AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER TONY THURMOND, CHAIR

MONDAY, APRIL 20, 2015

1:30 P.M. - STATE CAPITOL ROOM 447

ITEMS TO BE HEARD

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4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MEDI-CAL PROVIDER RATES

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Scott Ogus**, Finance Budget Analyst, Department of Finance
- **Felix Su**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

***Budget Issue*.** The Governor's budget continues the AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, Medi-Cal payment reductions and assumes total fund savings of $524 million ($262 million General Fund). See tables below for a summary of the savings the Governor's budget associates with AB 97.

Table 1: AB 97 Medi-Cal Provider Payment Reduction Summary in January Budget*

AB 97 Payment Reductions (Total Fund) (dollars in thousands)								
Provider Type	Retroactive Savings Period	Total Retroactive Savings	On-Going Annual Savings	Nov. 2014 Estimated Savings from AB 97 Reduction (1) (2) FY 2014-15 On Going	FY 2014-15 Retro	FY 2015-16 On Going	FY 2015-16 Retro	Remaining Retro Recoupment
Nursing Facilities - Level A	6/1/11-6/30/12	$246	$254	$254	$82	$254	$0	$0
ICF/DDs		$0	$5,413	$5,413	$0	$5,413	$0	$0
FS Pediatric Subacute	Exempt							
AB 1629 Facilities (3)	N/A							
DP/NF-B	6/1/11-9/30/13	$83,437			$3,793		$15,170	$49,304
Phase 1 Providers (4)	6/1/11-12/20/11	$21,286	$44,776	$38,793	$0	$44,776	$0	$0
Physician 21 yrs+		$0	$49,746	$49,746	$0	$49,746	$0	$0
Medical Transportation		$0	$14,461	$14,461	$0	$14,461	$0	$0
Medical Supplies & DME	6/1/11-10/23/13	$39,428	$17,394	$17,394	$2,503	$17,394	$7,510	$19,402
Dental		$0	$60,458	$60,458	$0	$60,458	$0	$0
Clinics		$0	$18,512	$18,512	$0	$18,512	$0	$0
Pharmacy	6/1/11-2/6/14	$296,621	$113,718	$113,718	$17,977	$113,718	$53,931	$170,782
Phase 3 Providers		$0	$2,414	$1,811	$0	$2,414	$0	$0
Managed Care			$120,261	$140,980	$0	$120,261	$0	$0
Grand Total		$441,018	$447,407	$461,540	$24,365	$447,407	$76,611	$239,488

AB 97 Rate Freeze (Total Fund)								
Provider Type	Retroactive Savings Period	Total Retroactive Savings	On-going Annual Savings	FY 2014-15 On Going	FY 2014-15 Retro	FY 2015-16 On Going	FY 2015-16 Retro	Remaining Retro Recoupment
DP/NF-B	6/1/11-9/30/13	$144,229		$0	$8,556	0	$26,223	$85,227

Note:
(1) Data Source: Nov 2014 Estimate
(2) AB 97 injunctions were lifted on 6/25/2013.
(3) AB 1629 facilities includes Freestanding (FS) NF-B and FS Adult Subacute facilities. Implementation of payment reduction began May 1, 2012 and ended July 31, 2012. The Department paid back the 10% payment reduction to this facility type in December 2012.
(4) Phase I includes all subject providers, including the Pediatric Day Health Care (PDHC) and Audiology Program, except for the enjoined providers and the Child Health and Disability Prevention (CHDP) program.

*Please note these numbers will be updated at the May Revision.

AB 97 10% Rate Reduction Summary

	FY 2014-15		FY 2015-16	
	TF	GF	TF	GF
On Going	$461,540	$230,770	$447,407	$223,704
Retro	$24,365	$12,183	$76,611	$38,306
Total	$485,905	$242,953	$524,018	$262,009

The Governor's budget, and this chart, do not correctly reflect the savings associated with ICF/DDs. The corrected AB 97 savings for this provider type is $11.1 million (this will be reflected in the May Revision).

Primary Care Rate Increase Expired. The ACA required Medi-Cal to increase primary care physician service rates to 100 percent of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. The state received 100 percent federal financial participation (FFP or federal funding) for the additional incremental increase in Medi-Cal rates determined using Medi-Cal rates that were in effect as of July 1, 2009. Consequently, on an annual basis, this brought in approximately $1.6 billion in additional federal funds (to reach the Medicare rate). Also, an additional $91.5 million ($45.8 million General Fund) on an annual-basis was budgeted in order to bring Medi-Cal rates to the level in effect as of July 1, 2009 (as required by the ACA).

***Background*.** As a result of the state's fiscal crisis, AB 97 required the Department of Health Care Services (DHCS) to implement a ten percent Medi-Cal provider payment reduction, starting June 1, 2011. This ten percent rate reduction applies to all providers with certain exemptions and variations. Certain exemptions were specified in AB 97 and some are a result of an access and utilization assessment. AB 97 provides DHCS the ability to exempt services and providers if there are concerns about access. DHCS has formally established a process for pharmacy providers to seek exemption from the provider payment reductions.

On October 27, 2011, the federal Centers for Medicare and Medicaid (CMS) approved California's proposal to reduce Medi-Cal provider reimbursement rates. As part of this approval, CMS required DHCS to (1) provide data and metrics that demonstrated that beneficiary access to these services would not be impacted, and (2) develop and implement an ongoing healthcare access monitoring system.

DHCS had been prevented from implementing many of these reductions due to a court injunction. On June 14, 2013, the United States Court of Appeals for the Ninth Circuit denied the plaintiffs' motion for a stay of mandate in this case, allowing the implementation of all of the AB 97 Medi-Cal provider ten percent payment reductions. For the enjoined providers, DHCS began implementation of the retrospective payment reductions on a staggered basis, by provider type, starting in September 2013.

About 80 percent of Medi-Cal enrollees are enrolled in Medi-Cal managed care. The remaining 20 percent receive Medi-Cal through fee-for-service. Generally, those in FFS are persons with limited-scope aid codes, dual eligibles in the non-Coordinated Care Initiative counties, and persons who are exempt from managed care because of a medical exemption request.

Recoupment of Retroactive Savings. DHCS has begun the recoupment of retroactive savings for all affected providers except DP/NFs and Pharmacy. DHCS will give these providers a 60-day notice prior to recouping these savings. According to DHCS, each provider will receive a recoupment notice. If the provider contests the amount reflected, they can contact a service center and submit documentation contesting the amounts. While there is no formal appeals process, the provider may also contact DHCS if they do not believe the amount is correct and they do not get resolution at Xerox (the state's fiscal intermediary). If a Medi-Cal provider no longer participates in Medi-Cal or in fee-for-service Medi-Cal, the department's Third Party Liability and Recovery Division will set up an accounts receivable and follow the customary collection procedures.

Managed Care and Actuarial Soundness of Rates. Managed care rates can only be reduced by AB 97 on an actuarial basis and must support the required services. Consequently, as more and more individuals shift into Medi-Cal managed care, the negative impact of these reductions to access of Medi-Cal services is reduced. This is because health plans must meet access standards *and* a health plan's rate must be actuarially sound (i.e., generally, the rate cannot be reduced to a level that does not support the required services). In the Governor's budget, the AB 97 reductions to managed care plans as a percentage of their base rates are 0.62 percent in 2014-15 and 0.45 percent in 2015-16. If the reductions applicable to the elimination of the primary care physician rate increase are considered, then the reductions as a percentage of health plan base rates are 0.76 percent in 2014-15 and 0.71 percent in 2015-16.

The Governor's budget includes a placeholder rate increase for managed care plans of 3.57 percent in 2015-16. This is a net rate increase. Since managed care plan rates must be actuarially sound, although they are reduced by AB 97, on the net, managed care plans generally receive a rate increase every year.

LAO Findings and Recommendations. Last year, the LAO reviewed DHCS's baseline access analyses and quarterly monitoring reports and came away with numerous concerns about the quality of the data, the soundness of the methodologies, and the assumptions underlying the Administration's findings on access. In the LAO's view, these concerns are sufficient to render the Administration's public reporting of very limited value for the purpose of understanding beneficiary access in the fee-for-service (FFS) system. The LAO also found that much of the debate regarding the Medi-Cal provider payment reductions has focused mainly on FFS while access issues in managed care are gaining more importance (as a majority of Medi-Cal enrollees are in managed care). Since dental care will remain primarily a FFS benefit for the foreseeable future, the LAO recommends the Legislature create meaningful standards for monitoring Denti-Cal (FFS) access. In addition, the LAO recommends future oversight focus on

monitoring the managed care system. The LAO indicates that it plans to produce a more detailed analysis on this topic in the future.

Stakeholder Concerns. Consumer advocates, providers, provider associations, and other stakeholders are concerned that the existing Medi-Cal rates, payment reductions, and rate freezes directly impact an enrollee's ability to access Medi-Cal services. These stakeholders find that the existing payments do not cover the costs to provide services to Medi-Cal enrollees and are not sufficient enough to sustain their operations. On March 4, 2015, the Senate Health Committee and Assembly Health Committee held a joint hearing on the question of whether Medi-Cal rates ensure access to care.

SPECIAL ISSUES

Intermediate Care Facilities/Developmentally Disabled (ICF/DDs). In addition to the AB 97 payment reductions discussed above, rates for intermediate care facilities for the developmentally disabled (ICF/DDs), habilitative (ICF/DD-H), and nursing (ICF/DD-N) are frozen at 2008-09 levels. For ICF/DDs (all types), the budget assumes $11.1 million ($5.5 million General Fund) savings from the AB 97 rate reduction and $49.1 million ($24.5 million General Fund) from the rate freeze.

Beginning with the 2013-14 rates, effective for dates of service on or after May 27, 2014, ICF/DD, ICF/DD-H, and ICF/DD-N providers will be reimbursed at the facilities' rebased projected cost per day plus five percent, but no higher than the 65th percentile rate established in 2008-09, and no lower than the 65th percentile rate established in 2008-09, reduced by ten percent. DHCS will determine each facility's rebased projected cost by using cost or audited cost reports each year. The department has recently implemented a new rate methodology for these facilities which uses the most current facility-specific data. Advocates state that in 2009, when the rate freeze was imposed, DHCS concluded that the rates were 7-10 percent below the necessary rate for these facilities to stay open.

Concerns have been raised by these providers that ICF/DDs are closing because of the low Medi-Cal reimbursement rates and rate freeze resulting in some patients transitioning to other types of homes (e.g., negotiated-rate homes licensed) overseen by the Department of Developmental Services which have higher reimbursement rates, thereby, resulting in increased costs to the state. The negotiated-rate homes cost the state between $100 and $500 more per person per day than ICF/DDs.

According to the Administration, from 2010 to February 2015, 65 ICF/DD-Ns and ICF/DD-Hs closed and 58 new ICF/DD-Ns and ICF/DD-Hs opened. However, advocates for the facilities report a net reduction of 15 facilities during this time period. The administration reports that there is no evidence of ICF/DDs closing and transitioning into negotiated-rate homes; however, DHCS does not track or know where the individuals in the closed facilities went after their ICF/DD closed.

Community Based Adult Services (CBAS)/Adult Day Health Care (ADHC)
The California Association for Adult Day Services (CAADS) reports that 51 (17 percent) CBAS/ADHC centers have closed since ADHC was eliminated in 2011, thereby significantly reducing access to this service. CAADS also states that at least 9,454 people have lost CBAS/ADHC services since 2011. CAADS explains that center closures are primarily a reflection of rate cuts. The most recent CBAS closure, in February of 2015, was the S. Mark Taper Foundation Adult Day Health Care Center, a part of the St. Barnabas Senior Services in Los Angeles, one of the oldest ADHCs in the state. CAADS is requesting:

1. ***Relief from the AB 97 rate cut for all CBAS centers***. ADHC providers were not a party to the lawsuit that secured an injunction for the AB 97 (2011) 10 percent Medi-Cal rate cuts, and therefore was one of the first provider groups to experience this reduction. As stated above, many ADHCs have closed since the elimination of the ADHC benefit, clearly indicating a reduction in access and a significant financial struggle faced by the remaining ADHCs and CBAS programs. The cost to repeal the AB 97 ten percent reduction to CBAS would be $24.1 million ($12 million General Fund).

2. ***Reinstatement of a rate floor***. The existing 1115 Waiver, which expires in August 2015, includes a "rate floor" for CBAS, stipulating the minimum rate by tying managed care rates to the Medi-Cal fee-for-service rates. This rate floor was not included in the recent application to the federal Centers for Medicaid and Medicare Services (CMS) for the new 1115 Waiver. DHCS explains that the goal of the new Waiver is to provide managed care organizations (MCOs) with the flexibility that they need to set rates at levels that they believe best serves their patients, particularly given the transition of fiscal risk for long-term services (LTSS) and supports, including nursing facilities, to MCOs. DHCS intends for there to be no rate floors in Medi-Cal, once MCOs have experience managing these LTSS.

Dental
Substantial advocacy efforts are underway to highlight both low rates for dental services, coupled with inadequate access to dental services. A recent Bureau of State Audits (BSA) audit, *Department of Health Care Services: Weaknesses in Its Medi-Cal Dental Program Limit Children's Access to Dental Care*, found that California's dental provider rates fall far below those of other states, and that access to dental care for children is inadequate. Specifically, the Audit reports that less than half of the children who were eligible for basic dental services were able to get in to see a dentist even once during the year. Current provider rates for the top 10 children's dental services offered are 35 percent of the national average. Denti-Cal rates have not been increased since 2000-2001 and were included in the AB 97 10 percent rate cut in 2011. The BSA audit includes the following key findings:

1. California's utilization rates are lower than those of many states. Federal data shows that nearly 56 percent of the 5.1 million children enrolled in Medi-Cal did not receive dental care through the program.

2. While the number of active providers statewide appears sufficient to provide services to child beneficiaries, some counties may not have enough providers to meet the dental needs of child beneficiaries.

    - In 2013, five counties with at least 2,000 child beneficiaries may not have any active providers and no dental providers were willing to accept new Medi-Cal patients in 11 counties.

    - In 16 counties, the number of dental providers willing to accept new Medi-Cal patients appeared to be insufficient.

3. California's reimbursement rates for Medi-Cal fee-for-service dental services have not increased since fiscal year 2000–01 yet the rates are significantly lower than national and regional averages and lower than those of other states.

Disability Rights California (DRC) has brought information to the Subcommittee about severely inadequate access to the use of general anesthesia for individuals for whom it is necessary in order to receive dental care. DRC believes that the Medi-Cal reimbursement rate has contributed to this lack of access. As a result of this lack of access, many people with disabilities do not receive the dental care that they need, leading to more serious medical and dental health conditions. To address this issue, DRC proposes:

1. ***Desensitization/Management Fee***. This is a fee, offered by some other states, to dental providers who complete specialized courts to qualify to receive the fee for additional time or expertise in serving consumers with disabilities. DRC estimates the cost of this to be $4.5 - $9 million ($2.25 - $4.5 million General Fund, assuming this qualifies for federal matching funds).

2. ***Rate Increases for Preventive Dental Care.*** DRC and many other advocates propose increasing the rates for preventive care, and for Denti-Cal to cover services such as scaling and root cleaning and periodic comprehensive evaluations.

Clinical Labs

Clinical labs that serve Medi-Cal patients are receiving several reductions simultaneously. The labs were subject to the AB 97 10 percent reduction adopted in 2011, and AB 1494 (2012 budget trailer bill) authorized the development of a new rate methodology as well as an additional 10 percent reduction to be in place until implementation of the new rate methodology. DHCS recently submitted the proposed new methodology to the federal CMS and anticipates approval within 30 days; this also represents a significant reduction to labs. Therefore, labs are subject to the following:

1. AB 97 10 percent rate reduction -- since 2011 and on-going

2. AB 1494 10 percent rate reduction -- approved to take effect only until a new rate methodology is implemented; however, it still has not yet been implemented due

to a long delay in securing CMS approval. Hence, DHCS expects to implement prospectively beginning in June 2015, and retroactively beginning in December 2015.

3. New rate methodology -- DHCS expects to begin implementing this in July of 2015.

Distinct Part Skilled Nursing Facilities (DP-SNF)

As indicated in the AB 97 charts above, DP-SNFs were removed from the prospective AB 97 10 percent reductions; their rates, since October 2013 and going forward, do not reflect this rate cut. Nevertheless, DP-SNFs are still subject to the retroactive reductions, which DHCS expects to begin recouping in June or July of this year. The LA Jewish Home, which operates a DP-SNF (Joyce Eisenberg Keefer Medical Center), states that the 10 percent reduction was taken off of the 2008-09 rates, resulting in a 25 percent reduction for many DP-SNFs. The retroactive cut will cost this particular DP-SNF $5.5 million for services provided 2-4 years ago. The LA Jewish Home states that they will be forced to reduce services and re-consider a planned expansion. DHCS states that they are in discussions with the LA Jewish Home about the anticipated impact of this retroactive cut, and that they are open to negotiating a recoupment rate of lower than 5 percent should a facility need it.

PACE

PACE programs have informed the Subcommittee of their concerns regarding a significant rate differential between Northern and Southern California PACE programs, which they state leaves the Southern California PACE programs significantly under-reimbursed. CalPACE, an association of PACE programs, states that an analysis prepared by Optumas actuaries for CalPACE found that barriers to accessing services including inpatient hospital, nursing facility, pharmacy, and personal care, likely result in abnormally low rates of utilization for these services in the affected counties by the Medi-Cal fee-for-service population. The problem lies in the fact that the utilization data for these services are used to build the PACE rates. DHCS states that in Southern California, there are more facilities, more competition, and a lower cost of doing business, ultimately resulting in lower PACE rates.

Pediatric Rates

Children's advocates propose specific increased investments in children's health care, including through provider rates, based on the future increase in federal CHIP (Children's Health Insurance Program) funding that will be coming to California. The Affordable Care Act (ACA) approves of new state-federal matching rates which increases the federal financial participation for California from approximately 65 percent to 88 percent, representing significant new savings for California estimated to be approximately $500 million for 2015-16, based on the new matching rate beginning October 1, 2015. The U.S. House of Representatives reauthorized the funding for this purpose and advocates are very confident that the legislation will be approved by the U.S. Senate and signed into law by the President. Advocates state that Congress intends for these funds to be invested in children's health care, and that extending (or reinstating) the primary care rate increase (also included in the ACA but expired in

2014, as discussed in detail above) for children's services would be a significant step towards increasing access to care for children.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an assessment of Medi-Cal rates and an overview of the AB 97 rate reductions, and to respond to the following:

1. What is the justification for keeping rates frozen for one (or any) facility type? Does DHCS believe that facilities, such as ICF/DDs, can stay open without any rate increases indefinitely?

2. When ICF/DDs have closed, where have the residents gone to live?

3. In light of the BSA audit, does DHCS believe that access to dental care is adequate and that dental rates are sufficient?

4. Does DHCS believe that there is sufficient access to DP-SNFs?

Staff Recommendation: No action is recommended at this time.

ISSUE 2: SCHOOL MEDICAID ADMINISTRATIVE ACTIVITIES PROGRAM

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Yang Lee**, Principal Program Budget Analyst, Department of Finance
- **Felix Su**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

California school districts receive matching federal Medicaid funds for administrative services they provide to identify and enroll students into Medi-Cal. This funding has helped schools develop Family Resource Centers, and outreach and enrollment programs. On June 26, 2012, the federal government informed DHCS that the SMAA program was put on deferral due to deficiencies in DHCS' claiming plan. DHCS has not yet received approval from the federal government for a revised claiming plan and school districts have not been reimbursed for their expenses since July 1, 2012, and are owed over $850 million dollars. In the meantime, school districts have been forced to reduce or eliminate their programs due to insufficient funds. It is reported that about 20% of school districts have now dropped out of the program and their General Fund expenditures are no longer matched by federal dollars.

BACKGROUND

DHCS is the state agency responsible for the School Based Medi-Cal Administrative Activities (SMAA) program that reimburses school districts for a range of Medi-Cal outreach, referral, translation, program development and policy planning activities. Local Education Agencies (LEAs) providing these activities receive federal reimbursement upon the submission of invoices; the reimbursement rate is 50 percent of their allowable costs.

The DHCS has delegated the day-to-day administration of the SMAA program to Local Government Agencies (LGA), where these programs are administered, and eleven Local Education Consortiums (LECs). LEAs may contract with their regional LEC or their county LGA- if one is available, to participate in the SMAA program. About 8 LGAs contract with LEAs for the SMAA program. The LECs and LGAs are responsible for overseeing the LEAs' SMAA programs. They must ensure the accuracy of review the quarterly invoices prepared by the LEAs before submitting them to DHCS. The DHCS has final oversight, and are responsible for reviewing the accuracy of the claims before sending them to CMS for reimbursement.

In June of 2012, the federal Center for Medicare and Medicaid Services (CMS) notified DHCS that all LEA claims would be put in deferral status until improvements were made to the program. A subsequent CMS financial review and preliminary findings from an audit by the Office of the Inspector General identified problems with invoices, lack of compliance with federal regulations, and lack of oversight at all levels of the program. The only exception was Los Angeles Unified School District, which had adopted a

claiming methodology using the Random Moment Time Survey (RMTS) in FY11, and the Santa Barbara County Office of Education, whose documentation was reviewed by CMS and found to be in good order. Santa Barbara's claims covered special education services while LAUSD covered a broader range of services.

All other districts in the State had been using what is known as a worker day log methodology to determine the amount of time (and related cost) that can be federally reimbursed. CMS asked California to adopt a RMTS methodology to improve the accuracy of time reporting, which DHCS began implementing in January 2015.

To resolve the issues identified in the deferral, CMS required that DHCS submit a new plan for its SMAA program by September 2012. DHCS complied with this request. However, according to school districts, the plan DHCS originally submitted had insufficient input from the LEAs. The districts argue that DHCS developed the plan with significant input only from the LECs.

In October of 2014, DHCS agreed to a preliminary settlement with CMS, which included implementation of the new RMTS process as well as a requirement that all districts claiming over $25,000 per quarter settle their invoices using "backcasting," applying data from the new RMTS system to their deferred invoices (going back as far as January 2010).

CMS gave the State until April 1st to come up with a backcasting plan. An original proposal agreed to by the LEAs and submitted by DHCS in February would have provided 75% of all claims over $25,000 with no backcasting. Instead, CMS requested DHCS to return to their original proposed settlement in October to:

1. Pay all districts with invoices under $25,000 per quarter (2.2% of the total invoices) at 100% with no backcasting,
2. Make interim payments of 75% of the total amount on invoices between $25,000 and $50,000; and
3. Agree that the rest of the invoices receive 40% of what they were owed, subject to backcasting.

DHCS states that these terms are the only option available from CMS, despite the grave concerns expressed by the education community. School districts state that losses on past invoices could be as high as $460 million out of the $850 million claimed by the program between 2006 and 2013.

School districts report having tried repeatedly to alert DHCS to the negative effects of the settlement and the fact that the settlement is inequitable. For example, they state that San Diego Unified would receive 40% of its costs and stand to lose even more with backcasting. In contrast, the 91 districts in the Kern LEC have already received 100% of their deferred claims and do not have to backcast. Claims from a sample of the Kern districts cleared from the deferral were compared to those of San Diego and there was little difference between the claims. School districts also point out that backcasting will not be completed until 2018 and a final settlement will not be known until then. As a result, districts have indicated that they will not allow the programs that use these funds

for outreach and services until a final settlement is reached, thus limiting these Medi-Cal related activities at school sites.

The settlement of the deferral has been complicated by the fact that DHCS used state General Funds of $110 million to pay school districts, and have not received any federal reimbursement on these payments because of the deferral. DHCS had signed off on the invoices before they were transmitted to CMS for payment. As a result, the districts are now required to repay a minimum of 60%, and possibly more, once backcasting is applied. For some districts, this repayment goes back to 2009-10. Advocates report that Alameda County districts, for example, will lose 95% of the interim payment funding for the program when considering the amount they must pay back to DHCS. The districts in the Kern LEC have no repayment obligation for invoices covered by the deferral period.

School districts have asked DHCS to appeal the CMS decision, but DHCS has been unwilling to do so. School districts state that there are sufficient grounds for an appeal, namely the fact that the backcasting methodology as a method for reconciling claims will likely result in further losses for school districts.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present an overview of this issue and respond to the following:

1. How many school districts have dropped out of the SMAA program as a result of this prolonged federal deferral?

2. What is the reason that DHCS has not been willing to file an appeal with CMS?

3. Does DHCS consider this program a priority and a value to the state's children, and therefore invest the necessary time and resources to ensure it operates effectively?

4. How much money are school districts going to lose based on DHCS's agreement with CMS?

Staff Recommendation: No action is recommended at this time.

ISSUE 3: SUBSTANCE USE DISORDER SERVICES

PANELISTS

- **Karen Baylor,** Deputy Director, Mental Health & Substance Use Disorder Services, DHCS
- **Don Braeger**, Chief, Substance Use Disorders – Prevention, Treatment, and Recovery Services Division, DHCS
- **Marlies Perez**, Chief, Substance Use Disorders –Compliance Division, DHCS
- **Karen Johnson**, Chief Deputy Director, Policy and Program Support, DHCS
- **Tanya Homman**, Chief, Provider Enrollment Division, DHCS
- **Amelia Lawless**, Finance Analyst, Department of Finance
- **Carla Castañeda**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

Budget. The Drug Medi-Cal (DMC) program provides medically necessary substance use disorder treatment services for eligible Medi-Cal beneficiaries. The proposed budget includes $401.8 million for DMC in 2015-16. See the following table for DMC funding summary.

Drug Medi-Cal Program Funding Summary (*Dollars in Thousands*)

	2014-15				2015-16			
Service Description	**General Fund**	**County Funds**	**Federal Funds**	**Total Funds**	**General Fund**	**County Funds**	**Federal Funds**	**Total Funds**
Narcotic Treatment Program		$59,580	$72,494	$132,074		$60,655	$77,949	$138,604
Residential Substance Use Services*		$5,704	$5,792	$11,496	$19,610	$7,738	$44,277	$71,625
Outpatient Drug Free Treatment Services		$30,564	$33,512	$64,076		$25,205	$36,657	$61,862
Intensive Outpatient Services**	$24,400	$10,482	$56,519	$91,401	$32,811	$10,938	$72,846	$116,595
Provider Fraud Impact		-$27,850	-$27,850	-$55,700		-$27,850	-$27,850	-$55,700
Drug medi-Cal Program Cost Settlement		$393	$3,036	$3,429		$393	$3,036	$3,429
Annual Rate Adjustment					$793	$2,409	$4,605	$7,807
County Administration	$1,617	$7,005	$13,465	$22,087	$2,113	$6,553	$15,629	$24,295
County Utilization Review &		$4,990	$9,268	$14,258		$11,644	$21,626	$33,270

Quality Assurance								
3rd Party Validation of Providers	$125		$125	$250				
TOTAL	**$26,142**	**$90,868**	**$166,361**	**$283,371**	**$55,327**	**$97.685**	**$248,775**	**$401,787**

*Previously named “Perinatal Residential Substance Abuse Services
**Previously name “Day Care Rehabilitative Services”

BACKGROUND

In 2011, funding for the DMC program was transferred from the Department of Alcohol and Drug Programs (DADP) to DHCS as part of the Public Safety Realignment initiated by AB 109 (Committee on Budget), Chapter 15, Statutes of 2011. Prior to the realignment of the DMC program, DMC was funded with General Fund and federal funds. Enactment of the 2011 Public Safety Realignment marked a significant shift in the state’s role in administering programs and functions related to substance use disorder (SUD) treatment. Realignment also redirected funding for DMC and discretionary substance use disorder programs to the counties. Consequently, counties are responsible for providing the non-federal match used to draw down federal Medicaid funds for DMC services as they existed in 2011 and for individuals eligible for DMC under 2011 Medi-Cal eligibility rules (pre-health care reform). Additionally, the enactment of the 2012-13 and 2013-14 state budgets transferred the responsibility for the SUD programs including DMC, from the former DADP to DHCS.

Current regulations create requirements for oversight of DMC providers at both the state and county levels. DHCS is tasked with administrative and fiscal oversight, monitoring, auditing and utilization review. Counties can contract for DMC services directly, or contract with DHCS, which then directly contracts with DMC providers to deliver DMC services. Counties that elect to contract with DHCS to provide DMC services are required to maintain a system of fiscal disbursement and controls, monitor to ensure that billing is within established rates, and process claims for reimbursement. As of November 2013, DHCS contracts with 44 counties for DMC services. Another county has direct provider contracts thus resulting in DMC services being offered in 45 total counties. DHCS also has 15 direct provider contracts for DMC services in five counties (Imperial, Orange, San Diego, Solano, and Yuba-Sutter).

Health Care Reform Expansion of SUD Benefits. The federal Affordable Care Act (ACA) requires states electing to enact the ACA's Medicaid expansion to provide all components of the “essential health benefits” (EHB) as defined within the state’s chosen alternative benefit package to the Medicaid expansion population. The ACA included mental health and substance use disorder services as part of the EHB standard, and because California adopted the alternative benefit package, Medi-Cal is required to cover such services for the expansion population.

SB 1 X1 (Hernandez and Steinberg), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session, required Medi-Cal to provide the same mental health and substance use disorder services for its enrollees that they could receive if they bought a particular Kaiser small group health plan product designated in state law as the EHB benchmark plan for individual and small group health plan products. SB 1X 1 required this benefit expansion for both the expansion population and the pre-ACA Medi-Cal population. Consequently, those individuals previously and newly-eligible for Medi-Cal will have access to the same set of services. For SUD-related services, SB 1 X1:

- Expanded residential substance use services to all populations (previously these benefits were only available to pregnant and postpartum women);

- Expanded intensive outpatient services to all populations (previously these benefits were only available to pregnant women and postpartum women and children and youth under 21); and

- Provided medically necessary voluntary inpatient detoxification (previously this benefit was covered only when medically necessary for physical health reasons).

DHCS received approval from CMS to expand intensive outpatient services to all populations and to provide medically necessary voluntary inpatient detoxification in general acute hospital settings. However, CMS asked the state to remove the expansion of residential substance use services to all populations and the provision of inpatient voluntary detoxification in other settings in its state plan amendment (SPA) because of the Institutions for Mental Disease (IMD) payment exclusion, which is discussed in greater detail later.

Medi-Cal Substance Use Disorder Services. Substance use disorder services are provided through both the Drug Medi-Cal program and also through Medi-Cal managed care and fee-for-service.

Drug Medi-Cal program services include:

- **Narcotic Treatment Services** – An outpatient service that utilizes methadone to help persons with opioid dependency and substance use disorder diagnoses detoxify and stabilize. This service includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions.

- **Residential Treatment Services** – These services provide rehabilitation services to persons with substance use disorder diagnosis in a non-institutional, non-medical residential setting. (Room and board is not reimbursed through the Medi-Cal program.) Prior to SB 1 X1 this benefit was only available to pregnant and postpartum women. Although, SB 1 X1 expanded this benefit to the general population, it is only currently being provided to pregnant and postpartum women as the state has not yet received federal approval to expand this benefit due to the IMD payment exclusion.

- **Outpatient Drug Free Treatment Services** – These outpatient services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with a substance abuse diagnosis in an outpatient setting. Services include individual and group counseling, crisis intervention, and treatment planning.

- **Intensive Outpatient Treatment Services** – These services include outpatient counseling and rehabilitation services that are provided at least three hours per day, three days per week. Prior to SB 1 X1 this benefit was only available to pregnant and postpartum women and children and youth under 21.

Other Medi-Cal SUD benefits, that are not included in DMC, include:

- **Medication-Assisted Treatment** – This service includes medications (e.g., buprenorphine and Vivitrol) that are intended for use in medication-assisted treatment of substance use disorders in outpatient settings. These medications are provided via Medi-Cal managed care or Medi-Cal FFS, depending on the medication.

- **Medically Necessary Voluntary Inpatient Detoxification** – This service includes medically necessary voluntary inpatient detoxification and is available to the general population. This service is provided via Medi-Cal FFS.

- **Screening and Brief Intervention** – This service is available to the Medi-Cal adult population for alcohol misuse, and if threshold levels indicate, a brief intervention is covered. This service is provided in primary care settings. This service is provided via Medi-Cal managed care or Medi-Cal FFS, depending on which delivery system the patient is enrolled.

Proposed Drug Medi-Cal Waiver. DHCS is pursuing a DMC Organized Delivery System Waiver as an amendment to the current Section 1115 Bridge to Reform Demonstration Waiver. DHCS proposes that this amendment would demonstrate how organized substance use disorder care increases successful outcomes for DMC beneficiaries. The state's proposal is currently under federal CMS review. DHCS anticipates hearing back from CMS by the end of April.

DHCS states the waiver will give state and county officials more authority to select quality providers to meet drug treatment needs. DHCS indicates the waiver will support coordination and integration across systems, increase monitoring of provider delivery of services, and strengthen county oversight of network adequacy, service access, and standardize practices in provider selection.

Key elements of the proposed waiver amendment include:

- **Continuum of Care:** Participating counties will be required to provide a continuum of care of services available to address substance use, including: early intervention, physician consultation, outpatient treatment, case

management, medication assisted treatment, recovery services, recovery residence, withdrawal management, and residential treatment.

- **Assessment Tool:** Establishing the American Society of Addiction Medicine (ASAM) assessment tool to determine the most appropriate level of care so that clients can enter the system at the appropriate level and step up or step down in intensive services, based on their response to treatment.

- **Case Management and Residency:** Case management services to ensure that the client is moving through the continuum of care, and requiring counties to coordinate care for those residing within the county.

- **Selective Provider Contracting:** Giving counties more authority to select quality providers. Safeguards include providing that counties cannot discriminate against providers, that beneficiaries will have choice within a service area, and that a county cannot limit access.

- **Provider Appeals Process:** Creating a provider contract appeal process where providers can appeal to the county and then the State. State appeals will focus solely on ensuring network adequacy.

- **Provider Certification:** Partnering with counties to certify DMC providers, with counties conducting application reviews and on-site reviews and issuing provisional certification, and the State cross-checking the provider against its databases for final approval.

- **Clear State and County Roles:** Counties will be responsible for oversight and monitoring of providers as specified in their county contract.

- **Coordination:** Supporting coordination and integration across systems, such as requiring counties enter into memoranda of understanding (MOUs) with Medi-Cal managed care health plans for referrals and coordination and that county substance use programs collaborate with criminal justice partners.

- **Authorization and Utilization Management:** Providing that counties authorize services and ensuring Utilization Management.

- **Workforce:** Expanding the pool of Medi-Cal eligible service providers to include licensed practitioners of the healing arts for the assessment of beneficiaries, and other services within their scope of practice.

- **Program Improvement:** Promoting consumer-focused evidence-based practices including medication-assisted treatment services and increasing system capacity for youth services.

This proposed waiver will only be operational in counties that elect to opt into this organized delivery system. However, DHCS has stated that the early phases are considered demonstration projects but the goal is for the model to be eventually implemented statewide. Counties that opt into this waiver will be required to meet specified requirements, including implementing selective provider contracting (selecting which providers participate in the program), providing all DMC benefits, monitoring providers based on performance criteria, ensuring beneficiary access to services and an adequate provider network, using a single-point of access for beneficiary assessment and service referrals, and data collection and reporting. In a county that does not opt-in, there will be no change in services from the current delivery system.

DHCS proposes a phasing-in of this waiver, and anticipates that Phase 1 will be the Bay Area counties and would occur April – June of 2015.

Potential Relief from IMD Payment Exclusion. DHCS has also indicated that it has received informal approval from CMS that under this waiver proposal, the Institutions for Mental Disease (IMD) payment exclusion would not apply for counties that opt-into this demonstration. Consequently, federal funds would be available to provide residential treatment services to all eligible adults and inpatient voluntary detox in chemical dependency treatment facilities and freestanding psychiatric facilities. (See below for background information on the IMD exclusion.)

Background - Institutions for Mental Disease (IMD) Exclusion. In preparing to implement the newly expanded residential DMC benefit for all adults, as required by SB 1 X1, DHCS encountered an issue with the Institutions for Mental Disease (IMD) federal Medicaid payment exclusion. IMDs are inpatient facilities of more than 16 beds whose patient roster is more than 51% people with severe mental illness.

The IMD exclusion prohibits federal financial participation (FFP) from being available for any medical assistance under federal Medical law for services provided to any individual who is under age 65 who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. The IMD exclusion was designed to ensure that states, rather than the federal government, continue to have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group. The IMD exclusion is unusual in that it is one of the very few instances in which federal Medicaid law prohibits FFP for care provided to enrolled beneficiaries.

Based on CMS current interpretation of the IMD exclusion, DHCS is prohibited from using federal funds to reimburse for any Medi-Cal service when a Medi-Cal beneficiary is receiving SUD services in residential facilities larger than 16 beds. In February 2014, DHCS indicated that there are 783 licensed SUD residential treatment facilities in California, with a total statewide licensed capacity of 18,155 beds. However, because of the federal IMD exclusion, DHCS estimates that only 1,825 beds (of the 18,155 licensed beds) are reimbursable under Medi-Cal.

Additionally, federal funding is not available for facilities that provide inpatient voluntary detoxification that are chemical dependency treatment facilities or freestanding psychiatric facilities, as the IMD payment exclusion applies to these facilities.

DHCS requested that CMS employ a different interpretation of the IMD exclusion that recognized California's unique market. However, CMS did not approve the request. Consequently, the residential benefit has not yet been expanded and voluntary detoxification can only be provided in general acute hospitals.

Drug Medi-Cal Program Integrity. In July 2013, an investigation by the Center for Investigative Reporting (CIR) and CNN uncovered allegations of widespread fraud in California's Drug Medi-Cal (DMC) program. Most of the examples of alleged fraud occurred in Los Angeles County and ranged from incentivizing patients with cash, food, or cigarettes to attend sessions, to billing for clients who were either in prison or dead. Most of the providers that were the focus of the investigation primarily offered counseling services and rely on Medi-Cal as the sole payer for services. The reports suggested that the state's oversight and enforcement bodies were not working well in tandem: county audits of providers identified a number of serious deficiencies, but failed to terminate contracts or prevent the problems from continuing.

As of March 27, 2015, this review has resulted in a total of 79 temporary provider suspensions (at 217 sites). Many of these cases (96) have been referred to the California Department of Justice for criminal investigation and prosecution.

BUDGET CHANGE PROPOSALS

Provider Enrollment BCP

***Budget Proposal*.** PED requests to extend 11 limited term positions that expire June 30, 2015 for one more year for work associated with certifying and recertifying Drug Medi-Cal providers. According to DHCS, these requested positions are essential to address provider fraud, waste, and abuse in the DMC program by certifying only providers meeting standards of participation in Medi-Cal, and decertifying fraudulent providers by conducting a thorough screening including collecting disclosure statements, performing monitoring checks, and making referrals to the DHCS Audits and Investigations Division for onsite reviews. In addition, DHCS has internally redirected six positions for this workload.

According to DHCS, the new workload related to DMC provider certification requirements includes:

- Requiring the enrollment of medical licensed staff. Current DMC program certification standards state that each substance abuse clinic must have a licensed physician designated as the medical director and that the medical director assumes medical responsibility of all of its patients.

- Requiring the submission of provider agreements. Although it is a federal requirement to have provider agreements from participating Medi-Cal providers,

most DMC providers had not signed a provider agreement. The provider agreement serves as the contract between the provider and DHCS and is mandatory for participation or continued participation as a provider in the Medi-Cal program pursuant state and federal law.

- Requiring the submission of fingerprinting and criminal background checks. DHCS has designated new DMC certification applicants and DMC providers applying for recertification at the high categorical risk level. Providers designated at the high-risk categorical level must submit to fingerprinting and are subject to a criminal background check. PED will be required to review conviction information and work with the Office of Legal Services in determining the eligibility of the applicants to participate in the DMC program if a conviction is identified through the criminal background process.

- Timely reporting of changes that affect certification, such as ownership changes. Additionally, database checks will be performed on a monthly basis to determine if DMC providers and their managing employees, owners, agents, or those with a control interest appear on the List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), Medicaid and Children's Health Insurance Program, CHIP, State Information Sharing System (MCSIS), and Social Security Death Match databases. A test sample of over 2,700 DMC providers run against these databases showed as many as 55 percent had matches.

Provider Application and Validation for Enrollment (PAVE). PED is automating its enrollment processes. PAVE will transform provider enrollment from a manual paper-based process to a web-based portal that providers can use to complete and submit their application, verifications, and to report changes. In the spring of 2014, DHCS indicated that PAVE would be up-and-running in September 2014 and that this system would help facilitate the workload to certify Drug Medi-Cal providers. However, implementation of PAVE has been delayed until at least September 2015.

Concerns have been raised that the process to certify and recertify Drug Medi-Cal (DMC) providers is cumbersome and unreasonable and will prove to be an impediment to the success of the proposed Drug Medi-Cal waiver as there will be an insufficient number of Drug Medi-Cal providers (particularly residential treatment providers) available to provide these services. Providers are reporting it taking over one year to complete this application process. Currently new providers who are attempting to become certified to be Medi-Cal providers and existing providers who make changes such as moving locations or adding new sites must submit applications manually to the Provider Enrollment Division (PED).

As a result of the expanded DMC benefit, the allegations of fraud that have come to light, and new requirements under the Affordable Care Act, there is a temporary, but substantial increase in the PED workload. Existing providers must be recertified and/or more closely scrutinized and new providers are needed to meet the increased demand for services.

Of the 427 new applications/changes to existing certification, 204 (47 percent) have been processed and only 77 (or 18 percent) have been approved. Additionally, of the 306 non-continued certification applications (see below for definition of these applications) submitted to PED after January 1, 2014, 111 (36 percent) have been processed and only 25 (or eight percent) have been approved.

Drug Medi-Cal Provider Monitoring BCP

***Budget Proposal*.** DHCS requests 10 positions in its Substance Use Disorder Prevention, Treatment, and Recovery Services Division for workload associated with monitoring Drug Medi-Cal (DMC) providers.

According to DHCS, these positions would be used to increase program integrity within the program and mitigate the risk of fraud, waste, and abuse. For example, these positions would review the on-site operations of every DMC provider at least once every five years (approximately 133 sites annually) and be responsible for follow up with DMC providers on all corrective action plans to ensure any deficiencies DHCS identifies are rectified by the DMC providers.

Additionally, these positions would be used to design and implement a DMC system monitoring protocol similar to the department's "Program Oversight and Compliance Annual Review Protocol for Consolidated Mental Health Services and Other Funded Services." This protocol includes monitoring for access; authorization; beneficiary protection; funding, reporting, and contracting requirements; provider relations; program integrity; quality improvement; and chart review.

***Background*.** Upon the transfer of the administration of the DMC program and applicable Medicaid functions to DHCS (from the former Department of Alcohol and Drug Programs) in June 2012, DHCS began a review of the DMC program. Based on issues it identified, DHCS initiated a complete review of the DMC program in an effort to address fraud, waste, and abuse allegations. One of the findings from this review was that monitoring of DMC providers was not occurring.

According to DHCS, identified health and safety issues would be avoided in the future with the implementation of on-site monitoring of the operations of DMC providers. Some of the issues recently identified with DMC providers that would be rectified with a DMC monitoring program are: DMC providers who should not be operating due to their status on federal excluded lists; medical directors with suspended or other action against their license; non-qualified staff providing services; beneficiary health and safety at risk due to unsanitary facilities; providers operating facilities out of compliance with local use permit requirements; inaccessible facilities; inadequate or no policies and procedures to guide operations; lack of adequate staffing to provide services; non-treatment services being provided; etc. Additionally, this monitoring function would strengthen the department's ability to ensure DMC providers are in compliance with specific requirements related to operating a DMC program on a school site, as well as ensuring the students' ability to receive treatment services safely and confidentially.

Substance Use Recovery & Treatment Services (AB 2374) BCP

***Budget Proposal*.** DHCS requests to establish two permanent, full-time positions at a cost of $246,000 (General Fund) due to the enactment of AB 2374 (Mansoor), Chapter 815, Statutes of 2014.

AB 2374 requires a counselor certifying organization (CO), prior to registering or certifying a counselor, to contact DHCS-approved COs to determine whether a counselor has previously had a certification or registration revoked. The requested positions would be used to address this new workload.

AB 2374 also requires licensed residential treatment facilities to report resident deaths to DHCS by phone and in writing. The report requires the inclusion of specific information, including a description of the follow-up action that is planned, including, but not limited to, steps taken to prevent a future death. The death reporting requirements of AB 2374 closely align and expand upon the requirements that currently exist in the California Code of Regulations Title 9 § 10561 and DHCS's internal death investigation policy. For this reason, DHCS requests no resources for this component of AB 2374.

***Background*.** Prior to the approval of AB 2374, DHCS only had the authority to ensure that COs maintained a business office in California and remained accredited with the National Commission for Certifying Agencies (NCCA). Once approved, DHCS had no authority to monitor, suspend or revoke approval of a CO unless they lost their NCCA accreditation. Ten COs were originally approved in regulations to register and certify individuals providing Alcohol and Other Drugs (AOD) counseling in California's licensed and/or certified AOD facilities. DHCS currently recognizes four approved counselor COs. The other six COs lost their accreditation with the NCCA, thereby, losing approval from DHCS. Those four organizations have approximately 28,000 SUD counselors, of which roughly half are certified and half are registered while working towards certification.

AB 2374 establishes new requirements for DHCS' oversight of COs. This new oversight authority includes periodic reviews of the COs and administrative tasks related to periodic reviews to properly monitor the approved COs' adherence to state requirements. DHCS will develop regulations to clarify the CO provisions in AB 2374. DHCS currently has no staff devoted to CO oversight and no funding intended for that purpose. According to DHCS, the anticipated workload associated with AB 2374 is beyond DHCS's ability to absorb and continue to provide the levels of service that existing mandates require.

STAKEHOLDER PROPOSALS

Naloxone Grant Program. Advocates propose $2 million for DHCS to implement a community grant program for the distribution of naloxone kits to first responders, patients, families and at-risk drug users. Naloxone is a safe, easy-to-administer, lifesaving overdose reversal medication. Advocates cite data that shows that an average of eight Californians die of drug overdose every day, and of those eight, seven are caused by opiate drugs. Annually, over 2,700 Californians die from opioid overdoses. Nationally, the rates of fatal drug overdoses doubled over the last ten years. Based on research, advocates believe that a $2 million investment in a naloxone kit distribution grant program could be expected to save an estimated 800 lives. Moreover, the use of Naloxone has been found to reduce emergency room costs. According to the federal Centers for Disease Control and Prevention in 2012, there were at least 188 overdose education and response programs in the U.S. that provided naloxone to community members, and that between 1996 and 2010, these programs, in 15 states and the District of Columbia trained and provided naloxone to 53,032 people, resulting in 10,171 drug overdose reversals using naloxone. Advocates also cite a San Francisco program as a model. The Drug Overdose Prevention Education project of San Francisco trained 5,508 drug users and their friends, family or service providers, resulting in 1,580 reported reversals. The annual number of heroin deaths dropped from a peak of 130 per year to fewer than 10, and emergency room visits for heroin overdose were cut in half during this same time period.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the Drug Medi-Cal program and budget, provide a brief overview of the proposed Drug Medi-Cal waiver, and respond to the following:

1. Please provide an overview of the Drug Medi-Cal provider certification and re-certification process.

2. Please describe the efforts DHCS has undertaken to assist providers in certification, such as provider call lines and training webinars.

3. Has DHCS identified particular services or regions that have severe access inadequacies that could be remedied with a speedier certification process?

4. Please describe the most recent provider fee increase. How much more revenue will the program receive and what will it fund?

The Subcommittee requests the Legislative Analyst's Office to briefly present the stakeholder proposal described in this section of the agenda.

Staff Recommendation: Staff recommends holding open the Substance Use Disorder proposals at this time to allow additional time for review and input.

ISSUE 4: COMMUNITY MENTAL HEALTH SERVICES

PANELISTS

- **Karen Baylor**, Deputy Director, Mental Health and Substances Use Disorder Services, DHCS
- **Brenda Grealish**, Assistant Deputy Director, Mental Health and Substances Use Disorder Services, DHCS
- **Amelia Lawless**, Finance Analyst, Department of Finance
- **Carla Castañeda**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSED BUDGET

Background. California has a decentralized public mental health system with most direct services provided through the county mental health system. Counties (i.e., county mental health plans) have the primary funding and programmatic responsibility for the majority of local mental health programs. See table below for a summary of county community mental health funding.

Community Mental Health Funding Summary:

Fund Source	2013-14	2014-15	2015-16
1991 Realignment			
Mental Health Subaccount (base & growth)*	$41,690,000	$64,636,000	$125,386,000
2011 Realignment			
Mental Health Subaccount (base & growth)*	$1,129,700,000	$1,136,400,000	$1,134,700,000
Behavioral Health Subaccount (base)**	$992,363,000	$1,051,375,000	$1,198,071,000
Behavioral Health Growth Account	$60,149,000	$146,696,000	$140,885,000
Realignment Total	**$2,223,902,000**	**$2,399,107,000**	**$2,599,042,000**
Medi-Cal Specialty Mental Health Federal Funds	$1,425,814,863	$2,153,244,000	$2,772,568,000
Medi-Cal Specialty Mental Health General Fund	$5,803,134	$117,209,000	$138,004,000
Mental Health Services Act Local Expenditures	$1,246,741,000	$1,392,014,000	$1,362,650,000
TOTAL FUNDS	**$3,476,446,134**	**$6,061,574,000**	**$6,872,264,000**

*2011 Realignment changed the distribution of 1991 Realignment funds in that the funds that would have been deposited into the 1991 Realignment Mental Health Subaccount, a maximum of $1.12 billion, is now deposited into the 1991 Realignment CalWORKs MOE Subaccount. Consequently, 2011 Realignment deposits $1.12 billion into the 2011 Realignment Mental Health Account.

**Reflects $5.1 million allocation to Women and Children's Residential Treatment Services. Includes Drug Medi-Cal.

BACKGROUND

Medi-Cal Mental Health. As of January 1, 2014, there are three systems that provide mental health services to Medi-Cal beneficiaries:

1. County Mental Health Plans (MHPs) - California provides Medi-Cal "specialty" mental health services under a waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's specialty mental health services are provided under the federal requirements of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for persons under age 21. County mental health plans are the responsible entity that ensures specialty mental health services are provided. Medi-Cal enrollees must obtain their specialty mental health services through counties.

2. Managed Care Plans (MCPs) - Effective January 1, 2014, SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session expanded the scope of Medi-Cal mental health benefits and required these services to be provided by the Medi-Cal Managed Care Plans (MCP), excluding those benefits provided by county mental health plans. Generally, these are mental health services for those with mild to moderate levels of impairment. The mental health services provided by the MCPs include:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation

3. Fee-For-Service Provider System (FFS system) - Effective January 1, 2014 the mental health services listed below are also available through the Fee-For-Service/Medi-Cal provider system:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation

Behavioral Health Realignment Funding. SB 1020 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2012, created the permanent structure for 2011 Realignment. SB 1020 codified the Behavioral Health Subaccount which funds Medi-Cal Specialty Mental Health Services (for children and adults), Drug Medi-Cal, residential perinatal drug services and treatment, drug court operations, and other non-Drug Medi-Cal programs. Medi-Cal Specialty Mental Health and Drug Medi-Cal are entitlement programs and counties have a responsibility to provide for these entitlement programs.

Government Code Section 30026.5(k) specifies that Medi-Cal Specialty Mental Health Services shall be funded from the Behavioral Health Subaccount, the Behavioral Health Growth Special Account, the Mental Health Subaccount (1991 Realignment), the Mental Health Account (1991 Realignment), and to the extent permissible under the Mental Health Services Act, the Mental Health Services Fund. Government Code Section 30026.5(g) requires counties to exhaust both 2011 and 1991 Realignment funds before county General Fund is used for entitlements. A county board of supervisors also has the ability to establish a reserve using five percent of the yearly allocation to the Behavioral Health Subaccount that can be used in the same manner as their yearly Behavioral Health allocation, pursuant Government Code Section 30025(f).

Consistent with practices established in 1991 Realignment, up to 10 percent of the amount deposited in the fund from the immediately preceding fiscal year can be shifted between subaccounts in the Support Services Account with notice to the Board of Supervisors, pursuant to Government Code Section 30025(f). This shift can be done on a one-time basis and does not change base funding. In addition, there is not a restriction for the shifting of funds within a subaccount, but any elimination of a program, or reduction of 10 percent in one year or 25 percent over three years, must be duly noticed in an open session as an action item by the Board of Supervisors, pursuant to Government Code Section 30026.5(f). Government Code Section 30026.5(e) also requires 2011 Realignment funds to be used in a manner to maintain eligibility for federal matching funds.

DHCS issued Mental Health Services Division Information Notice 13-01 on January 30, 2013, to inform counties that 2011 Realignment did not abrogate or diminish the responsibility that, “they must provide, or arrange for the provision of, Medi-Cal specialty mental health services, including specialty mental health services under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit.” As noted above, Government Code Section 30026.5(k) specifies fund sources for Medi-Cal Specialty Mental Health Services. The Administration continues to work with the California State Association of Counties and the California Behavioral Health Directors Association to ensure all counties are aware of these entitlement programs and clients cannot be denied services.

On May 19, 2014, DHCS issued Mental Health and Substance Use Disorder Services Information Notice 14-017 indicating that first priority of the Behavioral Health Growth Account funding would be given to reimburse counties for the two entitlement programs, Medi-Cal Specialty Mental Health EPSDT and Drug Medi-Cal. Specifically, this allocation provided additional funding to eight counties in which the approved claims for EPSDT and Drug Medi-Cal services in 2012-13 were greater than the funding they

received in 2012-13 from the Behavioral Health Subaccount. The remaining balance of this growth account would then be distributed using the same percentage schedule used to distribute the funds allocated to the Behavioral Health Subaccount. The Administration indicates that it plans to follow the same allocation formula for the $60.1 million in 2013-14 Behavioral Health Growth Account funds that will be distributed later this spring. As displayed on the previous table, the projected 2014-15 Behavioral Health Growth Account is $146.7 million and the projected 2015-16 Behavioral Health Growth Account is $140.9 million.

Mental Health Services Act (Proposition 63, Statutes of 2004). DHCS plays a significant role in the administration and oversight of Proposition 63. Specifically, counties are required to submit annual expenditure and revenue reports to both DHCS and the MHSOAC. DHCS monitors county's use of MHS funds to ensure that the county meets the MHSA and MHS Fund requirements. DHCS works with counties to determine the county allocations, and is also the lead agency on the expenditures of MHSA State Administration funds, which are capped at 5 percent of total MHSA revenue. DHCS issues an annual report to the Legislature on the expenditures of MHSA funds, including State Administration funding. The following table shows where these funds are expended:

MHSA State Administration Expenditures (*Dollars in Thousands*)	**2013-14 Actual**	**2014-15 Estimated**	**2015-16 Projected**
Judicial Branch	$1,038	$1,058	$1,050
State Controller's Office	$40	$0	$0
California Health Facilities Financing Authority	$4,474	$4,000	$4,000
Office of Statewide Health Planning & Development	$12,490	$3,907*	$3,307*
Department of Health Care Services	$8,897	$9,399	$9,134
Department of Public Health	$1,620	$18,557*	$50,070*
Department of Developmental Services	$1,128	$1,180	$1,211
Mental Health Services Oversight & Accountability Commission	$18,083	$60,742*	$41,372*
Department of Education	$178	$136	$145
Community Colleges Board of Governors	$117	$87	$103
Financial Information System for California	$225	$70	$188
Military Department	$1,138	$1,387	$1,590
Department of Veterans Affairs	$376	$511	$504
University of California	$0	$15,000*	$0
TOTAL STATE ADMINISTRATION	**$49,804**	**$116,034**	**$112,674**
TOTAL PROPOSITION 63 REVENUE	**$1,296,545**	**$1,508,048**	**$1,475,324**

*A portion of these funds were reappropriated from prior year administrative funds and are attributed to the 5% administrative cap fora different fiscal year in which they are expended.

The following describes the varied uses of the MHSA State Administration funding:

Judicial Branch Positions for workload relating to mental health prevention and early intervention for juveniles in the juvenile court system. Positions to address workload relating to mental illness in adults in the criminal justice system.
State Controller's Office Funds supported toe 21st Century Project, a new human resource management system payroll system for state departments.
California Health Facilities Financing Authority One-time MHSA funds for county mobile crisis personnel grants.
Office of Statewide Health Planning & Development Funds Statewide Workforce Education & Training (WET) program to develop mental health workforce.
Department of Health Care Services Funds the work of the Mental Health Services Division which provides fiscal and program oversight of MHSA. Funds staff of California Mental Health Planning Council which advocates for children and adults with serious mental illnesses, and advises the state on mental health issues. Provides statewide technical assistance to improve the MHSA.
Department of Public Health Funds staff for the California Reducing Disparities Project within the Office of Health Equity.
Department of Developmental Services Administer a statewide community-based mental health services system (via Regional Centers) for people with developmental disabilities.
Mental Health Services Oversight & Accountability Commission Funds oversight & accountability of the MHSA.
Department of Education Funds positions to increase capacity in staff and students to build awareness of student mental health issues and promote healthy emotional development. CDE is the student mental health contractor for CalMHSA to provide stigma reduction strategies.
Community Colleges Board of Governors Supports one position to develop policies and practices to address the mental health needs of community college students.
Financial Information System for California (FI$Cal) Supports the development of FI$Cal, the state's integrated financial management system, used by state agencies with accounting systems.
Military Department Funds 8.2 positions for provide 24/7 support for a behavioral health outreach program to improve coordination between the California National Guard, local County Veterans' Services Officers, county mental health departments, and others to meet mental health needs of guard members and their families.
Department of Veterans Affairs Funds 2.0 positions to inform veterans and their family members about federal benefits, local

mental health department services, and other mental health services. Administers grant programs to improve mental health services to veterans, develops Veteran Treatment Courts, and educates incarcerated veterans about benefits and services.
University of California One-time funds for two Behavioral Health Centers of Excellence (at UCLA and UCD) for research on behavioral health care and the integration of medical and mental health services.

For the 2014-15 fiscal year, the State Administrative Cap is overprescribed by approximately $8 million. In March, the Legislature was notified that the annual adjustment amount for fiscal year 2013-14 was $154 million less than what was estimated in the Governor's January Budget ($94 million instead of the estimated $249 million in the January budget).

BUDGET CHANGE PROPOSAL

Performance Outcome System BCP

***Budget Proposal*.** DHCS requests three full-time permanent positions at a cost of $377,000 ($189,000 General Fund and $188,000 Federal Trust Fund) to support the program management, coordination with counties and other partners, data collection and interpretation and research needs of the Performance Outcomes System project as required by SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012 and AB 82 (Committee on Budget), Chapter 34, Statutes of 2013.

The purpose of the Performance Outcome System is to provide the capability to understand the statewide outcomes of specialty mental health services provided, in order to best ensure compliance with the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirement. Although the non-federal share of funding for the Medi-Cal Specialty Mental Health program has been realigned to the counties, the state maintains a responsibility for ensuring access to the federal entitlement for the Medi-Cal Specialty Mental Health program. For children and youth up to age 21 in this program, federal law further requires EPSDT to ensure access to medically necessary specialty mental health services. The Performance Outcomes System will measure individual outcomes as clients receive managed care or specialty mental health services.

To carry out and support the objectives for the Performance Outcomes System, DHCS requests the following three positions**:**

Two Research Analysts II (RA II)

- Provide support in producing reports, gathering, compiling, analyzing, and applying statistical methods to data.
- Work as a liaison with county information technology (IT) staff to clean the data and resolve any system issues.
- Monitor county data submissions and provide training to counties on data interpretation and utilization.
- Format reports and product.

One Associate Information Systems Analyst (AISA)

- Supports the more complex IT functions for the Performance Outcomes System and maintains the research analytics data requirements, including system connectivity and database design.
- Leads the technology activities associated with data systems, Electronic Health Record Systems, and Health Information Exchange systems, to provide data reporting solutions for the 56 county mental health systems.
- Assists with complex data analysis and writes complex programming logic to extract and compile data for analysis.
- Provides recommendations for report development.
- Performs system testing.

***Background*.** SB 1009 requires DHCS to develop a Performance Outcomes System for Medi-Cal Specialty Mental Health Services for children and youth. Consistent with statute, DHCS has produced a Performance Outcomes System Implementation Plan. DHCS released the Performance Outcomes System Implementation Plan with the 2014-15 Governor's budget, and a budget change proposal with initial resources (four staff) to begin to implement and operate this system.

In 2013, SB 1009 was amended through AB 82, to add the requirement for mental health screening of children/youth as part of Medi-Cal managed care. The legislation also required the development of measures for screening and referring Medi-Cal beneficiaries to mental health services and supports, making recommendations regarding performance and outcome measures, and providing an updated Performance Outcomes System plan to the fiscal and appropriate policy committees of the Legislature by October 1, 2014. The amendment also requires the department to propose how to implement the updated Performance Outcomes System plan by January 10, 2015. The Legislature has not yet received this updated system plan.

DHCS indicates that it has experienced unanticipated delays in implementing the Performance Outcomes System and has determined that additional resources are needed. According to DHCS, these ongoing challenges include:

- The work to identify the reporting metrics was more labor-intensive than originally anticipated, and is expected to be an ongoing and changing process as different data reporting needs are identified by the Subject Matter Expert Workgroup, the larger System Stakeholder Advisory Committee, DHCS and its partners (e.g., counties, other state agencies).

- The incorporation of the Katie A. data reporting requirements into the system, which involves continuous collaboration with the California Department of Social Services staff. (The *Katie A. vs. Bonta* case was first filed on July 18, 2002, as a class action suit on behalf of children, who were not given services by both the child protective system and the mental health system in California. See Part B of this agenda for more information on Katie A.)

- The continuous nature of working with counties to improve the quality of the data submitted to DHCS, which are critical and more labor-intensive than originally anticipated.

*Initial Performance Outcomes System Statewide Reports***.** On March 24, 2015, DHCS posted initial performance outcomes system statewide reports that focus on the demographics of the children and youth under 21 who are receiving Specialty Mental Health Services, based on approved claims for Medi-Cal eligible beneficiaries. The statewide reports establish a foundation for ongoing reporting and will be updated every six months. Three reports will be provided: statewide aggregated data (which was released on March 24th); county groups; and county-specific data. Additionally, in the future, DHCS indicates that foster care information will be delineated in these reports.

STAKEHOLDER PROPOSALS

Community mental health stakeholders have raised several issues of concern, including:

1. ***Employment support for individuals with mental illness that used to exist in the former Department of Mental Health***. DHCS agrees that this is important and is in the process of exploring this issue and meeting with the Department of Rehabilitation and stakeholders.

2. ***Reduction to county documentation requirements for federal billing standards***. Advocates report that a national expert reviewed the documentation requirements of California counties and found that it took 20 minutes to prepare progress notes for a single psychotherapy session, as compared to five minutes in other states. Advocates believe that mandating a reduction to county documentation requirements would save the state a substantial amount of money. Advocates propose contracting with an expert consultant for this purpose.

3. ***State funding for residential crisis care for children***. Advocates state that providing funding for residential crisis care for adults, but not for children, is a violation of federal law. DHCS agrees that this type of care is required to be covered, and that counties must provide this care to children who need it; however, a county may provide the care outside of the county of residence. DHCS also acknowledges that residential crisis care beds for kids and adults have been declining for years.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of community mental health programs, present the Budget Change Proposal and respond to the following:

1. Please explain DHCS's activities related to oversight and monitoring of the Proposition 63 funds distributed to counties (e.g., audits, cost reporting analysis). If deficiencies are found, what tools does DHCS have to remediate the problems?

2. Please provide an update on counties reporting Proposition 63 revenues and expenditures for 2012-13 (the most current information available). How does DHCS work with counties that have not submitted this information?

3. When will the Legislature receive the Performance Outcomes System Plan Update (due October 2014) and the Performance Outcomes System Implementation Plan Update (due January 2015)?

The Subcommittee requests the Legislative Analyst's Office to provide a brief description of the stakeholder proposals included in this section of the agenda, and requests DHCS to provide technical assistance reactions to them.

Staff Recommendation: Staff recommends holding open the Performance Outcome System Budget Change Proposal pending receipt of the required Plan and Implementation Plan Updates.

4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 1: OVERVIEW & STAKEHOLDER PROPOSALS

PANELISTS

- **Toby Ewing,** Executive Director, Mental Health Oversight & Accountability Commission
- **Amelia Lawless**, Finance Analyst, Department of Finance
- **Carla Castañeda**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

Mental Health Services Act (Proposition 63, Statutes of 2004). The Mental Health Services Act (MHSA) imposes a one percent income tax on personal income in excess of $1 million. These tax receipts are reconciled and deposited into the MHSA Fund on a "cash basis" (cash transfers) to reflect funds actually received in the fiscal year. The MHSA provides for a continuous appropriation of funds for local assistance.

The purpose of the MHSA is to expand mental health services to children, youth, adults, and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources).

Most of the act's funding is to be expended by county mental health departments for mental health services consistent with their approved local plans (three-year plans with annual updates) and the required five components, as contained in the MHSA. The following is a brief description of the five components:

- **Community Services and Supports for Adult and Children's Systems of Care.** This component funds the existing adult and children's systems of care established by the Bronzan-McCorquodale Act (1991). County mental health departments are to establish, through its stakeholder process, a listing of programs for which these funds would be used. Of total annual revenues, 80 percent is allocated to this component.

- **Prevention and Early Intervention.** This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations. Of total annual revenues, 20 percent is allocated to this component.

- **Innovation.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and promote interagency

collaboration. This is funded from five percent of the Community Services and Supports funds and five percent of the Prevention and Early Intervention funds.

- **Workforce Education and Training.** The component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of $460.8 million. Counties have 10 years to spend these funds.

- **Capital Facilities and Technological Needs.** This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports, and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of $460.8 million. Counties have 10 years to spend these funds.

Mental Health Services Oversight and Accountability Commission. The Mental Health Services Oversight and Accountability Commission (MHSOAC) was established in 2005 and is composed of 16 voting members. Among other things, the role of the MHSOAC is to:

- Ensure that services provided, pursuant to the MHSA, are cost effective and provided in accordance with best practices;

- Ensure that the perspective and participation of members and others with severe mental illness and their family members are significant factors in all of its decisions and recommendations; and,

- Recommend policies and strategies to further the vision of transformation and address barriers to systems change, as well as providing oversight to ensure funds being spent are true to the intent and purpose of the MHSA.

MHSOAC Budget. The table below shows the MHSOAC funding (MHSA State Administration funds) over three years. The significant changes in funding reflects the implementation of the Investment in Mental Health Wellness, which provided substantial funding to the MHSOAC to implement triage grants, including $19.3 million in 2014-15 in the form of a reappropriation from 2013-14 due to insufficient time for full expenditure of funds in 2013-14.

	2013-14 Actual	2014-15 Estimated	2015-16 Proposed
Total MHSOAC Funds	$18,085,000	$82,742,000	$63,372,000
Positions	25.2	30.0	30.0

Overview of MHSOAC Evaluation Efforts. On March 28, 2013 the MHSOAC approved an Evaluation Master Plan which prioritizes possibilities for evaluation investments and activities over a five year course of action. The MHSOAC five-year Evaluation Master Plan (July 2013 – June 2018) describes seven activities related to performance monitoring, ten evaluation projects, and eight exploratory/developmental work efforts. Of these 25 activities, 2 have been completed, 12 are in progress, 2 are in planning stages and will begin in 2015-16, and 9 are a lower priority and are scheduled to begin later than 2015-16. The 2013 budget provided resources for six positions to implement the Evaluation Master Plan. In total, the MHSOAC has completed 8 evaluation projects since adoption of the Master Plan in March 2013, has 17 in progress and 6 in planning. The MHSOAC also points out that this is a summary of evaluation projects being facilitated by MHSOAC, however there are many other entities engaged in MHSA evaluation projects, including by counties.

Improving Community Mental Health Data. Current mental health data collection and reporting systems do not provide timely data that allows the MHSOAC to evaluate all aspects of the MHSA and broader public community-based mental health systems. Consequently, the MHSOAC has contracted with an outside vendor to prepare an advanced planning document and/or a feasibility study report to improve the data systems at the Department of Health Care Services (DHCS) to fully address the data needs of the MSHOAC and DHCS. This contract will identify the MHSOAC's current data and reporting needs, compare them to what is available via current data systems, and draw conclusions regarding data elements that are missing and not available.

Triage Grants. SB 82 (Committee of Budget and Fiscal Review), Chapter 34, Statutes of 2013, enacted the Investment in Mental Health Wellness Act of 2013 which appropriated $54.4 million to the MHSOAC as follows:

> $54 million ($32 million Mental Health Services Act [MHSA] State Administration and $22 million federal) in ongoing funding to add 600 mental health triage personnel in select rural, urban, and suburban regions. Also required the MHSOAC to provide a status report to the Legislature on the progress of allocating the triage personnel funding. This report was submitted to the Legislature on February 28, 2014.

To conduct a competitive grant process for this funding, the MHSOAC developed Request for Applications guidelines for submitting grant proposals. In this process, MHSOAC gathered subject matter experts to advise staff on the grant criteria. Additionally, the MHSOAC used the five regional designations utilized by the California Mental Health Directors Association to ensure that grants would be funded statewide in rural, suburban, and urban areas. As such, the $32 million of MHSA funds available annually was divided between the following regions:

Southern	$10,848,000
Los Angeles	$9,152,000
Central	$4,576,000
Bay Area	$6,208,000
Superior	$1,216,000
Total	**$32,000,000**

Grants cover four fiscal years, with grant funds allocated annually for 2013-14 (for five months), 2014-15, 2015-16, and 2016-17.

A total of 47 grant applications were submitted to the MHSOAC. Twenty-four counties were awarded grant funding. The MHSOAC approved 24 triage grants and allocated funds for 491 triage positions. As of March 16, 2015 counties have hired 86 triage staff and continue to expand the number of mental health personnel available to provide crisis support services that include crisis triage, targeted case management and linkage to services for individuals with mental health illness who require a crisis intervention. These personnel will be located in hospitals, emergency rooms, jails, shelters, high schools, crisis stabilization and wellness centers, and other community locations where they can engage with persons needing crisis services. According to the MHSOAC, counties are having extreme difficulty in hiring due to workforce shortages in the selected classification. The MHSOAC is continuing to work with counties to evaluate these hiring issues.

STAKEHOLDER PROPOSALS

CAYEN. Advocates propose an augmentation to an existing MHSOAC contract with the California Youth Empowerment Network (CAYEN) by $300,000 to allow more youth to participate and to get better responses to survey strategies. The current contract is for $300,000 and this proposal is to double that amount, using MHSA State Administration funds. This contract brings transition age (16-25) perspective to the development of mental health services and policies.

REMHDCO. REMHDCO (Racial and Ethnic Mental Health Disparities Coalition) proposes to transfer the contract with REMHDCO from the Department of Public Health's (DPH) Office of Health Equity to the MHSOAC, as the current contract with DPH expires February 29, 2016. The three month cost of this contract (April – June) is about $187,000 and a full year cost is $560,000. REMHDCO proposes a new 3-year contract with MHSOAC funded with MHSA State Administration funding. REMHDCO is a statewide coalition of individuals from non-profit state-wide and local organizations whose mission is to work to reduce mental health disparities through advocacy for racial and ethnic communities.

Statewide Prevention & Early Intervention (PEI) Programs. Advocates propose that new funding be identified to continue statewide PEI programs for which the existing funding structure is coming to an end. CalMHSA is a joint powers authority created to implement statewide mental health strategies and develop best practices for counties to adopt on a long-term basis. CalMHSA has been funded by Proposition 63 contributions from counties with a four-year contract which expires soon. The statewide PEI programs implemented by CalMHSA include: 1) suicide hotline; 2) student mental health; and 3) stigma and discrimination reduction. The future of these programs, and of CalMHSA, is unknown at this point in time. Therefore, advocates have suggested that either Proposition 63 State Administration funds, or possibly Proposition 63 county funds, via a statutory requirement on counties, could be used to continue these projects. The MHSOAC suggests that if the suicide hotline were to become a state responsibility,

other more stable and appropriate funding sources should be explored, such as using the 911 funding system which utilizes a fee on phone users.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests MHSOAC to provide an overview of the Commission and respond to the following:

1. Please explain how the MHSOAC ensures that services provided, pursuant to the MHSA, are cost effective and consistent with the MHSA.

2. Please provide a review of the MHSOAC's evaluation efforts and activities.

3. How is MHSOAC monitoring counties' implementation of the Triage grants? Why have counties established only 86 of the 490 positions?

4. Please describe the amount of funding available as MHSA state administration and whether there is sufficient funding to make it possible to support new activities such as those proposed by stakeholders.

The Subcommittee requests the Legislative Analyst's Office to provide a brief description of the stakeholder proposals included in this section of the agenda, and requests MHSOAC to provide technical assistance reactions to them.

Staff Recommendation: No action is recommended at this time.