May 12, 2020

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Re: Coalition Request for Flexibility with Mental Health Service Act Requirements to Address COVID-19 Public Health Crisis

Dear Secretary Ghaly, Director Gilbert, Director Ewing, President pro Tem Atkins, Speaker Rendon, Chair Mitchell and Chair Ting:

In the weeks following the COVID-19 pandemic, many of the undersigned organizations weighed in with varying proposals for ways to modify the Mental Health Services Act (MHSA) to address the needs of public behavioral health clients and communities during this public health emergency. Following broad stakeholder engagement, the undersigned organizations have agreed to offer the following recommendations for temporary changes to the MHSA rules and requirements as consensus recommendations provided for consideration as part of executive and legislative action. We believe these recommendations balance the counties' need for immediate flexibility and the clients' and communities' needs for consumer input, transparency, and accountability. These are necessary actions in the immediate time frame to ensure vital mental health services reach those most in need during the pandemic.

With an unprecedented and evolving public health crisis continuing to unfold, the need for behavioral health services is growing. Recently the Kaiser Family Foundation reported:

- Recent data showing that a significantly higher portion of people who were sheltering in place (47%) reported negative mental health effects resulting from worry or stress related to coronavirus, including 21% who reported a major negative impact on their mental health.
- Negative mental health effects due to social isolation may be particularly pronounced among older adults and households with adolescents, as these groups are already at risk for depression or suicidal ideation.
- Fifty-four percent of those who recently lost income or employment reported negative mental health impacts from worry or stress over coronavirus, including 26% who reported major negative impacts on their mental health.

The pandemic has also caused innumerable obstacles for counties to secure and expend MHSA funds. The MHSA is the second largest source of funding for the public behavioral health delivery system after federal financial participation, and along with federal match leveraged with MHSA funds, represents one out of every five dollars spent by counties in Medi-Cal. Currently, the MHSA leverages close to one billion dollars in funding for Medi-Cal. Given the significance of MHSA funds within Medi-Cal and more broadly to fund those services not funded by Medicaid, such as prevention services and the "whatever it takes" approaches to addressing serious mental illness, these recommendations are crucial to the state's response to Californians' mental health needs during and after the pandemic.

The undersigned coalition represents counties, consumers, family members/caregivers, community-based organizations, providers, advocates, and other key behavioral health stakeholders that should be part of any MHSA decision-making. In outlining coalition proposals on MHSA flexibility, the undersigned coalition ensured the attached overarching guiding principles served to guide these recommendations. These guiding principles include:

- The MHSA must continue to be guided by the MHSA General Standards (Community Collaboration; Cultural Competence; Client Driven; Family Driven; Wellness, Recovery, and Resilience Focused and Integrated Service Experience) 9 CCR § 3320.
- Services must continue to be driven by clients, family members, and those with lived experience; and the unserved, underserved, and hard to reach populations must remain a focus.
- Local control and fund allocation are crucial to ensure programs and services are designed to meet the needs of the unique and diverse populations across the state.
- California must support a public mental health system that does not require people to deteriorate before receiving services.
- The MHSA must retain the voluntary nature of services that the Act is based upon.
- The local Community Planning Process is a foundation of the MHSA and must remain a key foundation of service planning and delivery.
- Reducing disparities must remain a priority.

With these guiding principles in mind, the undersigned organizations urgently request collaboration to implement the orders, statutory and regulatory changes necessary to ensure we can leverage MHSA funds to more appropriately respond to the challenges associated with COVID-19:

- **Flexibility in Accessing Prudent Reserves:** The Department of Health Care Services (DHCS) has informed stakeholders that they intend to finalize proposed revised financial regulations released in February 2020. Under the proposed regulations, counties can spend down prudent reserves only if: DHCS determines revenues for the Mental Health Services Fund (MHSF) are below the average of the five (5) previous fiscal years; or a county's projected allocation of funds for the Community Services and Support (CSS) Account is not sufficient to continue to serve the same number of individuals in CSS, as specified. The county's projected allocation for the CSS Account must be based on projected revenues in the Governor's Budget.

  The hurdles a county must circumvent to access prudent reserves are highly problematic under the current circumstances when county MHSA monthly distributions are projected to plummet in the current fiscal year due to the economic downturn and the deferral of the tax filing deadline. Although some of this revenue will be reinstated in the next fiscal year, the impact of the economic downturn will result in a projected 25% reduction in MHSA revenue, which will be compounded by the loss in federal matching funds leveraged using MHSA funds.

  - *The coalition requests broad flexibility to allow immediate access to prudent reserves if monthly distributions are significantly below anticipated levels. Counties would be authorized to access prudent reserves if MHSA monthly distribution levels decrease by 7.5% or more.*

- **Flexibility to Move Funds Within Components and Between Components, With Limitations:** In the upcoming months, counties and local stakeholders participating in the MHSA Community Program Planning Process and Local Review Process will need to make difficult financing and programmatic decisions. These choices are still more difficult because of the rigidity in MHSA funding distributions for different MHSA components. MHSA dictates funding levels for each component including:

  1. Community Services and Supports (CSS) - 76% of Revenue
  2. Prevention and Early Intervention (PEI) - 19% of Revenue
  3. Innovation (INN) - 5% of Revenue

  (These distributions take into account the MHSA funds allocated for state administration and oversight.)

Additionally, *within* many of the components existing funding mandates limit flexibility in responding to the expected economic crisis and maintaining core services for those most in need. For example, the MHSA places limits or a cap on the amount of CSS funding that can be used for capital and workforce components – both which are vital in addressing community needs during the pandemic.

Unless counties and local MHSA stakeholders are granted the flexibility to make funding decisions which align with the significant changes in service delivery and overall funding needs, as MHSA funds decline, counties and local MHSA stakeholders will be forced to make unreasonable funding decisions. MHSA local plans, for example, may be required to expend MHSA funding to implement a new Innovation program, while at the same time, reducing services for existing CSS clients with serious mental illness or existing effective PEI programs; or counties may be unable to address critical workforce or capital needs directly related to the aftermath of COVID-19 response because diminishing CSS funds are unavailable.

- *The coalition requests flexibility for distributing MHSA funds within components and service categories funded by CSS to meet local needs in response to COVID-19. (See WIC § 5892(b)(1); 9 CCR § 3615.) Distributing MHSA funds within components and service categories funded by CSS will continue to be made in accordance with the MHSA's Community Program Planning Process and Local Review Process, as outlined by statute and regulation.*

- *The coalition requests flexibility for distributing MHSA funds within program categories funded by PEI to meet local needs in response to COVID-19. (See 9 CCR § 3706.) Distributing MHSA funds within PEI program categories will continue to be made in accordance with the MHSA's Community Program Planning Process and Local Review Process, as outlined by statute and regulation, and described in greater detail below.*

- *The coalition also requests flexibility in using unallocated INN funds to maintain CSS and PEI services as MHSA funds decrease. Furthermore, the coalition requests the ability to use funds subject to reversion at the end of the current fiscal year to fund gaps caused by the decline in MHSA funds. The use of INN funds to support existing CSS and PEI services and the use of retained funds that were subject to reversion will be made in accordance with local stakeholder engagement and approval processes, as outlined by statute and regulation.*

- *For those counties that decide to retain INN funds in the INN component, the coalition further requests the adoption of a simplified and expedited process for review and approval of new INN plans for programs specifically designed to improve or enhance direct response to the COVID-19 crisis and its impacts.*

- *PEI funds are used to serve California's traditionally unserved, underserved, and inappropriately served client populations in an effort to help prevent behavioral health conditions from developing and to address any emerging behavioral health issues at the earliest onset of the condition. Based on the importance of the PEI component, the coalition does not support diverting PEI resources to fund another component of the MHSA.*

- *The authority to move funds within and between components, as narrowly described above, and all other requested flexibilities described above, should be temporary and end no later than 6 months after the Governor lifts the declared state of emergency enacted on March 4, 2020, in response to the spread of COVID-19.*

- **Request to Extend Three-Year Plans, Updates, and Submissions of RERs:** Under the MHSA, counties must develop Three-Year Plans and Annual Updates with significant stakeholder

engagement. In addition to developing these plans and updates with community members, such as those with lived experience, family members, and parents/caretakers, mental health boards and commissions conduct public hearings to review Three-Year Plans and County Boards of Supervisors approve plans. Counties were in the process of finalizing Three-Year Plans, including securing the necessary approvals and reviews when California declared a state of emergency. Because of necessary public health initiatives, including social distancing and stay at home orders, many counties are now unable to comply with all the requirements for a timely submission of their Three-Year Plan. Currently, many mental health boards and commissions are meeting, but some have been unable to secure quorum necessary to take official action. The current urgent circumstances have many County Boards of Supervisors unable to address any local issues beyond urgent COVID-19 responses. Without an approved Three-Year Plan, complying with other requirements, such as timely submission of Updates and other reports, are also impacted.

- *Now more than ever, counties must continue to provide opportunities for community involvement to inform local priorities during the current pandemic and beyond. To ensure the ongoing and robust Community Program Planning (CPP) Process required by statute and regulations, the coalition requests that counties ensure they are allocating up to 5% of annual MHSA revenues to fund emergency COVID-19 planning, and all MHSA planning moving forward. (See WIC § 5892(c); 9 CCR § 3300.) Counties are encouraged to continue online/virtual meetings for local stakeholders, including broadcast of accessible meetings and hearings, and implement innovative methods to meaningfully include clients and other stakeholders in all MHSA planning, as required by statute and regulations.*

- *For those county behavioral health agencies unable to comply with timely submission of a Three-Year Plan because of COVID-19 related circumstances outside of their direct control, the coalition requests that these counties be allowed to continue following existing Three-Year Plans until these counties can finalize the Local Review Process required by statute and regulations. (See WIC § 5848; 9 CCR § 3315.) County behavioral health directors must certify to DHCS the COVID-19 related reason they were unable to complete the Local Review Process in a timely manner and certify that the Three-Year Plan will be submitted as soon as the Local Review Process can be completed, but no later than 6 months after the Governor has lifted the declared state of emergency enacted on March 4, 2020.*

- *Because many Three-Year Plans were drafted prior to the current public health emergency, some Three-Year Plans are insufficiently responsive to the changed circumstances and must be drastically revised. Any redraft of a Three-Year Plan must comply with the CPP and Local Review Processes, as outlined in statute and regulations. The coalition requests that counties be allowed to redraft Three-Year Plans. These counties must certify to DHCS the COVID-19 related reasons for drastically revising the Plan. To ensure sufficient time to complete the CPP and Local Review Processes, the coalition requests that these counties have until July 1, 2021 to submit new Three-Year Plans that comply with the CPP and Local Review Processes.*

- *The coalition also requests extended deadlines for submissions of MHSA-related reports that must be submitted to the state pursuant to existing statute and regulations. (See 9 CCR §§ 3500 – 3580.020.) The timeliness of these reports to the state are impacted by the inability to secure an approved Three-Year plan or by staffing limitations associated with COVID-19 response.*

- *Furthermore, the coalition requests assurances that counties will not face penalties, including adverse findings on program reviews/audits or the withholding of MHSA funds, for the inability to comply with the above described MHSA timely submission requirements so long as delays are attributable to circumstances related to COVID-19, as certified by the county behavioral health director.*

- **Flexibility with Deadlines:** Multiple MHSA deadlines related to funds subject to reversion are converging at the exact time the economic downturn due to COVID-19 has begun impacting MHSA. Counties are required to expend Assembly Bill (AB) 114 (Chapter 38, Statutes of 2017) reverted funds by July 1, 2020 and based on guidance issued in March 2019, counties are required to transfer any funds in excess of prudent reserve levels by June 30, 2020. In addition, some MHSA funds that counties planned to expend before the end of the fiscal year because these funds are subject to reversion cannot move forward due to COVID-19 related challenges. Counties have been diligently working to meet these deadlines, but COVID-19 has impacted this situation in multiple ways. Many counties intended to comply with deadlines through changes in existing plans or in newly developed Three-Year Plans but have been stymied by the inability to complete the local review process, as discussed above. Other counties cannot finalize bids and other processes because of statewide stay at home orders. Many of the mandated approval and programmatic processes are not available at this time and will take time to reschedule once the current state of emergency is lifted.

    - *Because COVID-19 prevents counties from completing the mandated approval and programmatic processes to meet these deadlines, the coalition requests the state extend the deadlines on funds subject to reversion at the end of this fiscal year. These funds should not be subject to reversion until 6 months after the Governor lifts the declared state of emergency and then, only if counties have not complied with guidance to expend these funds.*

The coalition supports DHCS suspending MHSA audits and desk reviews for those counties requesting delays because they are unable to gather the information associated with MHSA audits while stay at home orders and shelter in place mandates pervade. Audits have a critical accountability function and as such, the suspension of MHSA audits and desk reviews should be temporary and should once again begin no later than 6 months after the Governor lifts the declared state of emergency enacted on March 4, 2020.

In addition to the above requested MHSA flexibilities and in alignment with the attached guiding principles, the undersigned coalition reiterate our firm belief that any changes contemplated for the MHSA should include meaningful input from diverse groups of individuals with lived experience and all potentially affected client, provider and county stakeholder groups. Contemplated MHSA changes should also affirm the following:

- **The MHSA Must Retain its Existing General Standards as the Foundation of All Programs and Services.** The MHSA requires counties to adopt six specific General Standards in planning, implementing, and evaluating the programs and/or services funded by the MHSA. These Standards include: (1) Community Collaboration; (2) Cultural Competence; (3) Client-Driven and (4) Family-Driven services; (5) Wellness, Recovery, and Resilience Focused services; and (6) Integrated Service Experiences. (9 CCR § 3320.) These fundamental principles reflect the intent and purpose of the Act and articulate its mission to end "business as usual." The coalition is adamant that these General Standards, along with the Act's existing CPP and Local Review Processes, must be maintained. (See 9 CCR §§ 3300, 3315.)

- **The MHSA Must Retain its Support for Peer Support Services.** Regulations describing general requirements for Community Services and Supports require the incorporation of the General Standards described above for services funded through the CSS component. Regulations further require CSS programming to include peer support and family education services that provide equal opportunities for peers who share the diverse racial/ethnic, cultural, and linguistic characteristics of the individuals/clients served. (WIC § 5813.5(d); 9 CCR § 3610(b).) The coalition maintains that any modifications to the MHSA must protect or strengthen the role of peers in the delivery of such services.

- **The MHSA Must Retain its Provisions for Program Flexibility.** The MHSA permits counties to use funding for alternative practices, programs/services, procedures, and/or demonstration projects, so long as such alternatives meet the intent of the Act and its applicable regulations. (9 CCR § 3360.) The flexibility to implement alternative programs (such as community- and culturally-defined practices) is especially important during fiscal crises. The coalition strongly supports maintaining maximum MHSA program flexibility in any changes to the Act.

- **The MHSA Must Retain the Voluntary Nature of Services that the Act is Based Upon:** Services funded by the MHSA must be consistent with the Recovery Vision for mental health consumers, including to promote concepts key to the recovery for individuals such as hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. (WIC § 3815.5(d).) The Recovery Vision is inconsistent with involuntary treatment for behavioral health conditions and as such, the MHSA by-in-large funds voluntary community-based services. Counties can pay for short-term acute inpatient treatment for clients in Full Service Partnerships but are prohibited from using MHSA funds for long-term hospital and/or long-term institutional care. (9 CCR § 3620.) The coalition strongly supports the limitations imposed by existing law on using MHSA funds for involuntary treatment and we are opposed to any expansion on using MHSA funds for involuntary treatment.

We urge the Administration and the Legislature to refrain from sweeping, long-term changes in the MHSA during this crisis. The focus must remain on the crisis and how MHSA funds can be used to support those with existing and emerging behavioral health conditions. Any future efforts to change the MHSA must ensure the opportunity for meaningful stakeholder involvement and significant deliberation required to understand the lasting impact of any permanent changes on affected communities. In the immediate, we respectfully request your consideration and swift action to effectuate the proposed temporary changes outlined here as they will ensure communities are able to support the mental health and wellness of all Californians through more effectively using MHSA funding during the pandemic.

Respectfully,

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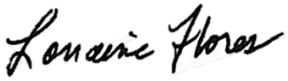

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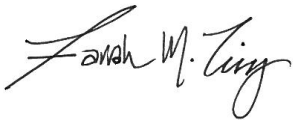

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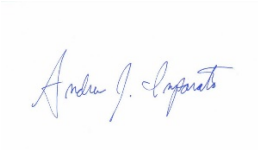

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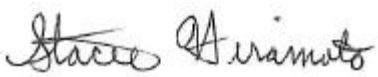

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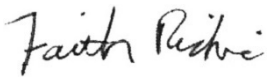

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