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California Legislature

JOINT OVERSIGHT HEARING
Accountability and Administrative Review Committee &
Health Committee

Wednesday, August 21, 2019
10:00 a.m. – noon, State Capitol, Room 447

Mental Health Services Act (Prop 63) Funds: Oversight and Accountability

About the Mental Health Services Act (MHSA)

More than 2 million children, adults, and seniors are affected by potentially disabling mental illnesses every year in California. To address their needs, the MHSA, also known as Proposition 63, was approved by voters in 2004 and enacted into law on January 1, 2005. The MHSA imposes a 1% tax on personal income above $1 million and the revenue generated is deposited into the Mental Health Services Fund (MHSF). The MHSA brings approximately $2 billion of new revenue into the mental health system each year.

The MHSA aims to transform the mental health system while improving the quality of life for Californians living with a mental illness. From 2004 until 2012, the California Department of Mental Health (DMH) was the primary state agency responsible for overseeing the implementation of the MHSA. In 2012, DMH was dissolved and the majority of its MHSA duties were transferred to the Department of Health Care Services (DHCS).

MHSA Components and Governance

The MHSA addresses a broad continuum of prevention, early intervention, and service needs as well as provides funding for infrastructure, technology, and training for the mental health system. The MHSA specifies five required components:

1) **Community Services and Supports (CSS)** - CSS is the largest component of the MHSA and focuses on community collaboration, cultural competence, client and family driven services and systems, a wellness focus, which includes concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and

underserved. Housing is also a large part of the CSS component.

2) **Prevention and Early Intervention (PEI)** - PEI helps counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects and programs.

3) **Innovation (INN)** - The goal of INN is to increase access to underserved groups, increase the quality of services, promote interagency collaboration and increase access to services. Counties select one or more goals and use those goals as the primary priority or priorities for their proposed INN plan. The Mental Health Services Oversight and Accountability Commission (Commission) controls funding approval for the INN component of the MHSA.

4) **Capital Facilities and Technological Needs (CF/TN)** - The goal of CF/TN is to create facilities that are used for the delivery of MHSA services to mental health clients and their families or for administrative offices. Funds may also be used to increase peer-support and consumer-run facilities, develop community-based settings, and technological infrastructure for the mental health system.

5) **Workforce Education and Training (WET)** - The goal of WET is to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes. They are able to work collaboratively to deliver client- and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers.

On a monthly basis, the State Controller's Office distributes funds deposited into the MHSF to counties. Counties expend the funds for the required components consistent with a local plan, which is subject to a community planning process (CPP) that includes stakeholders and requires approval by the County Board of Supervisors. Counties have three years to expend MHSA funds for their intended purpose; longer expenditure periods are allowed for other certain uses, such as capital projects. If funds are unspent after three years, those funds are required to be reverted to the state, which must then make the funds available for allocation to other counties. Additionally, the MHSA authorizes up to 5% of revenues for state administrative functions performed by a variety of state entities.

Each county mental health department is required to prepare and submit its three-year plan to the DHCS. The plan must be updated each year and approved by DHCS after review and comment by the Commission. DHCS is required to work with the Commission and the California Behavioral Health Directors Association to develop and administer instructions for the annual MHSA Revenue and Expenditure Report (annual report) that each county must complete. The annual report is publicly posted information that shows each county's annual expenditures for all MHSA components and identifies, among other things, unexpended funds.

As part of the process for developing the three-year program and expenditure plan, each county must undertake a robust CPP that includes circulating draft copies of it to representatives of stakeholders' interests and any other interested parties for the purpose of public comment. The county must also provide documentation that a public hearing was held. The CPP process must adhere to specified standards to ensure that the process and the plan include community collaboration, cultural competence, integrated services, is client and family driven and promotes wellness, recovery and resilience.

In addition, the CPP process requires inclusion of specific participants including clients and family members of individuals with serious mental illness/serious emotional disorders; and, other broad-based stakeholder constituents, such as adults and seniors with severe mental illness; law enforcement personnel; education and social service agency representatives; underserved populations; and, representatives that reflect the diversity of demographics of the county.

Mental Health Services Oversight and Accountability Commission

The Commission was created by the MHSA primarily to oversee the implementation of the MHSA and develop strategies to overcome stigma surrounding mental health issues. It is comprised of 16 voting Commissioners, including four elected officials and 12 members appointed by the Governor.

According to its website, the mission of the Commission is to:

1) Provide vision and leadership, in collaboration with clients, their family members, and underserved communities, to ensure Californians understand mental health is essential to overall health;
2) Hold public mental health systems accountable;
3) Provide oversight for eliminating disparities; promote wellness, recovery and resiliency; and,
4) Ensure positive outcomes for individuals living with serious mental illness and their families.

Initially, the Commission was responsible for review and approval of county plans for the PEI and INN components of the MHSA. Over time, its role shifted to also include providing training and technical assistance for county mental health planning as needed. Additionally, the Commission evaluates MHSA-funded programs throughout the state. The Commission receives all county three-year plans, annual updates, and annual reports. It offers technical assistance and training to counties, providers, clients and family members, and other stakeholders to support the goals of the MHSA.

Recent California State Auditor Report

In February 2018, the California State Auditor (CSA) issued a report entitled, "The State Could Better Ensure the Effective Use of Mental Health Services Act Funding," and noted that a general lack of oversight from the state, particularly DHCS, resulted in counties amassing unspent MHSA funds of $231 million, not including reserves, as of the end of fiscal year 2015-16, that should have been returned to the state to be redistributed among the counties. Of that $231 million, 63%, or $146 million, were funds for the INN component. According to the

report, counties have struggled to spend the funds due, in part, to a lack of clarity about the INN program approval process.

The report also found, for that same fiscal year, that counties cumulatively held reserves of $535 million in MHSA funds, of which the CSA estimated between $157 million and $274 million were excessive and should have been returned to the state. The CSA attributed this to DHCS not having developed a reversion process to recover the unspent funds, or a prudent reserve formula. According to the CSA, the lack of enforcement from DHCS acted as a disincentive for counties to submit the required annual reports, which would assist DHCS in tracking unspent funds. The CSA noted that in the same fiscal year, only one of the 59 county programs submitted the annual report by the regulatory deadline.

DHCS agreed with most of the recommendations from the audit and has since prepared corrective action plans, which will be discussed at this hearing, to implement them.

The Legislature also took action to address the issues raised by the audit. AB 114 (Committee on Budget), Chapter 38, Statutes of 2017, enacted a number of changes intended to enhance fiscal oversight, including a requirement for DHCS to develop a reversion calculation methodology, provide related guidance to counties, and report to the Legislature by October of each year identifying funds subject to reversion. Additionally, SB 192 (Beall), Chapter 328, Statutes of 2018, establishes a Reversion Account for unspent MHSA funds, a maximum prudent reserve calculation of 33%, and a timeline for counties to submit the unspent funds to the account.

The full CSA audit may be found at: https://www.auditor.ca.gov/reports/2017-117/index.html.

Key Policy Questions and Areas for Discussion

The purpose of this hearing is to determine whether the issues and concerns identified in the CSA audit have been addressed and processes put in place to ensure that similar issues do not arise in the future. This hearing is also intended to clarify whether the counties, DHCS and Commission are aligned in the areas of data reporting, policies, and procedures in order to ensure maximum effectiveness of the MHSA. The following represent the key policy questions and areas to be discussed.

1) What lessons have been learned since this audit and how does this inform future MHSA oversight? How have the findings from the audit shaped efforts to ensure MHSA funds are spent timely, appropriately and effectively?

2) How do counties and the state prepare for the volatility of the MHSA funding source?

3) What steps or processes have been undertaken on an ongoing basis to ensure that counties are using the MHSA funds as detailed in their three-year plans and annual expenditure reports or subsequent updates?

4) What is the current status of the reversion process? Has DHCS developed a process for determining the amount of funds subject to reversion on an annual basis and for collecting

the reverted funds? Has the methodology been developed and the related guidance provided to counties?

5) Describe the process implemented for redistributing reverted funds. How are those funds allocated?

6) Describe the accountability mechanisms in place to ensure counties are completing and submitting timely annual reports. How is the information/data from the reports used? Is it helpful in identifying and tracking unspent funds and triggering reversion, if necessary?

7) What data collection efforts exist with regard to the MHSA? How can that data be used to provide transparency and effective oversight? Is there consistency between county, state, and Commission data and, if not, why not? If not, how is the data reconciled?

8) Given that the audit uncovered that a majority (63%) of the unspent funds were for the Innovation (INN) component, please provide an update on the INN program approval process. What guidance has been provided to counties since the audit and have the funds since been reallocated?

9) What can the Legislature do to strengthen the relationship between DHCS, the Commission, and the counties in order to improve and ensure compliance with MHSA requirements as well as ensure oversight of program effectiveness?