-driven, culturally competent, recovery-oriented)**
- **Promotes *learning***
  - Learning ≠ program success
  - Emphasis on extracting information that can contribute to systems change

What OAC Staff Look For

- **Specific requirements regarding:**
  - Community planning process
  - Stakeholder involvement
  - Clear connection to mental health system or mental illness
  - Learning goals and evaluation plan
- **What is the unmet need the county is trying to address?**
  - Cannot be purely lack of funding!
- **Does the proposed project address the need(s)?**
- **Clear learning objectives that link to the need(s)?**
- **Evaluation plan that allows the county to meet its learning objective(s)?**
  - May include process as well as outcomes components

INNOVATION

El Dorado County
Innovation Plan
Presentation by:

Jamie Samboceti, MA, LMFT

HHSA, Behavioral Health
Deputy Director

Innovation

- In the last few years, El Dorado County Mental Health Department, now Behavioral Health, has had to become an out of the box thinking machine. Increased acuity and need for enhanced services in our community has led us to develop new partnerships and become more creative in meeting services needs with already limited resources.

Exciting Transformation

- ICM/FSP expansion/SLT and WS
- CIT Program/SLT and WS
- ARF opened on WS
- Expanded Transition Housing/SLT and WS
- Adopted AOT/implementation pending
- Developed 12 performance indicators
- Hired a clinician to work co-located in CWS for Katie A
- Increased justice services for AB109/co-locate with Probation
- Developed and implemented TAY DBT Program in our local high schools. In our second year/SLT and WS
- Developed and will implement Sept 1, a medically fragile house for 3 at risk clients with high level medical problems.

County Challenges

- Substance abuse is high County wide
- Domestic Violence is high County wide
- Mental Health needs in rural outlying areas
- High levels of low-socioeconomic population
- Rural community with poor transportation
- Over impacted jails
- High numbers of drug positive births
- High recidivism in jails and ER crisis contacts

County Strengths

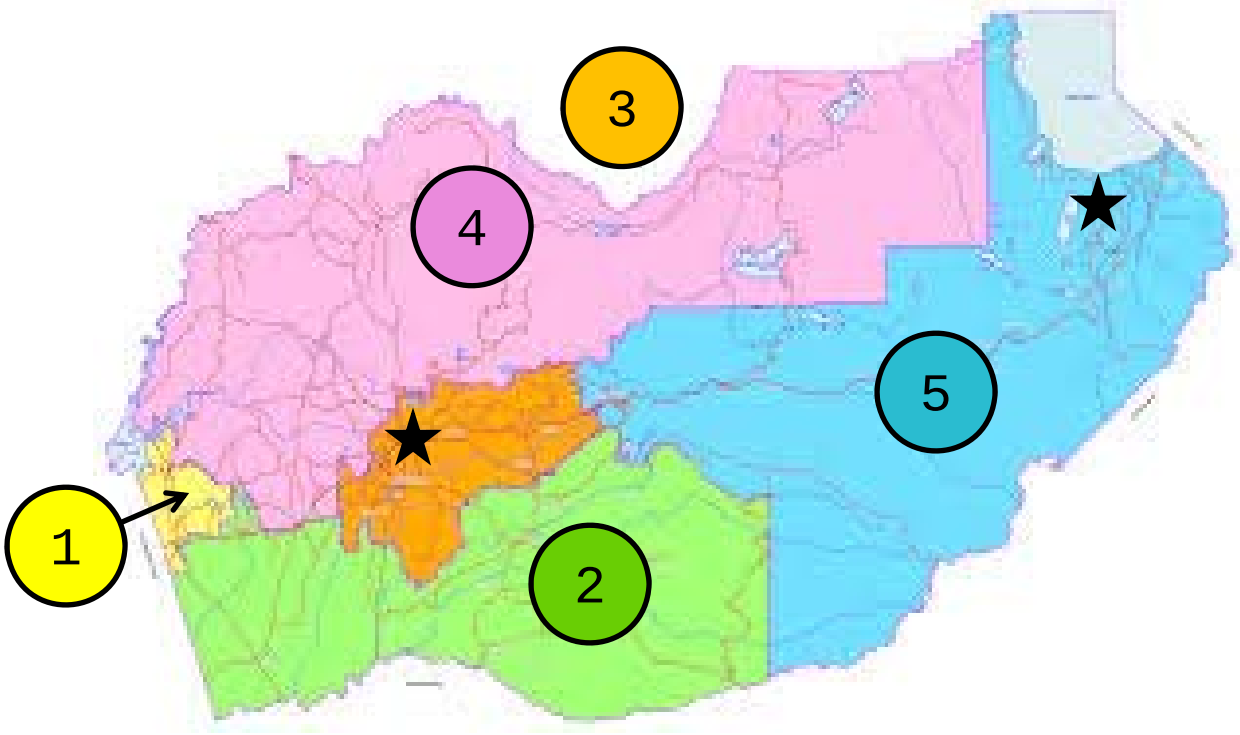
- HHSA Leaderships' commitment to ongoing strategic planning and the integration of services
- Behavioral Health's focus on whole person care
- Positive collaborative relationships with community partners
- View treatment as a community wide approach to meeting needs
- MDT's and Collaboratives that produce change

Hubs in our Libraries

Community-Based Engagement and Support Services

- Unique: Our project is a one stop shop model. It brings collaborative agencies together in the library setting to provide needed services to families with children 0-18.
- This differs from the Oregon Hub model which brings partner agencies together to identify needs and implements screenings in schools and Primary Care offices to identify appropriate treatment referrals.

EL DORADO COUNTY
Population: 183,087
1,788 sq miles



Hubs in our Libraries

- Services provided by Public Health Nurses and Community Health Advocates will be key to the success of this model. They will provide not only the necessary screenings for behavioral health and health care services, but will also provide case management services to support linkage with our community partners.
- This expands on the **Pima County** Model in Arizona where nurses only provide the traditional health screenings. Our PHN's will address behavioral health issues as well.

Service Implementation

- First 5, School Districts, and County Libraries have a healthy long standing collaborative partnership providing literacy and school readiness programs.
- Planning meetings have been occurring with all partners present.
- HHSA's Director, the prior Assistant Director of Health Services, who oversaw both Behavioral and Public Health, is committed to the fiscal and programmatic requirements, implementation and ultimate success of this plan.

Evaluation Hubs

- First 5 of El Dorado and El Dorado County Office of Education will measure specifics on school readiness and literacy standards.
- Public Health and Behavioral Health will measure:
  - number of screenings for mental health and substance use
  - number of referrals to Behavioral Health services
  - number who engage in treatment
  - types of treatment
  - and the length of treatment
- Public Health will monitor the number of toxicology positive births in our County and hope to measure success by a reduction in those referrals as the challenges of substance use, mental health issues, and related DV issues are being addressed.

BUDGET HUBS - Four Year Project

Funding Source	County Staff Costs	Operating Costs	Admin Costs	Evaluation Costs	Total Costs by Funding Source
Innovation	$1,203,285	$235,765	$1,320,971	$0	$2,760,021
Public Health	$2,480,327	$0	$565,665	$0	$3,045,992
First 5	$1,007,225	$0	$0	$43,715	$1,050,940
Total Project Costs	**$4,690,837**	**$235,765**	**$1,886,636**	**$43,715**	**$6,856,953**

Restoration of Competency in an Outpatient Setting

- El Dorado County's model is unique in its location within the Behavioral Health Department.
- Includes a clinician and mental health worker to provide the restoration education with our in-house Psychiatry staff.
- Includes FSP/ICM if qualified, CIT assigned, substance use treatment and groups as indicated, shuttle service if in the service area.
- The Wellness Center provides peer support, social, educational, and heath related activities, including job/volunteer readiness.

Restoration of Competency in an Outpatient Setting

- 16 States have OCR, but Per Journal of Psychiatry (2015), **“There is little information in the literature on the specifics of OCRP’s.”**
- There is more information in the literature regarding Restoration in a Jail Setting.
- Other models reviewed are different in that they include residential (Hawaii 5 bed cottage model)and use private agencies for restoration education (Wisconsin, Behavioral Health Consultants, Inc; Colorado, Denver first; Texas, OCR Contractors)
- These models use case management for referrals to behavioral health services as opposed to providing it directly.

Service Implementation

- Ready to hire the mental health worker for this role.
- Requisition pending for the next position, will be able to use existing list and hire quickly, if approved.
- Through internal restructuring we have a clinician ready to take on these duties, if approved.
- Given team approach, the staffing pattern of half time mental health worker and clinician is appropriate.

Restoration Evaluation

- Will measure:
  - length of stay in jail
  - days to restoration
  - maintain Behavioral Health services during and after restoration
  - missed appointments
  - return to jail or inpatient unit
- Justice services are part of Behavioral Health in the County and work closely with our mental health clinic, ADP, and field based services. While this is only a 2 year project, we are looking at restructuring our justice services to incorporate this program under that umbrella in the future.

Restoration Budget – Two Year Project

County Staff Costs	Operating Costs	Admin Costs	Evaluation Costs	Total Costs
$204,693	$7,000	$501,479	$13,838	$727,010

Future Potential Three Year Project

County Staff Costs	*Operating Costs*	*Admin Costs*	*Evaluation Costs*	*Total Costs*
$288,603	*$7,500*	*$311,691*	*$43,778*	*$651,572*

Summary

- We are a County of change through our data collection.
- The Hub Service Model is in line with our HHSA Strategic Plan.
- The Restoration of Competency in an Outpatient Setting will provide quality care for our clients, reduce the cost of State beds, keep clients out of jail, and will keep clients in the community connected to family and friends.

Proposed Motion

- **The MHSOAC approves El Dorado County's INN Projects as follows:**
  - **Name**: Restoration of Competency in an Outpatient Setting
  - **Amount**: $727,010
  - **Project Duration**: 2 Years

  - **Name**: Community Based Engagement and Support Services
  - **Amount**: $2,760,021
  - **Project Duration**: 4 years

COUNTY OF EL DORADO

HEALTH & HUMAN SERVICES

Patricia Charles-Heathers, Ph.D.
Director

Behavioral Health Division
Jamie Samboceti, MA, LMFT
Deputy Director

768 Pleasant Valley Road, Suite 201
Diamond Springs, CA 95619
530-621-6290 Phone / 530-622-1293 Fax

1900 Lake Tahoe Boulevard
South Lake Tahoe, CA 96150
530-573-7970 Phone / 530-543-6873 Fax

BOARD OF SUPERVISORS

RON "MIK" MIKULACO
District I
SHIVA FRENTZEN
District II
BRIAN K. VEERKAMP
District III
MICHAEL RANALLI
District IV
SUE NOVASEL
District V

INNOVATION: Community-Based Engagement and Support Services

In our rural County, many of our services are in isolated pockets. We have a poor transit system in regards to the outlying areas of our geographically distant County. In an effort to reach individuals who live in these outlying areas, El Dorado County has partnered with a team of agencies who were working toward a Hub based service delivery system. First 5 of El Dorado has a long standing relationship with our Libraries and School Districts providing literacy programs, language development, and school readiness.

Behavioral Health was approached by the team of agencies and asked how Mental Health could participate in the Hub Service Model. The conversation included funding a portion of Public Health Nurses and Community Health Advocates who would incorporate a mental health component into their screening and assessment process. This is a wonderful opportunity for Behavioral Health to have a presence in our outlying areas of service need. We have identified providing services in outlying areas in our strategic plan, but have not been able to implement due to the cost of staffing. With this program, screenings and assessments for mental health and substance use can be included in the services provided and thereby expand the continuum of integrated care we offer to the community.

Hub models include the Oregon model which does not deliver services in one location, but has a Collaborative Team who determines area needs, partners with the appropriate agency, and makes referrals based on screenings from schools and Primary Care Providers. El Dorado County's model will provide services in one location, the library, in each of 5 identified service areas. A library model, The Pima County model, has Public Health Nurses visit their libraries to support library and security staff to assist customers who arrive and have emotional issues. They also conduct basic health screenings for Blood Pressure and Blood Sugar issues.

Expected outcome measures will be in two different areas of focus:

- The outcome measures for First 5 and the School Districts will include collecting data on school readiness, literacy, and language development.
- Public Health and Mental Health will include data collection on:
    - referrals from Labor and Delivery MD due to toxicology positive births
    - number of service requests in the library setting
    - number of mental health and substance use screenings
    - number of mental health and substance use referrals
    - number who access the Behavioral Health services
    - length of stay in services, all through a trauma informed approach

Much of the data collected at the time of a referral to Behavioral Health will be tracked using our electronic health record. We have the ability to track where referrals come from and can produce an episode identifying it as a Hub participant, in addition to the length of stay, services utilized, and groups completed.

While this project contains many participants, the MHSA funds for this project are specifically targeted toward the Public Health Nurses and Community Health Advocates. Public Health staff will be addressing both health and safety issues through the trauma informed philosophy. The team expects to be able to fund the Public Health portion of this project independently after the project period ends. Public Health will look at internal reorganization to determine steps they may take to sustain the plan going forward. In addition, they are working with the El Dorado Community Foundation which has the ability and the contacts to help develop longer term more sustainable funding options.

COUNTY OF EL DORADO

HEALTH & HUMAN SERVICES

Patricia Charles-Heathers, Ph.D.
Director

Behavioral Health Division
Jamie Samboceti, MA, LMFT
Deputy Director

768 Pleasant Valley Road, Suite 201
Diamond Springs, CA 95619
530-621-6290 Phone / 530-622-1293 Fax

1900 Lake Tahoe Boulevard
South Lake Tahoe, CA 96150
530-573-7970 Phone / 530-543-6873 Fax

BOARD OF SUPERVISORS

RON "MIK" MIKULACO
District I
SHIVA FRENTZEN
District II
BRIAN K. VEERKAMP
District III
MICHAEL RANALLI
District IV
SUE NOVASEL
District V

INNOVATION: Restoration of Competency in an Outpatient Setting

Our County has experienced an increase in individuals found incompetent to stand trial over the last year. There has been a significant shift in the justice system and how they view incarceration of individuals with mental health issues. As such, we are seeing individuals with higher acuity; an increase in the resistance to treatment since implementation of AB109 and Prop. 47; and a lack of inpatient beds for competency restoration, funding, and long wait times. When an individual is in jail waiting for placement, time spent in isolation is 23 hours a day. Individuals have spent between two and eight months waiting for a bed during the last year. While restoration time per some of the literature appears to be quick in an inpatient setting vs an outpatient setting, the time spent in jail does not appear to be included in that calculation.

The County anticipates eight to ten individuals will need this service annually. Unlike other agencies, who only do the restoration education, this project will be housed within Behavioral Health and will include all available services. We will have 0.5 FTE Clinician and 0.5 FTE Mental Health Worker to provide case management and restoration education. In addition, the clients will have access to our Psychiatry services, our Full Service Partnership/Intensive Case Management team services if qualified (may include housing), Clinic Group Services, our Crisis Intervention Team connection with Law Enforcement, and our Wellness Center Services. Wellness Center activities include but are not limited to: Physical activity, Smoking cessation, Co-occurring group, DBT skills, Life Skills, Current Events, Self-Care, and Dual Recovery. Our clients who live in the service area will be able to take advantage of our daily Shuttle Service, which is a designated route for pick up and drop off. Full Service Partners have the opportunity to have services provided in their home and community environment, in addition to the Clinic based services.

Research has shown there are approximately 16 States that identify a Restoration Program. Of those, Hawaii has a residential 5 bed cottage model for misdemeanants and felons. This is a full service program. (World Journal of Psychiatry, 2015)

Washington DC, Outpatient Competency Restoration Program (OCRP), is contracted out by their Health Department and identifies a 32% restoration rate and stated low success due to the lack of forced medications. This is a group model of treatment, has interagency collaboration and does not offer transportation. This program identified additional needs of increased mental health services, case management, substance abuse support, transportation, and employment opportunities.

Wisconsin contracts with Behavioral Consultants, Inc. for a Behavior Specialist for the Restoration education component. In addition, they provide case management to address community based needs and referrals. They offer meetings 2x per week, case management 1x per week and identify a 75% restoration rate.

Colorado contracts with Denver First Restoration Services which are provided by Graduate Students. It does not include Psychiatric services or transportation.

Texas contracts out to OCR and provides Restoration Education only. They are in partnership with Mental Health and Managed Care Plans to connect individuals with additional services. Tri-County Services uses OPCRP, a low cost restoration program. This program includes daily groups, involuntary medications, and has a 42% restoration.

El Dorado County is proposing a full array of services including Restoration Education for our clients in an effort to maintain them in the community with local support from service providers, family, and all natural supports available.

Mental Health Services
Oversight & Accountability Commission

NEVADA COUNTY INNOVATION PLAN

August 25, 2016

WELLNESS • RECOVERY • RESILIENCE

Outline

- Summary
- OAC Process
- Nevada County Presentation
- Proposed Motion

Summary

- Nevada County seeks approval for the Integration of Rural Mental Health Services to Improve Outcomes project. Total INN amount sought: $375,000.
  - Primary purpose is to increase the quality of services by coordinating a cross-county integration of mental health services with Placer County in the Tahoe-Truckee area.
  - Amount: $375,000. Project duration: 5 years.
- Staff recommends that Nevada County's proposal has met or exceeded minimum program requirements.

Regulatory Criteria

- **Funds exploration of new and/or locally adapted mental health approach/practices**
  - Adaptation of an existing mental health program
  - Promising approach from another system adapted to mental health
- **One of four allowable primary purposes:**
  - Increase access to services
  - Increase access to services to underserved groups
  - Increase the quality of services, including measurable outcomes
  - Promote interagency and community collaboration
- **Addresses a barrier other than not enough money**
- **Cannot merely replicate programs in other similar jurisdictions**
- **Must align with core MHSA principles (e.g. client-driven, culturally competent, recovery-oriented)**
- **Promotes *learning***
  - Learning ≠ program success
  - Emphasis on extracting information that can contribute to systems change

What OAC Staff Look For

- **Specific requirements regarding:**
  - Community planning process
  - Stakeholder involvement
  - Clear connection to mental health system or mental illness
  - Learning goals and evaluation plan
- **What is the unmet need the county is trying to address?**
  - Cannot be purely lack of funding!
- **Does the proposed project address the need(s)?**
- **Clear learning objectives that link to the need(s)?**
- **Evaluation plan that allows the county to meet its learning objective(s)?**
  - May include process as well as outcomes components

Materials

- The following materials were included in the meeting packets and are posted on our website:
  - Staff Innovation Summary—Nevada County
  - County Innovation Plan—Nevada County

Nevada County Presentation

- Michele Violett, Senior Administrative Analyst, Nevada County Behavioral Health Department

Nevada County

MHSA Innovation Plan

Integration of Rural Mental Health Services to Improve Outcomes

Nevada and Placer County Collaboration

2016 - 2022

Overview: Tahoe Truckee Community

- The Tahoe Truckee Community is a remote, rural community that has some unique challenges.
- Both Nevada and Placer County are located in the Tahoe Truckee community.
- In some neighborhoods, residents on one side of the street live in Nevada County, and across the street, the residents live in Placer County.
- As a result, while one person may travel a mile to access mental health services, the neighbor across the street travels ten miles over a 7,000 foot pass to access mental health services.

Stakeholder Process

- MHSA stakeholders from both counties have identified the Tahoe Truckee area as a high priority for MHSA services.
- The Community Collaborative of Tahoe Truckee (CCTT) is comprised of over 45 health, education, and social service agencies who work together to address the fundamental needs of individuals needing mental health services, especially families.
- The CCTT developed a list of priorities during the FY 2014-2017 for strengthening services and identifying opportunities for cross-county collaboration to developed shared goals, strategies, and funding to improve services, outcomes, and reduce inefficiencies across the service delivery system.

Goals of Innovation Plan

- To learn how to develop and implement a coordinated, interagency, cross-county service delivery system of care to meet the needs of clients living in the Tahoe Truckee area, regardless of the county of residence.
- To create and enhance cross-county interagency structure, develop shared goals, and coordinate services and funding to improve outcomes for persons who need mental health services.
- To identify opportunities to improve access to services and efficiently utilize limited resources in this remote area.
- To maximize existing services and learn how to better meet the needs of our clients.

Overview of Existing Services in Tahoe

- The Tahoe Truckee area represents a small proportion of each county's population. For Nevada County, Tahoe Truckee has 17% of the population.
- Nevada County's mental health staff are county employees, while Placer County has contracted with an organizational provider.

Overview of Existing Services in Tahoe

- There are limited services for both counties.
- Nevada County:
  - 4 hours/Week Psychiatry
  - 1.0 FTE Bilingual Child Therapist
  - 1.0 FTE Adult Therapist (position is vacant)
  - Few hours for Promotore services

Overview of Existing Services in Tahoe

- Placer County (All Contract):
  - 4 hours/Week Psychiatry (different psychiatrist)
  - 1.0 FTE Child Therapist
  - 1.0 FTE Adult Therapist
  - 0.5 FTE Bilingual Case Manager (position is vacant)

Overview of Existing Services in Tahoe

- Both Counties
  - Limited Full Service Partnership (FSP)
  - Limited Housing Support
  - Limited Employment Services
  - Limited Peer Support
  - Limited Bilingual/Bicultural Services
  - Limited Transportation
  - Limited Crisis Intervention
  - No Peer Wellness Center(s) for Adults

Innovation Plan Staffing

- Utilize a coordinator who works across both counties in the Tahoe Truckee region.
- Expand the existing Placer County half-time Case Manager's position to be full time, to deliver services across both counties in the region
- Expand Family Resource Center of Truckee to provide additional bilingual, bicultural services

Focus of Innovation Project

- To train staff and community members on Motivational Interviewing, Wellness and Recovery Action Plans (WRAP), and/or Mental Health First Aid to enhance skills and promote access to mental health services.
- To make a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population, or community.

Learning Objectives

- To develop a cross-county interagency collaboration to coordinate services and resources to maximize the available staff and services, while expanding case management and bilingual support services to meet the needs of the community.
- To learn how to integrate case management and other mental health services across county lines, through the delivery of case management services by the same person across the two counties.

Learning Objectives

- To deliver culturally and linguistically appropriate services to the Latino population, across the region.
- To identify barriers to cross-county collaboration and develop strategies for resolving those barriers.
- To improve access for older adults by providing outreach into the community, delivering services at the local Family Resource Center, and visiting senior living apartments to help reduce stigma and enhance access to services.

Evaluation Components

- To serve 50 individuals each year, across the five year funding period.
- Evaluate interagency collaboration through administrator, staff, and client surveys
- Collect service-level data to measure the number of outreach activities, linkage to resources, number of contacts and duration of services, and location of services.
- Collect client perception of services at least annually to determine if services are helping to improve outcomes.

Summary

- MHSA Innovation Budget: $75,000 / Year; 5 years
- Involve stakeholders in all components of the Innovation Project, including planning, implementation, evaluation, and ongoing funding
- Meet at least quarterly with the CCTT, providers, case managers, and therapists, to discuss implementation strategies, barriers, opportunities to strengthen services, and successes.
- Utilize data to provide input on success and ensure sustainability and/or expansion of services.

OAC – THANK YOU!

Proposed Motion

- **The MHSOAC approves Nevada County's INN Project as follows:**
  - **Name:** Integration of Rural Mental Health Services to Improve Outcomes
  - **Amount**: $375,000
  - **Project Duration**: 5 Years

Mental Health Services
Oversight & Accountability Commission

Additional Funding for Stakeholder Contracts

Angela Brand
August 25, 2016
Agenda Item 5

WELLNESS • RECOVERY • RESILIENCE

Background

- The Mental Health Services Act (MHSA) provides funds to support stakeholder contracts.
- The Commission directed staff to strive for no break in advocacy support.
- Staff sought and obtained approval from the Legislature and the Department of Finance for the Commission to provide limited, short-term funding to extend existing contracts.

Current Contracts

- Current stakeholder contracts are held by:
  - National Alliance on Mental Illness, California
    $2,010,000 total – ending 9/30/2016
  - California Association of Mental Health Peer Run Organizations
    $547,950 total – ending 9/30/2016
  - California Association of Veteran Service Agencies
    $200,000 total – ending 6/30/2017
  - California Youth Empowerment Network
    $300,000 total – ending 9/30/2016
  - Racial and Ethnic Mental Health Disparities Coalition
    $200,000 total – ending 4/30/2017
  - United Advocates for Children and Families
    $1.3 million total – ending 9/30/2016

Staff Proposal

- To support continued advocacy, the Commission is requested to approve limited, short-term funding for current contractors up to $200,000 each. Staff will assess funding needs on a case-by-case basis, based on:
  - Review of existing contract balances.
  - Assessment of time between end of contracts and projected start of RFP-driven contracts.
  - Determine deliverables and capacity.

Proposed Motion

- The Commission authorizes the Executive Director to contract with current stakeholder contractors to provide short-term funding in an effort to ensure continued advocacy until the RFP process is complete.

Mental Health Services
Oversight & Accountability Commission

Request for Proposals (RFP) for Stakeholder Contracts

Angela Brand
August 25, 2016
Agenda Item 6

Background

- The Mental Health Services Act (MHSA) provides funds to support stakeholder contracts.

- In January, the Commission authorized six (6) RFPs:
  - Clients/Consumers ($548,000 per year / $1.6 million total)
  - Diverse Communities ($400,000 per year / $1.2 million total)
  - Families of Clients/Consumers ($669,000 per year / $2.1 million total)
  - Parents of Children and Youth ($437,000 per year / $1.3 million total)
  - Transition Age Youth ($500,000 per year / $1.5 million total)
  - Veterans ($400,000 per year / $1.2 million total)

Initial Requests for Proposals

- 6 RFPs were released in May 2016.
- In July 2016, staff announced one recommended award for the TAY contract. The remaining RFPs were cancelled.
- The Commission directed staff to learn from the process and re-issue a new round of RFPs.

Budget Changes for FY 2016-17

- In addition to authorizing the initial RFP, the Commission directed staff to seek funding for LGTBQ advocacy and increase available funds for all contracts.
- The 2016/17 Budget Act augmented funds to raise each contract to $670,000 per year and added contract funds for LGTBQ advocacy.
- Stakeholder funding has increased significantly, from $1.9M per year (2014) to $4.69M (2016).
- The Legislature directed the Commission to move away from sole-source contracting toward a competitive contracting process.

New Requests for Proposals

- Staff is seeking authority to release 7 RFPs for the following populations:
  - Clients/Consumers ($670,000 per year / $2,010,000 total)*
  - Diverse Communities ($670,000 per year / $2,010,000 total)*
  - Families of Clients/Consumers ($670,000 per year / $2,010,000 total)*
  - LGTBQ ($670,000 per year / $2,010,000 total)
  - Parents of Children and Youth ($670,000 per year / $2,010,000 total)*
  - TAY: ($170,000 per year + $200,000 one-time funds / $710,000 total)*
  - Veterans ($670,000 per year / $2,010,000 total)*

**maximum grant amount up to $2,010,000 per contract, as determined by use of funds for short-term contract extensions.*

Next Steps

- Consult with proposers to gather feedback on initial RFP.
- Retain existing RFP framework and Minimum Qualifications (MQs) in response to priority areas:
  - Advocacy
  - Education and Training
  - Outreach and Engagement
- Staff proposes that the MQs for the LGTBQ contract mirror those for the Veteran and Diverse Communities RFPs:
  - An established statewide organization with experience providing programs and services related to the mental health needs of California's LGTBQ population.

Projected Timeline

- Release RFP: October 2016
- Proposals due: December 2016
- Notice of Intent: February 2017
- Contracts begin: March 2017

Proposed Motion

- The Commission authorizes the Executive Director to issue RFPs for the following populations:
  - Clients/Consumers (up to $670,000 per year / $2,010,000 total)
  - Diverse Communities (up to $670,000 per year / $2,010,000 total)
  - Families of Clients/Consumers (up to $670,000 per year / $2,010,000 total)
  - LGTBQ (up to $670,000 per year / $2,010,000 total)
  - Parents of Children and Youth (up to $670,000 per year / $2,010,000 total)
  - Transition Age Youth (up to $710,000 total)
  - Veterans (up to $670,000 per year / $2,010,000 total)