AUGUST 21, 2019

# Overview of Public Community Mental Health Services Funding and the Mental Health Services Act

PRESENTED TO:

Assembly Committee on Accountability and Administrative Review

Hon. Cottie Petrie-Norris, Chair

and

Assembly Committee on Health

Hon. Jim Wood, Chair

LEGISLATIVE ANALYST'S OFFICE

# Financing Public Community Mental Health Services

## Overview

***Defining Public Community Mental Health.*** We define public community mental health as including publicly funded outpatient and inpatient mental health services and psychotropic medications provided primarily in community settings. It generally does not include services provided through the Department of State Hospitals, prisons, Medicare, private insurance, or the K-12 educational system.

***Financing of Public Community Mental Health Services Is Complex.*** The financing of public community mental health services is complex, relying on a variety of distinct funding streams, each of which can have distinct objectives and a unique set of rules. The figure on the next page summarizes the flow of funding in the public community mental health system and highlights the variety of services that are funded.

***Counties Are Primarily Responsible for Providing Public Community Mental Health Services.*** In California, counties are primarily responsible for providing mental health services to low-income residents, including those with the highest mental health needs. In some limited cases, other local entities such as cities administer some public community mental health services in place of the county. (Hereafter, we will refer to counties and these other local entities collectively as "counties.") For example, counties are responsible for providing mental health services for the following types of beneficiaries and/or programs:

- Children on Medi-Cal (the state's Medicaid program).
- Adults on Medi-Cal with severe mental illness.
- The bulk of Mental Health Services Act (MHSA) programs.
- Low-income residents without health insurance coverage (indigent care).

Public community mental health services that are not the responsibility of counties are typically administered directly by the state's Medicaid agency, the California Department of Health Care Services (DHCS), or by a Medi-Cal managed care plan.

# Financing Public Community Mental Health Services

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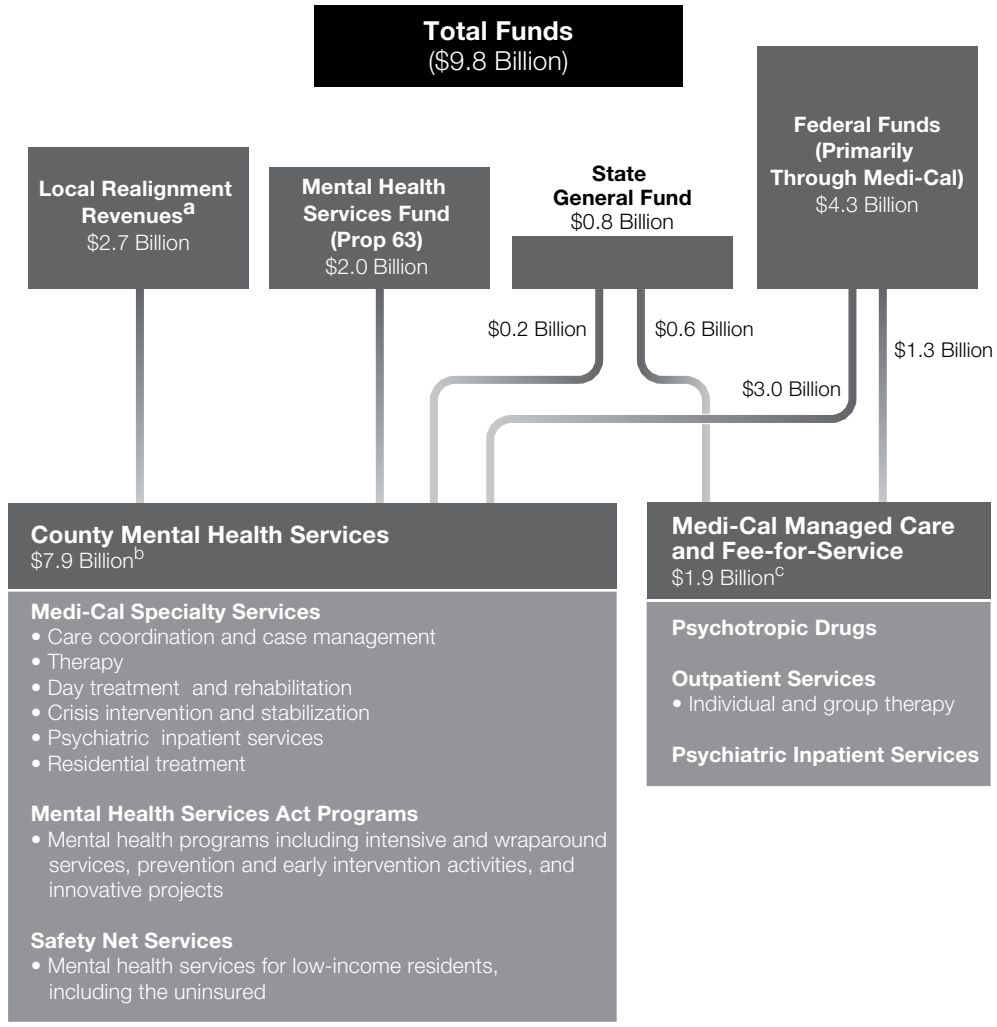
## Public Community Mental Health Services Funding

*2017-18 LAO Estimates*




[a] Includes funding that counties may use on substance use disorder services (not considered mental health services).

[b] Some counties provide further funding for mental health using County General Funds. County General Funds are not included in listed funding amount.

[c] Does not include funding for outpatient services that are provided through the fee-for-service system, or in community clinics, due to data limitations.

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# Financing Public Community Mental Health Services

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***Most Public Community Mental Health Funding Goes to Counties.*** To enable counties to meet their responsibilities, the state directs about 80 percent of total funding for public community mental health services to county mental health agencies. The remaining 20 percent of funding is either paid out directly by DHCS—for psychotropic medications, for example—or goes to Medi-Cal managed care plans to pay for outpatient therapy for Medi-Cal enrollees (primarily adults) with mild-to-moderate mental illness.

## Major Funding Sources

***Federal Funds Available Through Medi-Cal Reflect the Largest Source of Funding.*** Federal funds available through Medi-Cal comprise over 40 percent of total funding within the public community mental health system, or around $4 billion in 2017-18. Through Medi-Cal, the federal government shares in the cost of medically-necessary mental health services and psychotropic medications for individuals enrolled in the program. Only mental health services and psychotropic medications covered by Medi-Cal are eligible for this federal funding. Because the federal government only pays a portion of the costs of Medi-Cal services, nonfederal funds are needed to cover the remaining share of costs. We describe the state and local fund sources that provide for the nonfederal share below. In addition to the federal funding available through Medi-Cal, the federal government supports California's public community mental health system through grant funding in the low hundreds of millions of dollars annually.

***Local Realignment Revenues Reflect Over a Quarter of Total Funding.*** The next largest source of funding—around $2.7 billion in 2017-18—comprises local realignment revenues, which are portions of the state's sales tax and vehicle license fee revenues that the state dedicates to counties to pay for a number of county responsibilities, including mental health services (and some substance use disorder services). Realignment revenues generally serve as counties' primary source of general-purpose mental health funding, which they may flexibly deploy to meet their various related objectives and obligations. Principal among these obligations, this funding generally serves as the primary nonfederal fund source for Medi-Cal mental health services administered by counties.

# Financing Public Community Mental Health Services

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***MHSA Is a Major Fund Source.*** Approved by voters in 2004, the MHSA places a 1 percent tax on incomes over $1 million and dedicates the associated revenues to mental health services. The vast majority of MHSA revenues—around $2 billion in 2017-18—goes directly to counties, which use it to support a variety of services for individuals with or at risk of mental illness. Often, MHSA is also used as a nonfederal fund source for Medi-Cal services. Below, we provide additional detail related to MHSA financing.

***State General Fund Provides Remaining Share of Funding.*** In light of the dedication of other nonfederal fund sources (over $5 billion in realignment and MHSA revenues), a relatively small amount of state General Fund (about $800 million in 2017-18) goes to support the state's public community mental health system. Much of the state General Fund dedicated to mental health services funds the nonfederal share of non-county Medi-Cal mental health services—such as psychotropic medications, psychiatric inpatient hospitalization, and outpatient services for individuals with mild-to-moderate mental illness. In addition, the General Fund supports county mental health services for new services and expanded eligibility requirements imposed by the state since 2011. Most prominently, for example, the state General Fund pays for the nonfederal share of cost for county-based mental health services for the 3.8 million state residents enrolled in Medi-Cal under the Patient Protection and Affordable Care Act's (ACA) optional expansion, through which low-income, childless adults became eligible.

***Some Counties Augment Funding for Mental Health Services With County General Fund.*** Some counties dedicate their own county General Fund to support county mental health services. It is unknown how many California counties dedicate county General Fund to mental health services and how much, in the aggregate, is used.

***Growth in Funding Over Time.*** As shown in the figure on the next page, since the last recession, there has been significant growth in funding for county mental health services. Average annual growth has been almost 8 percent, driven in part by a near doubling in federal funding available through Medi-Cal. Much of this new federal funding is the result of the ACA establishing a 90 percent or greater federal share of cost for the optional expansion population.

# Financing Public Community Mental Health Services

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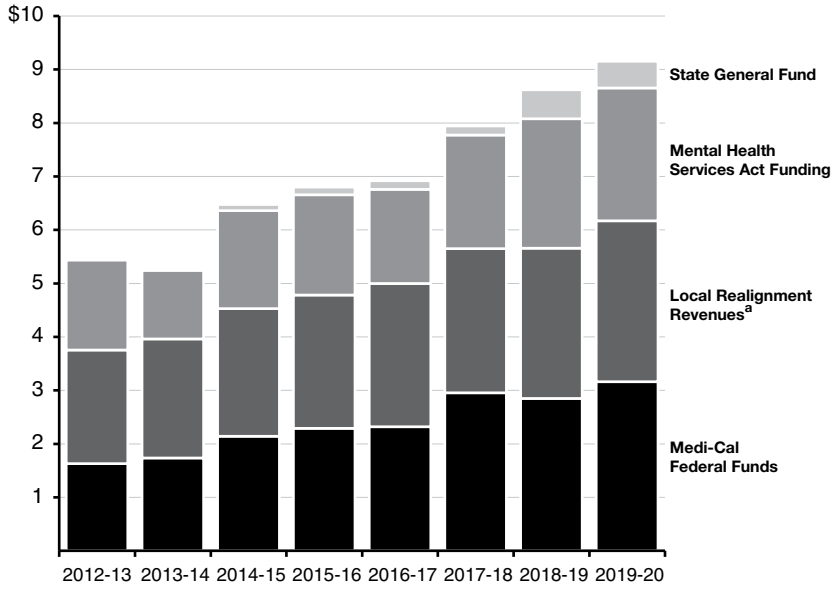
**Funding for County Mental Health Services Has Grown Significantly Since the Last Recession**

*(In Billions)*




[a] Revenues shown support county substance use disorder services in addition to mental health services.

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## Mental Health Services Act

***MHSA Establishes Parameters for How MHSA Funding May Be Spent.*** The MHSA establishes a variety of parameters for how MHSA funding may be spent, including the percent of funds which must—or sometimes may—be spent on specific kinds of activities. Below, we summarize several of the principal funding parameters. The figure on the next page illustrates how MHSA funding is allocated according to these parameters.

- ***Reserves a Small Amount of Funding for State Activities, With the Remaining Funding Going Directly to Counties.*** The MHSA establishes a maximum funding level of 5 percent of revenues for the state to administer the MHSA. This 5 percent is often referred to as the "state cap." Under current legislative practice, funding within the state cap that is not needed for direct MHSA administration—for example, oversight activities—is available for the Legislature to appropriate for various mental health programs. For example, since 2013-14, the state has used around $20 million to $30 million in annual state cap funding to provide grants to counties for the hiring of "triage" personnel who can quickly engage individuals experiencing a mental health crisis. The 95 percent of MHSA funding that is outside of the state cap goes directly to counties. Within the broad parameters described below, counties have flexibility in what programs and activities they fund using MHSA funding.
- ***Establishes Funding Levels for Direct Service Provision, Prevention and Early Intervention Activities, and Innovation Programs.*** The MHSA requires that the MHSA funding that falls outside of the state cap be spent in specified percentages in each of three ways:
  - ***Community Services and Supports.*** 76 percent of MHSA funding for counties must be used on Community Services and Supports, the primary MHSA funding category that supports direct service provision. At least 50 percent of this funding is directed by state rules toward Full-Service Partnerships, which provide mental health and wraparound services—such as, for

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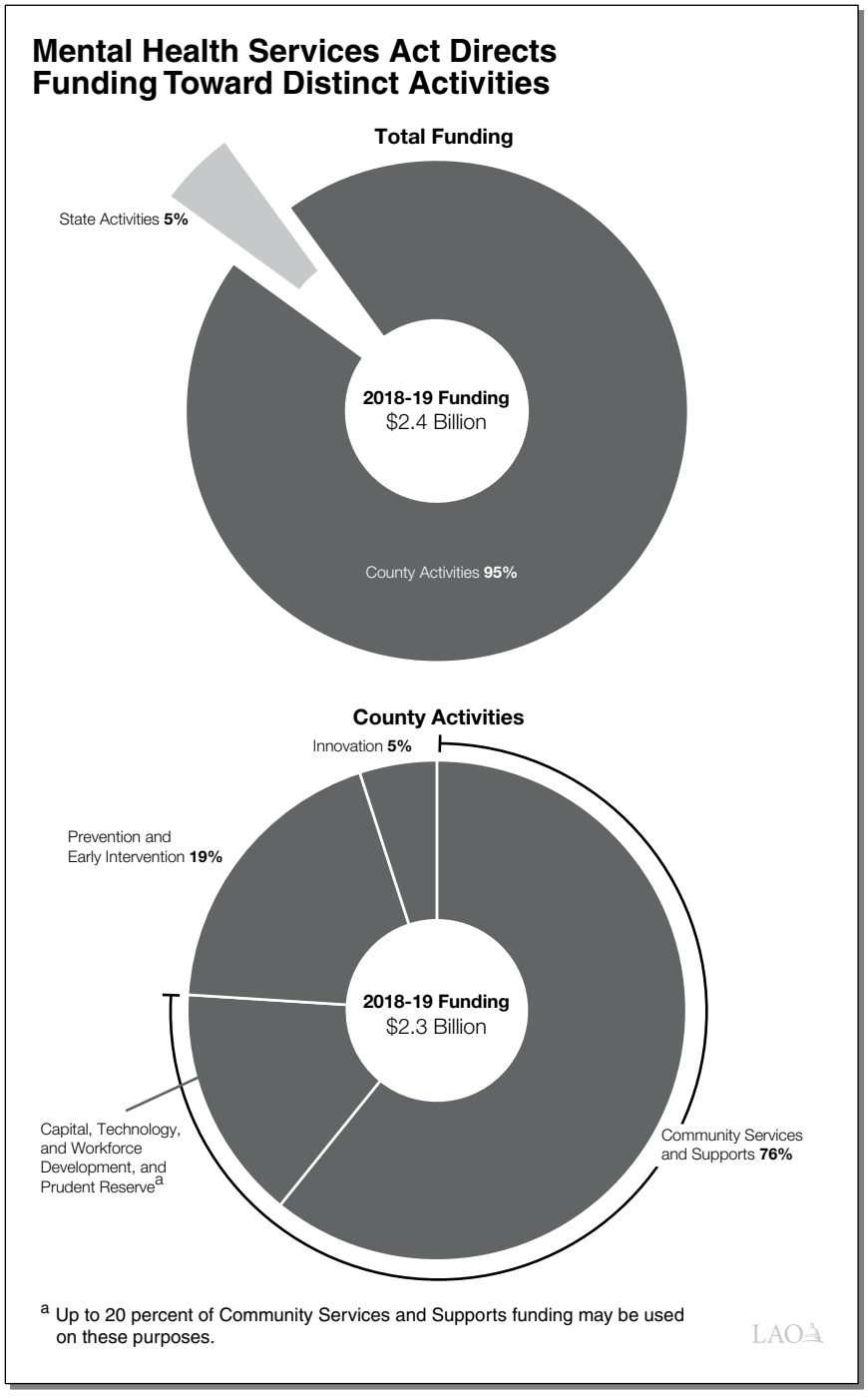

example, housing support—for individuals with the greatest mental health needs.

- ***Prevention and Early Intervention.*** 19 percent of MHSA funding for counties must be used on Prevention and Early Intervention activities, which are aimed at preventing mental illnesses before they become severe. Examples of programs and activities include direct services for individuals with early onset mental illness and mental health awareness campaigns.
- ***Innovative Programs.*** 5 percent of MHSA funding for counties is directed to be spent on Innovation programs, with the goal of encouraging counties to experiment with new approaches to treating and preventing mental illness. Unlike other county MHSA programs, Innovation programs must receive advanced approval from the state before being implemented.

- ***Authorizes a Maximum Funding Level for Counties to Support Their Local Mental Health System.*** The MHSA allows counties to dedicate up to 20 percent of the funding they receive under the Community Services and Support component to support their local mental health system. This funding can be used by counties to meet their capital facility and technological needs, on workforce development programs, and to maintain a prudent level of reserves.
- ***Unspent Funds Subject to Reversion After Specified Time Limits.*** The MHSA and subsequent legislation require that Community Services and Supports, Prevention and Early Intervention, and Innovation funding allocated to counties generally must be spent within three years (or five years for certain rural counties). Funding dedicated to supporting local mental health systems must be spent within ten years. Funding that is not expended within these time frames reverts to the state to be reallocated to other counties that fully expended their allocations.

# Financing Public Community Mental Health Services

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***Establishes Oversight Roles for Multiple State Agencies.*** The MHSA establishes a framework for state oversight of counties' MHSA activities, primarily granting oversight authority to two state agencies: DHCS and the Mental Health Services Oversight and Accountability Commission (OAC), which both have rule-making authority over the MHSA components that they individually oversee.

- DHCS oversees the Community Services and Supports component of the MHSA, collects MHSA revenue and expenditure information from counties, and has the power to withhold MHSA funds from counties for noncompliance with the requirements of the MHSA.
- The OAC, by contrast, oversees the Prevention and Early Intervention and Innovation components of the MHSA, and is tasked with advising the Legislature on matters related to mental health services, providing technical assistance to counties, and evaluating counties' spending and performance under the MHSA. The OAC is tasked with approving the Innovation activities proposed by the counties.

# Audit of MHSA Funding and Oversight

In February 2018, the State Auditor released a report evaluating the funding and oversight of the MHSA.

## Audit Identified Several Deficiencies

Major findings include:

- **Counties Accumulated Significant Unspent MHSA Funds**
  - DHCS had not developed a process to recover an estimated $231 million in unspent funds from counties, to be redistributed to other counties.
  - DHCS had not established guidance on the treatment of interest that counties earn on unspent MHSA funds.
  - DHCS had not established guidance on an appropriate level of counties' MHSA reserves. Reserves—totaling an estimated $535 million as of the end of 2015-16—were considered excessive.
- **DHCS Provided Minimal Oversight of Counties' Use of MHSA Funding**
  - DHCS had not enforced deadlines for counties to submit annual financial reports, and in many cases these reports were submitted long after deadlines.
  - DHCS had not completed any MHSA fiscal audits of counties as of December 2017 (shortly before the audit's release) and had not implemented regulations outlining a process for counties to appeal adverse fiscal audit determinations.
  - DHCS had not implemented a process to conduct comprehensive MHSA program audits, which would help ensure that counties' MHSA programs are effective and compliant with MHSA requirements.

# Audit of MHSA Funding and Oversight

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- **Counties Required Additional Technical Assistance From OAC**
  - Some counties had challenges anticipating which types of Innovation projects the OAC would approve.
  - Lessons learned from successful and unsuccessful Innovation projects were insufficiently shared among counties.
- **OAC Had Not Implemented Processes to Evaluate the Effectiveness of MHSA-Funded Programs.**
  - Processes for reviewing and analyzing counties' program status reports for activities related to MHSA Prevention and Innovation funding had not been finalized.
  - OAC had not established statewide metrics to evaluate the effectiveness of MHSA-funded crisis intervention, or triage, grants.

# Audit of MHSA Funding and Oversight

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## Steps Taken to Address Identified Deficiencies

The Auditor made several recommendations to address the identified deficiencies. As shown in the table below, a number of steps have been taken to address the recommendations in the Auditor's report.

| Agency | Auditor's Recommendation | Developments Since Audit's Release[a] |
|---|---|---|
| **DHCS** | Implement a fiscal reversion process to reallocate to other counties any MHSA funds that are unspent within the statutory reversion time frames. | Under authority provided by Chapter 38 of 2017 (AB 114, Committee on Budget), DHCS has implemented a fiscal reversion process through an all-county letter. |
| **DHCS** | Clarify that interest that counties earn on unspent MHSA funds is also subject to reversion. | DHCS released guidance clarifying the treatment of interest for purposes of reversion. |
| **DHCS** | Establish and enforce a reserve level for counties that is sufficient but not excessive. | Chapter 328 of 2018 (SB 192, Beall), limits reserves to 33 percent of average Community Support funding over the previous five years. |
| **DHCS** | Analyze whether a $225 million fund balance represents funding that should be distributed to counties. | DHCS determined that the $225 million fund balance erroneously represented old appropriation authority from 2004, with no additional funding to distribute to counties. |
| **DHCS** | Implement a process to withhold MHSA funds from counties that fail to submit annual financial reports on time. | DHCS implemented a process to withhold 25 percent of a county's MHSA allocation until overdue financial reports are submitted. |
| **DHCS** | Develop an MHSA fiscal audit process, independent of Medi-Cal reviews, to review revenues and expenditures for the most recent fiscal year. | DHCS is developing regulations related to MHSA fiscal audits. |
| **DHCS** | Establish process for conducting comprehensive program reviews. | DHCS initiated program reviews beginning in early 2019. |
| **OAC** | Continue engagement and dialogue with counties about innovative approaches that meet the requirements of the MHSA. | The OAC implemented an "Innovation Toolkit," developed a "Project Plan Recommended Template," and implemented an "Innovation Incubator" to support innovation plan development. |
| **OAC** | Complete internal processes for reviewing and analyzing program status reports. | As of February 2019, the OAC had partially implemented processes for reviewing and analyzing program status reports. The OAC has launched three anticipated data tools used to track counties' funding, services, and some outcomes. |
| **OAC** | Establish statewide outcome metrics for triage grants. | The OAC is contracting with a third party to conduct a statewide evaluation of triage grants. |

[a] Reflects LAO summary of developments since the audit's release. Does not necessarily reflect Auditor's determination of whether recommendations have been addressed.

DHCS = Department of Health Care Services and OAC = Mental Health Services Oversight and Accountability Commission.

# Additional Issues for Legislative Consideration

***Ensuring Robust State Oversight.*** Although steps have been taken to strengthen state oversight since the Auditor's report, many of these steps are not yet fully implemented. Other challenges remain. For example, fragmented oversight by DHCS and OAC will continue to require significant coordination to be effective.

***Service Coordination Across Multiple Systems of Care Is a Challenge.*** MHSA-funded activities represent only a portion of the state's public community mental health system. In general, this system is fragmented, with a variety of partially overlapping funding streams, program requirements, and target populations. Additionally, mental health services are not widely integrated with physical health services available to low-income residents through Medi-Cal. These factors make it challenging to effectively coordinate care for individuals who receive services through multiple systems of care.

***Balancing County Flexibility and State Prerogatives.*** The MHSA provides significant flexibility to local governments in how MHSA funds are expended and programs are implemented. This flexibility allows for local innovation and adaptation, but can potentially conflict with state-level interests in providing statewide policy direction and greater uniformity of services and outcomes. Since the MHSA was enacted by voter initiative, there are limits to what the state can do to change this balance. However, the Legislature can, and has, taken action to provide statewide policy direction on the use of MHSA funds and increase the technical assistance available to counties to promote better outcomes.