



Mental Health Services Act

The State Could Better Ensure the Effective Use of Mental Health Services Act Funding

Report 2017-117

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February 27, 2018

2017-117

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report concerning the funding and oversight of the Mental Health Services Act (MHSA). This report concludes that the Department of Health Care Services (Health Care Services) and the Mental Health Services Oversight and Accountability Commission (Oversight Commission) could better ensure that the 59 county and local mental health agencies (local mental health agencies) effectively use the MHSA funds they receive.

Despite having significant responsibility for the MHSA program since 2012, Health Care Services has allowed local mental health agencies to amass hundreds of millions in unspent MHSA funds. This occurred because Health Care Services has not developed a process to recover unspent MHSA funds that under state law must be reallocated to other local mental health agencies. Further, absent Health Care Services' guidance, the local mental health agencies accumulated \$81 million in unspent interest and set aside between \$157 million and \$274 million in excessive reserves that they could better use to provide additional mental health services. Moreover, until our inquiry, Health Care Services had not analyzed whether a \$225 million fund balance in the Mental Health Services Fund, which had existed since at least 2012, is potentially available to local mental health agencies to expand mental health services or is a long-standing accounting error. Finally, Health Care Services' oversight of local mental health agencies is minimal: it does not enforce annual revenue and expenditure reporting nor has it performed fiscal or program audits to ensure local mental health agencies comply with fiscal and program requirements contained in state laws and regulations. Health Care Services' poor oversight of the MHSA program is troubling given the importance of providing mental health services to Californians.

The Oversight Commission, which also oversees the MHSA, is implementing processes to evaluate the effectiveness of MHSA-funded programs. In addition, the Oversight Commission is helping local mental health agencies to understand how to develop innovative projects that meet MHSA requirements and provide mental health services, which should assist them in spending MHSA funds appropriately. However, the Oversight Commission has not developed statewide metrics to assess the effectiveness of MHSA-funded crisis intervention grants, which provided \$32 million in fiscal year 2015–16 to increase staffing of mental health personnel at locations such as emergency rooms and jails. Finally, our review of three local mental health agencies—Alameda, Riverside, and San Diego counties—determined that they allocate their MHSA funds appropriately and they generally monitored their MHSA-funded projects effectively.

Respectfully submitted,



ELAINE M. HOWLE, CPA
State Auditor

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SUMMARY

Providing effective services and treatment for those who suffer from mental illness or who are at risk of mental illness is an issue of statewide and national importance. In 2004 California voters approved Proposition 63—the Mental Health Services Act (MHSA)—to expand services and treatment for those who suffer from mental illness or are at risk of mental illness. The MHSA imposes a 1 percent income tax on individuals earning more than \$1 million a year in order to expand existing mental health programs and services, address the stigma and discrimination associated with seeking mental health services, and implement innovative programs that increase the quality of mental health services and improve access to underserved groups. For fiscal year 2015–16, the MHSA generated \$1.5 billion, which the State distributed primarily to the 59 county and local mental health agencies (local mental health agencies). For this audit, we evaluated the effectiveness of two state entities, the Department of Health Care Services (Health Care Services) and the Mental Health Services Oversight and Accountability Commission (Oversight Commission), in providing oversight of MHSA funding. We also visited three local mental health agencies—Alameda, Riverside, and San Diego counties—to assess their monitoring of the projects that they support with MHSA funding. This report draws the following conclusions:

Health Care Services’ Ineffective Oversight of Local Mental Health Agencies and the Mental Health Services Fund Allowed Hundreds of Millions of Dollars to Remain Unspent

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Despite having significant responsibility for the MHSA program since 2012, Health Care Services has not developed a process—known as reversion—to recover unspent MHSA funds from local mental health agencies after the statutory time frames for spending the funds have elapsed. As a result, the local mental health agencies have had less incentive to spend MHSA funds in a timely manner and had amassed unspent funds of \$231 million—not including reserves—as of the end of fiscal year 2015–16 that they should have reverted to the State for it to reallocate to other local mental health agencies. However, the Legislature enacted a one-time change in state law in 2017 that allowed local mental health agencies to retain all funds that were subject to reversion as of July 1, 2017. Nevertheless, this one-time allowance does not resolve the larger issue that Health Care Services has been slow in implementing a process to revert unspent MHSA funds.

In addition, in the absence of Health Care Services’ guidance, local mental health agencies have been inconsistent in how they treat the interest they have earned on MHSA funds. As a result, the local mental health agencies had accumulated a total of \$81 million in unspent MHSA interest through fiscal year 2015–16. Further, Health Care Services has not established a process for overseeing the sufficiency of local mental health agencies’ MHSA fund reserves, which totaled \$535 million as of the end of fiscal year 2015–16. As a result of the absence of Health Care Services’ oversight, we estimate that local mental health agencies held between \$157 million and \$274 million in excessive reserves as of the end of fiscal year 2015–16. Finally, until our inquiry, Health Care Services had not questioned the reason for a \$225 million fund balance in the Mental Health Services Fund (MHS Fund) and

whether the amount represented funds due to local mental health agencies or was a long-standing accounting error. As a result of our inquiry, Health Care Services is working with the State Controller's Office to resolve this issue.

Page 21**Health Care Services Has Provided Only Minimal Oversight of the MHSAs That Local Mental Health Agencies Received**

Health Care Services has made only minimal efforts to ensure that local mental health agencies submit their annual revenue and expenditure reports (annual reports) on MHSAs funding on time. As a result, most local mental health agencies have failed to submit their annual reports in a timely manner; in fact, only one of the 59 local mental health agencies submitted its fiscal year 2015–16 annual report by the regulatory deadline. These late annual reports have significantly hampered Health Care Services' ability to calculate MHSAs reversion amounts and to properly oversee local mental health agencies' MHSAs spending. In addition, Health Care Services has been slow to implement MHSAs fiscal and program oversight of local mental health agencies. Although Health Care Services developed an MHSAs fiscal audit process in 2014, it has focused its audits on data and processes that are at least seven years old, and it has not developed regulations it believes are necessary to allow local mental health agencies to appeal findings. In addition, Health Care Services has not implemented a program review process to ensure MHSAs projects that local mental health agencies operate comply with program requirements contained in state laws and regulations.

Page 27**The Oversight Commission Is Implementing Processes to Evaluate the Effectiveness of MHSAs-Funded Programs**

The Oversight Commission is undertaking efforts to provide technical assistance and improve dialogue with the local mental health agencies regarding its process for approving MHSAs funds intended for innovative projects that address individuals' mental health needs. One of the Oversight Commission's responsibilities is approving local mental health agencies' plans for developing such projects. However, the absence of clear guidance and understanding of the approval process may have contributed to the local mental health agencies' failure to spend funds in a timely manner. As of the end of fiscal year 2015–16, \$146 million of the \$231 million in MHSAs funds subject to reversion were intended for innovative projects. In addition, to promote accountability and oversight for certain MHSAs programs, the Oversight Commission requires local mental health agencies to submit reports on an annual basis that describe the outcomes and progress of these programs, the first of which were due in December 2017. However, the Oversight Commission has not completed an internal process to review and analyze these reports. The Oversight Commission is also required to evaluate the effectiveness of grants to local mental health agencies to provide services to individuals with mental illnesses who require crisis intervention, yet it has not developed metrics to assess the outcomes of these grants on a statewide level.

Finally, our review of three local mental health agencies determined that their allocation of MHSAs funds was consistent with MHSAs planning requirements and that they generally monitored their MHSAs-funded projects effectively.

Summary of Recommendations

Health Care Services

To ensure that local mental health agencies spend MHSAs funds in a timely manner, Health Care Services should implement a fiscal reversion process to reallocate to other local mental health agencies any MHSAs funds that are unspent within the statutory reversion time frames. In addition, Health Care Services should clarify that the interest that local mental health agencies earn on unspent MHSAs funds is also subject to reversion requirements and should establish an MHSAs reserve level that is sufficient but not excessive.

Health Care Services should analyze the \$225 million fund balance in the MHS Fund by May 1, 2018, to determine why it existed and, if there is any impact on funding to the local mental health agencies, distribute those funds accordingly. It should also regularly scrutinize the MHS Fund to identify excess fund balances and the reasons for such balances.

To ensure that the State provides effective oversight of local mental health agencies' spending of MHSAs funds, Health Care Services should implement MHSAs fiscal and program oversight of local mental health agencies.

Oversight Commission

To ensure that local mental health agencies are able to spend funds intended for innovative projects in a timely manner, the Oversight Commission should continue its engagement and dialogue with local mental health agencies about the types of innovative approaches that would meet the requirements of the MHSAs.

To ensure that it provides proper oversight and evaluation of the programs for which it is responsible, the Oversight Commission should complete its internal processes for reviewing and analyzing program status reports no later than July 2018.

To ensure that the MHSAs grants for providing services to individuals with mental illnesses who require crisis intervention are an effective use of MHSAs funds, the Oversight Commission should establish statewide outcome metrics for these grants no later than July 2018.

Agency Comments

The Oversight Commission and Alameda County agreed with our report's conclusions and indicated that they would implement our recommendations. Although Health Care Services generally agreed with our conclusions and recommendations, it disagreed with our recommendation to focus the timing of its MHSAs fiscal audits on a more current period. Health Care Services also disagreed with our report text in several places and offered suggested changes. Finally, after initially stating that it would submit by June 2018 and September 2018 draft regulations it feels are necessary to implement elements of its MHSAs responsibilities, Health Care Services pushed back these timelines in its response to January 2019 and Spring 2019, respectively.

INTRODUCTION

Background

The provision of effective services and treatment to those who suffer from mental illness or who are at risk of mental illness is an issue of statewide and national importance. According to the U.S. Department of Health and Human Services' 2015 and 2016 data, 17 percent of California adults—nearly 5 million people—have mental health needs, while about 4 percent suffer from serious mental illnesses. Moreover, the U.S. Department of Housing and Urban Development estimated that in 2016 more than one-fourth—31,000 individuals—of California's homeless population suffered from serious mental illnesses.

To address California's mental health needs, in 2004 California voters approved Proposition 63—the Mental Health Services Act (MHSA)—to expand services and treatment for those who suffer from mental illness or who are at risk of mental illness. To support its purposes, the MHSA imposes a 1 percent income tax on individuals earning more than \$1 million a year. In fiscal year 2015–16, the MHSA generated \$1.5 billion, of which the State allocated \$1.4 billion to local mental health programs. The State deposits MHSA funds into the Mental Health Services Fund (MHS Fund) and distributes the majority of these funds to the 59 county and local mental health agencies (local mental health agencies).¹ The local mental health agencies use the funds to expand existing mental health programs and services, to prevent mental illnesses from becoming severe and disabling, and to provide programs that use innovative approaches to increase the quality of mental health services and improve access to underserved groups. The local mental health agencies must spend MHSA funds to expand mental health services and cannot use them to replace existing state or county funding.

MHSA Programs

The MHSA requires that local mental health agencies use MHSA funds for five different mental health services program categories—Community Services and Supports (Community Support), Prevention and Early Intervention (Prevention), Innovation, Capital Facilities and Technological Needs (Capital Facilities), and Workforce Education and Training (Workforce Training). As Table 1 on the following page describes, each of these program categories targets different aspects of mental health services. The local mental health agencies either can contract with vendors to operate specific MHSA-funded projects within these program categories or can operate the projects themselves. Figure 1 on page 7 displays the State's allocation of MHSA funds to the five program categories in fiscal year 2015–16.

The Department of Health Care Services (Health Care Services) explained that it believes the requirement in state law that any funds left unspent within the statutory time frames must be returned—reverted—to the State for reallocation to the local

¹ The 59 local mental health agencies consist of the city of Berkeley, Tri-City Mental Health Services (a joint powers authority that the cities of Claremont, La Verne, and Pomona adopted), Sutter-Yuba Behavioral Services (a joint powers authority that the counties of Sutter and Yuba adopted), and agencies representing the remaining 56 California counties.

mental health agencies is an incentive to make full use of their MHSAs funding allocations. As Figure 1 shows, the law specifies that local mental health agencies have three years to spend Community Support, Prevention, and Innovation funds and 10 years to spend Capital Facilities and Workforce Training Funds.²

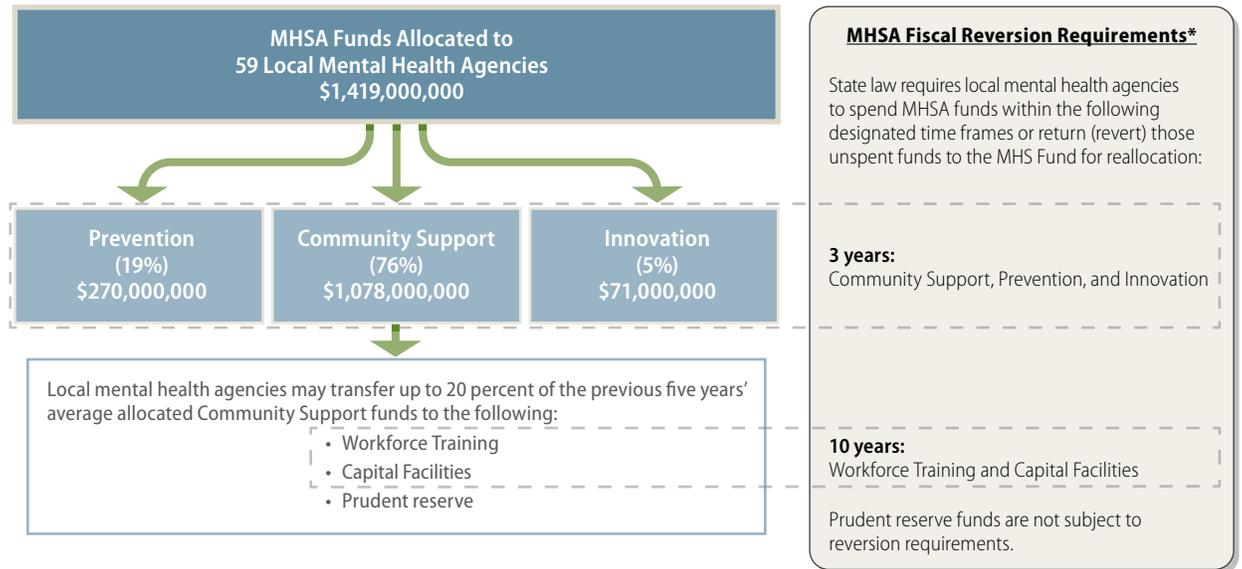
Table 1
MHSA Program Categories

PROGRAM CATEGORY	DESCRIPTION
Community Support	<ul style="list-style-type: none"> Provides mental health treatment, health care treatment, and housing assistance. Includes full-service partnerships under which local mental health agencies—in collaboration with the consumers and their families, when appropriate—plan for and provide a full spectrum of community services. These services include mental health services and support, such as peer support and crisis intervention services, as well as other services and supports, such as food, clothing, housing, and medical treatment. Example: Alameda County contracted with a vendor to provide a full-service partnership for homeless adults. The partnership provides a range of services, with a focus on community service, peer support, and stable housing.
Prevention	<ul style="list-style-type: none"> Provides services to help prevent individuals' mental illnesses from becoming severe and disabling, including reducing the stigma and discrimination associated with mental illness diagnoses or with seeking mental health services. Requires that projects emphasize strategies to reduce seven negative outcomes that may result from untreated mental illness—suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes. Example: San Diego County contracted with a vendor to conduct a media campaign to increase awareness and understanding of mental illness, prevent suicide, and reduce the stigma associated with mental illness.
Innovation	<ul style="list-style-type: none"> Introduces either new mental health practices or approaches or changes to existing practices or approaches. Requires that projects increase access to services, increase the quality of services, and promote interagency collaboration, among other things. Example: Riverside County created a new service model that provides mental health services within the context of a partnership involving the consumers, their families, supportive individuals, and providers. The service is designed to empower family members to become the primary supports in facilitating the recoveries of individuals with mental illnesses.
Capital Facilities	<ul style="list-style-type: none"> Creates additional infrastructure, such as clinics and facilities, and develops technological infrastructure for the mental health system, such as electronic health records for mental health services. Example: Alameda County purchased and renovated a property to develop a behavioral health care support center.
Workforce Training	<ul style="list-style-type: none"> Provides training for existing employees, recruitment of new employees, and financial incentives to recruit or retain employees within the public mental health system. Example: San Diego County contracted with a vendor to provide training and continuing education for county staff working in mental health services.

Sources: Welfare and Institutions Code, California Code of Regulations, and local mental health agencies' MHSAs projects.

² In 2017 state law was amended to extend the time frame to spend Community Support, Prevention, and Innovation program funds from three years to five years for local mental health agencies that serve populations of less than 200,000.

Figure 1
Allocation of MHSA Funds to the Local Mental Health Agencies
Fiscal Year 2015–16



Sources: Welfare and Institutions Code and the fiscal year 2017–18 California State Budget.

* In 2017 state law was amended to extend the time frame to spend Community Support, Prevention, and Innovation funds from three years to five years for local mental health agencies that serve populations of less than 200,000.

Oversight Responsibilities

From 2004 until 2012, the California Department of Mental Health (Mental Health) was the primary state agency responsible for overseeing the implementation of the MHSA. However, a 2012 change in state law dissolved Mental Health and transferred the majority of its MHSA duties to Health Care Services. In addition, the State’s responsibilities related to overseeing MHSA funding changed significantly in 2011. Specifically, before 2011, state law required the State to approve local mental health agencies’ plans to use MHSA funds before issuing those funds to them. Under this process, the MHSA required that the local mental health agencies submit plans to Mental Health detailing how they intended to use their MHSA funds over the next three years. Mental Health would then evaluate these plans, and if it approved them, the State Controller’s Office (State Controller) distributed funds to the local mental health agencies. However, the 2011 change in state law eliminated this requirement. Instead, the State Controller now distributes MHSA funding from the MHS Fund directly to the local mental health agencies each month.

Under current state law, the local mental health agencies must comply with a number of requirements to ensure that their spending is appropriate. For example, state law requires each local mental health agency to prepare a three-year plan that details how it will use MHSAs funds. Following a period for public review and comment by community stakeholders, the local mental health agency's county board of supervisors must approve its plans. Further, each local mental health agency's mental health director and auditor-controller must certify the plan as MHSAs-compliant. Each local mental health agency must subsequently update its three-year plan on an annual basis to reflect any changes in funding or adjustments to programs.

Nonetheless, the State still has certain responsibilities related to ensuring that the local mental health agencies spend MHSAs funds appropriately. For example, state law requires Health Care Services to calculate the MHSAs fund allocations for each local mental health agency. As part of its methodology for calculating the fund allocations, Health Care Services designed a formula based on several factors, including each one's share of the total state population, population at the poverty level, and prevalence of mental illness in their areas. State law and regulations also require Health Care Services to develop instructions for the MHSAs annual revenue and expenditure reports (annual reports) that the local mental health agencies must submit by December 31 following the end of each fiscal year and allows Health Care Services to withhold MHSAs funding when local mental health agencies do not submit these reports on time. Further, under its agreements with local mental health agencies, Health Care Services has the authority to determine whether they appropriately disclose MHSAs revenue and expenditures in their annual reports. In addition, a 2016 amendment to state law requires Health Care Services to conduct program reviews of the local mental health agencies to assess whether they are complying with the MHSAs. Finally, Health Care Services has the authority under its agreements with local mental health agencies to conduct MHSAs fiscal audits of the local mental health agencies' use of MHSAs funds and is responsible under state law for overseeing the reversion process to ensure that local mental health agencies return any unspent MHSAs funds to the State for reallocation.

The State also provides oversight of the MHSAs funds through the Mental Health Services Oversight and Accountability Commission (Oversight Commission), which consists of 16 voting commissioners (commissioners) and supporting staff, led by an executive director. Established by the MHSAs, the Oversight Commission's main statutory responsibilities include providing technical assistance to local mental health agencies, evaluating local and statewide projects and programs supported by MHSAs funds, and approving local mental health agencies' use of Innovation funds. Innovation is the only MHSAs program that specifically requires state approval before the local mental health agencies can spend these funds. The Oversight Commission also oversees the triage grant program, which helps

recipient local mental health agencies expand the number of mental health personnel available at various points of access throughout the community, such as emergency rooms, jails, homeless shelters, and clinics. The Oversight Commission also advises the Governor and the Legislature on mental health policy.

The MHSA provides the State with up to 5 percent of all MHSA annual revenues to cover its administrative costs, including costs associated with evaluating the local mental health agencies' use of MHSA funds. Table 2 on the following page lists the state entities that received MHSA administrative funds in fiscal year 2015–16 and the purpose of the funding. Since fiscal year 2012–13, Health Care Services has annually spent between \$7.9 million and \$8.6 million to implement its oversight responsibility.³ Specifically, in fiscal year 2015–16, Health Care Services spent \$7.9 million for staff salaries, contracts, and operating expenses. The Oversight Commission spent \$38 million in fiscal year 2015–16, including \$31 million for the triage grant program and the remaining \$7 million for staff salaries, contracts, and operating expenses. Health Care Services and the Oversight Commission had the equivalent of 13.4 and 26.6 full-time staff positions, respectively, in fiscal year 2015–16.

Prior Audit and Reports

In our August 2013 audit report titled *Mental Health Services Act: The State's Oversight Has Provided Little Assurance of the Act's Effectiveness, and Some Counties Can Improve Measurements of Their Program Performance*, Report 2012-122, we determined that Mental Health and the Oversight Commission had provided little oversight of local mental health agencies' implementation of MHSA programs. As we describe above, Health Care Services received most of Mental Health's MHSA oversight responsibility in 2012. In our September 2013 High Risk report, we designated Health Care Services as a high-risk agency because of its new responsibilities under the MHSA. Subsequently, in a March 2015 letter report, we continued to designate Health Care Services as high risk, in part because it had not fully implemented nine of the 12 recommendations from our August 2013 audit.

As of August 2017, Health Care Services had still not fully implemented seven recommendations from our August 2013 audit report. These recommendations include conducting comprehensive on-site reviews of county MHSA-funded projects, coordinating with the Oversight Commission to issue necessary guidance or regulations to ensure that local mental health agencies effectively implement and evaluate their MHSA projects, collecting complete and relevant

³ In fiscal year 2011–12, prior to assuming Mental Health's oversight responsibilities, Health Care Services spent \$452,000 for its MHSA state operations.

MHSA data from local mental health agencies for evaluation, and providing technical assistance to local mental health agencies on the MHSA local planning review process. We discuss later in this report Health Care Services' lack of progress in conducting fiscal and program reviews and providing guidance regarding MHSA requirements, such as maintaining a prudent reserve. In response to our 2013 recommendations, Health Care Services has stated that it is working to improve its data collection so that it will have accurate and complete data to track project outcomes and that it will complete this project by early 2019. In addition, Health Care Services has stated that it is planning to provide training and technical assistance to the local mental health agencies regarding stakeholder regulations through a vendor contract.

Table 2
MHSA Funding Actuals for State Administration, by State Agency
Fiscal Year 2015–16

STATE AGENCY	MHSA FUNDING	PURPOSE OF FUNDING
Oversight Commission	\$38,049,000	To oversee MHSA-funded projects, among other responsibilities. Since 2013 the Oversight Commission received \$32 million annually from its appropriation to provide triage grants to local mental health agencies to expand the number of crisis intervention personnel available throughout the community.
Office of Statewide Health Planning and Development	15,501,000	To administer statewide Workforce Training funds and develop mental health programs that support qualified medical services personnel serving individuals with mental illnesses.
Health Care Services	8,415,000	To provide fiscal and program oversight of local mental health agencies.
California Department of Public Health	5,097,000	To oversee the California Reducing Disparities Project to improve access and to better provide services to underserved populations.
University of California	3,564,000	To support funding for research centers at the Davis and Los Angeles campuses of the University of California. This grant funding allows researchers to explore areas such as the delivery of behavioral health care, the economics of prevention, and the better integration of medical and mental health services into clinical settings.
California Military Department	1,467,000	To support an outreach program to improve coordination of care between the California National Guard, County Veteran Service Officers, county mental health departments, and other public and private support agencies.
Judicial Branch of California	1,070,000	To address the increased workload relating to mental health issues in the area of prevention and early intervention for juveniles with mental illness who are in the juvenile court system or at risk for involvement in the system.
Department of Developmental Services	482,000	To oversee funding for regional-based mental health services for those with developmental disabilities and co-occurring mental health diagnoses.
California Department of Veterans Affairs	236,000	To support statewide administration to inform veterans and their family members about federal benefits, local mental health agencies, and other services.
Financial Information System for California (FI\$Cal)	188,000	To support the development of the State's new financial management system.
California Department of Education	129,000	To support student mental health needs throughout the State.
Board of Governors of the California Community Colleges	85,000	To assist in developing policies and practices that address the mental health needs of California's community college students.
Total	\$74,283,000	

Health Care Services' Ineffective Oversight of Local Mental Health Agencies and the MHS Fund Allowed Hundreds of Millions of Dollars to Remain Unspent

Key Points

- Health Care Services has not developed a process to recover unspent funds from local mental health agencies. As a result, the local mental health agencies have had less incentive to spend MHSA funds on mental health programs in a timely manner and had amassed unspent funds of \$231 million—not including reserves—as of the end of fiscal year 2015–16 that the State might have been able to reallocate to other local mental health agencies.
- In the absence of Health Care Services' guidance, local mental health agencies have not consistently spent the interest they have earned on MHSA funds. As a result, they had accumulated \$81 million in unspent MHSA interest as of the end of fiscal year 2015–16.
- Health Care Services has neither established a formal process to maintain oversight of local MHSA reserves—which totaled \$535 million as of the end of fiscal year 2015–16—nor required the local mental health agencies to adhere to a standard reserve level. We estimate that local mental health agencies held between \$157 million and \$274 million in excessive reserves as of the end of fiscal year 2015–16.
- Until our inquiry, Health Care Services had not questioned the reason for a \$225 million fund balance in the MHS Fund and whether the amount represented funds due to local mental health agencies or was an error. As a result of our inquiry, Health Care Services is working with the State Controller to resolve this issue.

Health Care Services Has Not Developed a Process to Recover Unspent Funds From Local Mental Health Agencies

The MHSA intended for local mental health agencies to provide services for the mentally ill, not amass unspent funds. Nonetheless, Health Care Services has not ensured that local mental health agencies revert their unspent MHSA funds to the MHS Fund for the State to reallocate to other local mental health agencies. As we discuss in the Introduction, state law requires local mental health agencies to revert unspent MHSA funds within certain time frames. As Figure 1 on page 7 in the Introduction shows, this time frame is either three years or 10 years, depending on the program category.⁴ Nonetheless, Health Care Services has not developed a methodology for the local mental health agencies to revert unspent funds, as Table 3 on the following page shows.

⁴ In 2017 state law was amended to extend the time frame to spend Community Support, Prevention, and Innovation program funds from three years to five years for local mental health agencies that serve populations of less than 200,000.

Table 3
Health Care Services' Oversight of Unspent MHSAs Funds

RESPONSIBILITY	PROCESS FOR IMPLEMENTATION	STATUS
Fiscal reversion (beginning 2012)	Establish a process for MHSAs funds that are unspent past statutory time frames and have reverted, and provide guidance related to this process to local mental health agencies.	✗
	Establish a reversion calculation methodology and provide guidance related to this methodology to local mental health agencies.	✗
	Require that the interest that the local mental health agencies earn on unspent MHSAs funds be subject to the same reversion requirements as the funds themselves.	✗
	Establish a prudent MHSAs reserve level for the local mental health agencies.	✗
	Establish controls over local mental health agencies' deposits to and withdrawals from their MHSAs reserves.	✗
MHS Fund administration (beginning 2012)	Review and analyze its MHS Fund balance.	✗

Sources: California State Auditor's analysis of state laws and regulations and Health Care Services' policies and practices.

✗ = Not established.

Absent an incentive to spend their MHSAs funds in a timely manner, local mental health agencies had accumulated \$2.5 billion in unspent MHSAs funds as of fiscal year 2015–16. The Appendix lists the local mental health agencies' unspent funds balances by MHSAs programs. Although local mental health agencies may spend each year's allocation of MHSAs funds over several years and may also maintain MHSAs funds as reserves, Health Care Services estimated that as of September 2017 local mental health agencies should have returned \$231 million of this \$2.5 billion to the State because they did not spend it within required time frames. However, the Legislature enacted a one-time change in state law in 2017 that allowed local mental health agencies to retain all funds that were subject to reversion as of July 1, 2017. Furthermore, this 2017 change in state law requires Health Care Services to develop a reversion calculation methodology and provide related guidance to the local mental health agencies. The MHSAs reversion requirements begin again for the fiscal year 2017–18 funding cycle.

Although Health Care Services is now developing the reversion calculation methodology, we find it troubling that Health Care Services has been slow in implementing a reversion process. Health Care Services asserted that it did not enforce the reversion requirements because it believed that it must first develop regulations to establish processes for determining the amount

of funds subject to reversion and for collecting the reverted funds. Although Health Care Services determined that it needed such regulations in fiscal year 2015–16, it claimed that other MHSA-related priorities delayed it from developing them. According to Health Care Services, examples of the competing priorities included administering MHSA revenue and expenditure reports, developing performance contracts with local mental health agencies, serving as a subject matter expert for suicide prevention workgroups or activities, developing the Suicide Hotline Report, and responding to external reviews.

Health Care Services began development of draft regulations in 2016, but it does not plan to submit them for regulatory review until June 2018.⁵ State law generally requires state agencies to follow the Administrative Procedures Act when adopting regulations. Under this act, Health Care Services must engage in a public comment process after it proposes regulations and must simultaneously submit the proposed regulations to the Office of Administrative Law for review. This review process can take between four and 12 months. The Office of Administrative Law then publishes the proposed regulations in the California Regulatory Notice Register. As a result, if Health Care Services does submit the regulations in June 2018, these regulations would not be in place until sometime between October 2018 and June 2019. However, as the Introduction explains, Health Care Services has spent from \$7.9 million to \$8.6 million annually over the past four fiscal years to administer the MHSA, and since assuming responsibilities for the MHSA in 2012, its statutory authority includes developing regulations necessary to implement the MHSA. Given the funding it has received and the amount of time that has elapsed since it became responsible for developing these regulations, we believe Health Care Services should already have taken appropriate action to implement a reversion process.

Had Health Care Services met its statutory responsibilities to oversee the reversion of unspent MHSA funds, the local mental health agencies could have used other local mental health agencies' unspent MHSA funds to provide critical mental health services, as the MHSA intended. For example, absent a reversion process, local mental health agencies statewide had accumulated a total of \$85.2 million in unspent MHSA Community Support and Prevention funds as of the end of fiscal year 2015–16, as Table 4 on the following page indicates. However, the three local mental health agencies we visited—Alameda, Riverside, and San Diego counties—had little or no Community Support and Prevention funds subject to reversion as of

⁵ Health Care Services initially stated that it would submit the draft regulations by June 2018. In its response to this audit on page 51, Health Care Services indicates that it has pushed back this timeline to January 2019.

the end of fiscal year 2015–16. In fact, Health Care Services' records indicate that 46 local mental health agencies did not have Community Support funds subject to reversion and 28 local mental health agencies did not have Prevention funds subject to reversion as of the end of fiscal year 2015–16. These numbers suggest that many local mental health agencies could have used some of the \$85.2 million in unspent MHSA funds to further support their Community Support and Prevention programs, if the local mental health agencies holding those unspent funds had reverted them as required. We will discuss reversion of Innovation funds later in this report.

Table 4
Local Mental Health Agencies' MHSA Funds Subject to Reversion as of the End of Fiscal Year 2015–16

LOCAL MENTAL HEALTH AGENCY	MHSA FUNDS SUBJECT TO REVERSION			TOTAL
	COMMUNITY SUPPORT	PREVENTION	INNOVATION	
Alameda County	—	—	\$5,013,000	\$5,013,000
Riverside County	—	\$505,000	12,764,000	13,269,000
San Diego County	—	—	7,224,000	7,224,000
All local mental health agencies*	\$15,331,000	69,866,000	145,638,000	230,835,000

Source: Health Care Services' calculation, as of September 2017, of MHSA funds subject to reversion as of the end of fiscal year 2015–16.

* As of December 2017, nine of the 59 local mental health agencies, including Los Angeles County, had not submitted their fiscal year 2015–16 annual reports, and an additional three had not finalized their annual reports in response to Health Care Services' concerns. Consequently, for these 12 agencies, we had to rely on prior years' annual reports.

Health Care Services Has Not Taken Steps to Ensure That Local Mental Health Agencies Are Consistently Spending MHSA Interest

Although Health Care Services is primarily responsible for overseeing local mental health agencies' spending of MHSA funds, it has not established guidance regarding the proper treatment of interest they earn on MHSA funds. As a result, local mental health agencies reported having accumulated \$81 million in interest earned on MHSA funds through fiscal year 2015–16, as Table 5 shows. State law requires that local mental health agencies use the interest they earn on MHSA funds for their MHSA programs. However, state law does not specify the MHSA programs on which the local mental health agencies may spend interest or whether the interest is subject to reversion. Without statutory instructions to the contrary, the interest a government entity earns on deposited funds is generally subject to the same requirements as the funds earning the interest. Thus, accrued interest on MHSA funds, if not spent, is subject to the same three- or 10-year reversion time frames as the MHSA funds themselves.

Table 5
The 59 Local Mental Health Agencies’ MHSAs Revenue and Expenditures
Fiscal Year 2015–16

ALL 59 LOCAL MENTAL HEALTH AGENCIES	COMMUNITY SUPPORT	PREVENTION	INNOVATION	WORKFORCE TRAINING	CAPITAL FACILITIES	RESERVE	INTEREST	TOTAL
Unspent funds available	\$854,851,000	\$351,033,000	\$231,593,000	\$81,014,000	\$195,413,000	\$530,106,000	\$67,414,000	\$2,311,424,000
Revenue*	1,120,396,000	295,642,000	78,330,000	9,005,000	19,662,000	5,066,000	17,597,000	1,545,698,000
Expenditures	883,814,000	270,074,000	58,092,000	29,308,000	78,361,000	—	4,297,000	1,323,946,000
Ending balance	1,091,433,000	376,601,000	251,831,000	60,711,000	136,714,000	535,172,000	80,714,000	2,533,176,000

Sources: The 59 local mental health agencies’ MHSAs annual reports.

Note: As of December 2017, nine of the 59 local mental health agencies had yet to submit their fiscal year 2015–16 annual reports, and an additional three had not finalized their annual reports in response to Health Care Services’ concerns. Therefore, we relied on prior years’ annual reports for these 12 local mental health agencies.

* Revenue includes adjustments and transfers to reserves, Workforce Training projects, and Capital Facilities projects.

Absent Health Care Services’ guidance, the three local mental health agencies we visited—Alameda, Riverside, and San Diego counties—have not established policies governing how to spend interest on MHSAs funds. For example, Alameda County reported \$3.9 million in unspent MHSAs interest as of fiscal year 2015–16. It stated that it has treated this interest as an additional fiscal reserve because it did not believe interest was subject to state law’s reversion requirements. Further, Riverside County indicated that due to unclear guidance from Health Care Services, it had accumulated \$6.6 million in interest as of the end of fiscal year 2015–16 and did not believe interest was subject to reversion. Nonetheless, it indicated that it developed a five-year MHSAs spending plan that incorporates the spending of interest into its long-term expenditures. Similarly, San Diego County amassed \$11 million in MHSAs interest and, lacking Health Care Services’ guidance, expressed uncertainty as to the proper treatment of this interest and whether it was subject to reversion. In contrast, we noted that some local mental health agencies have spent the interest they earned on MHSAs funds. For example, Sacramento County reported that it spent all \$772,000 of the interest it earned in fiscal year 2015–16 because it believed that consistent expenditure of accrued MHSAs interest funds further promotes its mental health service programs.

The local mental health agencies’ inconsistent treatment of MHSAs interest indicates the need for guidance from Health Care Services. Health Care Services confirmed that it plans to include guidance for how local mental health agencies should spend MHSAs interest as part of the regulations it is developing. However, as we mentioned previously, it does not anticipate submitting these regulations for

regulatory review until June 2018.⁶ Health Care Services' delay in developing regulations regarding the interest on MHSA funds has allowed local mental health agencies to amass a growing balance of interest earnings that Health Care Services should have directed them to use to fund MHSA programs.

Lacking Health Care Services' Guidance, the Local Mental Health Agencies Maintain Excessive MHSA Reserves

Since becoming responsible for overseeing the MHSA in 2012, Health Care Services has not defined what constitutes the appropriate reserve level that local mental health agencies should maintain from their MHSA fund allocations. We indicated in our August 2013 audit report that the State had not established any formal guidance on reserve requirements and recommended that Health Care Services issue such guidance. However, Health Care Services has not fulfilled this recommendation. State law requires local mental health agencies to maintain a reserve of MHSA funds to ensure that they do not have to significantly reduce mental health services during years when revenues fall below the average of previous years. However, state law does not specify the necessary reserve level. When Mental Health was responsible for the MHSA program, it required that local mental health agencies maintain reserves equal to 50 percent of the Community Support and Prevention funds they received in the prior year. However, Mental Health rescinded this requirement in 2011 without providing an explanation and instead permitted the local mental health agencies to use their own discretion to set reserve levels. Health Care Services continues to allow this practice.

Moreover, Health Care Services has not established a process for overseeing the local mental health agencies' deposits to and withdrawals from their MHSA reserves. Before 2012 Mental Health was responsible for reviewing and approving such deposits and withdrawals; however, Health Care Services has not developed a similar approval process. Consequently, local mental health agencies are currently able to deposit funds to or withdraw funds from their reserves at their discretion. Further, because their MHSA reserves are not subject to reversion requirements, local mental health agencies can currently direct any unspent MHSA funds allocated to Community Support into their reserves to shelter the funds from reversion. As Table 5 shows, the local mental health agencies had collectively amassed \$535 million in reserves as of the end of fiscal year 2015–16.

⁶ Health Care Services initially stated that it would submit the draft regulations by June 2018. In its response to this audit on page 51, Health Care Services indicates that it has pushed back this timeline to January 2019.

Lacking direction from Health Care Services, the 59 local mental health agencies set their reserve levels inconsistently. Specifically, for fiscal year 2015–16, the local mental health agencies' reserves ranged from nonexistent for Mariposa and Shasta counties to 123 percent of the agency's prior-year Community Support funds for Mono County.⁷ In this fiscal year, the cumulative reserves of all 59 local mental health agencies equaled 47 percent of their total prior-year Community Support funds.⁸ For example, Alameda County maintained a reserve of \$18.1 million, or 56 percent of its prior-year Community Support funds. Riverside and San Diego counties maintained reserves of \$28.5 million, or 42 percent, and \$42.2 million, or 40 percent, respectively. We contacted the three local mental health agencies that had the lowest and highest reserve balances for an explanation of their reserve levels. Mariposa stated that its reserve was depleted to pay off its overspending of Community Support funds in previous years, but that it expects to establish a reserve in fiscal year 2017–18. Shasta County indicated that it does not maintain an MHSA reserve because it makes its Community Support funds available to spend each year. In contrast, Mono County maintained a reserve of \$1.7 million, or 123 percent, which it indicates is sufficient to cover its operation costs for one year.

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The cumulative reserves of all 59 local mental health agencies equaled 47 percent of their total prior-year Community Support funds.

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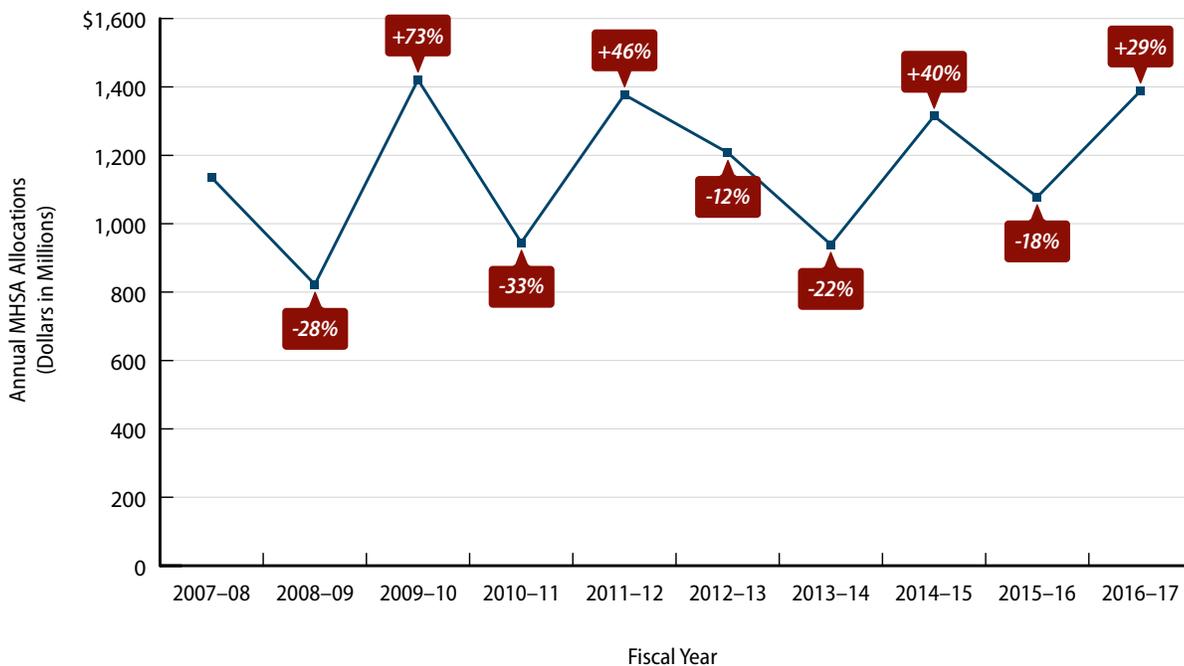
We believe Health Care Services could use historical declines in MHSA funding for Community Support to establish a reasonable reserve level for local mental health agencies. As Figure 2 on the following page indicates, the MHSA funds that the State distributed to the local mental health agencies for Community Support fluctuated from year to year over the past 10 fiscal years. We identified 33 percent as the worst decline in this funding to the local mental health agencies in any one fiscal year, while the average decline—for fiscal years in which declines occurred—was 23 percent. Health Care Services could use either of these numbers

⁷ As of December 2017, nine of the 59 local mental health agencies had yet to submit their fiscal year 2015–16 annual reports, and an additional three had not finalized their annual reports in response to Health Care Services' concerns. Therefore, we relied on prior years' annual reports for these 12 local mental health agencies when analyzing these data.

⁸ According to state law, local mental health agencies may transfer up to 20 percent of the average funding over the past five years for Community Support to MHSA reserves.

to determine a reasonable reserve level and to establish a process for allowing local mental health agencies to move funds to or from their reserves. We estimated that if Health Care Services had required the local mental health agencies to maintain reserve levels of 23 percent for fiscal year 2015–16, they could have had an additional \$274 million available to provide mental health services. Alternately, under a more conservative approach, Health Care Services could have set the reserve level at 33 percent, in which case we estimate that the local mental health agencies would have had an additional \$157 million to spend on mental health services in fiscal year 2015–16.

Figure 2
Percentage Change in Local Mental Health Agencies' Total Community Support Allocations
Fiscal Years 2007–08 Through 2016–17



Sources: The State Controller's annual reports on the local mental health agencies' MHSA apportionments and the 2017–18 California State Budget.

Health Care Services intends to include a standard reserve level in regulations on MHSA fiscal issues that it will submit for regulatory review by June 2018, as we previously discussed.⁹ However, we are concerned that the reserve level it may eventually set may be too high. Specifically, Health Care Services contracted with a consultant

⁹ Health Care Services initially stated that it would submit the draft regulations by June 2018. In its response to this audit on page 51, Health Care Services indicates that it has pushed back this timeline to January 2019.

in December 2016 to determine an optimal range of reserve levels to maintain services during an economic downturn. The consultant determined that a range of between 64 percent and 82 percent of total MHSA expenditures would be prudent. The consultant based its calculation on what it believed to be sufficient levels of reserves for local mental health agencies to serve the same number of clients during the most recent economic recession. However, we believe the consultant's range is excessive when compared to the MHSA revenue trends that we identified in Figure 2. If Health Care Services implemented the consultant's recommendation, it could result in a reduction of funds available to provide MHSA services.

Absent Health Care Services' establishment of a reasonable reserve level, local mental health agencies may continue to amass excess reserves instead of using these funds to provide additional mental health services. Moreover, those reserves will continue to earn interest, for which—as we noted previously—the local mental health agencies lack spending guidance.

Health Care Services Had Not Questioned Whether the \$225 Million Fund Balance in the MHS Fund Was Potentially Available to Local Mental Health Agencies

Health Care Services has not exercised appropriate oversight of the MHS Fund balance under its authority, which totaled \$225 million as of the end of fiscal year 2015–16. In 2012, when Health Care Services became responsible for the MHSA, it also became responsible for its departmental appropriations from the MHS Fund. Annually, these appropriations have included spending up to \$8.6 million for Health Care Services' oversight responsibilities and a much larger amount—\$1.4 billion in fiscal year 2015–16—for allocation to local mental health agencies. However, as of the end of fiscal year 2015–16, the MHS Fund had a fund balance of \$225 million, which relates to Health Care Services. Our analysis of the MHS Fund balance discovered this amount, which the State Controller's accounting records indicate has existed since at least the time that Health Care Services took over the administration of MHSA in 2012.

Health Care Services stated that it was aware of the \$225 million fund balance as part of its monthly reconciliations to the State Controller's accounting records, but acknowledged that it did not recognize that this balance needed further review to determine the nature of the appropriation, whether it represented funds that were due to local mental health agencies, or why it existed in the MHS Fund balance. Following our discussion in January 2018, Health Care Services reviewed the MHS Fund balance and asserted that the \$225 million balance does not represent funds that are due to local mental health agencies, but it could not provide

evidence to support its assertion or explain why the fund balance existed. Moreover, in February 2018, the State Controller made an adjustment to the MHS Fund to remove the \$225 million fund balance. Health Care Services indicated that it will work with the State Controller to ascertain the reason for this adjustment and determine if there is any impact on funding to local mental health agencies. However, until Health Care Services completes its analysis of the fund balance to determine why it existed, there is uncertainty as to whether the fund balance represents cash that it could distribute to local mental health agencies or a long-standing accounting error that Health Care Services failed to identify and correct.

Recommendations

To effectively monitor MHSA spending and provide guidance to the local mental health agencies, Health Care Services should publish its proposed regulations in the *California Regulatory Notice Register* by June 2018 and subsequently take the following actions:

- Develop an MHSA fiscal reversion process to ensure that the State can reallocate any MHSA funds that local mental health agencies do not spend within the statutory reversion time frames to other local mental health agencies that are better positioned to use the funds to meet the MHSA's intent.
- Clarify that the interest the local mental health agencies earn on unspent MHSA funds is subject to the same reversion requirements as the MHSA funds they receive.
- Establish and enforce an MHSA reserve level that will allow local mental health agencies to maintain sufficient funds to continue providing crucial mental health services in times of economic hardship, but that will not result in them holding reserves that are excessive. Health Care Services should also establish controls over local mental health agencies' deposits and withdrawals to their reserves.

Health Care Services should complete its analysis of the \$225 million fund balance in the MHS Fund by May 1, 2018, to determine why this balance existed, whether there is any impact on funding to the local mental health agencies and, if so, distribute those funds accordingly. Further, it should establish a process to regularly scrutinize the MHS Fund to identify any excess fund balances and the reasons for such balances.

Health Care Services Has Provided Only Minimal Oversight of the MHSAs That Local Mental Health Agencies Received

Key Points

- Health Care Services has made minimal efforts to ensure that local mental health agencies submit their annual reports on time. As a result, some local mental health agencies have not submitted timely annual reports for years, hampering Health Care Services' ability to calculate MHSAs reversion amounts and to properly oversee MHSAs spending.
- Health Care Services has been slow to implement oversight of local mental health agencies' MHSAs spending and programs. Although Health Care Services developed a MHSAs fiscal audit process in 2014, it has limited the audits' usefulness because it focused its reviews on data and processes that were at least seven years old.
- Further, Health Care Services has not developed regulations to establish an appeals process for local mental health agencies to challenge findings. In addition, it has not implemented a program review process to ensure the MHSAs projects that local mental health agencies operate comply with program requirements contained in statute and regulations.

Health Care Services Has Not Enforced MHSAs Reporting Deadlines

As Table 6 on the following page shows, although Health Care Services developed reporting instructions, it has made little effort to ensure that local mental health agencies submit their MHSAs annual reports on time. State law requires Health Care Services to administer, collect, and publish the annual reports, which identify each local mental health agency's MHSAs Fund revenues, expenditures, and interest earned. Because state law requires Health Care Services to use the annual reports to determine any MHSAs funds subject to reversion, their timeliness is critical to its ability to perform its oversight functions. State regulation requires the local mental health agencies to submit their annual reports by December 31 following the end of the fiscal year, June 30. Although Health Care Services developed instructions to facilitate completion of the annual reports, its records show that most local mental health agencies have failed to submit their annual reports on time over the past four years. For example, only one of the 59 local mental health agencies submitted its fiscal year 2015–16 annual report by the regulatory deadline.

Further, Health Care Services' records contain numerous instances of local mental health agencies submitting their reports long after the deadlines have passed. For example, as of December 2017, nine local mental health agencies had yet to submit their fiscal year 2015–16 annual reports, and an additional three had not finalized their annual reports in response to Health Care Services' concerns. One of the nine local mental health agencies that did not submit its fiscal year 2015–16 annual report is Los Angeles County (Los Angeles)—the largest local mental health agency in the State. Los Angeles indicated that it expects to submit the fiscal year 2015–16 annual report in early 2018, and it asserted that it will

be able to meet the submission deadline for future reports after it finalizes an overhaul of its cost reporting process, which it expects to complete by fiscal year 2018–19. In addition, Lake County has not submitted annual reports since fiscal year 2011–12, which it attributes to an administrative oversight and staff turnover, and it is currently working to prepare the missing reports. Because Health Care Services has not ensured that the local mental health agencies submit their annual reports in a timely manner, it lacks current information regarding their MHSA funding, hampering its efforts to calculate MHSA reversion amounts and to monitor local mental health agencies' spending of MHSA funds.

Table 6
Health Care Services' Oversight of MHSA Spending

RESPONSIBILITY	PROCESS FOR IMPLEMENTATION	STATUS
Annual reports (beginning 2012)	Develop instructions for local mental health agencies to complete the annual reports.	✓
	Establish and enforce a process to withhold MHSA funds from local mental health agencies that fail to submit their annual reports by the statutory deadline.	✗
Fiscal audits (beginning 2012)	Establish a fiscal audit process for local mental health agencies' use of MHSA funds.	✓
	Establish a schedule for fiscal audits of local mental health agencies' use of MHSA funds.	✗
Program reviews (beginning 2016)	Establish a review process for local mental health agencies' MHSA programs.	✗
	Establish a schedule for reviews of local mental health agencies' MHSA programs.	✗

Sources: California State Auditor's analysis of state laws and regulations and Health Care Services' policies and practices.

✓ = Established.

✗ = Not established.

Lacking stronger enforcement by Health Care Services, local mental health agencies do not have an incentive to submit their annual reports in a timely manner. Although Mental Health had established regulations allowing it to withhold funds from local mental health agencies that did not submit the annual reports on time, Health Care Services concluded in 2014 that state law did not clearly support these regulations and that it might be at risk of legal challenges if it followed them. Nevertheless, Health Care Services has made minimal effort to address its perceived lack of enforcement authority. In fact, Health Care Services has had the legal authority, as well as the funding, to establish regulations that would allow it to implement sanctions against local mental health agencies that do not comply with the annual reporting

requirements since 2012, when it became responsible for the MHSA. Although Health Care Services intends to address this issue in regulations it is currently developing, it does not anticipate submitting these regulations for regulatory review until June 2018.¹⁰ As we discussed previously, our legal counsel indicated that this review process can take between four and 12 months.

In 2016 Health Care Services developed an outreach process to provide technical assistance to the local mental health agencies when they complete the annual reports, and it adopted annual report deadline reminders, including an internal tracking sheet that identifies the status of outstanding annual reports. However, Health Care Services acknowledged that as part of its outreach process, it extended annual report deadlines for some local mental health agencies, stating that it did so because it believed it had no clear legal authority to enforce report deadlines. Absent specific legal authority for allowing it to formally change the submission deadline, our legal counsel believes that Health Care Services' deadline extensions are unlawful. Furthermore, Health Care Services explained that it is not tracking the number of deadline extensions it has granted to the local mental health agencies and will not enforce the established annual report submission deadline until it implements new regulations that give it the right to do so. Unless it ensures that local mental health agencies submit their annual reports on time, Health Care Services will hamper its own efforts to effectively monitor MHSA spending, reserves, interest earned, and funds subject to reversion.

Health Care Services Has Not Effectively Implemented Fiscal Audits and Program Reviews of Local Mental Health Agencies' Use of MHSA Funds

Health Care Services has not implemented meaningful oversight of local mental health agencies' MHSA spending and programs. According to state law, Health Care Services must enter a performance contract with each local mental health agency that establishes how the local mental health agency will implement MHSA requirements (performance contract). As part of the performance contract, the local mental health agency must agree to comply with all state laws and regulations regarding the allocation and use of MHSA funds, and it also must agree to allow access to its records and programs for state audits and reviews. Health Care Services decided to begin conducting MHSA fiscal audits in 2014. However, Health Care Services has been slow to begin conducting local MHSA fiscal audits and program reviews despite having

¹⁰ Health Care Services initially stated that it would submit the draft regulations by June 2018. In its response to this audit on page 51, Health Care Services indicates that it has pushed back this timeline to January 2019.

had the authority and the funding to fulfill these responsibilities. Further, some of its decisions regarding the fiscal audits it has conducted have significantly limited their usefulness.

Although Health Care Services has taken some steps toward implementing fiscal audits, it had not completed an audit for any local mental health agency as of December 2017. Specifically, in 2014 Health Care Services developed a process for MHSA fiscal audits and hired three permanent audit staff. However, as of December 2017, it had completed fieldwork at only three local mental health agencies—San Diego, Glenn, and Solano counties—and these audits are not yet finalized. Health Care Services stated that before it conducts additional audits, its MHSA audit and program staff will need to collaborate to develop a schedule of planned audits. Further, Health Care Services indicated that it will not release audit results for local mental health agencies until it establishes a regulatory appeals process that enables them to challenge any of its findings of unallowed costs. Health Care Services indicated that these appeals regulations are separate from its regulations for fiscal issues, and it will not submit the appeals regulations for regulatory review until approximately September 2018¹¹—four years after it developed its audit process. As described previously for the regulatory approval process, if Health Care Services submits its regulations for regulatory review in September 2018, this process may take between four and 12 months, and thus these regulations would not be in place until sometime between January 2019 and September 2019.

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Health Care Services had completed fieldwork at only three local mental health agencies and these audits are not yet finalized.

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Further, Health Care Services made a decision regarding the focus of its fiscal audits that has limited their value and relevance for assessing fiscal controls over the current operations of local mental health agencies. Specifically, Health Care Services decided to conduct its MHSA fiscal audits in conjunction with its reviews of California Medical Assistance Program (Medi-Cal) cost reports to ensure that the reported expenditures from both MHSA and Medi-Cal programs were consistent and unduplicated. However, a backlog of overdue Medi-Cal cost reports has resulted in Health

¹¹ Health Care Services initially stated that it would submit the draft regulations by September 2018. In its response to this audit on page 56, Health Care Services indicates it has pushed back this timeline to Spring 2019.

Care Services focusing on significantly outdated data and processes during the three fiscal audits for which it has completed fieldwork. For example, its audit of San Diego County (San Diego) focused on fiscal year 2008–09 MHPA funding. Thus, the audit’s findings and recommendations would be of limited value given the age of the information under review. According to Health Care Services, San Diego’s Medi-Cal report submissions are backlogged and fiscal year 2008–09 was the most recent year for which Health Care Services could review both Medi-Cal and MHPA information in San Diego. Health Care Services acknowledged that performing fiscal audits on more recent fiscal years may be needed to ensure more relevant reviews and findings of controls over MHPA funds.

In addition, Health Care Services has been slow to implement a comprehensive MHPA program review process that will enable it to assess how each local mental health agency allocates, spends, and monitors its MHPA funds. In our August 2013 report, we noted that we had found no evidence that the State conducted systematic and comprehensive monitoring of local mental health agencies to ensure that their MHPA programs were both effective and compliant with MHPA requirements. Thus, we recommended that Health Care Services conduct such comprehensive on-site MHPA program reviews. We remain concerned that Health Care Services has still not fulfilled this recommendation. A 2016 amendment to state law requires that at least once every three years Health Care Services conduct program reviews of the local mental health agencies’ performance contracts. The intent of the program reviews is to determine the local mental health agencies’ compliance with the terms of the performance contracts and with MHPA requirements. Although this law took effect in 2016, Health Care Services has yet to establish a schedule of program reviews and does not anticipate beginning the program reviews until July 2018 at the earliest. Health Care Services indicated that it first needs to develop the review process.

Recommendations

To ensure that it provides effective oversight of local mental health agencies' reporting of MHPSA funds, Health Care Services should publish its proposed regulations in the *California Regulatory Notice Register* by June 2018. Health Care Services should then subsequently implement a process that will enable it to withhold MHPSA funds from local mental health agencies that fail to submit their annual reports on time.

To ensure that local mental health agencies appropriately spend MHPSA funds, Health Care Services should publish its proposed regulations in the *California Regulatory Notice Register* by September 2018. It should then develop and implement an MHPSA fiscal audit process, independent of the Medi-Cal reviews, to review revenues and expenditures for the most recent fiscal year.

To ensure that local mental health agencies comply with their performance contracts and MHPSA requirements, Health Care Services should establish a process for conducting comprehensive program reviews and begin conducting those reviews by July 2018.

The Oversight Commission Is Implementing Processes to Evaluate the Effectiveness of MHSA-Funded Programs

Key Points

- The Oversight Commission is undertaking efforts to provide technical assistance and improve dialogue with the local mental health agencies regarding the Innovation project approval process, as shown in Table 7. The absence of clear guidance and understanding of the Innovation program approval process may have contributed to local mental health agencies holding excessive unspent Innovation program funds. As of the end of fiscal year 2015–16, the local mental health agencies had \$146 million in Innovation funds subject to reversion.
- The Oversight Commission required that the local mental health agencies submit annual reports for Prevention and Innovation programs beginning in December 2017, which is an important step in its efforts to evaluate the progress of these programs to help ensure that the local mental health agencies are achieving the goals of the MHSA. However, the Oversight Commission has not completed an internal process for reviewing and analyzing these reports to ensure that the local mental health agencies submit timely and reliable data.
- Although the Oversight Commission requires the local mental health agencies to evaluate the MHSA-funded triage grants at the local level, it has not developed metrics to evaluate the outcome of the triage grants on a statewide level. This statewide evaluation is necessary to help ensure that the triage grant program is meeting its intended goals of expanding the number of mental health personnel available at emergency rooms, jails, homeless shelters, and clinics.

Table 7
The Oversight Commission’s MHSA Oversight

RESPONSIBILITY	PROCESS FOR IMPLEMENTATION	STATUS
Innovation project approvals (beginning 2012)	Establish and follow a process for approving the local mental health agencies’ Innovation projects.	✓
	Adopt a process that results in the local mental health agencies’ improved understanding of Innovation projects.	✓
Innovation project reporting (beginning 2015)	Adopt regulations for Innovation project reporting.	✓
	Establish and follow checklists and guidelines for staff to review annual Innovation status reports.	✗
Prevention project reporting (beginning 2015)	Adopt regulations for Prevention project reporting.	✓
	Establish and follow guidelines for staff to review Prevention status reports.	✗
Triage grants (beginning 2013)	Establish and follow a schedule for the local mental health agencies to submit reports on the progress and outcomes of their triage grants.	✓
	Establish outcome metrics to evaluate the effectiveness of triage grants.	✗

Sources: California State Auditor’s analysis of state laws and regulations and the Oversight Commission’s policies and practices.

✓ = Established.

✗ = Not established.

MHSA Innovation Projects

State law requires that an Innovation project do one of the following:

- Introduce a new practice or approach to the mental health system, including, but not limited to, prevention and early intervention.
- Make a change to an existing mental health practice or approach, including adapting it to a new setting or community.
- Introduce a new application of a promising community-driven practice or an approach that has been successful in contexts or settings other than mental health.
- Support a housing program designed to stabilize a person's living situation while also providing supportive services onsite.

Further, an Innovation project must address one of the following as its primary purpose:

- Increasing access to underserved groups, which may include providing access through the provision of permanent housing.
- Increasing the quality of services, including measurable outcomes.
- Promoting interagency and community collaboration.
- Increasing access to services, which may include providing access through provision of permanent housing.

Source: Welfare and Institutions Code.

The Oversight Commission Is Implementing Processes to Provide Technical Assistance to and Improve Dialogue With the Local Mental Health Agencies Regarding Innovation Projects

As we discuss in the Introduction, the Oversight Commission is responsible for reviewing and approving local mental health agencies' uses of Innovation funds before the agencies spend those funds. As the text box shows, state law requires that Innovation projects focus on the provision of creative services and approaches to meet certain purposes, such as increasing the quality of services or increasing access to underserved populations. However, local mental health agencies have struggled to spend Innovation funds within the required time frames. In fact, even though Innovation funds are only 5 percent of the total MHSA funds that local mental health agencies receive, Health Care Services identified that they make up \$146 million—or 63 percent—of the \$231 million in MHSA funds subject to reversion as of the end of fiscal year 2015–16.

Several factors in particular may have contributed to the local mental health agencies' inability to spend Innovation funds in a timely manner. Specifically, the Oversight Commission's Innovation subcommittee noted three challenges that local mental health agencies face when

developing viable Innovation projects. The first challenge is pressure from their stakeholders to focus on direct services that are less risky and that result in easily attainable outcomes. The second challenge is a lack of clarity as to the types of projects the commissioners, who vote whether to approve a project, consider "innovative." The third challenge local mental health agencies face is not enough dissemination of lessons learned from project ideas that did not succeed and limited sharing of new project ideas among local mental health agencies. In addition, the three local mental health agencies we visited—Alameda, Riverside, and San Diego counties—expressed frustration with the approval process because the commissioners do not always approve their Innovation project even though they worked with the Oversight Commission to prepare the plans. For example, San Diego indicated that the commissioners did not initially approve requests to extend and expand an existing Innovation project because they questioned the innovativeness of the proposals and the outcomes. However, the commissioners had approved the initial Innovation project. Further, Riverside County noted that the commissioners did not approve its

proposed project—a collaboration with San Bernardino County to improve access to mental health care in emergency rooms—even though the Oversight Commission had given only positive feedback about the project over the course of three consultation calls. Among other concerns, the commissioners said that the proposed project had inconsistencies, such as expanding mental health services in emergency rooms while stating a need to divert mental health consumers from emergency rooms. The commissioners encouraged the two counties to resubmit the project after revising it to address these concerns.

The Oversight Commission asserted that actions it is taking are improving the local mental health agencies' understanding of projects that the commissioners find innovative. Specifically, the Oversight Commission established a subcommittee on Innovation projects, which held its first meeting in May 2017 to listen to and engage with MHSAs stakeholders—such as local mental health agencies, health care providers, consumers, and family members—regarding strategies to support and improve opportunities for using Innovation funds. The subcommittee met again in July 2017, and based on that meeting, it developed a flowchart that details the steps for project approval, as well as a template to assist local mental health agencies in developing and presenting their Innovation projects. Although Health Care Services already had an existing template it made available to local mental health agencies, the subcommittee's updated template provides specific details about the information that the agencies should include in their proposed Innovation projects, such as a narrative description of the project, the problem in the community that the project addresses, the sustainability of the project, and recommended content and structure of the presentation to the commissioners. However, the Oversight Commission stated that the subcommittee has fulfilled its mission to engage with local mental health agencies on strategies to support Innovation projects, and it is unclear whether it will keep or disband the subcommittee. Until the Oversight Commission can demonstrate that local mental health agencies are spending Innovation funds within the required time frames, we believe that it should maintain the Innovation subcommittee or a similar mechanism to evaluate whether its efforts are effective in improving local mental health agencies' understanding of innovative projects.

In addition, the Oversight Commission stated that it wants to create opportunities for local mental health agencies to share ideas and disseminate lessons learned from previous Innovation projects. To this end, the Oversight Commission partnered with local mental health agencies, community members, and private sector groups to organize a one-day Innovation event in February 2018 to bring together 250 mental health and innovation leaders to identify technical assistance resources available to local mental health

agencies. At this event, participants engaged in activities to help create innovative solutions and approach problem solving in new ways to improve the mental health system.

We believe these actions are reasonable steps to encourage more engagement and dialogue between the local mental health agencies and the Oversight Commission. However, it is too soon to know the impact that these actions will have on improving local mental health agencies' understanding and reducing the level of unspent Innovation program funds.

Innovation Project Approval Process

A local mental health agency can expend funds for an Innovation project upon approval by the Oversight Commission. To secure the Oversight Commission's approval for an Innovation project, a local mental health agency must do the following:

- Post the Innovation plan for a 30-day public review period, hold a local mental health board hearing, and receive the approval of its county board of supervisors.
- Submit the Innovation project, including a budget, to the Oversight Commission. The Oversight Commission reviews whether the project meets regulatory requirements and works with the local mental health agency to resolve its concerns, which could include requiring the resubmission of the project.
- Present the formal Innovation project to the Oversight Commission for approval. After making a decision on the project, the Oversight Commission formally notifies the local mental health agency by mail. If the Oversight Commission does not approve the project, the local mental health agency can revise and resubmit it at any time.

Sources: Welfare and Institutions Code and the Oversight Commission's *Innovation Review Process* flowchart.

The length of the Oversight Commission's approval process does not appear to have been one of the factors affecting the ability of local mental health agencies to spend Innovation funds. As the text box indicates, local mental health agencies must undergo a multistep process to receive approval for their Innovation project from the Oversight Commission. The Oversight Commission does not have a standard time frame for how long this approval process should take because it believes that establishing a standard approval time frame is not practical. Specifically, it stated that the review time depends on when a local mental health agency submits its Innovation project and when the Oversight Commission meets to review that project. We found that from December 2015 through August 2017, the Oversight Commission approved 58 Innovation projects and denied four projects that it received. The Oversight Commission reviewed 48 of the 58 approved Innovation projects, or 83 percent, within three months of their receipt. It approved six additional projects within six months, while it took more than six months to approve the remaining four projects.

The Oversight Commission noted that the local mental health agencies may delay the approval process by withdrawing and resubmitting their projects based on their level of readiness for review. As discussed previously, the Oversight Commission is undertaking efforts to provide technical assistance and improve dialogue with the local mental health agencies regarding its process for approving Innovation projects. These efforts should help reduce delays in the approval process.

The Oversight Commission Is Adopting a Process for Analyzing the Local Mental Health Agencies' Status Reports for Prevention and Innovation Projects

The Oversight Commission is taking steps to implement its responsibility to evaluate the effectiveness of the Prevention and Innovation projects. In response to a 2013 change in state law, the Oversight Commission issued regulations in October 2015 requiring local mental health agencies to annually provide detailed demographic data on individuals that their Prevention projects have served. Additionally, in response to the same 2013 state law change, the Oversight Commission issued regulations that require the local mental health agencies to annually submit status reports for each Innovation project. According to the Oversight Commission, it intends to use both of these sources of information to determine who the Prevention and Innovation projects are serving and thus enable detailed reporting on access to care. Further, the Oversight Commission's goal is to promote public accountability and oversight by tracking funding, services, and outcomes. The Oversight Commission required that local mental health agencies submit their first Prevention and Innovation status reports by the end of December 2017.

Although the Oversight Commission has hired new staff and is streamlining its internal processes to focus on research and evaluation—including the development of reporting templates—it has not yet fully developed processes to guide staff in their monitoring efforts. In particular, the regulations for the Prevention status reports require detailed demographic data on the populations that the local mental health agencies serve. With these data, the Oversight Commission intends to be able to evaluate strategies for monitoring outcomes, to measure how well the local mental health agencies are achieving the goals of the MHSA, and to explore strategies for improvement. However, when the Oversight Commission adopted the regulations, local mental health agencies expressed three main concerns with the reporting requirements. First, they believed that providing all the required information would be difficult because Health Care Services did not have the ability to electronically receive the more detailed data. Second, they believed that the regulatory requirements might be inconsistent with the manner in which they initially established their MHSA programs. Finally, the local mental health agencies were concerned about the lack of a standard to measure and report the durations of untreated mental illnesses. In response, the Oversight Commission agreed to modify the regulations, a process that it expects to complete no later than July 2018.

Moreover, according to the Oversight Commission, it has not developed internal processes to review and analyze the Prevention and Innovation reports because it believes it cannot determine what areas the staff will need to monitor until it finds out whether the local mental health agencies will submit all the required data on time and whether the data they report will be valid and reliable. The Oversight Commission has asserted that it does not have the enforcement authority to ensure that local mental health agencies comply with the reporting requirements; rather, it only has the authority to refer issues for enforcement to Health Care Services. Thus, the Oversight Commission anticipates that developing the ability to analyze the data the local mental health agencies report will take about one year. Despite these anticipated challenges, we believe that the Oversight Commission should implement a process in a timelier manner to review and evaluate the status reports to provide oversight and accountability of MHSA programs as the law requires.

The Oversight Commission only has the authority to refer issues for enforcement to Health Care Services.

In addition, the Oversight Commission is currently developing data tools that track local mental health agencies' funding, services, and outcomes. In August 2017, the Oversight Commission launched an online MHSA fiscal transparency tool that uses an interactive map to display the 59 local mental health agencies' annual MHSA revenues, expenditures, and year-end balances of unspent funds. However, the effectiveness of this tool is dependent on the local mental health agencies' annual reports, and as we discussed previously, because of the lack of enforcement by Health Care Services, the local mental health agencies have often submitted the annual reports late or not at all. The Oversight Commission stated that the fiscal transparency tool is a first step in its plan to develop online tools to enhance public accountability for the local mental health agencies' spending of MHSA funds. The second step is a tool to provide the public with information on the MHSA services available in each county, and the Oversight Commission expects to launch an initial version of this tool by December 2018. The third step involves a tool for tracking project outcomes, and the Oversight Commission estimated that it will be between three and five years before it adopts metrics on MHSA outcomes because it is currently analyzing existing data sources, developing data use agreements, and establishing the legal authority to access needed data.

Although we believe that the Oversight Commission is now taking adequate steps to develop data tools that enhance public accountability and awareness of the MHSA, it acknowledges that it has faced challenges in its ability to report and evaluate outcomes due to its limited resources dedicated to research and evaluation. To fulfill its statutory responsibility, the Oversight Commission should ensure that it launches all three data tools as planned.

The Oversight Commission Is Developing Statewide Metrics to Evaluate the Effectiveness of MHSA-Funded Triage Grants

The Legislature created the MHSA triage grants in 2013 with the intent of establishing a competitive grant process, administered by the Oversight Commission, that would enable local mental health agencies to add at least 600 mental health triage personnel statewide, among other objectives. The intent of these triage grants is to expand the number of mental health personnel available at various points of access throughout the community, such as emergency rooms, jails, homeless shelters, and clinics. The funding for triage grants comes from the MHSA's 5 percent state administrative funds.

In its 2014 status report to the Legislature, the Oversight Commission indicated that in its first funding cycle it had awarded three-year grants to 22 local mental health agencies in fiscal year 2013–14, with an annual total allocation of \$32 million in MHSA funds. Additionally, the Oversight Commission awarded three-year grants to two more local mental health agencies because it had unexpended funds from fiscal year 2013–14. In 2016 the Legislature approved the funding of the triage grant program through June 2018. According to the Oversight Commission, it granted amendments to 18 of the 24 local mental health agencies that had received grants in fiscal year 2013–14 to extend these grants for one more year, through fiscal year 2017–18. The Oversight Commission announced availability of the grants for the next three-year funding cycle in December 2017 and plans to award the grants in summer 2018.

Although state law anticipates that the Oversight Commission will evaluate the effectiveness of the services provided through the grants, the Oversight Commission has indicated that it has faced challenges in creating a consistent statewide picture based on the local mental health agencies' individual evaluations. The Oversight Commission requires the local mental health agencies that receive the grants to submit progress reports on the number of triage personnel they have hired, the individuals they have served, and the encounters with individuals that have led to referrals to mental health services. The Oversight Commission reviews these reports

and conducts site visits to ensure that the grantees have attained the goals they identified in their grant applications. Nonetheless, the Oversight Commission stated that during the initial round of triage grant awards, it prioritized implementing services, and consequently it did not develop a unified evaluation approach but rather chose to let the grant applicants specify how their projects would be evaluated.

In October 2016, the Oversight Commission conducted a survey to which 20 local mental health agencies responded to assess which local mental health agencies were collecting data that could be used to evaluate the success of the triage grants. The Oversight Commission expressed that these survey data provided some basis for a statewide assessment of the effectiveness of the triage grant program. However, it also stated that the evaluations it received from the local mental health agencies represented different approaches and proved too diverse for the Oversight Commission to aggregate and translate into a statewide picture. The Oversight Commission indicated that it will allocate a portion of the newest round of triage grant funds for a statewide evaluation that may include the use of a third-party contractor to conduct a statewide analysis.

Although these steps are reasonable, we question why the Oversight Commission did not establish a process for evaluating the effectiveness of the MHSA triage grants sooner, given that the law has been in place since 2013. The Oversight Commission stated that the focus for the first round of triage grants was to implement services as quickly as possible, rather than to establish statewide evaluation criteria. Without the statewide metrics, local MHSA stakeholders are unable to fully evaluate the effectiveness of the triage grants and the Oversight Commission is not fulfilling its statutory responsibility to conduct such evaluations.

Recommendations

To ensure that local mental health agencies are able to spend Innovation program funds in a timely manner, the Oversight Commission should continue its efforts to help local mental health agencies understand the types of Innovation projects that the commissioners believe are appropriate. These efforts should include engagement and dialogue with local mental health agencies through Innovation events and forums about the types of innovative approaches that would meet the requirements of the MHSA. The Oversight Commission should use meetings of the Innovation subcommittee or a similar mechanism to evaluate the progress of its efforts to reduce unspent Innovation funds and the need for continued engagement and dialogue with local mental health agencies.

To ensure proper oversight and evaluation of outcomes for the Prevention and Innovation projects, the Oversight Commission should finalize its internal processes for reviewing and analyzing the program status reports no later than July 2018. Further, in order to fulfill its statutory responsibility to provide oversight and accountability for MHSA programs, the Oversight Commission should ensure that it launches all three data tools to track local mental health agencies' funding, services, and outcomes as it intends.

To ensure that the MHSA-funded triage grants are effective, the Oversight Commission should require that local mental health agencies uniformly report data on their uses of triage grants. It should also establish statewide metrics to evaluate the impact of triage grants by July 2018.

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OTHER AREAS WE REVIEWED

To fully address the audit objectives that the Joint Legislative Audit Committee (Audit Committee) approved, we also reviewed the subject areas described below. The text that follows indicates the results of our review and any associated recommendations that we do not discuss in other sections of this report.

The Local Mental Health Agencies We Reviewed Allocated MHSA Funds Appropriately

Under state law, the 59 local mental health agencies receive MHSA funds to expand mental health services to individuals requiring these services. For this audit, we reviewed three local mental health agencies—Alameda, Riverside, and San Diego counties—to assess how they allocated and monitored their MHSA funds. These three local mental health agencies complied with MHSA legal requirements regarding allocation of their MHSA funding. Specifically, they complied with state law that requires them to prepare three-year plans that detail how they will use MHSA funds for mental health services projects. In compliance with state law, they also provided periods for public review and comment regarding these plans, then obtained approval from their respective county board of supervisors. In addition, the counties' mental health directors and auditor-controllers certified the plans as compliant with the MHSA. The three local mental health agencies we visited had their MHSA three-year plans and annual updates publicly available on their websites. Our review found that the local mental health agencies' plans detailed their various MHSA-funded projects and the planned benefits from these projects.

The Local Mental Health Agencies We Reviewed Generally Monitored Their MHSA-Funded Projects Effectively

To assess how the three local mental health agencies monitored the spending and outcomes of the MHSA projects they funded, we reviewed 10 MHSA-funded projects—two from each of the five program categories—at each of the three local mental health agencies we visited. At each local mental health agency, vendors or the agency itself operated these projects. Although the outcomes that we reviewed varied due to differences in program structure, we found that the three local mental health agencies generally had sufficient controls to ensure that they paid vendors appropriately. We also found that two of the three local mental health agencies appropriately monitored their MHSA programs.

San Diego County

San Diego had appropriate processes to monitor MHSA projects and adequate payment controls for vendor invoices. For example, for each of the 10 projects we reviewed, San Diego conducted a risk assessment, performed monitoring activities such as site visits and reviews of progress reports, and collected outcome data. Further, for the 10 invoices we reviewed, San Diego had support for the total amounts that the vendors requested and followed its internal control policies when making the payments to the vendors.

Riverside County

The Riverside County local mental health agency (Riverside) appropriately monitored its MHSA projects and vendor invoices. We reviewed 10 MHSA projects at Riverside—five that it operated and five that were vendor-operated. We found that Riverside performed appropriate monitoring of these 10 projects through site visits or other review activities. In addition, we found that Riverside properly approved the five vendor invoices we reviewed, including requiring that the vendors provide proper support for the services for which they claimed payment.

Alameda County

Although we found that the Alameda County local mental health agency (Alameda) had appropriate payment controls for vendor invoices and grantee disbursements, it did not adequately monitor its MHSA projects. We reviewed 10 invoices and grantee disbursements and determined that Alameda had adequate payment controls and proper support for the amounts it paid. However, Alameda was unable to demonstrate that it actively monitored four of the 10 projects we reviewed. For example, it contracted with a vendor to provide rehabilitation services for adults with mental illnesses and co-occurring substance use disorders. However, Alameda was unable to demonstrate how it monitored the outcomes of this vendor's services. In addition, for the two Innovation projects we reviewed, Alameda did not document the results of its site visits. According to Alameda, it has faced challenges in developing a structured and systematic monitoring system due to staffing capacity, staff vacancies and turnover, and changes in leadership. Alameda acknowledged that its monitoring could be improved and stated that it intends to strengthen its efforts.

Recommendation

Alameda

To strengthen its monitoring of MHSA projects and ensure that it spends MHSA funds appropriately, Alameda should develop and implement MHSA program monitoring guidelines to ensure that staff appropriately perform and document their monitoring activities.

MHSA Funding of the No Place Like Home Program

Despite legal challenges, the Department of Housing and Community Development (Community Development) has taken reasonable actions to implement the No Place Like Home Program (Home Program), which the MHSA will fund. In 2016 state law enacted the Home Program and dedicated \$2 billion in bond proceeds to finance the capital costs of permanent, supportive housing for individuals who are in need of mental health services and who are experiencing homelessness or chronic homelessness, or who are at risk of chronic homelessness. Community Development is responsible for administering grants to the local mental health agencies to implement the Home Program—including \$1.8 billion it will award in competitive grants to local mental health agencies and \$200 million in financing for permanent supportive housing that it will distribute to the local mental health agencies based on their homelessness populations. Community Development has developed program guidelines and is in the process of developing forms and instructions that it believes will be ready when the MHSA funds become available.

However, Community Development is currently involved in court proceedings that have stalled its ability to execute the Home Program grants. In November 2016, a private citizen filed a lawsuit contending, among other issues, that the Home Program violates the intent of the MHSA because, the individual asserts, the Home Program would use MHSA funds to build housing for individuals who are not mentally ill. However, Community Development indicated that it will require local mental health agencies to demonstrate that they are meeting the Home Program's criteria of providing housing for individuals with a mental illness. Community Development anticipates that the lawsuit will be decided in the spring of 2018 and is hopeful that it will announce the availability of the grants in the summer of 2018.

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SCOPE AND METHODOLOGY

The Audit Committee directed the California State Auditor to review the funding and oversight of the MHSA. The audit scope includes eight audit objectives. Table 8 lists the audit objectives and the methods we used to address them.

Table 8
Audit Objectives and the Methods Used to Address Them

AUDIT OBJECTIVE	METHOD
1 Review and evaluate the laws, rules, and regulations significant to the audit objectives.	Reviewed relevant state laws, regulations, and other background materials applicable to the MHSA.
2 Review and evaluate the roles and responsibilities of Health Care Services, the Oversight Commission, the State Controller, and any other state agency related to the MHSA and the programs and activities funded by the MHSA. Determine whether these entities are meeting the requirements of the MHSA.	<p>For this audit we focused on Health Care Services and the Oversight Commission because state laws and regulations authorize these entities to ensure that local mental health agencies spend MHSA funds appropriately. Further, beginning in 2016, Community Development is responsible for administering \$2 billion in MHSA-funded grants to local mental health agencies for the Home Program.</p> <ul style="list-style-type: none"> Obtained and reviewed internal policies and procedures and interviewed officials at Health Care Services, the Oversight Commission, the State Controller, and Community Development to identify and determine their roles and responsibilities related to the MHSA.
3 Review Health Care Services’ MHSA funding allocation and positions for the most recent five-year period and evaluate how the agency is using these funds to implement and oversee the MHSA.	<p>To review Health Care Services’ MHSA funding allocations and positions, we performed the following:</p> <ul style="list-style-type: none"> Interviewed Health Care Services’ management and budget personnel. Obtained and reviewed Health Care Services’ MHSA monitoring policies and procedures and interviewed its management and budget personnel—including MHSA reversion requirements and calculation methodologies, MHSA annual reporting instructions, and its processes for implementing MHSA program reviews and fiscal audits of the local mental health agencies. Obtained and reviewed Health Care Services’ MHSA funding and position allocation for fiscal years 2011–12 through 2015–16.
4 Determine and evaluate the process by which reversion amounts are calculated, communicated to relevant entities, and returned to the State from the relevant entities. Assess whether these processes comply with the MHSA.	To identify the State’s MHSA reversion process and determine if it complies with MHSA requirements, we reviewed state laws. We also interviewed officials at Health Care Services and the three local mental health agencies we visited—Alameda, Riverside, and San Diego counties—regarding policies and procedures for implementing MHSA reversion requirements.
5 To the extent possible, determine and analyze the following over the past five fiscal years:	To assess this objective, we performed the following tasks at Health Care Services and the three local mental health agencies we visited—Alameda, Riverside, and San Diego counties:
a. The amount of MHSA funds that were subject to reversion.	<ul style="list-style-type: none"> Reviewed Health Care Services’ proposed methodology, as of September 2017, for determining the MHSA funds subject to reversion, which indicated that \$231 million was subject to reversion as of the end of fiscal year 2015–16.
b. The amount of MHSA funds that actually reverted to the State.	<ul style="list-style-type: none"> Reviewed relevant governing MHSA reversion requirements, including a one-time change in law in 2017 that allowed local mental health agencies to retain all MHSA funds subject to reversion before fiscal year 2017–18.
c. The program sources of reverted funds, including Community Support, Prevention, and Innovation.	
d. The total amount of reverted funds that were reallocated to local mental health agencies.	
e. Whether any state entity received reverted funds that were reallocated. If so, determine whether the state entity spent reverted funds appropriately.	

continued on next page ...

AUDIT OBJECTIVE	METHOD
<p>6 Determine whether any MHSAs have been used for State General Fund purposes in the most recent five-year period. If so, determine the amount of funds and evaluate whether those funds have been used in accordance with the MHSAs.</p>	<p>To determine whether any MHSAs had been used for General Fund purposes, we performed the following:</p> <ul style="list-style-type: none"> • Interviewed officials at the State Controller. • Reviewed state laws regarding the appropriate use of MHSAs. • Obtained and reviewed MHSAs claim schedules and allocation letters. • Noted only one instance: legislation effective March 2011 shifted \$861 million in MHSAs funds to cover General Fund obligations for other mental health programs.
<p>7 For a selection of three local mental health agencies, perform the following over the most recent five-year period:</p> <p>a. Review and assess how each local mental health agency allocates, spends, and monitors the MHSAs funds they receive each year.</p> <p>b. Determine the amount of funds that were subject to reversion and the amount of funds that were actually reverted to the State.</p> <p>c. Review and assess the methods each local mental health agency uses to determine and report to the State the amount of MHSAs funds subject to reversion, and their process for reverting these funds.</p> <p>d. Determine whether the local mental health agencies have spent funds subject to reversion and determine whether any reimbursement with interest is owed to the State.</p>	<p>To assess this objective, we performed the following tasks at Alameda, Riverside, and San Diego counties:</p> <ul style="list-style-type: none"> • Obtained and reviewed procurement and monitoring policies and procedures and interviewed management and procurement personnel at each of the local mental health agencies. • Reviewed each local mental health agency's three-year plan active during fiscal year 2015–16 and plan updates regarding allocation of MHSAs funding. • To assess how the local mental health agencies monitored the spending and outcomes of their MHSAs projects, we reviewed 10 MHSAs-funded projects at each of the three local mental health agencies. • To gain assurance that we selected MHSAs-funded projects from the complete population of expenditures for Alameda and Riverside counties, we traced 29 project contracts to the data and found no errors. • We did not conduct completeness testing in San Diego County because once an MHSAs contract is executed, the County scans the contract into its system and then destroys the original hard copy contract. • We discuss the local mental health agencies' processes for implementing MHSAs reversion requirements in Objective 4 above.
<p>8 Review and assess any other issues that are significant to the audit.</p>	<p>To identify and evaluate the MHSAs Fund balance, we reviewed the state budget, State Controller's financial records, and MHSAs monthly allocation letters. We also interviewed officials at Health Care Services, the State Controller, and Department of Finance.</p>

Sources: California State Auditor's analysis of audit request number 2017-117 as well as state law, regulations, and information and documentation identified in the table column titled *Method*.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the Scope and Methodology section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,



ELAINE M. HOWLE, CPA
State Auditor

Date: February 27, 2018

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APPENDIX

LOCAL MENTAL HEALTH AGENCIES' MHSA FUND BALANCES

State law requires Health Care Services to collect and publish annual reports that identify each local mental health agency's MHSA Fund revenues, expenditures, reserves, interest earned, and funds subject to reversion. These reports are due no later than December 31 following the end of the fiscal year. Table A beginning on the following page details the 59 local mental health agencies' MHSA ending fund balances by program and is based on the local mental health agencies' annual reports for fiscal year 2015–16. As Table A shows, the local mental health agencies had amassed \$2.5 billion in unspent MHSA funds as of this fiscal year, including \$535 million in reserves that are not subject to reversion requirements. However, as of December 2017, nine of the 59 local mental health agencies had yet to submit their fiscal year 2015–16 annual reports, and an additional three had not finalized their annual reports in response to Health Care Services' concerns. For these 12 local mental health agencies, we relied on prior years' annual reports to complete this table.

Table A
The 59 Local Mental Health Agencies' MHA Fund Balances
Fiscal Year 2015–16

LOCAL MENTAL HEALTH AGENCIES	COMMUNITY SUPPORT	PREVENTION	INNOVATION	WORKFORCE TRAINING	CAPITAL FACILITIES	RESERVE	INTEREST	TOTAL
Alameda County	\$49,485,000	\$11,454,000	\$9,015,000	\$2,933,000	\$9,890,000	\$18,066,000	\$3,896,000	\$104,739,000
Alpine County	3,173,000	1,503,000	535,000	450,000	922,000	541,000	361,000	7,485,000
Amador County	3,172,000	793,000	737,000	191,000	330,000	1,102,000	29,000	6,354,000
City of Berkeley	6,467,000	1,417,000	596,000	306,000	1,397,000	1,612,000	67,000	11,862,000
Butte County	577,000	—	1,189,000	57,000	293,000	2,458,000	271,000	4,845,000
Calaveras County	3,656,000	1,016,000	346,000	74,000	49,000	975,000	82,000	6,198,000
Colusa County	4,135,000	743,000	533,000	26,000	—	418,000	340,000	6,195,000
Contra Costa County	25,863,000	4,179,000	4,301,000	783,000	952,000	7,125,000	2,753,000	45,956,000
Del Norte County	2,078,000	352,000	545,000	368,000	801,000	813,000	14,000	4,971,000
El Dorado County	5,099,000	2,345,000	2,101,000	81,000	462,000	1,898,000	142,000	12,128,000
Fresno County	52,279,000	14,152,000	6,181,000	3,708,000	6,243,000	12,824,000	—	95,387,000
Glenn County	2,707,000	391,000	112,000	210,000	—	89,000	2,000	3,511,000
Humboldt County	183,000	2,108,000	969,000	317,000	509,000	1,169,000	119,000	5,374,000
Imperial County	3,075,000	2,915,000	1,765,000	177,000	416,000	130,000	—	8,478,000
Inyo County	1,675,000	433,000	86,000	250,000	139,000	649,000	94,000	3,326,000
<i>Kern County (2014–15)</i>	<i>26,704,000</i>	<i>13,533,000</i>	<i>5,734,000</i>	<i>521,000</i>	<i>1,634,000</i>	<i>12,365,000</i>	<i>586,000</i>	<i>61,077,000</i>
Kings County	5,585,000	295,000	1,430,000	—	1,112,000	2,138,000	382,000	10,942,000
<i>Lake County (2011–12)</i>	<i>627,000</i>	<i>322,000</i>	<i>90,000</i>	<i>443,000</i>	<i>576,000</i>	<i>1,139,000</i>	<i>31,000</i>	<i>3,228,000</i>
Lassen County	1,770,000	630,000	462,000	—	649,000	805,000	3,000	4,319,000
<i>Los Angeles County (2014–15)</i>	<i>233,051,000</i>	<i>140,582,000</i>	<i>84,319,000</i>	<i>33,742,000</i>	<i>29,397,000</i>	<i>192,054,000</i>	<i>24,465,000</i>	<i>737,610,000</i>
<i>Madera County (2014–15)</i>	<i>7,942,000</i>	<i>1,516,000</i>	<i>890,000</i>	<i>—</i>	<i>—</i>	<i>34,000</i>	<i>78,000</i>	<i>10,460,000</i>
Marin County	9,681,000	1,778,000	2,100,000	608,000	1,768,000	2,175,000	570,000	18,680,000
Mariposa County*	(1,355,000)	825,000	434,000	149,000	(192,000)	—	2,000	(137,000)
Mendocino County	799,000	1,219,000	1,452,000	311,000	584,000	2,198,000	23,000	6,586,000
Merced County	8,715,000	4,136,000	2,193,000	211,000	4,864,000	4,104,000	525,000	24,748,000
Modoc County	1,187,000	880,000	245,000	126,000	512,000	472,000	75,000	3,497,000
Mono County	144,000	994,000	536,000	554,000	1,053,000	1,672,000	96,000	5,049,000
<i>Monterey County (2013–14)</i>	<i>8,867,000</i>	<i>1,214,000</i>	<i>2,437,000</i>	<i>—</i>	<i>—</i>	<i>3,063,000</i>	<i>16,000</i>	<i>15,597,000</i>
Napa County	668,000	46,000	1,196,000	72,000	400,000	898,000	167,000	3,447,000
<i>Nevada County (2013–14)</i>	<i>926,000</i>	<i>1,011,000</i>	<i>364,000</i>	<i>55,000</i>	<i>—</i>	<i>1,142,000</i>	<i>266,000</i>	<i>3,764,000</i>
Orange County	92,495,000	38,639,000	21,044,000	941,000	6,587,000	70,922,000	11,303,000	241,931,000
Placer County	11,884,000	2,170,000	945,000	—	1,994,000	2,706,000	1,504,000	21,203,000
<i>Plumas County (2013–14)</i>	<i>4,384,000</i>	<i>856,000</i>	<i>638,000</i>	<i>171,000</i>	<i>95,000</i>	<i>1,037,000</i>	<i>157,000</i>	<i>7,338,000</i>
Riverside County	35,653,000	20,341,000	11,370,000	3,238,000	14,916,000	28,525,000	6,578,000	120,621,000
Sacramento County	76,487,000	13,740,000	10,700,000	2,155,000	3,523,000	19,392,000	—	125,997,000

LOCAL MENTAL HEALTH AGENCIES	COMMUNITY SUPPORT	PREVENTION	INNOVATION	WORKFORCE TRAINING	CAPITAL FACILITIES	RESERVE	INTEREST	TOTAL
San Benito County	\$4,466,000	\$1,575,000	\$1,080,000	\$176,000	\$1,489,000	\$932,000	\$356,000	\$10,074,000
San Bernardino County	75,783,000	11,054,000	4,340,000	307,000	4,860,000	22,152,000	2,423,000	120,919,000
San Diego County	93,767,000	8,966,000	17,148,000	406,000	11,769,000	42,193,000	11,031,000	185,280,000
San Francisco County	13,303,000	343,000	3,848,000	—	—	4,325,000	597,000	22,416,000
San Joaquin County	6,896,000	9,525,000	5,041,000	1,233,000	5,573,000	11,655,000	1,998,000	41,921,000
San Luis Obispo County	8,285,000	1,448,000	1,375,000	158,000	—	2,813,000	667,000	14,746,000
San Mateo County	9,693,000	1,528,000	5,540,000	799,000	—	600,000	266,000	18,426,000
Santa Barbara County†	1,810,000	157,000	2,047,000	188,000	262,000	2,023,000	(30,000)	6,457,000
Santa Clara County (2014–15)	71,879,000	18,719,000	11,574,000	(45,000)	9,269,000	20,118,000	1,704,000	133,218,000
Santa Cruz County (2013–14)	4,241,000	3,409,000	720,000	265,000	2,748,000	3,470,000	530,000	15,383,000
Shasta County	4,083,000	2,985,000	2,524,000	22,000	465,000	—	45,000	10,124,000
Sierra County (2014–15)	2,315,000	1,100,000	370,000	20,000	542,000	607,000	1,665,000	6,619,000
Siskiyou County	1,705,000	582,000	1,055,000	153,000	—	940,000	236,000	4,671,000
Solano County	15,659,000	5,034,000	2,988,000	597,000	420,000	2,725,000	473,000	27,896,000
Sonoma County	3,412,000	1,631,000	551,000	—	—	905,000	106,000	6,605,000
Stanislaus County	18,408,000	4,513,000	2,520,000	144,000	868,000	500,000	—	26,953,000
Sutter-Yuba joint powers authority (2012–13)†	1,610,000	1,288,000	1,903,000	813,000	(267,000)	272,000	152,000	5,771,000
Tehama County	818,000	1,302,000	137,000	102,000	346,000	546,000	5,000	3,256,000
Tri-City joint powers authority	10,239,000	980,000	989,000	204,000	25,000	3,517,000	97,000	16,051,000
Trinity County	1,605,000	109,000	—	11,000	—	493,000	106,000	2,324,000
Tulare County	27,888,000	3,571,000	5,453,000	721,000	1,517,000	7,252,000	2,971,000	49,373,000
Tuolumne County	2,538,000	275,000	255,000	3,000	120,000	411,000	31,000	3,633,000
Ventura County	15,099,000	5,171,000	2,284,000	728,000	2,940,000	9,499,000	—	35,721,000
Yolo County (2014–15)	6,093,000	2,808,000	499,000	478,000	1,893,000	514,000	288,000	12,573,000
Totals	\$1,091,433,000	\$376,601,000	\$251,831,000	\$60,711,000	\$136,714,000	\$535,172,000	\$80,714,000	\$2,533,176,000

Sources: The local mental health agencies' MHPA annual reports for fiscal year 2015–16.

Note: As of December 2017, nine of the 59 local mental health agencies had yet to submit their fiscal year 2015–16 annual reports, and an additional three had not finalized their annual reports in response to Health Care Services' concerns. Therefore, we relied on prior years' annual reports for 12 local mental health agencies to complete this table as shown below:

FISCAL YEAR OF MOST RECENT ANNUAL REPORTS	LOCAL MENTAL HEALTH AGENCIES
2014–15	Kern County, Los Angeles County, Madera County, Santa Clara County, Sierra County, Yolo County
2013–14	Monterey County, Nevada County, Plumas County, Santa Cruz County
2012–13	Sutter-Yuba joint powers authority
2011–12	Lake County

* Mariposa County indicated that its past overspending of Community Support funding resulted in it reporting a negative total balance.

† We did not contact other local mental health agencies with negative balances in individual categories because their total balances were positive.

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JENNIFER KENT
Director

State of California-Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
Governor

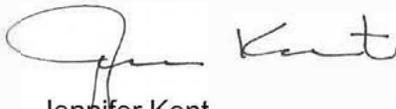
Ms. Elaine M. Howle*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Health Care Services (DHCS) hereby responds to the draft findings of the California State Auditor's (CSA) report entitled, *Mental Health Services Act: The State Could Better Ensure the Effective Use of Mental Health Services Act Funding*. The CSA conducted this audit and issued seven findings and seven recommendations.

DHCS disagrees with the CSA recommendation 6. DHCS agrees on all other recommendations and has prepared corrective action plans to implement them. Additionally, DHCS has feedback on other components of the draft audit report. DHCS requests CSA publish DHCS' comments in addition to the responses to the audit findings in the final published report. DHCS appreciates the work performed by the CSA and the opportunity to respond to the findings. If you have any questions, please contact Ms. Sarah Hollister, External Audit Manager, at (916) 650-0272.

Sincerely,



Jennifer Kent
Director

Enclosure

Ms. Elaine M. Howle
Page 2

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Department of Health Care Services' (DHCS) Response to the California State Audit report entitled *Mental Health Services Act: The State Could Better Ensure the Effective Use of Mental Health Services Act Funding 2017-117*

DHCS has not developed a process to recover unspent funds from Local Mental Health Agencies.

Finding #1: DHCS has not developed a process to recover unspent funds from Local Mental Health Agencies (LMHA). As a result, LMHA's have had less incentive to spend Mental Health Services Act (MHSA) funds on mental health programs in a timely manner and amassed unspent funds of \$231 million as of the end of fiscal year 2015-16 that DHCS might have been able to reallocate to other LMHA's.

Recommendation 1: DHCS should develop a MHSA fiscal reversion process to ensure that they can reallocate MHSA funds that LMHA's do not spend within the statutory reversion time frames to other LMHA's that are better positioned to use the funds to meet MHSA's intent.

Response: **DHCS agrees with the recommendation.**

DHCS agrees that a MHSA fiscal reversion process is necessary to reallocate MHSA funds that are not spent within the statutory time frame. DHCS is currently working with the State Controller's Office and the Department of Finance to develop the mechanism necessary to collect and redistribute funds subject to reversion. DHCS expects to have the mechanics developed by July 2018.

In addition, in Fiscal Year 2015-16, DHCS began collaborating with the Mental Health Services Oversight and Accountability Commission and the County Behavioral Health Directors Association of California to develop draft fiscal regulations, which also address reversion, among other relevant topics such as prudent reserve and accounting practices. By January 2019, DHCS intends to submit the public notice that announces these proposed regulations and initiates the 45-day public comment period to the Office of Administrative Law for publication in the California Regulatory Notice Register. ①

Furthermore, in accordance with Assembly Bill (AB) 114 (Chapter 38, Statutes of 2017), DHCS developed a fiscal reversion process for funds subject to reversion as of July 1, 2017. This includes all funds subject to reversion from Fiscal Year 2005-06 through Fiscal Year 2014-15. DHCS communicated the process to counties on December 28, 2017, in MHSUDS Information Notice No. 17-059. DHCS also developed an interim appeal process available to a ②

county regarding the determination of unspent funds. The process for determining unspent funds and the appeal process are included in the draft fiscal regulations.

Finding #2: In the absence of DHCS' guidance, LMHA's have not consistently spent the interest they have earned on MHA funds. As a result, they had accumulated an additional \$81 million in unspent MHA interest as of the end of fiscal year 2015-16.

Recommendation 2: DHCS should clarify that the interest the LMHA's earn on unspent MHA funds is subject to the same reversion requirements as the MHA funds they receive.

Response: **DHCS agrees with the recommendation.**

DHCS agrees that clarification should be provided to specify that interest earned on unspent MHA funds is subject to the same reversion requirements as the MHA funds they receive. The draft fiscal regulations that were developed in collaboration with the Mental Health Services Oversight and Accountability Commission and the County Behavioral Health Directors Association of California will provide the necessary clarification. By January 2019, DHCS intends to submit the public notice that announces these proposed fiscal regulations and initiate the 45-day public comment period to the Office of Administrative Law for publication in the California Regulatory Notice Register.

①

To meet the requirements of Assembly Bill (AB) 114 (Chapter 38, Statutes of 2017), DHCS recently applied the principles regarding interest that are in the draft fiscal regulations to calculate the amount of unspent funds subject to reversion. To perform these calculations, DHCS used the interest earned that was reported by counties on their Annual MHA Revenue and Expenditure Report. This process was detailed in MHSUDS Information Notice No. 17-059, which communicated that counties must spend funds allocated to Community Services and Supports, Prevention and Early Intervention, and Innovation components, plus interest earned on the MHA funds, within three fiscal years, including the fiscal year when the funding was made available. In addition, it stated that counties must spend funds allocated to Capital Facilities and Technological needs and Workforce Education and Training components, plus interest earned, within ten fiscal years, including the fiscal year when the funding was made available.

②

Finding #3: DHCS has neither established a formal process to maintain oversight of local MHA reserves—which totaled \$535 million as of the end of fiscal year 2015-16—nor required the LMHA's to adhere

to a standard reserve level. The California State Auditor estimates that LMHA's held between \$157 million and \$274 million in excessive reserves as of the end of fiscal year 2015-16.

Recommendation 3: DHCS should establish and enforce a MHA reserve level that will allow LMHA's to maintain sufficient funds to continue providing crucial mental health services in time of economic hardship but will not result in them holding reserves that are excessive. DHCS should also establish controls over LMHA's deposits and withdrawals to their reserves.

Response: **DHCS agrees with the recommendation.**

The fiscal regulations that DHCS has drafted in collaboration with the Mental Health Services Oversight and Accountability Commission and the County Behavioral Health Directors Association of California address prudent reserve, including the minimum levels of funding a county would be required to maintain, as well as a maximum level of funding a county would be permitted to maintain. The draft regulations clarify the requirements that must be met in order for a county to access their prudent reserve, and also specifies the process for counties to fund their prudent reserve using Community Services and Supports funding. By January 2019, DHCS intends to submit the public notice that announces these proposed regulations and initiates the 45-day public comment period to Office of Administrative Law for publication in the California Regulatory Notice Register. ①

While DHCS agrees with this recommendation, we do not agree with the calculation methodology that the California State Auditor used to develop the finding. During the development of the draft fiscal regulations, DHCS contracted with a fiscal consultant to produce an estimate of the maximum prudent reserve level. This estimate factored in declines in revenue, proposed expenditures, and inflation, and recommended between 64% and 82% for prudent reserve maximum level. The California State Auditor measured declines in funding over a ten-year period, but did not take into consideration expenditures or inflation. ③

Finding #4: Until the CSA's inquiry, DHCS had not analyzed whether an additional \$225 million in unspent MHA funds that existed since at least 2012 are potentially available to LMHA's to expand mental health services.

Recommendation 4: Health Care Services should complete its analysis of the \$225 million fund balance in the MHA Fund by May 1, 2018, to determine why this balance existed and, if there is any impact on funding to the local mental health agencies, distribute those funds accordingly.

Further, it should establish a process to regularly scrutinize the MHS Fund to determine the reasons for any excess fund balances.

Response: **DHCS partially agrees with the recommendation.**

- ④ The \$225 million identified by the CSA is the beginning and ending 2004 appropriation balance. By definition, an appropriation is "an authorization from a specific fund to a specific agency to make expenditures/incur obligations for a specified purpose and period of time" (also known as expenditure authority). During the Fiscal Year 2012-2013 transition of the former Department of Mental Health to the Department of Health Care Services, the State Controller's Office transferred the 2004 appropriation to DHCS, and also established a separate 2012 appropriation. On February 2, 2018, the State Controller's Office eliminated the 2004 appropriation balance of \$225 million. DHCS does not believe that any funds in this appropriation remain. DHCS will work with SCO and DOF to confirm this information and DHCS will revise its monthly reconciliation process to review all available appropriation and cross-check against available cash.

DHCS has provided only minimal oversight of the MHSA funds that local LMHA's receive.

Finding #5: DHCS has made minimal efforts to ensure that LMHA's submit their annual reports on time. As a result, some LMHA's have not submitted timely annual reports for years, hampering DHCS' ability to calculate MHSA reversion amounts and to properly oversee MHSA spending.

Recommendation 5: To ensure DHCS provides effective oversight of LMHA's reporting and spending of MHSA funds, DHCS should publish its proposed regulations in the California Regulatory Notice Register by June 2018. DHCS should then subsequently implement a process that will enable it to withhold MHSA funds from LMHA's that fail to submit their annual reports on time.

Response: **DHCS partially agrees with the recommendation.**

DHCS agrees that the MHSA fiscal regulations need to be published in the California Regulatory Notice Register; therefore, the regulations package is currently under active development. DHCS has several complex regulation packages currently under internal legal review and development. Due to the other regulatory workload, the Department estimates the regulations will be

submitted to the Office of Administrative Law no later than January 2019, thereby initiating the 45-day comment period. ①

To address the issue of untimely submission of the Annual MHSAs Revenue and Expenditure Reports, DHCS is developing a process for withholding funds, which is expected to include an appeal process, from counties that fail to submit the Annual MHSAs Revenue and Expenditure Report by the required submission date. DHCS will work with the State Controller's Office and the Department of Finance regarding the mechanism necessary to withhold funds from counties. DHCS expects to have the mechanics for withholding funds in place by July 2018.

Finding #6: DHCS has been slow to implement oversight of LMHA's MHSAs spending and programs. Although DHCS developed a MHSAs fiscal audit process in 2014, it has limited the audits' usefulness because it focused its reviews on data and processes at least seven years old.

Recommendation 6: To ensure that LMHA's appropriately report and spend MHSAs funds, DHCS should publish its proposed regulations in the California Regulatory Notice Register by September 2018. DHCS should then develop and implement a MHSAs fiscal audit process, independent of the Medi-Cal reviews, to review revenues and expenditures for the most recent fiscal year.

Response: **DHCS disagrees with the recommendation.**

DHCS does not agree that an MHSAs fiscal audit process should be developed and implemented independent of the Short Doyle Medi-Cal cost report audits (referred to above as the Medi-Cal reviews), nor do we agree that revenues and expenditures should be reviewed for the most recent fiscal year. Conducting fiscal audits of MHSAs funding separate from the cost report audits is problematic because the federal financial participation (FFP) has not yet been finalized. As such, it is impossible to determine final MHSAs expenditures if the FFP has not been finalized by an audit. Any action taken as a result of an MHSAs audit completed prior to the Short Doyle Medi-Cal cost report audit, which will extend beyond the most recent fiscal year, would be preliminary and subject to change. ⑤

That said, DHCS does agree that fiscal audits of county MHSAs funds are necessary. Accordingly, DHCS intends to draft an audit and appeal regulations package for the provision of fiscal audits and program oversight. DHCS expects to submit the public notice that announces these proposed regulations and initiates the 45-day public comment period to the Office of Administrative Law for

- ⑥ publication in the California Regulatory Notice Register by Spring 2019.
-

Finding #7: DHCS has not developed regulations to establish an appeals process for LMHA's to challenge findings. In addition, DHCS has not implemented a program review process to evaluate the effectiveness of the MHSA projects that LMHA's operate.

Recommendation 7: To ensure that LMHA's comply with their performance contracts and MHSA requirements, DHCS should establish a process for conducting comprehensive program reviews and begin conducting those reviews by July 2018.

Response: **DHCS agrees with the recommendation.**

DHCS has drafted a protocol and process for conducting program reviews of county performance contracts and MHSA requirements. DHCS has hired four staff to conduct onsite program reviews, who were deployed in January 2018. It is expected that these staff will pilot the review protocol and process in four to six more counties before fully operationalizing the program reviews. DHCS expects to fully implement this recommendation in September 2018.

DHCS Response to CSA Audit Report Text
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PAGE	TEXT	COMMENT	PROPOSED AMENDED LANGUAGE
3, 14	<p>Finally, until our inquiry, Health Care Services has not analyzed whether an additional \$225 million in unspent MHSA funds, which have existed since at least 2012, are potentially available to local mental health agencies to expand mental health services.</p>	<p>The CSA identified a \$225 million appropriation balance that the State Controller’s Office (SCO) transferred from the former Department of Mental Health (DMH) to DHCS in 2012. This statement is internally inconsistent. It first references \$225 million in unspent funds. This indicates that the CSA identified \$225 million in the MHSF that is unspent. That is not a true statement. An appropriation of funds is not the same as having the cash available to spend. An appropriation provides the Department with the authority to spend funds. This sentence then goes on to say that those funds are potentially available to local mental health agencies. This part of the sentence seems to back off of the idea that the funds are available to spend by saying that the funds are potentially available to local mental health agencies to expand local mental health services.</p>	<p>Finally, until our inquiry, Health Care Services had not analyzed whether a \$225 million appropriation balance from the Mental Health Services Fund is available to distribute to local mental health agencies to expand mental health services.</p>

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DHCS Response to CSA Audit Report Text
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PAGE	TEXT	COMMENT	PROPOSED AMENDED LANGUAGE
⑩ 4 and 27	In addition, Health Care Services has not implemented a program review process to evaluate the effectiveness of the MHSA projects that local mental health agencies operate.	DHCS is not responsible for evaluating the effectiveness of MHSA programs. Effectiveness refers to whether or not a particular intervention produces the desired results. DHCS would need to engage a researcher to design a study to evaluate whether or not a particular intervention produced the desired result. In 2016, DHCS became responsible to ensure that local mental health agencies comply with the MHSA program requirements contained in statute, regulation, and the performance contract.	In addition, Health Care Services has not implemented a program review process to ensure MHSA projects that local agencies operate comply with program requirements contained in statute and regulation.
⑪ 8	Health Care Services explained that to incentivize local mental health agencies to make full use of their MHSA funding allocations, state law requires that any funds left unspent within statutory time frames must be returned – or reverted – to the State for reallocation to the local mental health agencies.	DHCS did not write the Proposition and is not in a position to say that the reversion clause in state law was intended to incentivize local mental health agencies to make full use of their MHSA funding allocations. Implementation of the reversion process alone may not solve the problem of counties having large amounts of unspent PEI and INN component funds.	Health Care Services explained that it believes the requirement in state law that any funds left unspent within statutory time frames must be returned – or reverted – to the State for reallocation to the local mental health agencies provides local mental health agencies with an incentive to make full use of their MHSA funding allocations.

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PAGE	TEXT	COMMENT	PROPOSED AMENDED LANGUAGE
		<p>Unless action is taken to better understand and address the issues associated with the lack of county spending for the PEI and INN components, a large portion of these funds will continue to indefinitely cycle through the reversion process because reverted funds are mandated to be reallocated to the component from which they originated, as per Assembly Bill 114 (Chapter 38, Statutes of 2017).</p>	
10	<p>For example, state law requires Health Care Services to calculate the MHSA fund allocations for each local mental health agency using a formula based on several factors...</p>	<p>This sentence implies that the law prescribes the factors DHCS uses to calculate the fund allocations, which is not accurate. The statute only requires DHCS to provide the SCO an allocation schedule. It does not prescribe factors to include in developing that allocation schedule.</p>	<p>For example, state law requires Health Care Services to provide the SCO an allocation schedule that the State Controller uses to calculate fund allocations.</p>
11-12	<p>Since fiscal year 2012-13, Health Care Services has annually spent between \$7.9 million and \$8.6 million to implement its oversight responsibility. Specifically, in fiscal year 2015-16, Health Care Services spent \$7.9 million for staff</p>	<p>This statement is misleading. During FY 2015-16, DHCS expended \$8.4 million in MHSA administrative funds. Of these funds, \$4.1 million was used to support training and technical assistance provided by a</p>	<p>Since fiscal year 2012-13, Health Care Services has annually spent between \$7.9 million and \$8.6 million to administer the MHSA. Specifically, in fiscal year 2015-16, Health Care Services spent \$8.4 million in administrative funds. \$4.1</p>

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DHCS Response to CSA Audit Report Text
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PAGE	TEXT	COMMENT	PROPOSED AMENDED LANGUAGE
	salaries, contracts, and operating expenses.	contractor; \$800,000 was used to collect mental health questions included as part of the California Health Information Survey. The balance of funding was used to support staffing and operating expenses for the Department and the California Mental Health Planning Council.	million was used to administer training and technical assistance to county mental health departments and community mental health providers; \$800,000 was used to support the collection of mental health data as part of the California Health Information Survey. Remaining funds were used to support staffing and operating expenses for the Department and the California Mental Health Planning Council.
14 16	Absent an incentive to spend their MHA funds in a timely manner, local mental health agencies had accumulated \$2.5 billion in unspent MHA funds as of fiscal year 2015-16.	This statement is misleading. It follows a discussion of reversion being the incentive to spend MHA funds timely. This statement implies that the lack of a reversion process has produced \$2.5 billion of unspent funds. The report goes on to state that local mental health agencies should have returned \$231 million to the state because they did not spend it within required time frames. Reversion only impacts the \$231 million and has no impact on the other portion of the \$2.5 billion.	DHCS recommends deleting this sentence.

DHCS Response to CSA Audit Report Text
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PAGE	TEXT	COMMENT	PROPOSED AMENDED LANGUAGE
17	According to Health Care Services, examples of competing priorities included administering MHSAs revenue and expenditure reports, developing performance contracts with local mental health agencies, implementing a state-level suicide prevention program, and responding to external reviews.	DHCS did not implement a state-level suicide prevention program. DHCS staff responded to requests for information and participated in work groups that focused on suicide prevention, student mental health, and veteran's mental health. DHCS was also responsible for developing the Suicide Hotline Report in 2016.	According to Health Care Services, examples of competing priorities included administering MHSAs revenue and expenditure reports, developing performance contracts with local mental health agencies, serving as a subject matter expert for suicide prevention workgroups or activities, developing the Suicide Hotline Report, and responding to external reviews.
20	Health Care Services' delay in developing regulations regarding the interest on MHSAs funds has allowed local mental health agencies to amass a growing balance of interest earnings that Health Care Services should have directed them to use to fund MHSAs programs.	DHCS recommends that the CSA report clarify that interest earned on MHSAs funds is included in the \$231 million subject to reversion. This section implies that in addition to the \$231 million subject to reversion, counties are amassing revenue earned from interest on MHSAs funds.	
20	Further, because their MHSAs reserves are not subject to reversion requirements, local mental health agencies can currently direct any unspent MHSAs funds at the end of a fiscal year into their reserves to shelter the funds from reversion.	This statement is not accurate. Statute clearly states that local mental health agencies may only transfer CSS funds into the prudent reserve. Therefore, local mental health agencies may not transfer PEI, INN, Workforce Education and Training component, or Capital Facilities and Technological	Further, because their MHSAs reserves are not subject to reversion requirements, local mental health agencies can currently direct any unspent MHSAs funds allocated to the Community Supports component into their reserves to shelter the funds from reversion.

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DHCS Response to CSA Audit Report Text
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PAGE	TEXT	COMMENT	PROPOSED AMENDED LANGUAGE
		Needs component funds into the prudent reserve to shelter them from reversion.	
⑰ 23	Health Care Services has not exercised appropriate oversight of the MHS fund balance under its authority, which totals \$225 million, to determine the reason for this fund balance and whether any of this amount is due to local mental health agencies.	DHCS believes this statement is about the \$225 million appropriation balance rather than the MHS fund balance. This statement is not accurate as written.	Health Care Services had not exercised appropriate oversight of the MHS appropriation balance under its authority.
⑨ 23-25	Health Care Services was Unaware of additional MHSA Funds of \$225 million that are Potentially Available to Local Mental Health Agencies	This section of the report is misleading and should be rewritten. The heading should say that Health Care Services was unaware of a \$225 million reserve for unencumbered balances of continuing appropriations. The report should explain what this accounting term means to the lay audience. The report should be careful to not mislead the reader to believe that the MHS Fund balance contains \$225 million that can be distributed to local mental health agencies.	
⑱ 30-31	Health Care Services has been slow to begin conducting local MHSA fiscal audits and program reviews despite having had the	DHCS does not believe it had the funding to begin conducting program reviews until Fiscal	

DHCS Response to CSA Audit Report Text
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PAGE	TEXT	COMMENT	PROPOSED AMENDED LANGUAGE
	authority and the funding to fulfill these responsibilities.	Year 2016-17 with the No Place Like Home legislation.	
32-33	Although the law took effect in 2016, Health Care Services has yet to establish a schedule of program reviews and does not anticipate beginning the program reviews until July 2018 at the earliest. However, Health Care Services indicated that it needs to first develop the review process and hire and train staff.	This statement about hiring and training staff isn't accurate. DHCS has hired staff. DHCS is finalizing the review protocol.	

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COMMENTS

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

To provide clarity and perspective, we are commenting on the response to our audit from Health Care Services. The numbers below correspond to the numbers we have placed in the margin of Health Care Services' response.

We are disappointed that Health Care Services now states that it intends to submit its proposed regulations to the Office of Administrative Law to begin the process of establishing regulations by January 2019. As recently as January 2018 Health Care Services stated to us that it intended to submit its regulations for review by June 2018. Moreover, as we state on page 13 Health Care Services has spent from \$7.9 million to \$8.6 million annually over the past four fiscal years to administer the MHSA, and has had statutory authority to develop necessary regulations since 2012. However, it only began drafting these regulations in 2016. Given the funding it has received and the amount of time that has elapsed since it became responsible for developing these regulations, we believe Health Care Services should already have taken appropriate action to implement a reversion process.

①

Although Health Care Services agrees with our recommendation, its response confuses the issue by making reference to its December 2017 Information Notice No. 17-059. Health Care Services acknowledges in its response that it only developed the fiscal reversion process in response to the 2017 change in state law and that it is an interim process that does not apply to MHSA funds subject to reversion after July 1, 2017.

②

We stand by our conclusion that Health Care Services' consultant's range of between 64 percent and 82 percent for prudent reserve maximum level is excessive when compared to the MHSA revenue trends. State law requires local mental health agencies to maintain a prudent reserve to ensure services are not reduced in years when revenues decline below the average of previous years. As we state on page 17, over the past 10 fiscal years we identified 33 percent as the worst decline in this revenue to the local mental health agencies in any one fiscal year, while the average decline—for fiscal years in which declines occurred—was 23 percent. Even adjusting the MHSA decline in revenue for inflation during this time period resulted in nominal changes and far below the consultant's proposed minimum of 64 percent. Specifically, adjusting for inflation over the past 10 years, we identified 33 percent as the

③

worst decline in funding and 22 percent as the average decline. Our calculation did not include MHSA expenditures because, as indicated above, state law contemplated declines only in MHSA revenues when establishing a prudent reserve.

- ④ Health Care Services' response does not clarify the key issues related to the \$225 million MHS Fund balance that has existed since at least 2012. As we state on page 20, there is uncertainty as to whether the fund balance represents cash that it could distribute to local mental health agencies or a long-standing accounting error that Health Care Services failed to identify and correct. Therefore, we stand by our recommendation that Health Care Services needs to complete its analysis of the fund balance by May 1, 2018, to determine why this balance existed and if there is any impact on funding to the local mental health agencies. Further, it should establish a process to regularly scrutinize the MHS Fund balance to determine the reasons for any excess fund balance.
- ⑤ We stand by our recommendation that Health Care Services should develop and implement a meaningful MHSA fiscal audit process, independent of the Medi-Cal reviews, to review revenues and expenditures for the most recent fiscal year. Health Care Services made a decision regarding the focus of its fiscal audits that has significantly limited their value and relevance for assessing fiscal controls over the current operations of local mental health agencies. Specifically, as we state on pages 24 to 25, Health Care Services decided to conduct its MHSA fiscal audits in conjunction with its Medi-Cal reviews. However, the backlog of overdue Medi-Cal cost reports has resulted in Health Care Services focusing on significantly outdated data and processes. For example, its Medi-Cal review of San Diego County (San Diego) focused on fiscal year 2008–09 MHSA funding. Thus, the audit's findings and recommendations would be of limited value given the age of the information under review. Moreover, as we state on page 25, Health Care Services acknowledged to us that performing fiscal audits on more recent fiscal years may be needed to ensure more relevant reviews and findings of controls over MHSA funds.
- ⑥ We are concerned that Health Care Services now intends to wait until Spring 2019 to submit its proposed regulations for fiscal audits. As recently as February 2018 Health Care Services stated to us that it intended to submit its regulations for review by September 2018. Moreover, as we state on page 13, Health Care Services has spent from \$7.9 million to \$8.6 million annually over the past four fiscal years to administer the MHSA, and statutory authority to develop necessary regulations for all of these years. Given the funding it has received and the amount of time that has elapsed since it became responsible for developing these regulations, we believe Health Care Services should already have taken appropriate action to implement a fiscal audit process.

During the publication process for the audit report, page numbers shifted. Therefore, the page numbers cited by Health Care Services in its response may not correspond to the page numbers in the final published audit report.

⑦

Health Care Services' inclusion of suggested wording changes in its response to the audit is both surprising and disappointing. As we do in all audits, we provided Health Care Services a five-day period to review and comment on a draft copy of the report, and we asked that if it had any concerns with the text to contact us. However, despite multiple contacts with Health Care Services during this period, including a phone conference to discuss the issue of the fund balance in the MHS Fund, Health Care Services failed to share with us its concerns on the draft report text. However, we carefully considered Health Care Services' comments and suggested text changes, and made changes that we believed were appropriate based on the evidence we obtained during the audit. Further, for several changes that Health Care Services suggested that were related to the issue on the fund balance in the MHS Fund, we had already informed it during the phone conference that we would be making the changes based on information that we received from Health Care Services and the State Controller during the five-day review period.

⑧

We had previously informed Health Care Services that we were changing the text related to the issue of the fund balance in the MHS Fund during the five-day review period.

⑨

We agree with Health Care Services' proposal, and we changed the text as appropriate.

⑩

Although our sentence as originally written was based on testimonial evidence that Health Care Services provided during the audit, we revised the text as Health Care Services proposed because in its response it provided us with a different perspective.

⑪

We clarified our text to more precisely mirror state law. However, the text that Health Care Services proposes is incorrect as state law specifically states that Health Care Services must provide an allocation *methodology* to the State Controller, not an allocation *schedule*.

⑫

We do not believe that the additional detail Health Care Services proposes is necessary. Further, Health Care Services' assertion that its expenditures were \$8.4 million incorrectly includes \$477,000 for the operations of the Mental Health Planning Council, which is a separate entity. Therefore, we stand by our statement that Health Care Services spent \$7.9 million for its staff, salaries, contracts, and operating expenses in fiscal year 2015–16.

⑬

- ⑭ We disagree with Health Care Services' proposed deletion of the sentence, and we do not believe our statement is misleading. Local mental health agencies would not have accumulated \$2.5 billion in unspent MHSA funds if Health Care Services had ensured they returned the \$231 million they failed to spend in the appropriate time frame and if it had established a reasonable reserve level for local mental health agencies to follow.
- ⑮ Although Health Care Services included some MHSA interest in its calculation of the \$231 million that was subject to reversion as of fiscal year 2015–16, its response does not address our concern that it has not established guidance for the local mental agencies on the proper treatment of MHSA interest. As a result, local mental health agencies reported having accumulated \$81 million in interest earned on MHSA funds through fiscal year 2015–16.
- ⑯ We edited the text to change “any” to “Community Support.”
- ⑰ We disagree with Health Care Services' proposed change and its assertion that the issue is about “appropriation balance” rather than “fund balance.” According to the State Controller's accounting records, the \$225 million is included in fund balance of the MHS Fund. Because the \$225 million remained in fund balance since Health Care Services assumed significant responsibility for the MHSA in 2012, the nature of this amount is unknown until Health Care Services performs the appropriate research to determine whether the amount represents funds available to local mental health agencies or a long-standing accounting error.
- ⑱ Health Care Services did not identify the lack of funding as a reason for its delay in implementing a comprehensive MHSA program review process until submitting its response to this audit. In fact, as we indicate on page 25, although a 2016 change in state law required Health Care Services to conduct these program reviews, it has not established a schedule of program reviews and does not anticipate beginning the program reviews until July 2018 at the earliest. Moreover, Health Care Services indicated to us during the audit that it first needs to develop the review process before it can perform the program reviews.
- ⑲ Although our sentence as originally written was based on testimonial evidence that Health Care Services provided during the audit, we revised the text as Health Care Services has proposed because in its response it provided us with a different perspective. Nevertheless, as indicated in our prior comment, although Health Care Services may have hired staff to conduct MHSA program reviews, it has not established a schedule of program reviews and it has not developed a review process.



STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor



WELLNESS • RECOVERY • RESILIENCE

JOHN BOYD, PsyD
Chair

February 9, 2018

KHATERA ASLAMI-TAMPLEN
Vice-Chair

Elaine M. Howle, CPA, State Auditor
California State Auditor
621 Capital Mall, Suite 1200
Sacramento, CA 95814

RENEETA ANTHONY
Commissioner

MAYRA ALVAREZ
Commissioner

LYNNE ASHBECK
Commissioner

Re: Response to State Audit Report 2017-117

JIM BEALL
Senator
Commissioner

Dear Ms. Howle:

BILL BROWN
Sheriff
Commissioner

The Mental Health Services Oversight and Accountability Commission respectfully submits the following response to the draft of the State Audit Report 2017-117. Please convey our appreciation to your audit team for its hard work and professionalism in preparing this report.

KEYONDRIA D. BUNCH, Ph.D.
Commissioner

ITAI DANOVITCH, M.D.
Commissioner

Overall Response

DAVID GORDON
Commissioner

The Commission appreciates the fundamental finding that the Commission is implementing processes to evaluate the effectiveness of the Mental Health Services Act (MHSA) and acknowledges that more can be, and is being done, to improve our efforts.

GLADYS MITCHELL
Commissioner

Response to Specific CSA Recommendations

LARRY POASTER, Ph.D.
Commissioner

MARA MADRIGAL-WEISS
Commissioner

The first recommendation concerns the Commission's continuing efforts to support local mental health agencies to develop, implement, evaluate, and disseminate learnings from robust Innovation projects. The Commission agrees that it is important for local agencies and the Commission to have a shared understanding of the goals of the Innovation component. We are committed to an ongoing process of engagement with county agencies and with stakeholders to improve awareness of Innovative project proposals, approvals, and evaluation results.

TINA WOOTON
Commissioner

TOBY EWING
Executive Director

Elaine M. Howle, CPA
Response to State Audit Report 2017-117
Page 2 of 2

The second recommendation concerns the Commission's ongoing efforts to work with county agencies to assess and improve investments in Prevention and Early Intervention (PEI) programming. The Commission agrees with the recommendation that the Commission continue to develop and strengthen its processes for reviewing and analyzing the impact of PEI services. Consistent with that recommendation, Commission staff are providing support to a statewide learning community among county agencies. The first meeting of this learning community, scheduled for March 1, 2018, will focus on policies, procedures, and strategies for counties to gather, report, and evaluate data collected to meet the PEI annual reporting requirements.

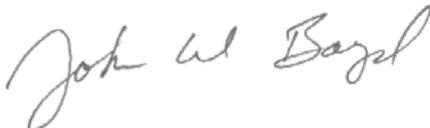
The Commission cautions that a July 2018 deadline for the Commission to "finalize" its internal processes in this area may not be feasible, recognizing that we anticipate delays in receiving county reports and that the Commission's analyses of those reports likely will evolve over time.

The third recommendation relates to the statewide evaluation of triage grants. The Commission agrees with the recommendation that our evaluation strategy should include the development of statewide metrics. In January, the Commission authorized \$10 million to contract with a third party to perform statewide evaluations of the triage grants.

The evaluator will work closely with grantees and Commission staff to devise evaluation strategies that will yield important statewide value while still serving the needs of local decision-makers. Recognizing the complexity of this charge, it may not be feasible to establish shared metrics for all triage grants by July 2018. The Commission does expect that a clear evaluation strategy will be in place for each grant prior to July 2019.

Thank you again for the opportunity to provide feedback on the draft report. The Commission is very appreciative of the thorough nature of your staff's engagement in preparation of this work. Most importantly, we agree that state and local agencies can and should do better in service to the people of California.

Respectfully,



John Boyd, PsyD
Chair



ALCOHOL, DRUG & MENTAL HEALTH SERVICES
CAROL BURTON, MSW, INTERIM DIRECTOR

2000 Embarcadero Cove, Suite 400
Oakland, California 94606
(510) 567-8100 / TTY (510) 533-5018

February 9, 2018

Dear Ms. Elaine Howle, California State Auditor,

Enclosed is Alameda County's response to the draft audit report, titled "Mental Health Services Act: The State Could Better Ensure the Effective Use of Mental Health Services Act Funding".

If you have any questions please feel free to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Tracy Hazelton". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Tracy Hazelton, MPH
MHSA Division Director
Alameda County Behavioral Health Care Services Agency
510-639-1285 Tracy.Hazelton@acgov.org

CC: Colleen Chawla, HCSA Director
Carol Burton, BHCS Interim Director
James Wagner, BHCS Deputy Director



Alameda County's Audit Response

Auditor's Recommendations:

To strengthen its monitoring of MHSA projects and ensure it spends MHSA funds appropriately, Alameda should develop and implement MHSA program monitoring guidelines to ensure staff appropriately perform and document their monitoring activities.

Alameda County's Response:

Alameda County agrees with the auditor's comments. We will develop and implement MHSA program monitoring guidelines by having each MHSA program contract manager document the policies and procedures currently used to monitor their respective MHSA programs by June 30, 2018. We will then consolidate these documents into one user manual that will be available to all staff members via our website in FY 18/19. Revisions to the users' manual will be made as needed to ensure the manual is current at all times. The staff will be advised of all revisions.

