

Mental Health Services Act Fiscal Reversion Policy Reconsidered: Challenges and Opportunities

A Report of the Mental Health Services Oversight and Accountability Commission

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Introduction

In 2004, California voters authorized the Mental Health Services Act (MHSA) under Proposition 63 and established a special tax to support investments in mental health services. The Act generates approximately \$2 billion annually for mental health programs. Under this law, MHSA funds distributed to California's 59 local mental health agencies must be spent within specific categories and within a defined period of time. In order to incentivize local (typically, county) mental health agencies to make full use of these allocations, any funds left unspent in those statutory timeframes must be returned to the state for reallocation. This expenditure incentive, known as a fiscal reversion policy, is the focus of this report.

The California Department of Health Care Services, which oversees fiscal rules governing California's mental health system, reports that no mental health funds have reverted since 2008 despite evidence of counties retaining MHSA revenues beyond the statutory time limit (Department of Health Care Services, n.d.). Typically, counties have three years in which to spend MHSA funds for their primary MHSA programs, but funds also can be set aside for workforce development and capital investments and those funds have a ten year reversion limit. Counties also can dedicate MHSA funds to a prudent reserve, which is not subject to reversion.

Despite these rules, mental health advocates have raised concerns that counties have retained MHSA revenues rather than dedicating those resources to unmet needs in their communities, and that the Department of Health Care Services is not requiring unspent funds to revert.

In response to these concerns, in early 2016, the Mental Health Oversight and Accountability Commission initiated a project to better understand the requirements of the MHSA fiscal reversion policy, how it has been implemented by the State, how counties have responded to those practices and whether there is sufficient public access to information on mental health revenues, expenditures and, of course, unspent funds. The balance of this report describes the context and background for the fiscal reversion requirement under the Mental Health Services Act, including how relevant aspects of the Act have changed and how this project was conducted. This report identifies key challenges and potential responses that emerged from that process.

Background

California's Welfare and Institution Code requires counties to spend their MHSA funds within three years of receipt, with certain exceptions. The statute (WIC Section 5892(h)) states that:

Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the (Mental Health Services) 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 ten years before reverting to the Fund.

Under current law, local mental health agencies, which are the legal entities that administer public mental health programming, and typically are the county mental health or behavioral

health department, hereafter referred to as “counties,” receive MHSA funds on a monthly basis from the State Controller’s Office based on the amount of revenues that are generated by the tax. Once distributed to the counties, these funds are distributed into three primary funding components. Eighty percent of the funds are attributed to Community Services and Support (CSS) and 20 percent to Prevention and Early Intervention (PEI). The counties then are required to shift five percent of the CSS and PEI amounts to exclusively fund Innovative Projects (thus leaving, on net, 76 of the original allocation in CSS and 19 percent in PEI).

Counties may then elect to transfer up to a total of 20 percent of the CSS funds received in any year to three further categories: a “Prudent Reserve” fund; Workforce Education and Training (WET); and Capital Facilities and Technological Needs (CFTN). As noted above, Welfare and Institutions Code Section 5892(h) specifies that the county must spend PEI and Innovation funds within three fiscal years of receipt, and must spend or transfer CSS funds within three years of receipt. Any funds transferred to WET or CFTN must be spent within ten years of initial receipt by the county, while funds placed in the Prudent Reserve are available until called upon by the county.

The practice of monthly deposits into county Mental Health Services Funds has been in place since 2012 with the enactment of Assembly Bill 100 (Chapter 5, Statutes of 2011). Prior to AB 100, the California Department of Mental Health distributed MHSA revenue to the counties in two annual payments. The first was an initial payment of approximately 25 percent of their estimated allocation, with the balance paid out later in the year pursuant to department approval of a county MHSA Three-Year Program and Expenditure Plan or an Annual Update to that plan. That process was intended to ensure that mental health funding was used by counties to support community priorities as determined through a required Community Planning Process (Welfare and Institutions Code 5848(a)).

In those early years after the passage of the MHSA and prior to the changes enacted by AB 100, the Department of Mental Health first established planning estimates on how much revenue each county would receive as funds were generated under the new tax. Counties used those projections to prepare their community plans for submission to the State. Under that process, the Department of Mental Health established policies and practices of reversion that tracked expenditures based on the date that MHSA revenues were made available to the counties. The Department’s Information Notices specified that any allocated funds not spent within three years of distribution would be returned to the state (DMH Information Notice 08-07; DMH Information Notice 10-13).

As that process was rolled out, the Department of Mental Health faced delays in approving local plans and distributing MHSA funding for essential services. As a result, county mental health leaders and mental health advocates called for changes to speed the distribution of funding from the state to the counties. The passage of AB 100 reflected that call for speeding and simplifying the distribution of MHSA funds. AB 100 eliminated the requirement for State approval of local plans and instead directly distributed revenue each month from the State fund to the local MHSA accounts according to a distribution formula developed by the Department of Health Care Services (Welfare and Institutions Code 5891(c)).

The shift that occurred under AB 100 was significant in several ways.

First, prior to AB 100, MHSA funds were distributed in defined amounts to each county. This practice provided the counties with certainty about how much MHSA funding they would receive. It also provided a clear “start date” for when the reversion clock was initiated and thus the deadline for spending those dollars. As the state changed the strategy for distributing MHSA funding, to more frequent distributions, based not on established spending plans but rather on a formula driven by the revenues received, that certainty was lost. Monthly, non-discretionary distributions of MHSA funds to the counties removed the delays caused by State review of county plans, but also may have created confusion with regard to how the State’s reversion policies would apply.

Second, as a practical matter of prudent cash management, the transition to monthly receipts rather than a lump sum payments requires the counties to hold substantial cash reserves from prior fiscal year allocations to insure that the local MHSA fund always has sufficient resources to pay the county’s MHSA bills during the year.

Third, when the State held MHSA revenues until the Department of Mental Health made its lump-sum allocations, interest income accrued to the State-level fund and was commingled with tax revenue deposits into the fund for distribution to the counties. Current law requiring monthly distributions to the counties reduces the balances held in the State Mental Health Services Fund available for generating interest income. Conversely, as counties receive and retain MHSA funds, interest accrues to the local MHSA accounts.

In order to monitor county spending of MHSA funds, state law requires the counties to submit an Annual Revenue and Expenditure Report (ARER). The California Department of Health Care Services is charged with implementing that requirement, including providing periodic updates to the reporting requirements (Welfare and Institutions Code 5899).

Current law specifies that one purpose of the ARERs is to “Determine reversion amounts, if applicable, from prior fiscal year distributions” (WIC Section 5899(b)(4)). These reports are used to document the revenues received by the counties, expenditures made from each fiscal year allocation to the counties, and unspent funds remaining by fiscal year of allocation, and to provide information necessary to evaluate the following programmatic categories (WIC Section 5899(c)):

1. Childrens’ systems of care.
2. Prevention and early intervention strategies.
3. Innovative projects.
4. Workforce education and training.
5. Adults and older adults systems of care.
6. Capital facilities and technology needs.

The law requires counties to submit their Annual Revenue and Expenditure Reports within six months of the close of the fiscal year. California’s fiscal year runs between July 1st and the following June 30th. Thus, ARERs are due by the end of each December. Under the law, ARERs must be certified by the counties as accurate, which typically means they are signed by each county’s independent auditor/controller prior to submission to the State.

Study Design

To support the development of this report, the Commission charged a subcommittee, consisting of Commissioners John Buck (Chair), John Boyd, Psy.D., and Larry Poaster, Ph.D., to understand how the MHSA reversion policies and practices are structured, how well they are working, and to identify recommendations for improving those policies and practices. The subcommittee held a public meeting on February 26, 2016 in Sacramento to invite discussion from the Department of Health Care Services, county representatives, the County Behavioral Health Director's Association, and other stakeholders.

Additionally, the subcommittee supported a series of panel presentations before the Commission at the Commission's August 25, 2016 meeting in Sacramento. The Commission heard expert testimony from a former key staff member from the Department of Mental Health who helped develop the original fiscal reversion policies; a fiscal policy expert from the Legislative Analyst's Office; Mr. Mike Geiss, a consultant on mental health fiscal data issues; fiscal experts from Humboldt and Napa Counties, and the assistant deputy director for Mental Health and Substance Use Disorder Services at DHCS. Members of the public also provided testimony.

Additional meetings were convened to discuss progress on this work, including the design and development of a web-based tool to publicly present and display the information included in county ARERs.

Lastly, the subcommittee directed staff to gather and develop background materials to contribute to this draft report.

Key Challenges

As part of its review, the Commission heard a range of concerns from counties and mental health stakeholders about the ARER reporting process and fiscal reversion policies, including:

- The ARER reporting process does not allow the counties to accurately report on their MHSA expenditures.
- ARER reports do not permit the public to adequately monitor how MHSA and related mental health funds are used and whether the State's reversion policies are being followed, and
- MHSA funds held by counties for longer than three fiscal years have not reverted back to the state, despite statutory requirements.
- Despite the statutory reporting requirements, many counties are not submitting their ARERs by the annual deadline.

In short, the State's reversion policies are not being implemented.

The Commission found that many counties had not met the statutory reporting deadlines for submitting certified ARERs. In some cases, counties were two or three years in arrears in submitting the required reports to DHCS and the Commission. In response to these concerns, the Commission asked the counties to explain the rationale for not submitting ARERs according to statutory deadlines and the extent that counties may owe funds under reversion.

Finding 1: DHCS's Annual Revenue and Expenditure Report forms restrict county reporting.

California county behavioral health departments are not submitting their Annual Revenue and Expenditure Report under the timelines required in statute. As of February, 2017, the Commission had received only 27 of 59 ARERs for the FY 2014-15 reporting period, due no later than December 31, 2015. Further, the Commission had received only 46 of 59 ARERs for the FY 2013-14 reporting period and was still missing four reports for the FY 2012-13 period.

Counties asserted that the forms required by DHCS limit their ability to accurately report expenditures, and thus they are unable to obtain the required validation from their independent Auditor/Controllers, or they are forced to submit inaccurate information.

Counties further report that the information they provide on their ARERs may not be consistent with other audited fiscal reports, because of the limitations built into the forms required by DHCS. For instance, the 2012-13 ARER form required the counties to report spending for each fiscal year and to itemize from which fiscal year those funds originated. However, the form provided by the Department prevents the counties from reporting expenditures from fiscal years prior to FY 2010-11. It also prevents the counties from reporting unspent funds remaining at the end of the reporting period for fiscal years prior to FY 2007-08, regardless of whether the counties had unspent funds from those years.

Counties reported that this feature of the required form results in inaccurate reporting. The counties suggest they are caught between certifying a form that is inaccurate and not submitting the form at all. As a result, many counties elect not to submit the mandatory reports.

Similarly, counties have expressed confusion over how to report interest earned on MHSA funding. Welfare and Institutions Code 5892(f) states that counties are required to invest unspent MHSA balances and capture interest in their local MHSA fund for expenditure in future years. Yet the Department has not clarified how interest income should be treated with respect to the reversion standard. Nor are county practices consistent in their treatment of interest income. Some counties report spending all of their interest income within the year in which it is earned; others do not. Of those who do not, some counties fold interest income into the unspent funds for the current fiscal year, while others carry unspent interest income as a separate reporting line item for unspent funds, which then appears to accumulate without regard to any reversion timeline.

In April 2016, the California Behavioral Health Directors Association sent a letter to the Department of Health Care Services asking the Department to revise its Annual Revenue and Expenditure Report reporting forms. In its response, the Department reports that it is actively drafting regulations regarding reversion (Department of Health Care Services. Letter to Kirsten Barlow, CBHDA. June 16, 2016).

County Behavioral Health Directors also report uncertainty over whether the Department will allow counties to submit updated ARERs for prior years. Counties report the need to periodically revise their expenditure reporting, based on audits, updated revenues, errors or other unanticipated challenges. In the interest of accurate reporting, county leaders suggest it would be

helpful to clarify that the Department of Health Care Services will allow revised ARERs when warranted.

2. Counties are Unclear on How to Deal with Funds Potentially Subject to Reversion.

According to the Department of Health Care Services, no funds have reverted since 2008 (Department of Health Care Services. MHSAs Funds Reverted. Accessed March 12, 2017). Yet based on a sample of the Annual Expenditure and Revenue Reports, numerous counties have funds in their MHSAs accounts that were received more than three years earlier, suggesting they are subject to reversion.

County behavioral health leaders recognize that they have funds that may be subject to reversion but they report that the State has been slow to update fiscal regulations governing reversion policies, has not notified counties of which funds are owed, nor has the State established a process for returning those funds to the State. Counties also report that long delays in Medicaid audits and adjustments—often occurring five years after the close of a fiscal year—require them to retain MHSAs funds in anticipation of audit exceptions to their Medicaid billing. The Commission has not been able to fully document the amount of unspent MHSAs funds held by the counties, because the State has not received the required Annual Revenue and Expenditure Reports. Nor has the Commission been able to document the reasons for withholding those funds. In testimony before the Commission, Ben Johnson, Fiscal and Policy Analyst with the Legislative Analyst's Office, suggested in response to the assertion that counties hold MHSAs in anticipation of MediCal audits, that the State more fully document the rationale for counties to retain MHSAs funds beyond three years and potentially modify reversion requirements in consideration of those concerns (Ben Johnson, LAO. August, 2016).

Consistent with the concerns raised by the counties with regard to the ARER forms and related reporting requirements, the Department of Health Care Services has pointed out that it inherited responsibility for MHSAs fiscal regulations in 2012 and is working to update those regulations (Department of Health Care Services. Letter to Kirsten Barlow, CBHDA. June 16, 2016). Yet the Department has already begun to alter its fiscal reporting rules. In June, 2016, the Department issued Information Notice 16-026 indicating that “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.” In other words, the Department has clarified to the counties that any unspent Innovation funds, from as far back as Fiscal Year 2008-09, will not be subject to reversion if spent prior to June 30, 2019.

The Information Notice appears to indicate that the Department is extending the reversion period, for Innovation Funds, from the statutory three years to as long as 11 years. It is not clear that the Department has the statutory authority to grant that extension. The Commission asked the Department to explain its legal authority to extend the reversion timeframe. The Department did not provide a response (Letter to Karen Baylor, August 11, 2016).

3. Uniform Reversion Policies May Not Align with the Goals of the MHSAs

The Mental Health Services Act stipulates that any funds left unspent three years from receipt must be returned to the State, except for funds transferred to the prudent reserve or allocated to

workforce education and training or capital facilities and technological needs, the latter two of which are to revert after ten years.

Current law states that any funds reverted from a county to the State fund are to be made available for distribution to other counties in future years. The law is silent on whether MHSA funds that revert from a specific component should be redistributed for expenditure in that same component (e.g., that reverted Innovation funds be redistributed only for Innovation expenditures).

Because no MHSA funds have reverted for nearly 10 years, it is unclear how reverted funds would be incorporated back into the State MHSA fund. In the absence of a specific policy, it appears that reverted funds would be co-mingled with new funds and redistributed based on the state's standard MHSA distribution formula. Under that formula, 80 percent of MHSA funds are dedicated to Community Services and Supports (CSS) and 20 percent for Prevention and Early (PEI). Five percent of CSS and PEI funds then are set aside exclusively for Innovation. Limited evidence suggests that Innovation and PEI funds are at greater risk for reversion, possibly because they cannot be shifted into the Prudent Reserve or for other purposes in the same way that CSS funds can be reserved. As result, under the default reversion redistribution policy, counties are more likely to see PEI and INN funds revert and upon redistribution, 80 percent of those funds would cycle back into CSS programs.

Similarly, anecdotal evidence suggests that very small counties face greater difficulties than their larger counterparts in spending all of their MHSA funds, possibly because of the categorical spending requirements across CSS, PEI and INN components. In some cases, these counties may find it difficult to sustain meaningful PEI programs or INN projects with their smaller MHSA allocations and fewer mental health funds overall. Under the default reversion redistribution policy, the vast majority of funds reverted from very small counties would be redistributed to larger counties.

Very small counties report the need to “save up” funding from these smaller distributions until they have accumulated sufficient resources to support expenditures they deem necessary to meet local needs, particularly for relatively short-term projects. For very small counties, extending the deadline for reversion may enable improved use of limited MHSA revenues.

The anticipated practice of returning reverted funds to the State Mental Health Services Fund for routine re-distribution to all counties under the standard distribution formula, may forego opportunities to dedicate those funds to unmet needs.

Recommendations

To address those challenges the Commission recommends that the Legislature and Governor consider modifications to MHSA policies and procedures to accomplish the following:

- 1. Reset Reversion Policies.**

The Department of Health Care Services should “reset” its reversion policies, to clarify that unspent funds will revert to the State three years after receipt. The Department of Health Care Services has already begun the process to revise fiscal reporting requirements. Those

requirements should continue to include itemized annual reporting of mental health funds, for each county, by source, including, but not limited to MHSA, Realignment 1, Realignment 2, Federal Funds under Medicaid, and other funds.

Updated reversion policies should take effect in 2017/18. As part of that “reset,” the Legislature needs to consider whether and how the State should enforce reversion policies for prior years. The reversion policy within the MHSA is intended to create an incentive for counties to use MHSA funds to address unmet needs. Although the counties have asserted that the Department of Health Care Service has not provided guidance on what funds are subject to reversion or how they are to be returned to the State, the Act is clear that unspent funds after three years are to be redistributed. Lack of clarity on the rules for reversion does not address the reversion liability held by the counties. Among the options the Legislature should consider:

Hold counties harmless for reversion prior to the re-start date. Some counties report that they are holding funds subject to reversion in special accounts in anticipation of the state requiring those funds to revert. The Legislature could enact legislation clarifying that no funds shall revert for funds distributed during the years 2008-2015 as long as those funds are spent by 2017-18.

Allow counties to retain a portion of reverted funds. The MHSA clearly states that unspent funds are to revert to the State MHSA fund as an incentive for counties to spend their MHSA allocations. Holding the counties harmless undermines this incentive built into the MHSA. In recognition of delays on the part of the State to update its reversion policies, the Legislature could reset reversion timelines, allowing the counties to retain a portion of their unspent funds, but directing that the balance of those funds would revert back to the state fund.

Hold counties harmless for reversion for specified fiscal years. According to the Department of Health Care Services, no MHSA funds have reverted since 2008. This reflects in part the fact that the State fundamentally reorganized its state administration of the MHSA, with the dissolution of the California Department of Mental Health and the transfer of mental health responsibilities to the Department of Health Care Services, and other departments. Those changes were enacted in 2011 and implemented in 2012. It is unclear why the Department of Health Care Services would be unable to calculate reversion amounts and requirements for funds distributed after that transition.

The Legislature could consider holding counties harmless for reversion based on funds received prior to a specific year. For example, the Legislature could hold counties harmless for reversion liabilities for funds received prior to, say 2012-13, but enforce reversion for the subsequent years. Establishing a “reset” date in the past recognizes the challenges that counties faced in adapting to policy changes enacted by the State earlier this decade while maintaining a significant incentive for counties to quickly spend down balances subject to reversion within the thoughtful community consultation process required under the MHSA.

As part of the process to reset reversion rules, the Department of Health Care Services should clarify that counties are to follow a “First-In/First-Out” expenditure policy with regards to tracking MHSA funds. That policy would be consistent with Information Notices established by

the Department of Mental Health in 2008 and which were applied to the earlier practice of state approval of county allocations and spending plans (DMH Information Notice 08-07).

That is, counties should be required to expend their oldest funds first in each MHSA component, exhausting funds most at risk of reversion before expending more recently received MHSA funds. Further, the Department of Health Care Services should clarify that the reversion “clock” for funds received throughout a fiscal year should begin at the end of that fiscal year, even if funds are received on a monthly basis. Similarly, interest income should be accrued, by MHSA component, to the fiscal year in which it was generated and be subject to reversion based on that fiscal year. In other words, interest income should be calculated annually and by applied to each component by fiscal year and thus subject to reversion three years following the accrual.

To improve monitoring of the performance of MHSA reversion policies, the Department of Health Care Services, in consultation with the counties, should annually report to the Legislature and the Commission on funds subject to reversion and funds that have reverted, and certify its determination when no funds are subject to reversion. Those reports should be made available to the Legislature, Commission and the public within nine months of the close of each fiscal year.

2. Extend Reversion from three years to five years for California’s smallest counties.

To the extent allowed under the voter-approved Mental Health Services Act, the Legislature should modify the Act to extend reversion requirements from three years to five years for very small counties when justified. In recognition of the challenges very small counties face in funding and sustaining adequate programs and projects with limited MHSA allocations, the Legislature should provide an avenue for an extension of their reversion timeline. As part of their annual reporting to the Department of Health Care Services, very small counties should publicly report the amount of unspent funds each year, the amount of those funds that have been held for more than three years and the rationale for retaining those funds. The Legislature should consider requiring state approval for extending the reversion timeline based on an approved MHSA expenditure plan. The five year reversion policy should apply only to funds initially subject to a three-year reversion policy and would not apply to funds that are not subject to reversion or that have a 10-year reversion timeframe.

3. The Department of Health Care Services should develop regulations or guidance, as appropriate, to clarify that counties can revise or correct their Annual Revenue and Expenditure Reports.

The Department of Health Care Services, under its regulatory authority, requires counties to submit an Annual Revenue and Expenditure Report that includes detailed fiscal information across multiple fiscal years. It is not clear whether counties are allowed to revise or update prior reported expenditures and unspent funds based on audits, updated information or other needs. The Department should clarify that counties are allowed—and encouraged—to revise prior year annual reports to ensure the public has access to the most accurate and up-to-date fiscal information on mental health revenues and expenditures.

Updating past-year reports could trigger the necessity to update a series of subsequent reports, however. DHCS should provide a rationale to support any regulations or guidance it issues on

this topic that emphasizes the importance of providing the public with clear and understandable explanations for how and why a county has submitted updated reporting.

4. Establish a state-level, MHSA Reversion Fund to capture reverted funds that can be allocated by the Legislature to meet local needs in the community mental health system.

The reversion policy of the Mental Health Services Act is intended to create an incentive for counties to spend MHSA funds on community needs. Under current law and policies, any reverted funds are to be blended in with new revenue deposited in the State fund and redistributed to the counties without regard to their “reverted” status.

The fact that many counties have not yet submitted their 2014-15 Annual Revenue and Expenditure Report, which was due no later than December 31, 2015, implies that the Department of Health Care Services is not actively monitoring county MHSA expenditures. As a result, despite unspent funds that legally should have reverted to the State fund, no MHSA funds have reverted since 2008. To highlight the level of unspent funds that are reverted to the state, the Legislature should establish an MHSA Reversion Fund. The monies in that fund should be made available for local assistance through the annual legislative budget process, to enable the Legislature to better address unmet needs statewide. Unmet needs should include attention to reducing disparities, improving capacity, enhancing opportunities for regional approaches to service delivery and supporting the needs of California’s small and very small counties.

Establishing an MHSA Reversion Fund would support the following goals:

- **Improve transparency.** According to the Department of Health Care Services’ website, it has not updated its MHSA reversion report since 2011. As a result, it is difficult for the Legislature and public to monitor the extent that MHSA are being reverted back to the State fund. Establishing a Reversion Fund that is included in the Governor’s annual budget and fund condition reporting, would improve public transparency with these funds.
- **Enhance incentives to spend MSHA allocations.** Fiscal reversion policies are a form of “use or lose it” incentive. Unenforced reversion policies undermine the intent of that incentive. Capturing unspent MHSA funds, and moving them into a state-administered fund increases the incentives for counties to spend their MHSA allocations before they revert.
- **Dedicate unspent funds on unmet needs.** In recent years, the Legislature has identified a range of unmet needs and has dedicated unspent MHSA state administrative funds to address these needs. The Mental Health Wellness Act (SB 82, Chapter 32, Statutes of 2013) and the work of the California Reducing Disparities Project are examples of those efforts. Capturing local MHSA funds that are unspent, and therefore subject to reversion, furthers the capacity of the Legislature to direct those funds toward unmet needs while preserving those funds for county mental health programs.

These reforms, if supported by the Governor and Legislature, would clarify California's reversion policies as they apply to Mental Health Services Act funds, resolve the liabilities that counties hold for un-reverted funds from prior years, provide greater flexibility and transparency for how MHSA funds are used and ensure unspent funds are dedicated to the most urgent unmet needs.