



**Governors Proposed FY 11/12 MHSA Redirection  
CMHDA Implementation Issues and Recommendations**

**January 31, 2011**

**Background and Rationale:**

***MHS Fund is designed to be a continuous source of funding for local MHSA services***

The Mental Health Services Act (MHSA) created a one percent tax on income in excess of \$1 million to expand mental health services. Welfare and Institutions Code (WIC) Section 5890 established the MHS Fund to continuously appropriate MHSA funds to the Department of Mental Health (DMH) so that DMH may enter into contracts with counties to implement expanded mental health services specified in the MHSA (WIC Section 5897). Due to the timing of determining the actual revenues earned by this tax through annual income tax returns, Section 19602.5(b) of the California Revenue and Taxation Code prescribes that 1.76 percent of the net personal income taxes received by the state shall be deposited into the MHS Fund on a monthly basis (referred to as cash transfers), and Section 19602.5(c) prescribes an annual adjustment process to reconcile between the amount actually earned as determined through income tax returns with the monthly cash transfers. Since the inception of the MHSA in November 2004, the annual adjustment amount has never been materially negative, even during the most recent recession, and in most years has been a significant additional amount of revenues to the MHS Fund. Thus, the monthly deposit of 1.76 percent of net personal income taxes prescribed in statute has proven to be a fairly conservative estimate of the amount of revenues ultimately earned under this tax.

***Aligning fund distribution with the statute will support seamless services***

The MHSA in WIC Section 5847 and 5848 directs counties to develop a locally-driven 3-year MHSA service and program plan with annual updates for approval by DMH, and in some cases the Mental Health Services Oversight and Accountability Commission (MHSOAC). A county plan also includes the establishment, maintenance and use of a prudent reserve intended to ensure that services do not have to decline significantly in years in which the MHSA revenues are in decline [see WIC Section 5847(a)(7) and WIC Section 5892(b)]. WIC Section 5847(f) identifies the process DMH shall use to notify counties of available funds, and WIC Section 5847(d) describes a much reduced and simplified review process for program expenditures that have already been approved in previous plan submissions. This is one mechanism that could support the consistent flow of MHSA revenues to counties for ongoing service obligations.\* (\*Note – Current conflict with SB 1392)

## **Proposed Recommendations:**

Considering the design and intent of MHS fund distribution, including the plan approval process to receive funds, CMHDA has developed the following **DRAFT** recommendations for consideration to guide implementation of the Governor's proposed budget redirection of MHS funds for FY 2011-12. If the intended proposal seeks to result in the least amount of harm to the individuals, families and communities needing community-based services for serious mental illness, then all four of our recommendations must be implemented. We further believe that these changes should remain in place beyond FY 11-12 to support efficient administration. DMH indicates that the current cash balance for the state MHS Fund is approximately \$2 billion. To address the Governor's proposed shift of \$861.2 million in MHS funds to cover State General Fund (SGF) obligations, CMHDA recommends the following:

### **1. Remove AB 3632 from the Proposal**

Do not reinstitute the funding from this source in FY 11/12 for the AB 3632 program (which was vetoed from the FY 10/11 state budget by the former Governor). This would reduce the "hit" on the MHS Fund by approximately \$100 million, and preserve this amount for current and future service commitments that are consistent with the specified intent of the voter initiative and the community plans submitted for funding.

### **2. Use the MHS Fund to Meet State Obligations in FY 11/12**

The first step would be to use the MHS Fund balance as of 6/30/11 to meet the Medi-Cal Specialty Mental Health Managed Care program obligation for FY11/12, which is estimated to be \$180 million statewide. The amount of funding to be distributed to each county should be based on a formula determined in consultation with CMHDA.

The second step would be to distribute funds to meet the EPSDT obligation for FY 11/12 on a quarterly or monthly basis from the state MHS Fund as revenues are received in the state MHS Fund (i.e., pay as you go) in FY 11/12. The amount of MHS funds to be distributed for EPSDT services to each county would be based on a formula to be determined in consultation with CMHDA. These funds would not be subject to reconciliation with actual EPSDT claims or cost settlement (i.e., amounts distributed would represent full and final payments) thereby eliminating the necessity for the state to reimburse EPSDT services on a claim by claim basis through the Short-Doyle 2 claims processing system.

Included in the amount of the FY 11/12 EPSDT obligation being funded with MHS funds are prior year audit settlements (\$20 million) and FY 08/09 cost report settlements (\$38 million). It is unclear how the state proposes to fund these prior year expenditures with MHS funds and stay in compliance with the non-supplant provisions of the MHS.

### **3. Align Current MHS Policies with Statute Providing Counties Discretion to Sustain Service Obligations**

While moving to monthly distributions from the MHS Fund (i.e., pay as you go) will help mitigate the local dilemma of cash available to support service obligations, we believe that services and programs

will be impacted in future years. There are two administrative practices currently used by DMH that would need to change and be more aligned with the statute in order for the “pay as you go” recommendation to result in the least amount of harm to the individuals, families and communities needing community-based services for serious mental illness.

First, the following administrative policies that govern the prudent reserve contained in DMH Information Notices 08-07, 09-16, 10-01 and 10-21 must be removed:

- a) 50% limit (cap) on how much MHSA funding can be placed in the prudent reserve,
- b) Ability to solely dedicate CSS funds to the prudent reserve, and
- c) Ability to access the prudent reserve when the three year average revenues are below recent averages would all be suspended.

Counties must be given discretion to put funds into the local prudent reserve from any MHSA component for future use in anticipation of a shortfall of future available funding and would be given discretion as to when they could access the prudent reserve in years in which an individual county’s available funding from the state is insufficient to continue to serve the same number of clients, not when revenue estimates are below recent three year averages. This is not just providing discretion, but better aligned with the intent of the statute regarding the establishment, maintenance and use of a prudent reserve. WIC Section 5847(a)(7) identifies the purpose of the prudent reserve as ensuring that services do not have to decline significantly in years in which the MHSA revenues are in decline. In addition, Counties would be directed to follow the guidance provided in WIC Section 5892(b), which states that the transfer of funds into the prudent reserve could not exceed 20% of the average amount of funds allocated to the counties for the previous 5 years.

Second, there must be clarification regarding how Innovation funds are appropriated. WIC Section 5892(a)(6) specifies that 5% of the funding set aside for Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) shall be used for Innovative programs. Funds specified for Innovative programs in accordance with WIC Section 5892(h) should be considered part of CSS funding (80%) and PEI funding (20%). In other words, counties will be informed by DMH, consistent with WIC Section 5847(f), of the level of MHSA funds that are available for the year, yet they will be paid as revenues come into the MHS fund on a monthly or quarterly basis. Counties have submitted or are currently submitting plans for Innovative programs to the MHSOAC according to MHSOAC guidance. This does not create any policy changes related to the MHSOAC’s authority outlined in WIC Section 5846 regarding Innovation program guidance and expenditure approval.

This clarification of current statute would also impact how reversion is calculated based on WIC Section 5892(a)(6). For the purposes of reversion, funds specified for Innovative programs in accordance with WIC Section 5892(h) should be considered part of the CSS funding (80%) or PEI funding (20%) from which the Innovative funds were derived for the purposes of applying reversion. Applying this calculation will result in counties having the ability to place needed funds at risk of reversion, particularly Innovation funds, into the local prudent reserve. The decisions about how to manage the fiscal impact of the MHSA redirection will still be conducted through a local planning process as required in WIC Sections 5847 and 5848.

#### 4. **Align MHS Fund Distribution Practices with Deposits into the MHS Fund and Link with Plan Approval Process**

Align MHS fund distribution practices with deposits into the MHS Fund, rather than requiring 100 percent of funding to be deposited into the MHS Fund prior to the start of the fiscal year as is current practice. Cash transfers received in a month (based on the 1.76 percent statutory requirement) should be distributed to counties in the succeeding month based on a distribution formula consistent with the estimated amount of available funding for the fiscal year, and determined in consultation with CMHDA per WIC Sec. 5892. This continuous distribution of MHS fund for approved MHS programs would somewhat mitigate the impact of reduced resources for mental health services at the local level in FY 12/13 due to the Governor's proposed one-time supplantation of MHS funds in FY 11/12. Specific details of the administration of this proposal would be negotiated between CMHDA, DMH and the MHSOAC, with the objective of making the distribution of MHS funds comparable to the distribution of existing sales tax and vehicle license fees under realignment while complying with the provisions of the MHS related to MHS Plan approval.

To mitigate any negative impact from reduced cash flow in FY11/12, the state would distribute a specific percentage of MHS funds to each county upon FY11/12 MHS Plan approval with the percentage calculated based on the total unobligated monies in the state MHS Fund after accounting for approximately \$180 million for the Medi-Cal Specialty Mental Health Managed Care program (the calculated percentage of MHS funds would probably be around 80%). Initial deposits into the state MHS Fund in FY 11/12 would go toward funding the EPSDT obligation (\$580 million) until that obligation was fully funded (probably around March of 2012). Deposits received after that point would be distributed to each county with an approved MHS Plan to expend on MHS programs under the approved Plan. Deposits received after that point would be distributed to each county with an approved MHS Plan to expend on MHS programs under the approved Plan.

In future fiscal years, and at some point when MHS revenues recover from the weak economy, the above practices will directly support a more efficient and focused plan approval process. While the statute requires an "annual update to a three year plan", [WIC Section 5874(a)], this annual report should be a simple report that measures program and fiscal performance, not a report on program elements and the processes conducted to develop a plan. WIC Section 5847(d) creates an efficient distinction for expedited approvals for on-going MHS funded service obligations. Only when there are revenues available to implement new programs or when an analysis of outcomes prompts a county and their community to want to significantly change a program, should a more detail plan be submitted.

**Note:** this recommendation has some minor conflicts with recent language that amended WIC Section 5891(c) [SB 1392 (Steinberg)]. The intent of this bill, which CMHDA supported, was to help cash flow within the constructs of the "cash-basis" fund distribution practices we have been working under due to the previous direction/leadership at DMH and DOF. It is important to remember that recommendation #4 above is still consistent with the intent and purpose of the MHS fund and fund distribution. SB 1392 added language to the MHS to ensure that DMH will distribute a county's total approved MHS funds in one lump sum. This does not change DMH's and/or the MHSOAC's authority to approve, deny or request further information regarding a county's plan.