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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

August 7, 2013

MHSD INFORMATION NOTICE NO.:13 - 15

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: MENTAL HEALTH SERVICES ACT: METHODOLOGY FOR DISTRIBUTIONS TO LOCAL MENTAL HEALTH SERVICES FUND

REFERENCE Welfare and Institutions Code Sections 5891 and 5892,
Information Notice No.: 08-36 MHSA Planning Estimates for FY 2009-10,
Letter No.: 05-02 Planning Estimates for MHSA Community Services and Supports

The purpose of this Information Notice is to provide the methodology used to determine the distribution of Mental Health Services Act (MHSA, Act) funds to each Local Mental Health Services Fund.

Per Welfare and Institutions Code (W&I) Section 5891, the State Controller's Office (SCO) will distribute MHSA funds to each Local Mental Health Services Fund. The amount of MHSA funds distributed monthly to each Local Mental Health Services Fund in Fiscal Year (FY) 2013-14 will be based upon the same percentages used to distribute funds in FY 2011-12 and FY 2012-13 (Enclosure 1). The SCO Remittance Advice will not include the amount of funding associated with each component, since MHSA funds are no longer distributed through Component Allocations; rather, it is the county's responsibility to ensure that funds are expended in accordance with the requirements of the Act. It is also the responsibility of the county to ensure compliance with the provisions of the MHSA, including section 5892, subdivision (f):

> Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The local Mental Health Services Fund balance shall be invested consistent with other county funds, and the interest earned on investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future years.

Accordingly, the county should transfer all interest earned on investments of local mental health services funds back into its local Mental Health Services Fund. Interest income may only be spent on MHSA activities per an approved plan or update[1]. All interest is to be reported on the county's annual Revenue and Expenditure Report (RER), per WIC section 5899.

Because the funding distributed each month is based on actual deposits into the Mental Health Services fund, the amount distributed monthly will fluctuate. The May 2013 MHSA revenue estimates are available in the MHSA Expenditure Report, pages 2 and 3, at: http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Mental%20Health/MHSA_MayExpendReport.pdf. Please note that on March 13, 2013, the Department of Finance updated the MHSA Estimated Receipts Annual Adjustment Amount for FY 2011-12 from $278.0 million to $153.5 million.

Methodology for Distribution of Funds

The basis for the FY 2013-14 allocation percentages resulted from a methodology developed in FY 2005-06 by the former Department of Mental Health, in consultation with the California Mental Health Director's Association (CMHDA). This methodology was updated in FY 2008-09 with the most current data at that time, per Information Notice 08-36. The criteria and data sources that were used to develop the percentage of funds that each county received are:

1) The need for mental health services in each county based on total population of each county on January 1, 2008, according to the State of California, Department of Finance, *E-1 City/County Population Estimates, with Annual percent Change, January 1, 2007 and 2008.* Sacramento, California, May 2008 (weighted at 50%);
2) Population most likely to apply for services (weighted at 30%)
    a. The poverty population, defined as households with incomes below 200% of the federal poverty level, according to the 2000 U.S. Census Bureau survey and updated to reflect the 2008 population; plus,
    b. The uninsured population (persons who did not have insurance at any time in the past year and persons who had insurance only part of the past year) with incomes above 200% of the federal poverty level, as determined by the 2005 California Health Interview Survey (CHIS) based at UCLA Center for Health Policy Research in Los Angeles, California;

[1] Welfare and Institutions Code § 5892 (g)

3) Population most likely to access services, which represents the prevalence of mental illness among different age groups and ethnic populations of poverty households in each county as estimated through a study conducted by Dr. Charles Holzer, Ph.D., in 2000. The 2000 results were updated to reflect the 2008 population (weighted at 20%);

Adjustments were made to the need for mental health services in each county based on:

a. The cost of being self-sufficient relevant in each county relevant to the statewide average as reported through *The Self-Sufficiency Standard for California 2003,* December 2003, a project of the National Economic Development and Law Center. A weighted average of households with one single childless adult (67%) and a single adult with two children (33%) was used to develop the adjustment (weighted at 40%);
b. Other non-MHSA resources available to the county in FY 2008/09 (1991 Realignment funding, State General Fund managed care allocations, other State General Fund community services allocations such as AB 3632 funding, federal Substance Abuse Mental Health Services Act (SAMHSA) block grants, federal Projects for Assisting the Homeless (PATH) grants, FY 2005/06 Early and Periodic Screening Diagnosis and Treatment (EPSDT) State General Funds, and the FY 2008/09 Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) Component Allocations. (Medi-Cal federal financial participation is excluded) (weighted at 20%).

Additionally, to provide a minimum level of funding for less populous counties, a minimum Component Allocation was established for each component based on recommendations from CMHDA. The minimum Component Allocation represented the minimum amount of funding to be made available to each county should the formula described above result in a lower amount.

1. Community Services and Supports: $250,000 is the minimum amount available to each county with a population of less than 20,000; $350,000 is the minimum amount available to all other counties;

2. Prevention and Early Intervention: $100,000 is the minimum amount available to each county;

3. Innovation: No minimum amount. Component Allocations for INN were based on the relative share of total CSS and PEI Component Allocations provided to each county, in order to be consistent with Welfare and Institutions Code § 5892(a)(6), in which funding utilized for innovative work plans is a proportion of CSS and PEI funding.

The Component Allocations for the two city-operated programs (Tri-City and the City of Berkeley) were based solely on the percent of statewide population in the area served by each city in 2007.

Allocation Methodology for Future Fiscal Years

Beginning in FY 2013-14, DHCS will review the allocation methodology, in consultation with the Mental Health Services Oversight and Accountability Commission and CMHDA, to determine if updates to the methodology are needed.

Sincerely,

Original signed by

TOBY DOUGLAS
Director

Enclosure