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Mental Health Services
Oversight & Accountability Commission

April 27, 2017
PowerPoint Presentations and Handouts

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MHSOAC
Mental Health Services
Oversight & Accountability Commission

Technical Assistance Contract

Brian Sala, Deputy Director

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Agenda Item 5
April 27, 2017

Purpose

The Executive Director is requesting approval from the Commission to enter into a contract with Alexan RPM for technical assistance in business processes and information technology services.

State Level Consideration

The Commission is responsible for managing accounting/budgeting functions, providing security for all of our assets, adhering to state statutes on information security policies and best practices, and fiscal oversight.

Information Security

- **Need**
  The Commission handles protected health information and other secure data from other State agencies and local governments as part of its legislative mandated function to provide oversight over the community mental health system.

- **Compliance**
  It is imperative that the data handled and maintained by the Commission follows all security policies to provide the utmost protections to this data.

Technology Support/Database Administrator

- **Need**
  The Commission has aggressively pursued a transparency and evaluation agenda to provide robust oversight of the Mental Health Services Act and technical assistance to counties. This agenda relies on mental health related and fiscal data from different sources including State and local entities.

- **Compliance**
  In order to maintain, collect, house, and support the display of data and evaluation results for public consumption, the Commission requires technology support and database administrative services.

Information Security Officer

- **Need**
  The Commission has lacked a dedicated information Security and Compliance Officer since separation from the Department of Mental Health. Based on the recent Department of Military's security assessment and State Information Management Manual there is an immediate need for an Information Security Officer.

- **Compliance**
  In order to comply with the recommendation from the Department of Military, the Commission needs support for management and oversight of the Commission's Information Security Program to ensure protection of the Commission's information assets and compliance with best practices regarding information security policies, standard and procedures.

Accounting/Budgeting

- **Need**
  The Commission contracts with the Department of General Services for accounting and budgeting functions to meet our fiduciary responsibilities. The Commission currently cannot reasonably and accurately report internal financial information on a timely basis to the Commissioners or control agencies. Bringing the accounting and budgeting in-house would allow the Commission to be more engaged in the quality and timeliness of the data, and allow immediate interaction with control agencies when questions arise.

- **Compliance**
  The Commission will work with the appropriate control agencies to gather support for moving this function directly under the Commission control.

Technical Assistance Contract

Alexan RPM contractors will provide support to the Commission for security and compliance to ensure the Commission maintains and complies with the State's security policies.

The contractors will also provide support to Commission staff on the budget and accounting self-sufficiency project.

Proposed Motion

The Commission approves the contract with Alexan Risk and Project Management Advisory Services (RPM) to provide technical assistance in business processes and information technology and authorizes the Executive Director to enter into a contract for up to $500,000.

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

A Report of the Mental Health Services Oversight and Accountability Commission

Revised: April 24, 2017

Prepared for Consideration at a meeting of the MHSOAC.

April 27, 2017. Sacramento, CA

Introduction

In 2004, California voters passed 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, the law requires that any funds left unspent in those statutory timeframes must be returned to the state for reallocation to local mental health agencies. This expenditure incentive, known as a fiscal reversion policy, is the focus of this report.

Under the law, counties have three years in which to spend MHSA funds for their primary MHSA programs. Counties may set aside a portion of those funds for workforce development and capital and technology investments. The law specifies that those set-aside funds must be spent within ten years from initial allocation to the county. Further, counties were required to place a portion of their funding aside in a special rainy-day "prudent reserve" to protect their ability to preserve core services in the event of an economic downturn. Prudent Reserve funds are not subject to reversion. 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.[1]

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 has not required unspent funds held beyond their statutory time frames to revert. Preliminary estimates suggest that only about 1.7 percent of the more than $6.9 billion in MHSA funds provided to the counties in Fiscal Years 2004-05 through 2011-12 remained unspent in "three-year" reversion categories as of the close of FY 2014-15. This share, however, amounted to in excess of $117 million.

In response to concerns about the nature and implementation of MHSA fiscal reversion policy, the Mental Health Oversight and Accountability Commission initiated a project in early 2016 to better understand the requirements of the 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 addresses those concerns. It 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, how this project was conducted, and some available evidence on the status of unspent funds held by the counties. And, finally, this report identifies key challenges and potential responses that emerged from that study process.

[1] Department of Health Care Services. 2011. MHSA Funds Reverted, Updated as of 03/23/2011. http://www.dhcs.ca.gov/services/MH/Documents/FundsReverted.pdf (accessed March 12, 2017).

Background

The Mental Health Services Act (MHSA) imposes a one percent surtax on personal incomes in excess of $1 million in California. The Governor's January 2017 budget projected that the surtax would generate $1.889 billion for the State Mental Health Services Fund in Fiscal Year 2017-18.

Up to five percent of the revenue annually in the fund is reserved to finance state operations under the MHSA. For example, the Governor's January Budget specifies that the Commission would receive just over $45 million in 2017-18, including $32 million to finance competitive grants to the counties under the SB 82 Triage Grant program. These funds are distributed through the annual appropriations process. Generally, appropriations not spent or encumbered before the end of the fiscal year in which they are appropriated must be returned to the State Fund.

The balance is distributed to county mental health agencies (hereafter, "counties"[2]). Under current law, counties receive monthly distributions of MHSA funds from the State Controller's Office, based on the amount of revenues generated by the tax. These county funds are earmarked by law into three primary funding components. Eighty percent of the funds are attributed to Community Services and Supports (CSS) and 20 percent to Prevention and Early Intervention (PEI). The counties then are required to use five percent of the CSS and PEI amounts exclusively to fund Innovative Projects (thus leaving, on net, 76 percent of the original allocation in CSS and 19 percent in PEI).

Counties may then elect to transfer a portion of CSS funds received in any year to one or more of three further categories: a "Prudent Reserve" fund; Workforce Education and Training (WET); and Capital Facilities and Technological Needs (CFTN).[3]

California's Welfare and Institution Code (WIC) requires counties to spend their MHSA funds within three years of receipt, with certain exceptions. Specifically, 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*

[2] California has 59 "Mental Health Plan" (MHP) entities, which are the legal entities that administer public mental health programming. With three exceptions, each county's mental health or behavioral health department is the designated MHP. The exceptions are Sutter and Yuba counties, which jointly operate an MHP; the City of Berkeley, which operates an MHP independently of Alameda County's MHP; and three cities in Los Angeles County (Claremont, La Verne, and Pomona), which operates Tri-City Mental Health Services independently of the Los Angeles MHP.

[3] A county may transfer from an annual CSS allocation up to 20 percent of the average annual CSS revenue it received over the five preceding years. Those funds may be transferred to the county's Prudent Reserve and/or to support Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CFTN). See WIC Section 5892(b).

> *education and training may be retained for up to ten years before reverting to the Fund.*

Practices Prior to AB 100

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). Initially, the California Department of Mental Health (DMH) distributed MHSA revenue to the counties in quarterly installments, based on Planning Estimates, which defined the amounts that would be available for counties to draw upon. Distributions were also contingent on State approval of county work plans. DMH and the Commission each were responsible for review or approval of specific portions of the plans.

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 using an allocation methodology that was applied to revenue generated under the new tax. Counties used those projections to prepare their community plans for submission to the State. This practice provided the counties with some surety as to how much MHSA funding they could receive for the year. It also provided a clear "start date" for when the reversion clock was initiated (release of the Planning Estimates) and, thus, a clear deadline for spending those dollars.

DMH further sought to manage county spending by requiring the counties to submit twice-annual Cash Flow Statements and an annual Revenue and Expenditure Report (RER, see, e.g., DMH Information Notice 06-08[4]), as well as detailed reporting on MHSA expenditures within the annual Cost Report (see, e.g., DMH Letter 06-07). However, it appears that the initial Cash Flow Statements were not due from the counties until the third quarter of calendar year 2007 (DMH Information Notice 07-20).

The Department then changed its distribution practice in Information Notice 07-25 (December 12, 2007) to provide a single, lump-sum payment of 75 percent of a county's approved plan amount upon approval of the plan, with the remaining 25 percent upon submission of required reports, including the two Cash Flow Statements and the RER. Implementation of the new arrangement was to begin with the FY 2007-08 allocations. This meant that counties whose plans had already been approved would receive accelerated distributions that year.

Information Notice 07-25 also set expectations that each county would fund a Local Prudent Reserve at a level equivalent to 50 percent of their most recent CSS funding level by July 1, 2010; clarified that interest earned in a fiscal year on unexpended funds in the local Mental Health Services Fund should be combined with allocations from the State Fund in the same fiscal year to determine available funding; and emphasized that funds not spent or appropriately reserved by a county within three years of the release of the planning estimates were to revert to the State Fund.

On March 13, 2008, DMH issued Information Notice 08-07, which sought to further define and clarify reversion policy under Welfare and Institutions Code Section 5892(h). The Information

[4] Links to Department of Mental Health Information Notices and Letters may be found at http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx.

Notice reemphasizes that counties are to consider MHSA funds spent "if their Auditor-Controller would consider the transaction an expenditure for the purpose of financial reporting in accordance with [Government Accounting Standards Board] Statements and [Generally Accepted Accounting Principles]" (p. 3). DMH required, and DHCS has continued to require counties to utilize a modified accrual basis for reporting net expenditures.

> *For purposes of reversion, spent includes MHSA Funds which are actually expended or are accrued prior to the end of the reversion period. MHSA funds encumbered through a contract, purchase order, or other written agreement are subject to reversion if an expenditure has not occurred (i.e., the encumbrance has not been liquidated) in the accounting period to which reversion is being applied and the total expenditures for the three or ten year period are less than funds distributed for the year in question* (DMH Information Notice 08-07, p. 3).

For example, MHSA funds allocated in the Planning Estimates to a county for FY 2005/06 had to be exhausted prior to the end of FY 2007-08. A service received in FY 2007-08 that was not invoiced until 2008-09 would have been considered "spent" when it was received under this standard. Conversely, funds encumbered in a service contract written in 2007-08 for services not received in 2008-09 could not be used to meet reversion requirements for FY 2005/06 because the services were not received within the permissible, three-year window.

Based on the record of DMH Information Notices and DMH Letters, as well as comments that Commission staff and the Subcommittee heard from several stakeholders, it appears that DMH policies and practices regarding fiscal data reporting standards changed several times during this period, possibly creating confusion amongst reporting counties and uncertainty in interpretation of reported data.

Post-AB 100 Practices

The Department of Mental Health experienced 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 decoupled plan approval from fund distribution. Instead, funds would be distributed directly 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)).

Additionally, AB 102 (Chapter 29, Statutes of 2011) began the process of transferring management of mental health programs functions to the Department of Health Care Services and a new Department of State Hospitals from DMH, which was continued and completed in several trailer bills in 2012. Significantly, one of these bills, AB 1467 (Chapter 23, Statutes of 2012) assigned to the MHSOAC responsibility for review and approval of the Innovative Project component of county plans.

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

First, monthly, non-discretionary distribution 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. As noted above, prior to AB 100, DMH considered publication of the Planning Estimates as the starting point for the "reversion clock" for MHSA funds, regardless of when or whether they were distributed to a county. This practice provided the counties with certainty about the maximum MHSA funding they could receive in a fiscal year, contingent upon approval of the county's plan. It also provided a clear "start date" for when the reversion clock was initiated and thus the deadline for spending those dollars.

The shift to non-discretionary, monthly distributions and subsequent transfer of mental health functions to DHCS seems to have confused the reversion timetable.

Second, this shift also appears to have removed county submission of the RERs from practical consideration in the management of county access to MHSA funds. Prior to AB 100, DMH considered an approved County Three-Year Plan to be a performance contract with the County. Because AB 100 removed the general requirement for State approval of County Three-Year Plans, DMH's (and shortly thereafter, DHCS's) enforcement role became less clear.

As a practical matter, the transition to monthly receipts rather than a lump sum payment also likely changed the counties' cash management needs. As noted above, beginning with FY 2007-08, counties received 75 percent of their funding upon State approval of their plans, roughly equivalent to nine months of monthly distributions. This change should have had no impact on fiscal reversion per se, as DMH policy was for funds to be counted as spent on a "first in, first out" basis. But it may have made it more difficult for counties to spend current-year allocations during the year in which they were received.

That is, receiving 75 percent of the county's allocation up front would have insured substantial cash on hand to pay invoices received early in the fiscal year. Conversely, receiving funds on a monthly basis likely puts greater emphasis on having unspent funds held over from prior years to pay invoices received early in the fiscal year.

As noted above, all counties were required to report MHSA expenditures using a modified accrual method. This means that funds to pay for services or goods were to be deemed "spent" at the time the services or goods were received, even if invoices were received months later.

Third, when the State held MHSA revenues until the Department of Mental Health made its lump-sum allocations, interest income was received by the State-level fund on the fund balance and was commingled with tax revenue deposits into the fund for eventual distribution. Interest income on balances held in the local MHS accounts was kept locally and added to new distributions from the State (see, e.g., DMH Information Notice 07-25). DMH expressly sought, through the semi-annual Cash Flow Statements and the RERs, to manage county cash balances to encourage timely spending.

Current law requiring monthly distributions to the counties leaves cash balance management almost entirely in the discretion of the counties, subject to application of fiscal reversion policy.

Counties have differed significantly in their handling of interest earning on unspent funds in their local MHS Funds, for example.

In order to monitor county spending of MHSA funds, State law requires each county to submit an annual RER. The California Department of Health Care Services is charged with implementing that requirement, including providing periodic updates to the reporting requirements (WIC 5899).

Current law specifies that one purpose of the RERs is to "Determine reversion amounts, if applicable, from prior fiscal year distributions" (WIC Section 5899(c)(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(d)):

1. Children's 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.

Current regulations require counties to submit their annual Revenue and Expenditure Reports within six months of the close of the fiscal year (see California Code of Regulations, Title 9, Section 3510). California's fiscal year runs between July 1st and the following June 30th. Thus, RERs are due by the end of each December. Under the law, RERs 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 (CBHDA), 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 public 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 RERs.

Lastly, the subcommittee directed staff to gather and develop background materials to contribute to this draft report. Related to that direction, Commission staff also participated during the fall of 2016 in informal work group meetings convened by DHCS staff to discuss issues relating to fiscal regulations.

The subcommittee met on March 20, 2017 to discuss a draft version of this report and hear public comment. The subcommittee unanimously approved the draft, with suggested revisions, for presentation to the Commission.

Key Challenges

As part of its review, the Commission heard a range of concerns from counties and mental health stakeholders about the RER reporting process and fiscal reversion policies. Some key challenges or concerns raised by these stakeholders included assertions that:

- The RER reporting process does not allow the counties to accurately report on their MHSA expenditures.
- RER 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.
- 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 RERs by the annual deadline.

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

The Commission found that many counties had not met DHCS's reporting deadlines for submitting certified RERs. In some cases, counties were two or three years in arrears in submitting the required reports to DHCS and the Commission.

As of February, 2017, the Commission had received only 27 of 59 RERs for the FY 2014-15 reporting period, due no later than December 31, 2015. Further, the Commission had received only 46 of 59 RERs for the FY 2013-14 reporting period and was still missing four reports for the FY 2012-13 period.

Subsequent discussions between MHSOAC staff and DHCS staff uncovered some gaps in inter-agency communication about reports received. MHSOAC and DHCS staff are actively cooperating to correct and improve that communication so that both entities may maintain accurate records and publish reports received in a timely manner.

The MHSOAC also has received newly submitted reports from several counties since February, 2017. As of early April, the MHSOAC had on file and had validated 38 of 59 RERs for FY 2014-15, 50 reports for FY 2013-14 and 55 for FY 2012-13. Very few RERs for the FY 2015-16 reporting period have yet been received.

In response to these concerns and throughout this study process, the Commission sought to understand from counties, DHCS, and stakeholders why so few counties were submitting RERs according to DHCS deadlines and the extent to which counties may owe funds under reversion.

The following sections of this report identify key project findings arising from the Commission's study process.

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

Some counties asserted that the forms required by the Department of Health Care Services (prior to the release of the Fiscal Year 2015-16 forms[5]) limited their ability to accurately report expenditures, and thus they were unable to obtain the required validation from their independent Auditor/Controllers, or they are forced to submit inaccurate information.

Counties further reported that the information they provide on their annual Mental Health Services Act Revenue and Expenditure Reports (RERs) may not be consistent with other audited fiscal reports, because of the limitations built into the forms required by DHCS.

For example, each RER requires the counties to report unspent funds from the prior fiscal year (FY), expenditures, adjustments, transfers, and unspent funds (at the close of the FY) by fiscal year from which the funds originated. The FY 2012-13 form distributed by DHCS did not allow counties to report unspent funds available from the prior FY for funds received in FY 2006-07 or FY 2007-08 for any components other than WET and CFTN. Similarly, the form did not allow counties to report expenditures of or adjustments to MHSA funds for most components from FY 2006-07 through FY 2009-10. Nor did the form permit counties to report unspent funds remaining at the end of the FY from FY 2006-07 or FY 2007-08 funds.

Similar reporting limitations applied to the FY 2013-14 and FY 2014-15 RER forms.

DHCS staff note, in response, that they have addressed these concerns in the FY 2015-16 RER form. They further note that some of the limitations in prior RER forms reflected DHCS's understanding that counties should not have had any unspent funds remaining from prior years subject to reversion prior to transfer of responsibilities from DMH to DHCS.

Some counties also have expressed confusion over how to treat interest earned on MHSA funding. 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

[5] Forms and instructions for the annual RERs are released as Information Notices. The FY 2015-16 form was released on January 24, 2017 via Information Notice 17-003. See http://www.dhcs.ca.gov/formsandpubs/Pages/2017-MHSUDS-Information-Notices.aspx.

those who do not, it appears that some counties may 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. The MHSOAC preliminarily estimates that statewide, counties at the end of FY 2013-14 held more than $45 million in unspent cumulative interest for components subject to the three-year reversion rule, compared to approximately $8 million in interest earned that year on unspent funds for those components. That is, the large majority of the cumulative unspent interest was due to interest earned in prior years.

The RER forms clearly required interest earned to be reported as revenue, by component for the reporting year. However, Section 3, the "Expenditure and Funding Sources" section of the Summary tab in the reporting form provides only a single expenditure line for "Interest", without reference to the source of years of the Interest spent. Similarly, Section 6, "Unspent Funds in the Local MHS Fund," provides a single line to report unspent Interest without reference to the years in which the interest was earned. The cells in this latter section of the form auto-populate based on formulas. Hence, if a county does not report interest earned in the reporting year as having been spent in that year in Section 3, the forms insured that the interest earned would be added to the "Cumulative Interest" amount shown in Section 1 ("Unspent Funds Available From Prior Fiscal Years,") and information pertinent to calculating a reversion period for cumulative interest would be lost.

DMH policy, as expressed, for example, in DMH Information Notice 07-25, was that counties were to combine interest earned on unspent funds in the local MHS fund with new allocations in order to determine funds available for expenditure from a given fiscal year. However, past RER forms did not provide clear direction to counties to include interest earned in a given FY as part of that year's available funds. Doing so would have clarified that the reversion time frame for interest earned is the same as for the MHSA component funds on which the interest was earned (three years or ten years).

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 reported that it was actively drafting regulations regarding reversion.[6]

County Behavioral Health Directors also reported uncertainty over whether and how the Department would allow counties to submit updated RERs for prior years. Counties stated 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 would allow revised RERs when warranted.

In partial response, DHCS staff noted in comments to MHSOAC staff that the existing forms provide counties with considerable latitude for adjusting prior reported values via Section 5,

[6] Department of Health Care Services. Letter to Kirsten Barlow, CBHDA. June 16, 2016.

"Adjustments," and a separate Adjustments Summary tab, which allows for explanatory notes for each reported adjustment.

DHCS staff also noted that some counties had expressed confusion over how to report expenditures in light of DMH Information Notice 11-15. That Information Notice provided that, for the purposes of calculating reversion only, counties were to proportionately recombine their Innovation funds with their CSS funds and PEI funds, and likewise proportionately combine their Innovation expenditures with their CSS expenditures and PEI expenditures. In other words, they were to treat for reversion calculation purposes 80 percent of their INN funds and expenditures as CSS funds/expenditures and 20 percent of INN funds/expenditures as PEI funds/expenditures, respectively, in order to calculate whether any of the combined funds would be subject to reversion. Using first-in, first-out principles, if these respective spending combinations (CSS spending plus 80 percent of INN spending; and PEI spending plus 20 percent of INN spending) exhausted the respective combined funds subject to a reversion deadline, DMH would deem the reversion rule for CSS and that portion of INN satisfied.

Information Notice 11-15 did not change how counties were to report actual expenditures and unspent funds, however. Nor did it permit counties to transfer INN funds to other components.

Finding 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.[7] Yet based on a sample of the annual Revenue and Expenditure Reports, numerous counties have funds in their MHSA accounts that were received more than three years earlier, suggesting they may be subject to reversion.

MHSOAC preliminary calculations estimate that about 1.7 percent of the more than $6.9 billion in MHSA funding allocated to the counties through FY 2011-12 currently resides in local MHS fund "three-year" component accounts. This percentage translates to at least $117 million, based on partial reporting for FY 2013-14 and FY 2014-15. Roughly $100 million of this amount is unspent funds reserved for the financing of Innovative Projects.

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.

The Commission has not been able to fully document the amount of unspent MHSA funds held by the counties, because the State has not received all of the required annual Revenue and Expenditure Reports. Nor has the Commission been able to document the reasons counties did not fully spend their MHSA funds.

[7] Department of Health Care Services. 2011. MHSA Funds Reverted, Updated as of 03/23/2011. http://www.dhcs.ca.gov/services/MH/Documents/FundsReverted.pdf (accessed March 12, 2017).

Counties have asserted that long delays in Medi-Cal audits and adjustments—often occurring five years after the close of a fiscal year—require them to retain MHSA funds in anticipation of audit exceptions to their Medi-Cal billing. 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 MHSA in anticipation of Medi-Cal audits, that the State more fully document the rationale for counties to retain MHSA funds beyond three years and potentially modify reversion requirements in consideration of those concerns[8].

Consistent with the concerns raised by the counties with regard to the RER forms and related reporting requirements, the Department of Health Care Services has pointed out that it inherited responsibility for MHSA fiscal regulations in 2012 and is working to update those regulations.[9] Department staff held a series of working-group meetings with county representatives and Commission staff during the fall of 2016 to discuss challenges in existing fiscal policy and potential solutions as the Department works toward new regulations. The Department has indicated informally that it hopes to release new fiscal regulations for public comment in late spring or early summer of 2017.

The Department also has begun to alter its fiscal reporting rules. On June 23, 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.

In doing so, the Department rescinded DMH Information Notice 11-15, which had protected counties from reverting unspent funds allocated to their Innovation component, but did not provide the counties with a mechanism for actually spending Innovation funds held more than three years.

The new 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 rationale for the policy.[10] In testimony at the August 25, 2016 Commission meeting, the Department explained that the original policy, provided in DMH Information Notice 11-15, was not allowable under statute and therefore had been rescinded. Since counties relied on guidance that reversion of Innovation funds would be calculated in this manner, DHCS determined it was necessary to honor the previous policy. The Department released Information Notice 16-026 to rescind the prior policy going forward and allow counties an additional three years to spend any Innovation funds over three years old. The Department has indicated that the three additional years were necessary to allow DHCS to promulgate fiscal regulations.

[8] Ben Johnson. August 25, 2016. Testimony Before the Mental Health Services Oversight and Accountability Commission. Sacramento.

[9] Department of Health Care Services. June 16, 2016. Letter to Kirsten Barlow, CBHDA.

[10] Toby Ewing. August 11, 2016. Letter to Karen Baylor, Department of Health Care Services.

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

The Mental Health Services Act provides funding for local mental health services to counties in ear-marked component categories, with only limited allowance for transfers across component to meet local needs. The Act also stipulates that any funds left unspent three years from allocation to a county must be returned to the State, except for funds transferred to the Prudent Reserve or re-allocated to workforce education and training or capital facilities and technological needs, the latter two of which are to revert after ten years.

The law is clear that any funds reverted from a county to the State fund are to be made available for distribution to other counties in future years. It is silent, however, on how reverted funds are to be redistributed. In particular, it does not address whether reverted MHSA funds should retain their original, earmarked purpose (e.g., that reverted Innovation funds be redistributed only for Innovation expenditures). Nor does it address how reverted MHSA funds should be redistributed geographically (i.e., whether the original distribution formula across counties should apply).

In the absence of a specific reversion policy, it appears likely that reverted funds would be co-mingled with new funds and redistributed based on the state's current MHSA allocation formula, both across components and across counties. Limited evidence suggests that Innovation and PEI funds are at greatest risk for reversion, for two reasons. First, the PEI and Innovation components are less programmatically mature than CSS. Evidence suggests that very little CSS funding has been held for more than three years by counties. Second, PEI and Innovation funds cannot be shifted into the Prudent Reserve or for other purposes in the same way that CSS funds can be reserved.

As a result, under the default reversion redistribution policy, counties are more likely to see PEI and INN funds revert. Further, upon redistribution, nearly 80 percent of those funds would cycle back into CSS programs, contrary to the intent of their original allocations.

While preliminary data suggest that MHSA funds subject to reversion are held in counties from very small to very large, anecdotal evidence also suggests that very small counties may face proportionately greater difficulties than their larger counterparts in managing 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 have suggested the need to "save up" funding from their small-scale distributions until they have accumulated sufficient resources to support expenditures they deem necessary to meet local mental health needs, particularly for relatively short-term projects. For very small counties, extending the deadline for reversion, particularly for Innovation projects, 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 allocation. 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 as soon as possible. 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 polices, 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.** No MHSA funds have reverted since 2008. This reflects both numerous changes in DMH administration of the Act prior to 2011 and the progressive roll-out of components during that time period, as well as the fact that the State fundamentally reorganized its state administration of the MHSA in 2011 and 2012 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. The Commission has found that DHCS RER data reporting standards have been relatively stable and consistent since FY 2012-13. This suggests that the transition to DHCS oversight could serve as a demarcation point in the application of reversion policy.
>
> The Legislature thus 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 re-clarify existing policy that counties should follow a "First-In/First-Out" expenditure policy with regards to tracking MHSA funds. 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. 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).

Further, the Department of Health Care Services should clarify the starting point for the reversion "clock" for funds received throughout a fiscal year. One option discussed between DHCS staff, Commission staff, and county representatives informally would be to designate the end of the fiscal year, when all MHSA funds for the given year have been distributed by the State Controller's Office (SCO), as that starting point. Alternatively, the starting point could be the beginning of the fiscal year, which would be consistent with DMH's original practice to start the reversion clock when it released the Planning Estimates.

Similarly, interest income should be attributed, by MHSA component, to a specific fiscal year. As interest-bearing accounts generally earn interest on balances throughout the year, the Commission believes that a reversion clock starting point consistent with the standard applied to SCO monthly distributions would be appropriate. Interest income for each MHSA component should be treated on the same basis as other MHSA unspent funds for the purposes of reversion.

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 counties.

To the extent allowed under the voter-approved Mental Health Services Act, the Legislature should modify the Act to extend the time period for expenditure of MHSA funds from three

years to five years for the very small counties when justified and, if feasible, for all counties. This recommendation recognizes the complexity of the MHSA and the challenges very small counties face in funding and sustaining programs and projects with limited MHSA allocations.

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 beyond the three-year standard. 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 those subject to a 10-year reversion timeframe.

3. The Department of Health Care Services should develop regulations or guidance, as appropriate, to better clarify how counties are to revise or correct prior annual Revenue and Expenditure Report data in subsequent RERs.

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. While the annual instructions for this form provide for county reporting of Adjustments, which can be used to correct or revise certain information provided in the counties' past reports, the instructions for the Adjustments section and the Adjustments Summary Worksheet are somewhat sparse. County complaints that they are unable to correct or revise past RERs in light of new information suggest that they may not be utilizing the Adjustments section fully. It is unclear to what degree the Department has in the past provided technical assistance to counties to clarify the purposes and uses of this section.

The Department should clarify that counties are encouraged to utilize Adjustments to revise data reported in 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. The Commission agrees with Department staff that a mechanism for wholesale revision of past RERs likely does not serve the public interest. 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. Current law and policies imply that 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.

Preliminary findings suggest that in excess of $117 million dollars distributed to counties in 2011-12 or earlier were held in county MHSA accounts subject to the three-year expenditure time frame under the law, as of the close of FY 2014-15. This figure including roughly $100 million earmarked for the Innovative Project component. Much of that latter figure was effectively held in administrative limbo due to DMH Information Notice 11-15, which protected older county INN funds from reversion but did not provide the counties with clear authority to spend the funds.

The Department of Health Care Services attempted to address this administrative conundrum by issuing Information Notice 16-026, which rescinded the prior DMH Information Notice and sought to provide the counties with an avenue to spend the older INN funds. One consequence seen by the Commission has been a recent rush by counties to bring to the Commission proposals for new Innovation projects and to extend and expand existing projects.

The Commission believes that the Department's intent in providing counties with three additional years in which to spend unspent INN funds is a reasonable policy response to the conundrum arising from DMH Information Notice 11-15. However, the Commission has not yet seen the Department's legal analysis supporting the time extension.

We addressed above several options the Legislature may wish to consider for a "reset" of reversion policy, which could include statutorily suspending reversion, completely or partially for funds remaining unspent from allocations made prior to the transfer of DMH functions to DHCS.

One possible approach to addressing the unspent MHSA funds subject to reversion would be to establish an explicit MHSA Reversion Fund to capture dollars reverted from the counties. 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 mental health needs statewide. Unmet mental health needs should include attention to reducing disparities, improving capacity, enhancing opportunities for regional approaches to delivering services to Californians with serious mental illnesses and supporting the needs of California's small and very small counties.

Establishing an MHSA Reversion Fund would support the following goals:

- **Improve transparency**. It has been difficult for the Legislature and public to monitor the extent that MHSA funds 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. Capturing unspent MHSA funds into a state-administered fund increases the incentives for counties to spend their MHSA allocations before they revert.

- **Dedicate unspent funds on unmet mental health needs**. In recent years, the Legislature has identified a range of unmet mental health needs and has dedicated unspent MHSA State administrative funds to address these needs. The Mental Health Wellness Act (SB 82, Chapter 32, Statues of 2013) and the work of the California Reducing Disparities Project are examples of those efforts. Capturing local MHSA funds that have gone unspent for an extended period and therefore are subject to reversion furthers the capacity of the Legislature to address unmet mental health needs while preserving those funds for county mental health programs.

These reforms, if supported by the Governor and Legislature, would clarify California's MHSA reversion policies, 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 help ensure that unspent funds are dedicated to the most urgent unmet mental needs.

Mental Health Services
Oversight & Accountability Commission

MHSA Fiscal Reversion Policy Report Overview

April 25, 2017

WELLNESS • RECOVERY • RESILIENCE

Outline

- Introduction
- Background
- Key Challenges
- Findings
- Recommendations
- Motion

Introduction

- Stakeholders have raised concerns about unspent funds held in county MHSA accounts
  - The public has lacked effective access to up-to-date information about county MHSA accounts.
  - No funds have been reverted from county accounts to the State fund since 2008
- This project was designed to clarify current fiscal reversion policy, identify challenges, and propose potential responses to meet the goals of fiscal reversion within the MHSA.

Background: Pre-AB 100

Growth, Change and Conflict

- Phased roll-out of MHSA Components
- Multiple changes in fiscal structure and reporting
- Information Notice 11-15
- Breaking up is hard to do

Background: Post-AB 100

A Need For Clarity

- No funds have reverted since 2008
- Preliminary estimates: at least $117 million remains unspent from FY 2010-11 and earlier “3-year” funds ($100 million in INN funds)
- County confusion about Information Notice 11-15
- Lack of clarity about Interest earned
- Concerns about Information Notice 17-026

Key challenges

Key concerns raised by stakeholders:

- RER reporting process does not allow accurate reporting
- RER reports inadequate for public monitoring of policy implementation
- MHSA funds have not reverted as required by law
- Counties are not meeting reporting deadlines

Findings

1. Prior DHCS RER forms were overly restrictive.
2. Counties are unclear on how to handle funds potentially subject to reversion.
3. Uniform reversion policies may not align with goals of MHSA.

Recommendations

1. “Re-set” reversion policies.
2. Extend spending period to 5 years from 3 years for at least very small counties.
3. Clarify process for revising/correcting/updating RER data.
4. Establish an MHSA Reversion Fund.

Proposed Motion

- **Proposed Motion:** The MHSOAC adopts the report: *Mental Health Services Act Fiscal Reversion Policy Reconsidered: Challenges and Opportunities*.

Electronic Behavioral Health Solutions (eBHS) and Innovations and Improvement Through Data (IITD)

Modoc County

Innovations Plan

4/27/17

Learning from Prior PDSA Cycles

- Electronic health records inadequacy
- Critical need for a data analytic system to meet multiple data needs, including day-to-day clinical dashboards, population management data reports, and aggregate outcomes reporting
- Overall lack of systemic use of data analytics systems beyond special projects in CA
- Critical need for strong implementation plan
- Real-time and proactive use of data for PEI, service delivery, and improvement.
- Data analytics system needs the flexibility to track individuals who not in the EHR, crosswalk from other data systems, include reminders, allow access for integrated care partners, and have potential for client portal capability in the future.

Proposed Project

- Through the proposed innovation, Modoc County would bring three equally effective, evidence-based strategies together to improve client outcomes and manage the Behavioral Health population more proactively.
- This three-pronged approach (IITD) was developed and modified by CiBHS for this project to increase the success of data collection initiatives and for implementation of this data analytics tool.
- The proposed approach includes:
  - 1) a uniquely flexible, cost-efficient web-based data analytic system;
  - 2) a strong implementation method;
  - 3) training on use of data in clinical practice and for beneficiary and population management.

Budget

- The County is requesting **$364,896 for four years** (4 years - 5/01/2017 to 4/30/2021)
- Contract: CIBHS, is $174,684 to provide the training, technical assistance and evaluation for the Innovation project.
- Evaluation is 7% (or $12,228 total for four years) of the contractor's budget.
- Non-recurring operating costs total $105,000 (~29% of the total Innovation budget) to support the system set-up, configuration, and equipment for eBHS web-based data collection system.
- Personnel cost (salary and benefits) is $85,212 (~23% of the total Innovation budget) is set aside for:
- - 0.1 FTE Modoc County Clinical Director - $8,801 per year
- - 0.25 FTE Modoc County Administrative Assistant/Analyst - $9,002 per year
- - 0.1 Modoc County MHSA Project Manager - $3,500 per year

- Additionally, the County intends to add in-kind funds from 1991 Realignment, FFP, MHSA PEI or Behavioral Health Subaccount to add to the project's total budget to cover additional staff salary and benefits (to implement the registry and contribution to the evaluation process), associated Administrative, Direct and Indirect Operating Costs at an estimated in-kind budget of $311,453.
- The estimated total combined budget for the project is $676,349.

Proposed Motion

- **Proposed Motion:** The MHSOAC approves Modoc County's Innovation Project, as follows:
  - **Name:** Electronic Behavioral Health Solutions (eBHS) and Innovations and Improvement Through Data (IITD)
  - **Amount:** $364,896
  - **Project Length**: 4 years

Kern Innovative Proposal:
Special Needs Registry Project – Smart 911

Primary Problem & Project Overview

- Calls to 911 have the potential to end adversely for persons experiencing a **mental health emergency** event.
- Smart 911's online special needs registry allows **the public** to create a free, username and password protected profile.
- Clients create their **password-protected user account**, and have the ability to provide information which is only accessed when they call 911 from a registered phone number or address.
- **HIPAA-secure**, user provided information will help emergency first responders make safer and better interventions

Innovative Solution

- **<u>Focus on Mental Health:</u>**
  - **40 online registration kiosks** will be placed in lobbies throughout the Kern BHRS System of Care, including rural locations.
  - Behavioral Health staff will be trained to assist clients with registering and with keeping their user profiles up to date, **as part of their appointments**.
  - **Ongoing community awareness** campaigns will focus on mental health
- Smart 911's **ONLINE** special needs registry is **FREE TO THE USER.**

Innovative Solution

- **Password-protected, HIPAA-Secure** user profiles are accessible only by the user.
- Installation of and training for Smart911 software will be provided for at **13 Public Service Access Points** (PSAPs) that support Kern.
- The ***information that registrants choose to include*** in their profiles, is **provided to emergency responders for 45 minutes**, whenever a 911 call originates from any of the phone numbers included in the user's profile (such as the phone numbers of family members).

Innovation and Learning

- Kern's Special Needs Registry will be the **first Smart 911 implementation** adapted for use with behavioral health emergencies.
- **This project will attempt to learn:**
  - If Smart911 leads to better emergency services for clients while experiencing a mental health emergency
  - If public safety agencies are more effectively and efficiently able to provide service during a mental health emergency event
  - If clients and families will use and be highly satisfied with Smart911

Budget

Anticipated Budget for five years= **$3,107,514**

- Personnel = **$1,737,517**
- Evaluation = **$223,270**
- Operating = **$952,000**
- Non-recurring = **$74,000**
- Administration = **$422,774**

Community Planning

- The **Special Needs Registry Project – Smart 911** was proposed, developed and received feedback over a two year period through:
  - **The Kern Crisis Intervention Team**
  - **Community partners**
  - **Those with lived experience**
  - **NAMI members**
  - **Kern County residents**
  - **Law Enforcement**
  - **Educators**
- **"We can possibly reduce use of force in some responses by having additional information up front when responding."**
  - Stakeholder feedback collected Sept. 21, 2016, Bakersfield, CA
- **"A great help for persons with mental illness when a crisis happens and law enforcement is called out."**
  - Stakeholder feedback collected November 15, 2016, Ridgecrest, CA

Proposed Motion

- **Proposed Motion:** Pending their Board of Supervisors approval, the MHSOAC approves Kern County's Innovation Project, as follows:
  - **Name:** Special Needs Registry Smart911
  - **Amount:** $3,170,514
  - **Project Length**: 5 years