AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, APRIL 17, 2023

2:30 PM, STATE CAPITOL, ROOM 127

This hearing may be viewed via its live stream on the Assembly's website at https://www.assembly.ca.gov/todaysevents.

We encourage the public to provide written testimony before the hearing. Please send your written testimony to: BudgetSub1@asm.ca.gov. Please note that any written testimony submitted to the committee is considered public comment and may be read into the record or reprinted.

The public may provide public comment after all witnesses on all panels and issues have concluded, and after the conclusion of member question by calling toll-free: ***877-692-8957, access code: 131 51 27***

ITEMS TO BE HEARD

NON-PRESENTATION ITEMS

LIST OF PANELISTS IN ORDER OF PRESENTATION

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 1: OVERVIEW OF COMMISSION AND COMMISSION'S BUDGET, INCLUDING SPRING FINANCE LETTER RE-APPROPRIATIONS

PANEL

- **Toby Ewing**, Ph.D., Executive Director, Mental Health Services Oversight and Accountability Commission (OAC)
- **Diana Vazquez-Luna**, Finance Budget Analyst, DOF
- **Guadalupe Manriquez**, Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, Legislative Analyst's Office (LAO)

CHILDREN AND YOUTH BEHAVIORAL HEALTH

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 2: OVERSIGHT: CHILDREN AND YOUTH BEHAVIORAL HEALTH

PANEL

- **Fiona Lu**, Youth Advocate, GENup
- **Kassy Poles**, Youth Mental Health Advocate, CYBHI Advisory Board Member
- **Melissa Stafford Jones**, Director, California Children and Youth Behavioral Health Initiative, California Health and Human Services Agency (CHHS)
- **Autumn Boylan**, Deputy Director Office of Strategic Partnerships, Department of Health Care Services (DHCS)
- **Toby Ewing**, Ph.D., Executive Director, OAC
- **Michelle Cabrera**, Executive Director, County Behavioral Health Directors Association (CBHDA)
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

ISSUE 3: CHHS: CYBHI RE-APPROPRIATION, SPRING FINANCE LETTER ISSUE 56

PANEL

- **Nina Hoang,** Finance Budget Analyst, DOF
- **Matthew Aguilera,** Principal Program Budget Analyst, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

ISSUE 4: DHCS: CHILDREN'S PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (AB 2317) TRAILER BILL

PANEL

- **Michelle Baass**, Director, DHCS
- **Christine Stoner-Mertz**, Chief Executive Officer, California Alliance of Child and Family Services
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

SUICIDE PREVENTION

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4150 DEPARTMENT OF MANAGED HEALTH CARE
4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 DEPARTMENT OF PUBLIC HEALTH
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 5: OVERSIGHT: SUICIDE PREVENTION ISSUES INCLUDING: OFFICE OF SUICIDE PREVENTION, CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE, SOCIAL MEDIA, STATEWIDE STRATEGIC PLAN, AND CALHOPE

PANEL

- **Lishaun Francis**, Senior Director, Behavioral Health, Children Now
- **Shari Sinwelski**, LPCC, Vice-President Crisis Care, Didi Hirsch Mental Health Services
- **Tara Niendam**, Ph.D., Professor in Psychiatry, Executive Director, UC Davis Early Psychosis Programs, Director, Early Psychosis Intervention Training and Technical Assistance Program for California
- **Sara Mann**, Violent Injury Policy and Program Section Chief, Center for Healthy Communities, California Department of Public Health (CDPH)
- **Ana Bolanos**, Assistant Deputy Director, Office of Health Equity, CDPH
- **Michelle Baass**, Director, DHCS
- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Toby Ewing**, Ph.D., Executive Director, OAC
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

ISSUE 6: 988 SUICIDE AND CRISIS LIFELINE BUDGET CHANGE PROPOSAL, TRAILER BILL, AND SPRING FINANCE LETTER PROVISIONAL LANGUAGE

PANEL

- **Kimberly Chen**, Assistant Secretary, Program and Fiscal Affairs, CHHS
- **Tara Gamboa-Eastman**, Senior Advocate, Steinberg Institute
- **Shari Sinwelski**, LPCC, Vice-President Crisis Care, Didi Hirsch Mental Health Services
- **Michelle Cabrera**, Executive Director, CBHDA
- **Diana Vazquez-Luna,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 7: OVERVIEW OF DEPARTMENT AND DEPARTMENT'S BUDGET

PANEL

- **Stephanie Clendenin**, Director, Department of State Hospitals (DSH)
- **Brent Houser**, Chief Deputy Director, Operations, DSH
- **Chris Edens**, Chief Deputy Director, Program Services, DSH
- **Nina Hoang,** Finance Budget Analyst, Department of Finance (DOF)
- **Matthew Aguilera,** Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

JUSTICE INVOLVEMENT AND BEHAVIORAL HEALTH

4260 DEPARTMENT OF HEALTH CARE SERVICES
4440 DEPARTMENT OF STATE HOSPITALS
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 8: OVERSIGHT: JUSTICE INVOLVEMENT ISSUES INCLUDING INCOMPETENT TO STAND TRIAL WAITING LIST

PANEL

- **Stephanie Clendenin**, Director, DSH
- **Chris Edens**, Chief Deputy Director, Program Services, DSH
- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Toby Ewing**, Ph.D., Executive Director, OAC
- **Phebe Bell**, Nevada County Behavioral Health Director, CBHDA
- **Nina Hoang,** Finance Budget Analyst, DOF
- **Matthew Aguilera,** Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 9: DSH: DEPARTMENT OF STATE HOSPITALS CRIMINAL OFFENDER RECORD INFORMATION DATA TRAILER BILL

PANEL

- **Jaci Thomson**, Deputy Director, Hospital Strategic Planning and Implementation, DSH
- **Janna Lowder**, Research Data Officer, DSH
- **Nina Hoang,** Finance Budget Analyst, DOF
- **Matthew Aguilera,** Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 10: DHCS: CALAIM JUSTICE INVOLVED INITIATIVE

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Phebe Bell**, Nevada County Behavioral Health Director, CBHDA
- **Kendra Tully,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

HOMELESSNESS AND BEHAVIORAL HEALTH

4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 11: OVERSIGHT: HOMELESSNESS ISSUES INCLUDING: EARLY PSYCHOSIS TREATMENT, FULL SERVICE PARTNERSHIPS, BRIDGE HOUSING, AND CALAIM HOUSING SUPPORTS

PANEL

- **Tara Niendam**, Ph.D., Professor in Psychiatry, Executive Director, UC Davis Early Psychosis Programs, Director, Early Psychosis Intervention Training and Technical Assistance Program for California
- **Jonathan Porteus**, Ph.D., Chief Executive Officer, WellSpace Health
- **Phebe Bell**, Nevada County Behavioral Health Director, CBHDA
- **Toby Ewing**, Ph.D., Executive Director, OAC
- **Michelle Baass**, Director, DHCS
- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 12: PROPOSED FUNDING DELAY: BEHAVIORAL HEALTH BRIDGE HOUSING AND BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE PROGRAM

PANEL

- **Michelle Baass**, Director, DHCS
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

ISSUE 13: DHCS: COMMUNITY ASSISTANCE, RECOVERY, AND EMPOWERMENT COURT (SB 1338) BUDGET CHANGE PROPOSAL

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Diana Vazquez-Luna,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 14: DHCS: ENHANCED LANTERMAN-PETRIS SHORT ACT DATA AND REPORTING (SB 929) TRAILER BILL

PANEL

- **Tyler Sadwith**, Deputy Director Behavioral Health, DHCS
- **Michelle Cabrera**, Executive Director, CBHDA
- **Diana Vazquez-Luna,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez**, Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

BEHAVIORAL HEALTH WORKFORCE

4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION
4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 15: OVERSIGHT: BEHAVIORAL HEALTH WORKFORCE ISSUES INCLUDING: CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE AND EARLY PSYCHOSIS TREATMENT

PANEL

- **Janet Coffman**, Associate Director, UCSF Institute for Health Policy Studies (*Remote Speaker*)
- **Tara Niendam**, Ph.D., Professor in Psychiatry, Executive Director, UC Davis Early Psychosis Programs, Director, Early Psychosis Intervention Training and Technical Assistance Program for California
- **Le Ondra Clark Harvey**, Ph.D., CEO, California Council of Community Behavioral Health Agencies
- **Michelle Cabrera**, Executive Director, CBHDA
- **Caryn Rizell**, Deputy Director, Health Workforce Development, Department of Health Care Access and Information
- **Joseph Donaldson**, Finance Budget Analyst, DOF
- **Matthew Aguilera**, Principal Program Budget Analyst, DOF
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

ISSUE 16: PROPOSED FUNDING DELAY: BEHAVIORAL HEALTH WORKFORCE INVESTMENTS

PANEL

- **Joseph Donaldson**, Finance Budget Analyst, DOF
- **Matthew Aguilera**, Principal Program Budget Analyst, DOF
- **Michelle Cabrera**, Executive Director, CBHDA
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

ISSUE 17: DSH: PSYCHIATRY WORKFORCE PIPELINE, RECRUITMENT, HIRING AND RETENTION BUDGET CHANGE PROPOSAL

PANEL

- **Brent Houser**, Chief Deputy Director, Operations, DSH
- **Dr. Katherine Warburton**, Statewide Medical Director, DSH
- **Nina Hoang,** Finance Budget Analyst, DOF
- **Matthew Aguilera,** Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

MANAGED CARE AND BEHAVIORAL HEALTH

4150 DEPARTMENT OF MANAGED HEALTH CARE
4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 18: OVERSIGHT: MANAGED CARE BEHAVIORAL HEALTH SERVICES

PANEL

- **Rachel Hotz**, Peer Advocate
- **Bonnie Hotz**, Family Advocate
- **Toby Ewing**, Ph.D., Executive Director, OAC
- **Michelle Cabrera**, Executive Director, CBHDA
- **Jedd Hampton**, Director of Legislative Affairs, California Association of Health Plans
- **Mary Watanabe**, Director, DMHC
- **Dan Southard**, Chief Deputy Director, DMHC
- **Michelle Baass**, Director, DHCS
- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Joseph Donaldson**, Finance Budget Analyst, DOF
- **Matthew Aguilera**, Principal Program Budget Analyst, DOF
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

ISSUE 19: DMHC: AUGMENT BEHAVIORAL HEALTH FOCUSED INVESTIGATIONS WORKLOAD, SPRING FINANCE LETTER ISSUE 42

PANEL

- **Mary Watanabe**, Director, DMHC
- **Dan Southard**, Chief Deputy Director, DMHC
- **Joseph Donaldson**, Finance Budget Analyst, DOF
- **Matthew Aguilera**, Principal Program Budget Analyst, DOF
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

CalAIM BEHAVIORAL HEALTH

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 20: OVERSIGHT: CALAIM BEHAVIORAL HEALTH

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Michelle Cabrera**, Executive Director, CBHDA
- **Diana Vazquez-Luna,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 21: CALIFORNIA'S BEHAVIORAL HEALTH COMMUNITY-BASED CONTINUUM (CALBH-CBC) WAIVER

PANEL

- **Tyler Sadwith**, Deputy Director Behavioral Health, DHCS
- **Michelle Cabrera**, Executive Director, CBHDA
- **Diana Vazquez-Luna,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 22: BEHAVIORAL HEALTH PAYMENT REFORM TRAILER BILL AND CASH FLOW FUNDING

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Michelle Cabrera**, Executive Director, CBHDA
- **Diana Vazquez-Luna,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 23: SACRAMENTO AND SOLANO COUNTIES KAISER SPECIALTY MENTAL HEALTH CARVE-OUT

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Ryan Quist**, Behavioral Health Director, Sacramento County
- **Emery Cowan**, LPCC, LMHC, Chief Deputy, Behavioral Health Director, Solano County Department of Health & Social Services
- **Diana Vazquez-Luna,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

SUBSTANCE USE DISORDERS PREVENTION AND TREATMENT

4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 24: OVERSIGHT: SUBSTANCE USE DISORDER PREVENTION AND TREATMENT ISSUES

PANEL

- **Laura Thomas**, MPH, MPP, Senior Director, HIV and Harm Reduction Policy, San Francisco AIDS Foundation (*Remote Speaker*)
- **Michelle Cabrera**, Executive Director, CBHDA
- **Michelle Baass**, Director, DHCS
- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Toby Ewing**, Executive Director, OAC
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

ISSUE 25: DHCS: OPIOID SETTLEMENTS FUND STATE DIRECTED PROGRAMS BUDGET CHANGE PROPOSAL

PANEL

- **Tyler Sadwith**, Deputy Director Behavioral Health, DHCS
- **Michelle Cabrera**, Executive Director, CBHDA
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

ISSUE 26: CDPH: FENTANYL PROGRAM GRANTS (AB 2365) AND INNOVATIVE APPROACHES TO MAKE FENTANYL TEST STRIPS AND NALOXONE MORE WIDELY AVAILABLE BUDGET CHANGE PROPOSAL

PANEL

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Alessandra Ross**, Harm Reduction Unit Chief, Office of AIDS, Center for Infectious Disease, CDPH
- **Laura Thomas**, MPH, MPP, Senior Director, HIV and Harm Reduction Policy, San Francisco AIDS Foundation (*Remote Speaker*)
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 27: CDPH: FENTANYL PROGRAM GRANTS REPORTING REQUIREMENTS (AB 2365) TRAILER BILL

PANEL

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Alessandra Ross**, Harm Reduction Unit Chief, Office of AIDS, Center for Infectious Disease, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 28: DHCS: STRENGTHENING OVERSIGHT FOR SUBSTANCE USE DISORDER LICENSING AND CERTIFICATION BUDGET CHANGE PROPOSAL AND TRAILER BILL

PANEL

- **Michelle Baass**, Director, DHCS
- **Robb Layne**, Executive Director, California Association of Alcohol and Drug Program Executives, Inc.
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

ISSUE 29: DHCS: DRUG MEDI-CAL CLAIMING TIMELINES TRAILER BILL

PANEL

- **Tyler Sadwith**, Deputy Director Behavioral Health, DHCS
- **Michelle Cabrera**, Executive Director, CBHDA
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

NON-PRESENTATION ITEMS

- ✓ There are no panels for non-presentation items (items 30 – 48), however any item can be moved to presentation at any time before or during the hearing by any Member.

- ✓ Public Comment will be taken on all issues on the agenda, including non-presentation items, after the completion of all panels and all discussion by the Members of the Subcommittee.

ITEMS TO BE HEARD

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 1: OVERVIEW OF COMMISSION AND COMMISSION'S BUDGET, INCLUDING SPRING FINANCE LETTER RE-APPROPRIATIONS

PANEL

- **Toby Ewing**, Ph.D., Executive Director, Mental Health Services Oversight and Accountability Commission (OAC)
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance (DOF)
- **Guadalupe Manriquez**, Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, Legislative Analyst's Office (LAO)

PROPOSAL

The Governor's Budget proposes $47.9 million (Mental Health Services Fund) for the Mental Health Services Oversight and Accountability Commission (Commission) for 2023-24, a reduction of approximately $161 million from 2022-23 and a reduction of approximately $135 million from 2021-22. This reduction reflects significant one-time appropriations to the Commission included in the 2021 and 2022 Budget Acts.

3-YEAR EXPENDITURES AND POSITIONS

		Positions			Expenditures		
		2021-22	2022-23	2023-24	2021-22*	2022-23*	2023-24*
4170	Mental Health Services Oversight and Accountability Commission	44.7	54.0	56.0	$182,924	$209,328	$47,969
TOTALS, POSITIONS AND EXPENDITURES (All Programs)		**44.7**	**54.0**	**56.0**	**$182,924**	**$209,328**	**$47,969**

FUNDING		**2021-22***	**2022-23***	**2023-24***
0995	Reimbursements	$-	$42,900	$-
3085	Mental Health Services Fund	182,924	166,428	47,969
TOTALS, EXPENDITURES, ALL FUNDS		**$182,924**	**$209,328**	**$47,969**

Expense Type	Item	Approved FY 22-23 Budget	Adjustment	Adjusted FY 22-23 Budget	Proposed FY 23-24 Budget
Operations	Personnel	$8,100,000	($720,000)	$7,380,000	$8,968,000
	Core Operations	$1,484,552	$300,000	$1,784,552	$4,295,000
Commission Priorities	Communications	$467,448	$420,000	$887,448	
	Innovation	$100,000		$100,000	
	Research	$1,116,000		$1,116,000	
Budget Directed	California Behavioral Outcomes Fellowship	$5,000,000		$5,000,000	
	Evaluation of FSP Outcomes (SB 465)	$400,000		$400,000	$400,000
	MHSSA Evaluation and Admin (avail over 5 years)	$16,646,000		$16,646,000	
Local Assistance	Mental Health Wellness Act	$20,000,000		$20,000,000	$20,000,000
	Mental Health Student Services Act	$8,830,000		$8,830,000	$7,606,000
	Community Advocacy	$6,700,000		$6,700,000	$6,700,000
	Children and Youth Behavioral Health Initiative	$42,900,000		$42,900,000	
Money Held for Reserve					
Total		$111,744,000		$111,744,000	$47,969,000

Significant recent one-time appropriations include:

2021 One-Time Appropriations

- $205 million – Mental Health Student Services Act Partnership Grant Program
- $5 million – Peer Social Media Anti-Bullying Project

2022 One-Time Appropriations

- $42.9 million – Children and Youth Behavioral Health Initiative
- $16.6 million – Staffing and Operations
- $5 million – California Behavioral Health Outcomes Fellowship for Transformational Change

The following three requests for re-appropriations were included in the Department of Finance Spring Finance Letter

1. *Allcove™ Youth Drop-In Centers Program Re-appropriation*—It is requested that Schedule 1 of Item 4560-490 be amended to specify that up to $2 million Mental Health Services Fund is available for re-appropriation from Item 4560-101-3085, Budget Act of 2019 to support the Allcove™ Youth Drop-In Centers Program, which provides grants to counties to increase the accessibility to mental health and wellness services for youth between the ages of 12 to 25 and their families.

2. *Early Psychosis Intervention Plus Program Re-appropriation*—It is requested that Schedule 2 be added to Item 4560-490 to re-appropriate $1,675,000 Mental Health Services Fund from Item 4560-101-3085, Budget Act of 2019 to support the Early Psychosis Intervention Plus Program. Program grantee implementation was delayed due to the impact of the COVID-19 public health emergency. As a result, the Commission requests an extended timeline to implement the corresponding Program public awareness campaign and evaluate county Program implementation.

3. *Mental Health Wellness Program Re-appropriation*—It is requested that Schedules 3, 4, and 5 be added to Item 4560-490 to re-appropriate $16,499,000 Mental Health Services Fund from Items 4560-001-3085, Budget Act of 2017 and 4560-101-3085, Budget Acts of 2019 and 2020 to support the Mental Health Wellness Program, previously known as the Triage Grant Program. In alignment with the expanded Program flexibility under Chapter 47, Statutes of 2022 (SB 184), the Commission proposes to repurpose unspent prior year Program funding to expand hospital emergency psychiatric assessment, treatment, and healing units which reduce unnecessary emergency department utilization and hospitalizations.

Amend Item 4560-490 as follows:

"4560-490—Reappropriation, Mental Health Services Oversight and Accountability Commission. The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for in those appropriations and shall be available for encumbrance or expenditure ~~until June 30, 2024~~ as specified below:

3085—Mental Health Services Fund

(1) Up to $2,000,000 Provision 4 of Item 4560-101-3085, Budget Act of 2019 (Chs. 23 and 363, Stats. 2019), as reappropriated by Item 4560-494, Budget Act of 2022, until June 30, 2024.

(2) Up to $1,675,000 in Provision 3 of Item 4560-101-3085, Budget Act of 2019 (Chs. 23 and 363, Stats. 2019), until June 30, 2024.

(3) Up to $2,521,000 in Item 4560-001-3085, Budget Act of 2017, as reappropriated by Item 4560-491, Budget Act of 2018, until June 30, 2025.

(4) Up to $8,184,000 in Provision 1 of Item 4560-101-3085, Budget Act of 2019 (Chs. 23 and 363, Stats. 2019), until June 30, 2025.

(5) Up to $5,794,000 in Provision 1 of Item 4560-101-3085, Budget Act of 2020 (Chs. 6 and 40, Stats. 2020), until June 30, 2025."

Mental Health Services Fund

Proposition 63, also known as the Mental Health Services Act (MHSA), was approved by voters in 2004 and became effective January 1, 2005. The MHSA imposes a 1- percent tax on personal income in excess of $1 million. Revenue from the Proposition 63 tax is

collected in the Mental Health Services Fund (MHSF), and 95 percent of it is automatically distributed to counties via formula by the State Controller. Five percent of the revenue stays with the state (in the "State Directed Purposes Cap") for state oversight of the MHSA and related programmatic functions.

Proposition 63 revenue is volatile, but remained at approximately $2 billion for many years prior to the pandemic, during which time the revenue rose significantly to approximately $5 billion. The information in the following chart is from the MHSF Fund Condition Statement in the Governor's Budget:

3085—Mental Health Services Fund (Dollars in Thousands)

2021-22	
Beginning Reserve	$102,512
Revenues	$5,443,071
Expenditures	$6,488,873
2022-23	
Beginning Reserve	-$943,290
Revenues	$3,493,194
Expenditures	$3,576,940
2023-24	
Beginning Reserve	-$1,027,036
Revenues	$3,426,537
Expenditures	$3,361,185
Ending Reserve	-$961,684

State Directed Purposes Cap

Up to 5 percent of MHSA revenue can be spent on state administration and state purposes. These funds are spent on various mental health-related programs and purposes throughout state government, as can be seen in the following chart:

Mental Health Services Act Fund
State Directed Purposes
2023 Governor's Budget
Numbers are in thousands

	2021-22[6/]	2022-23	2023-24
5% STATE DIRECTED CAP BEGINNING BALANCE [1/, 2/]	$ 102,512	$ 706,325	$ 622,579
REVENUE ADDED TO STATE DIRECTED CAP [3/]	753,767	174,660	171,327
TOTAL RESOURCES IN STATE DIRECTED CAP	856,279	880,985	793,906
STATE DIRECTED CAP APPROPRIATIONS			
0250 Judicial Branch	1,191	1,263	1,251
0977 California Health Facilities Financing Authority	16,070	18,219	4,000
2240 Department of Housing and Community Development	154	433	-
4140 Department of Health Care Access and Information	10,734	14,993	2,605
4260 Department of Health Care Services[4/]	13,990	41,771	38,028
4260 Less funding provided by the General Fund[5/]	(100,000)	-	-
4265 Department of Public Health	13,755	5,202	2,598
4300 Department of Developmental Services	1,004	1,251	1,251
4560 Mental Health Services Oversight & Accountability Commission	182,924	166,428	47,969
5225 Department of Corrections and Rehabilitation	1,049	1,082	1,081
6100 Department of Education	127	192	192
6870 California Community Colleges	110	115	115
7501 Department of Human Resources	-	150	150
8940 Department of the Military	1,261	1,604	1,661
8955 Department of Veterans Affairs	1,540	1,569	1,568
9892 Supplemental Pension Payments	509	509	505
9900 Statewide General Administration	5,536	3,625	3,001
TOTAL APPROPRIATIONS	149,954	258,406	105,975
FUND BALANCE	706,325	622,579	687,931

[1/] This chart represents Mental Health Services Fund appropriations subject to the five percent state directed cap pursuant to Welfare and Institutions Code Section 5892(d).
[2/] The beginning balance represents the cumulative fund balance of prior years. For example, 2023-24 is the cumulative total of prior year savings between 2012-13 and 2022-23.
[3/] 2021-22 includes prior year adjustments.
[4/] Includes local assistance for DHCS of $22,050,000 in 2022-23 and $22,750,000 in 2023-24 to train providers on delivering adverse childhood experiences screenings and $9,000,000 in 2022-23 and $4,577,000 in 2023-24 to support the CalHOPE Peer-Run Warm Line.
[5/] 2021-22 reflects an expenditure transfer of $100 million from the General Fund to the Mental Health Services Fund.
[6/] The Mental Health Services Fund 2021-22 actuals are not reconciled as of the 2023 Governor's Budget. Amounts reflect best estimates at the time of publication.
Last updated 4/6/2023.

BACKGROUND

The Commission provided the following background information, which is available on the Commission's website: www.mhsoac.ca.gov.

Commission's History and Mission

Proposition 63, approved by California voters in 2004, created the Mental Health Services Oversight and Accountability Commission to drive transformational change across the state's mental health system.

The Commission oversees the implementation of the far-reaching initiative, which imposed a 1 percent income tax on wealthy residents to pay for mental health services and established a framework for continuous improvement of mental healthcare in the state.

Partnering with public and private mental health agencies at all levels, the Commission works to ensure that people get the care they need in a timely, comprehensive, effective, and culturally competent manner. In everything, it vigorously promotes community collaboration.

A hallmark of the Mental Health Services Act (MHSA) is its directive that the Commission empower stakeholders and put them at the center of its decision-making process. Accordingly, the law reserves seats on the Commission for representatives of consumers and their families, service providers, law enforcement, educators, and employers, among others. The Commission also includes representatives of the Attorney General, the Superintendent of Public Instruction, the State Senate, and the State Assembly.

The Commission's primary function is to oversee the implementation of the Mental Health Services Act. The Commission distributes grants, collects and shares spending and efficacy data on local programs, spreads best practices, conducts research into critical subject areas like criminal justice involvement of people with mental health needs, and engages experts to develop policy proposals and other path-breaking solutions.

Data collection is an increasingly important focus for the Commission; its Transparency Suite is an online tool that provides high-level spending and outcome metrics for programs by county.

The Act charges the Commission with reviewing county spending of Mental Health Services Act money for prevention and early intervention programs. The Commission also distributes money raised through the Act for local innovation projects that pioneer new approaches to administration and treatment, like youth drop-in centers.

Another of the Commission's continuing endeavors is to develop ways to overcome the stigma that often faces people living with mental health challenges.

The Commission advises the Governor and Legislature on mental health policy. In addition, lawmakers have periodically given the Commission new responsibilities, including distributing grants to expand mental health services in schools, helping develop

voluntary standards to support mental health in the workplace, and helping to build a statewide suicide prevention plan.

Commission's Work

The following is an overview of major projects undertaken by the Commission and funded through the budgets over the past 3-5 years. Additional detail can be found in the Commission's PowerPoint document, prepared for this hearing, which can be found on the Subcommittee's website with this agenda:
https://abgt.assembly.ca.gov/sub1hearingagendas

Mental Health Student Services Act Partnership Grant Program

- 57 county behavioral health departments, serving 440 out of 1,021 school districts, 2,100 schools
- Engaged 50 county offices of education/superintendents of schools
- Invested more than $300 million to support school mental health initiatives
- 500 new mental health staff in schools funded by MHSSA

Suicide Prevention

- Partnered with the Legislature to draft a historic suicide prevention plan
- Partnered with CDPH to relaunch California's Office of Suicide Prevention
- Delivering training sessions on suicide risk screening
- More than 1,400 school personnel have received Commission-supported training
- Established a suicide prevention learning collaborative serving 35 counties

Full Service Partnerships

- In partnership with philanthropy and county behavioral health departments, the Commission launched a multi-county collaborative supported by MHSA innovation funding
- Partnered with the Legislature to require biennial reporting on FSP outcomes
- Built the data infrastructure to link service information to justice involvement and hospitalization

Substance Use Disorder Services

- Sponsored AB 2265 to established presumptive eligibility for MHSA care for persons with SUD needs
- Sponsored AB 638 to clarify MHSA PEI funds can be used for addiction services
- Developing Mental Health Wellness Act proposal to scale effective SUD services across county behavioral health systems
- Partnered with philanthropy, business, and community leaders to support Hiding in Plain Sight, a PBS national initiative on stigma reduction, behavioral health literacy, and awareness of mental health needs, including addiction

Early Psychosis Intervention Plus

- Leveraged innovation funding to expand access to best available care
- Supporting seven early psychosis programs in 14 counties across the state with funding from the 2019 Budget
- Partnered with public and private research universities to establish technical assistance and training capacity
- Funded data reporting system to monitor the effectiveness of care and related outcomes

Criminal Justice Prevention

- Launched the Innovation Incubator with $5 million in one-time funding from the 2017 Budget to reduce justice involvement
- Developed multi-county learning collaboratives to reduce justice involvement
- Partnered with federal agencies to identify national best practices and bring to California
- Leveraged nearly $30 million in county innovation funding to support a range of projects

Allcove™ Youth Drop-In Centers

- Adapted the model to California
- Facilitated youth leadership to design the brand, look, and feel of the sites
- Commission holds allcove™ trademark to create a consistent, evidence-based experience statewide
- Launched 2 sites, 4 sites in development

Workplace Mental Health

- Established first-in-the-nation voluntary standards for mental health in the workplace
- California joins the U.S. Surgeon General and World Health Organization to elevate workplace mental health
- Partnering with private sector leaders to expand awareness of the value of workplace mental health

Anti-Bullying

- rightourstory.com allows youth to share their stories of bullying and messages of support
- Stories are shared on social media
- A private, moderated forum board creates space for youth to support each other

Innovation

- Since 2016, the MHSA has supported more than 200 innovation projects with a $700+ million investment
- To strengthen county use of innovation dollars, the Commission sponsored an Innovation Summit in partnership with philanthropy, the private sector, and county leaders
- The Commission leverages county innovation funds to support multi-county learning collaboratives to explore high-priority challenges, scale best practices, and disseminate lessons learned

Transparency Suite

- mhsoac.ca.gov/transparency-suite/ provides best available data on MHSA funding and outcomes
- Highlighted unspent funds and challenges enforcing MHSA fiscal reversion, leading to fiscal reforms
- Elevated awareness of unspent innovation funding

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Commission provide an overview of the Commission, its work, and proposed budget, and respond to the following:

1. Please highlight the Commission's most significant work and achievements.

2. Does the Commission's work exceed the purposes outlined in the original MHSA statute? If so, please explain.

For DOF – Please explain the MHSF Fund Condition Statement:

1. What's the reason that expenditures exceed revenue, thereby leaving a negative fund balance?

2. Does the term "expenditures" refer to funding being distributed *to* the counties, or actual expenditures *by* the counties?

3. The state reported $5.4 billion of MHSA funds in 2020-21 but according to the State Controller's Office, counties only received approximately $3 billion. Can the state account for the $2.4 billion that did not go out to counties? When will counties receive the additional $2.4 billion? Are counties aware of this additional funding?

Staff Recommendation: This issue is primarily oversight, and therefore no action is recommended at this time. In addition, staff recommends approval of the requested re-appropriations at a future hearing.

CHILDREN AND YOUTH BEHAVIORAL HEALTH

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4150 DEPARTMENT OF MANAGED HEALTH CARE
4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 2: OVERSIGHT: CHILDREN AND YOUTH BEHAVIORAL HEALTH

PANEL

- **Fiona Lu**, Youth Advocate, GENup
- **Kassy Poles**, Youth Mental Health Advocate, CYBHI Advisory Board Member
- **Melissa Stafford Jones**, Director, California Children and Youth Behavioral Health Initiative, California Health and Human Services Agency (CHHS)
- **Autumn Boylan**, Deputy Director Office of Strategic Partnerships, DHCS
- **Toby Ewing**, Ph.D., Executive Director, OAC
- **Michelle Cabrera**, Executive Director, County Behavioral Health Directors Association (CBHDA)
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

OVERSIGHT

The purpose of this issue is to explore and better understand behavioral health issues specific to children and youth. Much of the focus of this issue will be on the state's $4.5 billion Children and Youth Behavioral Health Initiative (CYBHI), as described below.

BACKGROUND

CYBHI

Approved through the 2021 Budget Act, the CYBHI includes many programs administered by several state entities totaling $4.5 billion (total funds) over 2021-22 through 2026-27. About $3.4 billion of this funding comes from the state General Fund, with most of the rest coming from federal funds.

Additional information can be found in the Administration's PDF document, which can be found on the Subcommittee's website with this agenda: https://abgt.assembly.ca.gov/sub1hearingagendas

CYBHI includes the following key components:

Behavioral Health Virtual Services and E-Consult Platform ($974 Million)
This new virtual platform ($838 million) will provide behavioral health services to children and youth age 25 and younger—regardless of payer source—through (1) interactive exercises and games, (2) automated screening and assessment tools, and (3) direct services delivered by peers or coaches. The platform also will refer children and youth with higher behavioral health needs to licensed providers ($136 million).

Workforce Programs ($800 Million)*
The initiative includes $800 million over 2021-22 through 2023-24 to increase behavioral health workforce capacity targeted at children and youth ($427 million) and develop a state behavioral health counselor and coach workforce ($338 million).
**The CYBHI workforce investments will be discussed in more detail under issue #15 of this agenda on behavioral health workforce.*

Medi-Cal Dyadic Services Benefit ($664 million)
Makes dyadic care—a model of care which provides integrated physical and behavioral health screening and services to children and youth and their families—an ongoing covered Medi-Cal benefit funded at roughly $140 million per year.

School Behavioral Health Infrastructure Grants ($550 Million)
Grants to educational, governmental, and health care entities for infrastructure and capacity aimed at better coordination of school behavioral health services.

Grants to Support Evidence-Based Practices ($429 Million)
Grants to plans, providers, and other entities to support the provision of evidence-based behavioral health interventions to children and youth.

Mental Health Student Services Act (MHSSA) Grant Program ($282 Million)
The 2019-20 budget created the MHSSA program, which provides grants to encourage county-school partnerships and increase student access to mental health services. Eligible activities under this grant program include: (1) provision of school-based mental health services, (2) suicide prevention services, (3) dropout prevention services, and (4) outreach to vulnerable youth. The 2021-22 budget package included $205 million Mental Health Services Fund (MHSF) over 2021-22 and 2022-23 for the program, in addition to $40 million one-time and $10 million ongoing from the MHSF provided in the 2019-20 budget plan.

Other (About $750 Million)
Other activities funded under CYBHI include:

- Incentives for managed care plans to build behavioral health capacity ($389 million);

- Suicide prevention and response activities ($250 million)(discussed in more detail under issue #5 of this agenda on suicide prevention);
- Funding for health literacy and public awareness ($125 million);
- Free crisis counseling and support services through a centralized resource website ($45 million);
- Funding for development of, and support for, peer-to-peer programs ($10 million); and
- Development of a statewide fee schedule for behavioral health services provided in schools.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the panelists speak on children and youth behavioral health issues, provide an overview of state programs and policies that seek to address the behavioral health needs of children and youth, and respond to the following:

For Youth Panelists:

1. Do you have any recommendations for the state and Legislature based on your own experiences?
2. What are the most valuable types of supports for young people, and are they readily available?

For Administration Panelists:

1. Please provide updates on the timelines and expenditures of the various CYBHI work-streams.
2. How have youth been involved with the CYBHI and will there be ongoing youth involvement?
3. Is the state able to do oversight on CYBHI implementation in schools, to know whether partnerships between schools, counties, and managed care plans are working well?

For the Commission:

1. Do you see any significant gaps in the state's efforts to meet the behavioral health needs of children and youth?
2. Are counties using MHSA funds to serve children and youth effectively?

For CBHDA:

1. What are the most significant challenges that counties face in serving children and youth?
2. What is most challenging about implementing the CYBHI?

Staff Recommendation: This is an oversight issue and therefore no action is recommended at this time.

ISSUE 3: CHHS: CYBHI RE-APPROPRIATION, SPRING FINANCE LETTER ISSUE 56

PANEL

- **Nina Hoang,** Finance Budget Analyst, DOF
- **Matthew Aguilera,** Principal Program Budget Analyst, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

CHHS requests that Item 0530-490 be added to re-appropriate up to $8.8 million from Item 0530-001-0001 of the 2021 Budget Act to provide flexibility for CalHHS to fully expend funds from June 30, 2022 until June 30, 2025. The 2021 Budget Act allocated $50 million General Fund over five years for CalHHS to provide subject matter expertise and evaluation for the Children and Youth Behavioral Health Initiative.

Add Item 0530-490:

0530-490—Reappropriation, Secretary of California Health and Human Services. The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for in those appropriations and shall be available for encumbrance or expenditure until June 30, 2025:

0001—General Fund

(1) Up to $8,800,000 in Item 0530-001-0001, Budget Act of 2021, to support the Children and Youth Behavioral Health Initiative.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests that DOF present this proposal and clarify the source of these funds.

Staff Recommendation: Subcommittee staff recommends holding this item open for further consideration.

ISSUE 4: DHCS: CHILDREN'S PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (AB 2317) TRAILER BILL

PANEL

- **Michelle Baass**, Director, DHCS
- **Christine Stoner-Mertz**, Chief Executive Officer, California Alliance of Child and Family Services
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS is proposing trailer bill to "clean up" the statute governing Psychiatric Residential Treatment Facility (PRTFs) to align interdisciplinary team member requirements with federal statutes and make other technical changes to AB 2317 (Ramos, Chapter 589, Statutes of 2022).

The proposed language can be found here:
https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/856

BACKGROUND

The Administration provided the following background information:

In 2022, Governor Newsom signed AB 2317 (Ramos, Chapter 589, Statutes of 2022), which: 1) establishes PRTFs as a new category of residential health facilities licensed by DHCS; 2) defines "psychiatric residential treatment facility" as a licensed health facility, operated by a public agency or private organization, with a provider agreement with a state Medicaid agency, that provides inpatient services to individuals under 21 years of age in a nonhospital setting; and 3) requires DHCS in collaboration with the California Department of Social Services and other stakeholders to establish regulations and certifications consistent with Medicare and Medicaid regulations to maximize federal financial participation (FFP), as specified. Additionally, AB 2317 requires PRTFs to conform with existing laws pertaining to aftercare plans, confidential information sharing, background checks, seclusion and restraint, serious and unusual occurrences, and judicial review of placement of patients in PRTFs.

Although DHCS is moving forward with implementation, some of the bill's provisions relating to interdisciplinary team member requirements are inconsistent with federal regulations, which risks jeopardizing FFP, according to DHCS.

Therefore, DHCS is proposing cleanup language related to the PRTF interdisciplinary team members to align with federal statute and other technical changes.

AB 2317 added the following professions, in addition to what is currently required by federal law: a licensed vocational nurse and a mental health professional who has a master's degree in psychology, marriage and family therapy, nurse practitioner, social work, or counseling to the list of individuals, one of whom, must be included on the interdisciplinary team, which is inconsistent with federal regulations (Title 42, Code of Federal Regulations Section 441.156 (c) and (d)). DHCS is also concerned with the inclusion of a mental health professional, as it differs from the Centers for Medicare and Medicaid Services' requirements and the definitions of particular professional disciplines. DHCS proposes to align the composition and credentials of the interdisciplinary team members with federal regulations and CMS requirements (Uncodified Section 1 of Chapter 589, Statutes of 2022 and Welfare and Institutions Code (WIC) Section 4081(h)).

DHCS also proposes to make the following technical changes:

- Correct cross reference from subdivision (v) to apply to the entire section relating to licensing facilities serving individuals under the age of 21 (WIC Section 4081(v)(4)(B)).
- Correct cross reference from subdivision (v) to subdivision (w), which specifies the Department's bulletin authority (WIC Section 4081(n)(2) and (n)(3)).
- Correct cross reference from subdivision (o) to subdivision (p) to specify the enforcement actions that a facility may appeal (WIC Section 4081(r)).
- Correct chaptering issue from AB 204 (Committee on Budget, Chapter 738, Statutes of 2022). These provisions are necessary for DHCS's licensing and monitoring responsibilities to ensure that confidential records can be released to social workers and probation officers for individuals in the child welfare system for care coordination purposes (WIC Section 5328(a)(1)(A) and (B), (a)(4)(A) and (B), (a)(12)(A), (a)(20)(B)(vii) and (a)(28)).

Stakeholder Concerns:

The California Alliance of Child and Family Services was the sponsor of AB 2317 and has serious concerns with the limitations on PRTF staffing proposed by DHCS. Specifically, they are concerned with:

- The proposed deletion of the nurse practitioner, and the inclusion of a psychologist with a master's degree (stating that this type of professional does not exist in California);
- The use of the term psychiatric social worker, as this is not a professional degree or licensure.
- The proposed deletion of Licensed Vocational Nurses (LVNs), which the Alliance states are incredibly valuable team members;
- The reference to an individual plan of care, which the Alliance states is contrary to documentation reform under CalAIM.

The Alliance recommends:

- Inclusion of the option for a mental health professional who has a master's or doctorate degree in psychology, marriage and family therapy, social work, or counseling and who has been licensed/registered/waivered by the state;
- Inclusion of LVNs; and
- Increased flexibility related to documentation and alignment with CalAIM documentation reform.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal, address the concerns of stakeholders, and respond to the following:

1. For what reasons is the administration seeking to amend a 2022 policy bill through the budget? Does this trailer bill language impact the budget?

2. Has the Administration negotiated this language with Assemblymember Ramos, and the policy and Appropriations Committees in both houses?

Staff Recommendation: Subcommittee staff recommends holding this item open, but also recommends urging the administration to move this language into a policy bill.

SUICIDE PREVENTION

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4150 DEPARTMENT OF MANAGED HEALTH CARE
4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 5: OVERSIGHT: SUICIDE PREVENTION ISSUES INCLUDING: OFFICE OF SUICIDE PREVENTION, CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE, SOCIAL MEDIA, STATEWIDE STRATEGIC PLAN, AND CALHOPE

PANEL

- **Lishaun Francis**, Senior Director, Behavioral Health, Children Now
- **Shari Sinwelski**, LPCC, Vice-President Crisis Care, Didi Hirsch Mental Health Services
- **Tara Niendam**, Ph.D., Professor in Psychiatry, Executive Director, UC Davis Early Psychosis Programs, Director, Early Psychosis Intervention Training and Technical Assistance Program for California
- **Sara Mann**, Violent Injury Policy and Program Section Chief, Center for Healthy Communities, California Department of Public Health (CDPH)
- **Ana Bolanos**, Assistant Deputy Director, Office of Health Equity, CDPH
- **Michelle Baass**, Director, DHCS
- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Toby Ewing**, Ph.D., Executive Director, OAC
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

OVERSIGHT

This is an oversight issue to give the Subcommittee an opportunity to learn more about suicide, the state's response to suicide, and state suicide prevention efforts. The following are major recent state initiatives related to suicide:

Mental Health Services Oversight and Accountability Commission (Commission) Suicide Prevention Work

In 2017, this Subcommittee initiated and supported a small appropriation to the Commission to support development of a statewide suicide prevention strategic plan. The Commission completed this plan, *California Strategic Plan for Suicide Prevention 2020-*

2025: Striving for Zero, which includes a key recommendation for the establishment of a state office of suicide prevention, which has since been created through legislation (as discussed below). The Commission has done additional work on suicide as described under issue #1 of this agenda. *Striving for Zero* can be accessed here: https://mhsoac.ca.gov/wp-content/uploads/Suicide-Prevention-Plan_Final-1.pdf

State Office of Suicide Prevention

Consistent with the recommendation included in the Commission's *Suicide Prevention Strategic Plan: Striving for Zero*, AB 2112 (Ramos, Chapter 142, Statutes of 2020) established the State Office of Suicide Prevention (OSP) within CDPH, and resources for the OSP were included in the 2021 budget, including 5 positions and $2.8 million ongoing General Fund. According to CDPH, the OSP serves as the designated state entity responsible for coordinating and aligning statewide suicide prevention efforts and resources through planning and collaboration across diverse partners and systems. The OSP will be leading the Youth Suicide Prevention Project.

Suicide Prevention Components of the Children and Youth Behavioral Health Initiative

The 2022 budget includes $250,000,000 one-time General Fund, available over three years, to address urgent needs and emergent issues in behavioral health for children and youth age 25 and younger in the following areas:

- $50,000,000 - Youth Suicide Reporting and Crisis Response Pilot Program at CDPH
- $85,000,000 - Wellness and Resilience Building Supports for Children, Youth, and Parents at DHCS
- $15,000,000 - Video Series to Provide Parents with Resources and Skills to Support their Children's Mental Health
- $75,000,000 - Leveraging of Emerging Technologies to Develop Next Generation Digital Supports for Remote Mental Health Assessment and Intervention
- $25,000,000 - Support for Culturally Diverse Future Behavioral Health Workers

Youth Suicide Prevention Project

Youth Suicide Prevention Media Campaign

The Commission's *Striving for Zero: Strategic Plan for Suicide Prevention 2020-2025* highlights the need for a media campaign to reduce mental health stigma and discrimination and reduce relevant public safety threats, such as misuse of medication or unsafe gun storage practices. The Youth Suicide Prevention Project includes a media campaign, through a contract with a media/communications firm, which centers on youth, with an emphasis on youth disproportionally impacted by suicide. The 2022 budget includes $18 million to support a media contract for the development of messages and tools to be used with the Project's mini grantees. Data and formative research will be used to identify the specific priority audiences for this campaign and youth input will be

incorporated into the development and dissemination of the messages and tools. The media/communications firm activities in collaboration with youth may include the following:

- Conducting community focus groups
- Message development (including translation services)
- Asset development, testing and finalization
- Media buys
- Campaign deployment (multiple channels and social media)
- Special subpopulation marketing/media deployment
- Data collection, metrics, analysis, and report
- Comprehensive, multi-year report on campaign evaluation

Community-Based Organization Mini Grant Program

To complement the media campaign described above and assist with its dissemination and reinforcement of messages at the community level, the Youth Suicide Prevention Project includes $18.2 million to award 30-50 two-year mini grants to youth-serving community based organizations, ranging from $150,000 to $250,000 per year. Opportunities will be identified that may allow for a rapid and phased in approach to awarding these mini grants, such as augmenting existing CDPH grants/contracts. The mini grantees will:

- Promote the Youth Suicide Prevention Media Campaign as trusted messengers within communities disproportionately impacted by youth suicide.
- Support implementation of community-level evidence-based suicide prevention strategies (as described in the CDC's Preventing Suicide Technical Package), that amplify and build upon the media campaign messages.

CDPH committed to prioritizing implementation of strategies that have the most potential to save lives in the immediate term. Examples of strategies and approaches could include creating protective environments by reducing access to lethal means, strengthening access to care through tele-mental health, promoting connectedness through peer norm programs, and teaching coping and problem-solving skills through social emotional learning and family relationship programs.

Medi-Cal Mobile Crisis Response

The 2022 budget also includes $108 million total funds ($16 million General Fund), and trailer bill language, to add qualifying 24 hours a day, 7 days a week community-based mobile crisis intervention services, as soon as January 1, 2023, as a mandatory Medi-Cal benefit available to eligible Medi-Cal beneficiaries, statewide.

CalHOPE

The 2023 Governor's Budget includes $105 million total funds (including $96.4 million General Fund and $9 million Mental Health Services Fund (MHSF)) in FY 2022-23 and $44.6 million total funds (including $40 million General Fund and $4.6 million MHSF) in FY 2023-24 to continue operating the CalHOPE program, including:

- Media messaging to destigmatize stress and anxiety and promote help-seeking, including using trusted messengers to reach diverse populations.
- CalHOPE web services.
- CalHOPE Warm Line.
- CalHOPE Connect partnership with up to 30 community-based organizations, with over 400 peer crisis counselors.

BACKGROUND

The Administration provided the following background information on suicide:

Suicide, a self-directed form of violence, is a leading cause of premature death and is a major contributor of years of life lost due to its significant impact on young people. Deaths due to suicide leave a tragic loss for decedents' families and society at large. Thoughts of suicide affect people from all walks of life, but risk of suicide is especially significant among adolescents, older adults, veterans, Native American communities, and LGBTQ youth and adults.

In 2020, 4,140 Californians died by suicide and of those, 521 were youth (ages 10-24). There were 31,543 non-fatal self-harm related emergency department visits among California residents in 2020 and 16,845 of those visits were among California youth (ages 10-24). Rates of suicide vary greatly across the state with some counties experiencing rates more than twice the statewide level. Suicide is the third leading cause of death among adolescents and young adults aged 15-24 in California. Recent data show that youth between the ages of 10-18 experienced a 20 percent increase in suicide rates from 2019 to 2020. Additionally, Black youth, female youth, and Hispanic youth between the ages of 10-24 also experienced an increase in suicide rates during the same time period. Historically, youth suicide rates have been the highest among White youth; however, in 2020, Black youth surpassed White youth for having the highest youth suicide rates in California.

The COVID-19 crisis is having significant impacts on community mental health due to anxiety caused by many factors, such as isolation, grief over the loss of friends and family, exacerbated health concerns, increased substance abuse, domestic violence, child abuse, and the weight of economic hardship. More specifically, there are lasting concerns around stay-at home orders and physical distancing that put vulnerable communities at even greater risk for suicide.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the stakeholders on the panel share their expertise on suicide and make any recommendations they may have for state policies or programs that have the potential to prevent suicides.

The Subcommittee requests Administration and Commission panelists to provide an overview of, and implementation updates on, state suicide prevention activities, programs, and projects.

Staff Recommendation: This is an oversight issue and therefore no action is recommended at this time.

ISSUE 6: 988 SUICIDE AND CRISIS LIFELINE BUDGET CHANGE PROPOSAL, TRAILER BILL, AND SPRING FINANCE LETTER PROVISIONAL LANGUAGE

PANEL

- **Kimberly Chen**, Assistant Secretary, Program and Fiscal Affairs, CHHS
- **Tara Gamboa-Eastman**, Senior Advocate, Steinberg Institute
- **Shari Sinwelski**, LPCC, Vice-President Crisis Care, Didi Hirsch Mental Health Services
- **Michelle Cabrera**, Executive Director, CBHDA
- **Diana Vazquez-Luna,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

CalHHS Agency, the Department of Managed Care (DMHC), and Department of Health Care Services (DHCS) request $13,243,000 ($10,273,000 988 State Suicide and Behavioral Health Crisis Services Fund [988 Fund], $2,197,000 Managed Care Fund, and $773,000 federal funds) in 2023-24, $16,041,000 ($13,228,000 988 Fund, $2,085,000 Managed Care Fund, and $728,000 federal funds) in 2024-25, and $16,258,000 ($13,228,000 988 Fund, $2,302,000 Managed Care Fund, and $728,000 federal funds) in 2025-26 and ongoing, and corresponding statutory changes, to implement AB 988 (Bauer-Kahan, Chapter 747, Statutes of 2022).

CalHHS Agency

CalHHS Agency requests $5,500,000 one-time 988 Fund to fulfill duties and responsibilities as required by AB 988, including contract funding for technical and subject matter expertise, local jurisdiction coordination, stakeholder engagement, and quarterly convening of the state 9-8-8 advisory group until December 2024.

DHCS

DHCS requests 10.0 permanent positions and $1,546,000 ($773,000 988 Fund; $773,000 Federal Fund) in 2023-24 and $1,456,000 ($728,000 988 Fund; $728,000 Federal Fund) in 2024-25 and ongoing to provide oversight of county Behavioral Health Plans' (BHP) compliance, as required by AB 988. These resources are to implement and maintain the new workload resulting from AB 988 oversight activities that CalHHS Agency will delegate to DHCS. These activities include, but are not limited to: projecting performance outcomes, assimilating stakeholder input into policy development and guidance, originating and testing monitoring tools and templates, performing ongoing and expanded monitoring for BHPs timely access compliance, providing technical assistance, and development of corrective actions plans for plans and providers for Behavioral Health

Crisis Services and other ancillary services funded through Medi-Cal. DHCS also requests $4,000,000 in 2023-24 and $12,500,000 in 2024-25 and ongoing from the 988 Fund to support eligible 988 call center behavioral health crisis services.

DMHC

DMHC requests 7.5 permanent positions and $2,197,000 in 2023-24, $2,085,000 in 2024-25, $2,302,000 in 2025-26 and annually thereafter from the Managed Care Fund, pursuant to AB 988, to provide oversight of health care service plan coverage of medically necessary treatment of behavioral health crisis services provided at 988 call centers without prior authorization. This request includes consultant funding of $343,000 in 2023-24, $297,000 in 2024-25, $514,000 in 2025-26 and annually thereafter for a clinical consultant to assist in the clinical review of health plan policies and procedures and utilization management processes for compliance with the AB 988 requirements.

Trailer Bill

CalHHS, in collaboration with DHCS, DMHC, and California Department of Insurance requests statutory changes, per the Governor's AB 988 signing message, which, among other things:

1. Conforms the definition of AB 988 with federal requirements;

2. Extends the deadline for the five-year plan recommendations, end date for the advisory group to meet, and disbanding of the advisory group by one year;

3. Allows the 988 surcharge revenue to be used to pay state departments for their costs in administering the 988 Suicide and Crisis Lifeline;

4. Provides DHCS contract exemption; and

5. Aligns commercial and Medi-Cal coverage.

Department	Workload	Fund Source	2023-24	2024-25	2025-26 & Ongoing	Positions
CalHHS	Contract funding for: • Local jurisdictional coordination • Stakeholder engagement • Research and analysis to support the development of the five-year implementation plan. • In coordination with CalOES, a plan for the statewide coordination of 988, 911, and behavioral health crisis services	988 Fund	$5,500	$0	$0	0.0
DHCS	• Oversight of county behavioral health plans compliance with AB 988 • Stakeholder Engagement • CalHHS Delegated Workload	988 Fund	$773	$728	$728	
		Federal Fund	$773	$728	$728	10.0
	Supporting eligible 988 call center behavioral health crisis services	988 Fund	$4,000	$12,500	$12,500	
DMHC	Oversight of health care service plan compliance with AB 988	Managed Care Fund	$2,197	$2,085	$2,302	7.5
		Total	**$13,243**	**$16,041**	**$16,258**	**17.5**

CalHHS SFL

CalHHS requests that Provision 5 be added to Item 0530-001-0001 to provide flexibility for CalHHS to implement requirements of AB 988 through June 30, 2028 and exempt contracts from requirements contained in the Public Contracts Code and the State Administrative Manual and from the approval by the Department of General Services. This exemption is being requested so that a contractor can be hired immediately to help with subject matter expertise for stakeholder meetings to develop the five-year plan.

Add provision 6 to Item 0530-001-0001 as follows:

6. Of the amount appropriated in Schedule (1), $5,500,000 shall be available for encumbrance or expenditure until June 30, 2028 to contract for needed technical and subject matter expertise, local jurisdictional coordination, stakeholder engagement, development of legislative implementation status reports, and administration to fulfill one-time obligations associated with implementation of the Suicide and Crisis Lifeline pursuant to Chapter 747, Statutes of 2021.

a. For purposes of implementing this provision, the Secretary of California Health and Human Services may enter into exclusive or nonexclusive contracts or amend existing contracts, on a bid or negotiated basis, and may implement changes to existing information technology systems. Notwithstanding any other law, contracts entered into or amended, or changes to existing information technology systems, pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

BACKGROUND

The Administration provided the following background information:

The National Suicide Hotline Designation Act of 2020 (NSHD) designated 9-8-8 as the new three-digit number for the national suicide prevention and mental health crisis hotline. The NSHD requires the Federal Communications Commission (FCC) to designate 9-8-8 as the universal telephone number for a national suicide prevention and mental health crisis hotline, which operates through the National Suicide Prevention Lifeline. To adequately and sustainably fund the 9-8-8 system, NSHD authorized states to impose a fee on access lines for providing 9-8-8 related services. Revenue from the fee must be held in a designated account to be spent only in support of 9-8-8 services, and the FCC must submit an annual report on state administration of these fees. The fees may only be spent on 1) ensuring the efficient and effective routing of calls made to the 9-8-8 national suicide prevention and mental health crisis hotline to an appropriate crisis center; personnel; and 2) the provision of acute mental health crisis outreach and stabilization by directly responding to the 9-8-8 national suicide prevention and mental health crisis hotline.

AB 988 implements the National Suicide Hotline Designation Act of 2020 (NSHD), in compliance with the Federal Communication Commission's rules designating "988" as a three-digit number for the National Suicide Prevention Hotline now known as the 988 Suicide and Crisis Lifeline.

AB 988 includes, but is not limited to, the following:

- Requires the California Governor's Office of Emergency Services (CalOES) to appoint a 9-8-8 system director and convene an advisory board to guide how 9-8-8 is implemented and made interoperable with 911, including the creation of a new surcharge for 9-8-8 to fund the crisis services.
- Requires CalHHS to participate in the State 9-8-8 Technical Advisory Board convened by CalOES no less than quarterly until December 31, 2028.
- Requires CalHHS to convene a state 9-8-8 policy advisory group to advise on a set of recommendations for the implementation and administration of the five-year implementation plan for the 9-8-8 System;
- Requires CalHHS to convene the state 9-8-8 policy advisory group at least quarterly until December 31, 2023. The advisory group may be disbanded at the discretion of the CalHHS, but shall not be disbanded before January 1, 2024.
- Requires health plan and insurer coverage of 9-8-8 center services when medically necessary and without prior authorization;
- Establishes a 9-8-8 surcharge for the 2023 and 2024 calendar years at $0.08 per access line per month, and for years beginning January 1, 2025, at an amount based on a specified formula, but not greater than $0.30 per access line per month;
- Notes that it is the Legislature's intent, that by June 30, 2024, the CalHHS and the OES to develop a plan for the statewide coordination of 988, 911, and behavioral health crisis services. Specify the plan will be based on a five-year implementation plan that includes a landscape analysis of existing services and describes how to expand, improve, and link services with the goal of fully implementing the 988 system by January 1, 2030;
- Appropriates $300,000 from the General Fund to the 9-8-8 State Suicide and Behavioral Health Crisis Services Fund (previously the State Mental Health and Crisis Services Special Fund) to the Department of Tax and Fee Administration (DTFA) for purposes of implementing this bill; and
- Contains an urgency clause to verify that the provisions of this bill go into immediate effect upon enactment.

Related Investments

The Budget Act of 2022 includes $7.5 million GF in 2022-23, and $6 million ongoing, for CalOES to support equipment for transferring calls between the 9-8-8 National Suicide Prevention Lifeline and the 9-1-1 system. The budget also includes $8 million one-time GF to support the capacity of call centers to launch and operate the 9-8-8 National Suicide Prevention Lifeline, effective July 16, 2022. Lastly, the budget established qualifying

mobile crisis intervention services, as a Medi-Cal covered benefit through the Medi-Cal behavioral health delivery system, effective January 1, 2023.

Mobile Crisis Services

Effective January 1, 2023, counties will begin to implement mobile crisis services within the Medi-Cal behavioral health delivery systems. Mobile crisis services are an integral part of California's broader efforts to strengthen the continuum of community-based care for individuals who experience behavioral health crises, including the implementation of the 988 Suicide and Crisis Lifeline and the Crisis Care Mobile Units Program.

Mobile crisis services are a community-based intervention designed to provide de-escalation and relief to individuals experiencing a behavioral health crisis wherever they are, including at home, work, school, or in the community. Mobile crisis services are provided by a multidisciplinary team of trained behavioral health professionals in the least restrictive setting. Mobile crisis services include screening, assessment, stabilization, de-escalation, follow-up, and coordination with healthcare services and other supports. Mobile crisis services are intended to provide community-based crisis resolution and reduce unnecessary law enforcement involvement and emergency department utilization. The mobile crisis services benefit will support Medi-Cal beneficiaries' access to coordinated crisis care 24 hours a day, 7 days a week, 365 days per year.

Mobile crisis services are congruent with the 9-8-8 system in California which is designed to operate as an emergency suicidal, mental health, and substance use disorder crisis system that provides compassionate, appropriate, and easily accessible care to save lives and reduce law enforcement engagement, arrests, hospitalizations, and deaths. DHCS awarded $150 million General Fund to date in grants to counties to build out new crisis care mobile units.

CalHHS: Contract Funding for AB 988 requirements

$5,500,000 one-time 988 Fund, available over a five-year period

AB 988 as proposed to be amended by CalHHS would require CalHHS to do the following:

1. Participate in the CalOES administered State 988 Technical Advisory Board through 2028 to coordinate and advise on issues related to 911/988 interoperability and operations.
2. Create, no later than December 31, 2024, a set of recommendations to support a 5-year implementation plan for a comprehensive 988 system. CalHHS must convene a diverse and robust group of stakeholders who meet quarterly as the State 988 Advisory Group. This group will advise CalHHS on the set of extensive recommendations. The recommendations will specify what can be accomplished pursuant to existing administrative authority and what will require additional regulations or legislation for implementation.
3. Incorporate outcomes from the CalHHS proposed statutory changes, as directed by the Governor's AB 988 signing message.

CalHHS' responsibilities under AB 988 will be conducted with input from a wide variety of technical and subject matter experts, local implementation partners and stakeholders. CalHHS requests one-time contract funds to meet the obligations and responsibilities including but not limited to: 1) technical and subject matter expertise, 2) robust coordination with local jurisdictions, including county behavioral health and local public safety answering points, 3) stakeholder engagement, 4) public convenings of the State 988 Advisory Group at least quarterly through December 2024, and at the discretion of CalHHS, the group can be disbanded after December 2025, 5) development and dissemination of communication tools to verify statewide messaging regarding the implementation and build out of the 9-8-8 system, and 6) performance of administrative duties, as needed, to support transparent, and efficient deliverables.

DHCS: Oversight of county behavioral health plans compliance with AB 988
$1,546,000 ($773,000 988 Fund; $773,000 Federal Fund) in 2023-24 and $1,456,000 ($728,000 988 Fund; $728,000 Federal Fund) in 2024-25 and annually thereafter

The requested resources are needed to implement and maintain the new workload implementation activities that DHCS anticipates CalHHS will delegate to DHCS as California's designated Medicaid single State agency. These activities include the following: providing oversight of 9-8-8 implementation activities, ongoing compliance monitoring, and developing and issuing policy guidance as they relate to behavioral health providers and Medi-Cal services rendered within the 9-8-8 framework. DHCS would also need to develop the compliance monitoring tools and provide ongoing programmatic training and technical assistance to counties and follow up on resolution of corrective action plans (CAP).

Medi-Cal Behavioral Health Division (10.0 Permanent Positions)
5.0 Associate Governmental Program Analyst (AGPA)
3.0 Health Program Specialist I (HPS I)
1.0 Health Program Specialist II (HPS II)
1.0 Research Data Specialist II (RDS II)

Medi-Cal Behavioral Health Division (MCBHD) is responsible for the monitoring and compliance of behavioral health plan contractors with federal rules pertaining, but not limited to, timely access and network adequacy. MCBHD also monitors county BHP compliance with Behavioral Health program requirements that focus on administration and implementation Medi-Cal services rendered within the 9-8-8 framework. MCBHD requests additional resources within the County Provider Oversight and Monitoring Branch to oversee and provide programmatic and compliance technical assistance to county Behavioral Health agencies. This unit would perform ongoing monitoring, compliance, and overview of county BH agencies providing technical assistance through the Program requirements of AB 988.

DHCS: Stakeholder Engagement and CalHHS Delegated Workload

DHCS is required by AB 988 to participate in the CalHHS 988 state advisory committee and to collaborate with CalOES in the provision of information to render reports to the Legislature. Additionally, as the designated Medicaid single State agency, DHCS anticipates that CalHHS will delegate certain of the statutory mandates pursuant to AB 988 to DHCS. Specifically, by December 31, 2024, CalHHS shall create a set of recommendations to support a five-year implementation plan for a comprehensive 988 system. DHCS expertise will be necessary to assimilate stakeholder feedback, develop and issue policy guidance, originate and test monitoring tools and templates for services provided pursuant to AB 988, perform ongoing and expanded monitoring for BHPs timely access compliance, provide technical assistance to plans and providers pre and post implementation.

DHCS: Support for Eligible 988 Call Center Services

$4,000,000 in 2023-24 and $12,500,000 in 2024-25 and annually thereafter from the 988 Fund

AB 988 requires funds collected through the 988 surcharge to be prioritized to fund the 988 call centers, including the efficient and effective routing of telephone calls, personnel, and the provision of acute mental health services through telephone call, text, and chat to the 988 number.

DHCS requests $4,000,000 in 2023-24 and $12,500,000 in 2024-25 and annually thereafter from the 988 Fund to support eligible 988 call center services.

DMHC: Oversight of Health Care Service Plan Compliance with AB 988

$2,197,000 in 2023-24, $2,085,000 in 2024-25, $2,302,000 in 2025-26 and annually thereafter from the Managed Care Fund

The DMHC protects consumers' health care rights and supports a stable health care delivery system. As part of this mission, the DMHC licenses and regulates health plans under the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act). Embedded in the mission is the task of evaluating and promoting health care service plan (health plan) regulatory compliance and verifying enrollees have consistent access to timely and medically necessary health care services, including mental health and substance use disorder (MH/SUD) services. The DMHC regulates the majority of health care coverage in California including 96 percent of state regulated commercial and government markets. The health plans licensed by the DMHC provide coverage to more than 28 million enrollees.

AB 988 requires coverage of mental health and substance use disorder treatment to include medically necessary treatment of a mental health or substance use disorder provided through the 988 system, regardless of whether the provider is in the health plan's network. AB 988 specifies that health plans must reimburse 988 call centers and mobile

crisis units for the medically necessary treatment of a MH/SUD they provide to a plan enrollee. AB 988 prohibits health plans from requiring prior authorization for 988 services and limit an enrollee's financial obligation to the in-network cost sharing amount. AB 988 requires health plans to reimburse providers of 988 services according to existing applicable law. Health plans without contracts with 988 providers will be required to reimburse the non-contracting provider at a "reasonable and customary" amount. AB 988 also requires the DMHC and Department of Insurance (CDI) coordinate to verify 988 call centers are reimbursed for medically necessary behavioral health crisis services. AB 988 will affect 56 health plans providing or arranging for MH/SUD treatment pursuant to HSC Section 1374.72, including full-service commercial health plan, restricted commercial health plan and classic behavioral health plans.

Office of Plan Monitoring

The DMHC's Office of Plan Monitoring (OPM) performs routine medical surveys of DMHC-licensed health, behavioral and specialized plans. The DMHC's OPM anticipates additional workload to review health plan filings, modify existing survey methodologies and tools and revise policies and procedures to verify compliance with AB 988 provisions. The OPM estimates 21 routine surveys will be impacted each year by the reporting and review requirements of AB 988.

Contract Funding for Consultant Services

The DMHC's OPM is requesting consultant funding of $343,000 in 2023-24, $297,000 in 2024-25, $514,000 in 2025-26 and annually thereafter for a clinical consultant to review health plan eFilings to evaluate whether plan policies support coverage of the scope of services included in "behavioral health crisis services" as defined in Government Code section 53123.1.5 and are compliant with the requirements of AB 988.

This cost is based on an anticipated hourly rate of $350 from recent clinical consultant contracts. The work performed by these consultants requires the use of highly specialized medical and clinical expertise that is not available through the civil service system. Additionally, utilizing consultant contracts will provide flexibility to access expertise in various clinical areas that is not available when limited to a specific civil service classification.

Office of Enforcement

The DMHC's Office of Enforcement (OE) handles the enforcement needs of the DMHC, including referrals from offices within the DMHC that review the activities of plans for compliance with statute and regulation requirements. The OE anticipates receiving approximately three (3) referrals from the DMHC Help Center in 2023-24 and eighteen (18) referrals each year from the Help Center and OPM beginning in 2024-25 and ongoing following the passage of AB 988.

Stakeholder Concerns With the Proposed Trailer Bill:

The Steinberg Institute and Kennedy Forum, the sponsors of AB 988, have expressed significant concerns with the proposed trailer bill language, and assert that this language should be in a policy bill rather than budget trailer bill. They provided the following descriptions of their primary objections:

1. Removes Legislative Oversight: Proposed trailer bill language removes any requirement to report to the Legislature and the public on implementation of the 988 system. Given the 988 crisis care continuum will be developed over many years (through 2029) and that much discretion over the system has been extended to the administration via the 988 advisory group, it is critical that there be regular updates to the Legislature and the public to ensure the system is developed consistent with the intent of the Act.

2. Removes Reference to Lifesaving Mobile Crisis Teams: The national vision for 988 is for everyone to have someone to call, someone to come, and somewhere to go. A critical pillar of the 988 crisis continuum is connecting the number (call) to mobile crisis teams (response). However, proposed trailer bill language removes the requirement that the Agency even develop recommendations for statewide mobile crisis team response. This deletion stands in direct opposition to the intent of the National Suicide Hotline Designation Act of 2020 and that of the California Legislature when it passed The Miles Hall Lifeline and Suicide Prevention Act.

3. Weakens 988 Fee: The National Suicide Hotline Designation Act of 2020 authorized states to charge a small fee on phone lines to fund the 988 system. Proposed trailer bill language broadens the authorized uses for fee revenue while simultaneously removing critical guardrails. First, it removes language that would prevent the 988 fee revenue from being used for any other purpose. This is of grave concern given the history of 911 fee revenue being diverted for unrelated purposes across the nation. Additionally, proposed trailer bill language removes language that would require fund recipients, such as call centers and counties, to report if they billed health plans or insurance companies for services and were reimbursed before relying on fee revenue and systems performance including how they are meeting the needs of 988 callers. Removing these critical data reporting requirements is likely to lead to a misuse of taxpayer money and worse outcomes for those experiencing mental health crises.

4. Weakens Insurance Protections: No state laws should contradict or narrow enrollee protections afforded under federal law or existing state law; proposed trailer bill language does both. The proposed language includes standards for post-stabilization care that are out of alignment with the No Surprises Act (NSA). The definitions of behavioral health crisis services, stabilization services, and post-stabilization care all should be in alignment with federal law: the definition of behavioral health crises should align with definitions in Section 1317.1 or Section

1876(e)(1) of the federal Social Security Act (42 U.S.C. Sec. 1395dd(e)(1). The NSA mandates critical stabilization protections (45 CFR 149.410(b)) and post-stabilization protections (45 CFR 149.110(c)(2)(ii)) which also are out of alignment with current trailer bill language. It is also important the state does not narrow the protections extended under existing law in California, including by SB 855. Instead of setting Medi-Cal coverage as a floor, or minimum set of services that should be covered by commercial insurers, it sets Medi-Cal services as the benchmark, without respect to the comprehensive services that are required of commercial plans under SB 855 (Wiener, 2021). While proposed trailer bill language does add important protections, such as mandating payments for services rendered, in its current form it limits existing protections under state and federal law, narrowing the rights of enrollees seeking these services.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Administration present these proposals, respond to stakeholder concerns, and respond to the following:

1. For what reasons is this language not being proposed through a policy bill, given that it amends a 2022 policy bill?

2. Has the Administration negotiated this language with Assemblymember Bauer-Kahan, and the policy and Appropriations Committees in both houses?

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for additional conversations and consideration of stakeholder concerns, and also recommends urging the Administration to move the proposed trailer bill language into a policy bill.

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 7: OVERVIEW OF DEPARTMENT AND DEPARTMENT'S BUDGET

PANEL

- **Stephanie Clendenin**, Director, Department of State Hospitals (DSH)
- **Brent Houser**, Chief Deputy Director, Operations, DSH
- **Chris Edens**, Chief Deputy Director, Program Services, DSH
- **Nina Hoang,** Finance Budget Analyst, Department of Finance (DOF)
- **Matthew Aguilera,** Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

The Governor's Budget proposes $3.2 billion for the Department of State Hospitals (DSH), a 3 percent ($89.7 million) increase over the 2022 Budget Act. This increase reflects the various Budget Change Proposals included in the January Budget, and detailed throughout this agenda. Please see the chart below for additional detail on the DSH budget.

3-YEAR EXPENDITURES AND POSITIONS

		Positions			Expenditures		
		2021-22	2022-23	2023-24	2021-22*	2022-23*	2023-24*
4400010	Headquarters Administration	215.9	322.3	340.8	$80,419	$98,970	$100,173
4400020	Hospital Administration	199.9	297.0	325.7	105,882	123,503	154,398
4410010	Atascadero	1,411.3	2,271.1	2,299.1	368,031	381,872	394,670
4410020	Coalinga	1,549.7	2,504.1	2,512.0	400,676	435,303	433,646
4410030	Metropolitan	1,426.7	2,338.0	2,351.7	323,830	344,492	344,162
4410040	Napa	1,802.5	2,685.5	2,719.6	416,863	450,307	443,963
4410050	Patton	1,901.0	2,617.2	2,638.8	441,997	482,078	470,055
4410060	State Hospital Police Academy	-	-	-	723	4,635	4,553
4420010	Conditional Release Program	14.8	24.2	30.2	52,584	75,135	79,005
4420020	Conditional Release Program - Sexually Violent Predators	-	8.0	9.0	8,617	13,042	13,935
4430010	Admission, Evaluation, Stabilization Center	13.9	-	-	5,226	-	-
4430020	Jail Based Competency Treatment	-	-	-	72,319	-	-
4430030	Other Contracted Services	-	-	-	153,176	245,021	-
4430040	Other Contracted Services	-	4.0	4.0	-	925	927
4430050	Jail Based Treatment Programs	-	18.5	19.5	-	202,336	213,688
4430060	Community Based IST Programs	-	19.0	24.5	-	542,050	535,368
4440	Evaluation and Forensic Services	56.6	-	-	23,128	-	-
4450010	Offender with a Mental Disorder and Sex Offender Commitment Program Evaluation Services	-	50.3	50.3	-	22,417	21,933
4450020	Incompetent to Stand Trial Re-Evaluation Services	-	27.0	27.0	-	21,097	15,681
TOTALS, POSITIONS AND EXPENDITURES (All Programs)		**8,592.3**	**13,186.2**	**13,352.2**	**$2,453,471**	**$3,443,183**	**$3,226,157**

FUNDING		**2021-22***	**2022-23***	**2023-24***
0001	General Fund	$2,290,791	$3,167,196	$3,033,294
0814	California State Lottery Education Fund	17	19	19
0995	Reimbursements	162,663	192,844	192,844
3398	California Emergency Relief Fund	-	83,124	-
TOTALS, EXPENDITURES, ALL FUNDS		**$2,453,471**	**$3,443,183**	**$3,226,157**

State Hospitals Enrollment, Caseload, and Population:

DSH is responsible for the daily care and treatment of over 7,000 patients. This estimated caseload is projected to exceed 9,000 by the end of FY 2023-24, with a total of 5,468 across the state hospitals, 2,772 in contracted programs and 1,049 in CONREP (Conditional Release Program) Non-SVP (Sexually Violent Predator) and CONREP SVP programs. Over the last decade, the population demographic has shifted from primarily civil court commitments to a forensic population committed through the criminal court system. The table below displays patient caseload by commitment type and contract location.

STATE HOSPITALS POPULATION

Department of State Hospitals
2023-24 Governor's Budget Estimate

	2022-23 May Revision Projection	BUDGET YEAR 2023-24				
	June 30, 2023 Projected Census	July 1, 2023 Projected Census	Previously Approved Adjustments BY 2023-24	2023-24 November Adjustment BY 2023-24	2023-24 May Revision Adjustment BY 2023-24	June 30, 2024 Projected Census
POPULATION BY HOSPITAL						
ATASCADERO	1,000	1,001	0	0	0	1,001
COALINGA	1,311	1,327	0	0	0	1,327
METROPOLITAN	948	805	0	0	0	805
NAPA	1,122	1,014	0	0	0	1,014
PATTON	1,359	1,311	10	0	0	1,321
TOTAL BY HOSPITAL	**5,740**	**5,458**	**10**	**0**	**0**	**5,468**
POPULATION BY COMMITMENT						
Coleman - PC 2684[1]	169	115	0	0	0	115
IST - PC 1370	1,341	1,366	4	0	0	1,370
LPS & PC 2974	801	698	0	0	0	698
OMD - PC 2962	420	394	3	0	0	397
OMD - PC 2972	735	683	3	0	0	686
NGI - PC 1026	1,343	1,246	0	0	0	1,246
SVP - WIC 6602/6604	931	956	0	0	0	956
TOTAL BY COMMITMENT	**5,740**	**5,458**	**10**	**0**	**0**	**5,468**
CONTRACTED PROGRAMS						
JAIL BASED COMPETENCY TREATMENT PROGRAMS	610	451	164	0	0	615
COMMUNITY BASED RESTORATION	737	935	0	1,065	0	2,000
COMMUNITY INPATIENT FACILITIES	157	78	79	0	0	157
TOTAL - CONTRACTED PROGRAMS	**1,504**	**1,464**	**243**	**1,065**	**0**	**2,772**
CONREP PROGRAMS						
CONREP SVP	27	27	0	0	0	27
CONREP NON-SVP	653	655	0	0	0	655
CONREP FACT PROGRAM	180	180	0	0	0	180
CONREP STEP DOWN FACILITIES	185	187	0	0	0	187
TOTAL - CONREP PROGRAMS	**1,045**	**1,049**	**0**	**0**	**0**	**1,049**
BY POPULATION AND CONTRACTED TOTAL	**8,289**	**7,971**	**253**	**1,065**	**0**	**9,289**

Projected census will be adjusted as contracts are entered into as a result of the IST Solutions program implementation.
DJJ census is not displayed in accordance with data de-identification guidelines.
[1] *Coleman* - Reflects current census; pursuant to *Coleman v. Brown* 336 beds are available to *Coleman* patients.

DSH continues to seek solutions to address the significant demand for treatment. As of December 19, 2022, DSH has a total of 1,877 patients pending placement, of which 1,489 are deemed Incompetent to Stand Trial (IST). The enrollment, caseload and population estimates propose continued funding in both community-based and jail-based competency restoration treatment for individuals found to be IST, along with other adjustments related to serving patients in both the state hospitals and the CONREP.

DSH Budget Updates:

• *County Bed Billing Reimbursement Authority (No position authority or dollar change)*
The County Bed Billing Reimbursement Authority is comprised of the Lanterman-Petris-Short (LPS) population and Non-Restorable IST defendants which pertain to county financial responsibility. DSH assumes no adjustments to the current reimbursement authority. DSH will continue to monitor collections of reimbursement authority and provide an update in the 2023-24 May Revision.

• *DSH-Metropolitan Increase Secured Bed Capacity (-$11.2 million in FY 2022- 23)*
The DSH-Metropolitan Increased Secure Bed Capacity (ISBC) provides additional capacity to address the ongoing system-wide IST waitlist. Two of five units have been activated. DSH is experiencing a 1-year activation delay in the three remaining units, as one unit continues to be utilized for COVID-19 isolation space and the other two are being used for Skilled Nursing facility (SNF) swing space through July 2023. Due to this delay, DSH reflects a one-time savings of $11.2 million in FY 2022-23 associated with personal services savings.

• *Enhanced Treatment Program (ETP) (-$4.8 million in FY 2022-23)*
The ETP was developed to treat patients who are at the highest risk of violence and cannot be safely treated in a standard treatment environment. DSH is experiencing a 9-month activation delay with U-06 at DSH-Patton, with construction scheduled to be completed in December 2023 and unit activation scheduled for March 2024. Due to this delay, DSH reflects a one-time savings of $4.8 million in FY 2022-23 associated with personal services savings.

• *Mission Based Review – Court Evaluations and Reports (No position authority or dollar change)*
This staffing standard established population-driven methods for calculating staffing needs for the following forensic functions: Evaluations, Court Reports and Testimony, Forensic Case Management and Data Tracking and Neuropsychological Services (Neuropsychological Assessments and Cognitive Remediation Pilot Program). A total of 53.1 positions were allocated to support forensic evaluations, court reports and testimony, to be phased-in over four years. As of August 31, 2022, a total of 53.1 positions have been established and 42.3 positions have been filled. A total of 16.3 positions were allocated to support forensic case management and data tracking, to be phased-in over two years. As of August 31, 2022, a total of 16.3 positions have been established and 8.0 have been filled. Additionally, a total of 25.2 positions were allocated to support neuropsychological services, phased-in over three years. As of August 31, 2022, a total of 25.2 positions have been established and 18.5 positions have been filled. Additionally, DSH will conduct a Post Implementation Evaluation to assess all methodologies and data elements, identify any changes in operations, forensic processes, and statutory requirements and any impact to the forensic services workload. This will include a review

of the original forensic functions: Evaluations, Court Reports, and Testimony; Forensic Case Management and Data Tracking; and Neuropsychological Services.

• *Mission Based Review – Direct Care Nursing (-$17.1 million in FY 2022-23; - $4.8 million in FY 2023-24; and 29.0 positions in FY 2023-24 and ongoing)*
This staffing standard established population-driven methods for calculating staffing needs to support the workload of providing 24-hour care nursing services within DSH. A total of 335.0 positions were allocated to support the Medication Pass rooms to be phased-in over four years. As of August 31, 2022, a total of 254.5 positions have been established and 163.0 positions have been filled resulting in a one-time savings of approximately $13.1 million in FY 2022-23 and $3.1 million in FY 2023-24. Additionally, a total of 44.5 positions were allocated to provide nursing supervision afterhours to be phased-in over two years. As of August 31, 2022, a total of 44.5 positions have been established and 25.0 positions have been filled resulting in a one-time savings of $4.0 million in FY 2022-23 and $1.7 million in FY 2023-24. DSH is requesting position authority (no funding) for 29.0 non level of care positions allowing level of care positions to be put back on-unit. Additionally, DSH has begun conducting a Post Implementation Evaluation which will re-assess all methodologies and data elements from the original study to determine effectiveness and applicability following the impacts of the COVID-19 pandemic and any changes in patient population commitment type composition among the hospitals.

• *Mission Based Review – Protective Services (-$6.8 million in FY 2022-23)*
This staffing standard identifies protective service posts and establishes workload-driven staffing methodologies to allocate adequate resources for essential police functions and reduce overtime usage. A total of 104.1 positions were allotted to be phased in over two years to support full implementation. As of August 31, 2022, 80.8 positions have been established and 11.0 have been filled resulting in a one-time savings of approximately $6.8 million in FY 2022-23. Additionally, following the implementation of the MBR Protective Services Staffing Standards at DSH-Napa, DSH will conduct a Post Implementation Evaluation of all data elements and will consider the expansion of staffing standards to the four remaining state hospitals.

• *Mission Based Review – Treatment Team and Primary Care (-$21.1 million in FY 2022-23; -$19.3 million in FY 2023-24; and -$10.9 million in FY 2024-25 and FY 2025-26)*
This staffing standard uses data-informed methodologies for standardizing caseload for DSHs interdisciplinary treatment team and primary care, resulting in an increase in the number of treatment teams and primary care physicians in the state hospitals. A total of 213.3 positions were allotted to be phased in over five years to support implementation. As of August 31, 2022, 114.7 positions have been established and 36.0 have been filled. DSH is actively recruiting to fill these positions, however this delay is resulting in a one-time savings in FY 2022-23 of $21.1 million and $8.4 million in FY 2023-24. Due to the delays and challenges in hiring, DSH is requesting to shift a number of positions back to allow time to recruit for positions already authorized. This will allow DSH to focus on

current recruitment efforts and be better positioned for future hires. DSH is proposing to shift 46.5 positions that were scheduled to phase-in in FY 2023-24 until July 1, 2026. This results in an additional savings of $10.9 million in FY 2023-24, 2024-25, and 2025-26.

• *Patient-Driven Operating Expenses and Equipment (OE&E) ($20.3 million in FY 2022-23; $20.5 million in FY 2023-24)*
The Budget Act of 2019 included a standardized patient OE&E projection methodology based on past year actual expenditures and census estimates for FY 2019-20. Due to inflation and changes in patient census, DSH requests to redirect $20.3 million in FY 2022-23 savings and requests $20.5 million in FY 2023-24 and ongoing to support the increase in patient-driven support costs.

• *COVID-19 Response ($51.3 million in FY 2023-24)*
With the onset of the COVID-19 pandemic, DSH executed a COVID-19 response plan across its system and adjusts this plan on an ongoing basis to respond to the COVID-19 pandemic challenges. In FY 2023-24, DSH requests $51.3 million to continue to support infection control measures to protect the health and safety of its employees and patients beyond the State of Emergency end date.

BACKGROUND

The Administration provided the following background information:

DSH manages the nation's largest inpatient forensic mental health hospital system. The mission of DSH is to provide evaluation and treatment to patients in a safe and responsible manner, by leading innovation and excellence across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH was established on July 1, 2012, in accordance with AB 1470, Statutes of 2012. AB 1470 reorganized the Department of Mental Health (DMH), which formerly was responsible for managing the state hospital system and community mental health services. DSH was created to manage and operate the state hospital system and is governed by Welfare and Institutions Code Sections 4000-4027. The community mental health services functions under the former DMH were transferred to other state departments.

DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton). In addition to state hospital treatment, DSH provides services in contracted Jail-Based Competency Treatment (JBCT), Community-Based Restoration (CBR), pre-trial felony mental health diversion programs, other community-based facilities, and the conditional release program (CONREP). DSH is responsible for the daily care to over 7,000 patients, in fiscal year (FY) 2021-22, DSH served 8,055 across the state hospitals, 2,014 in JBCT and 813 CBR contracted programs and 885 in CONREP programs. In

addition, during FY 2021-22, 340 individuals were diverted from jail into county diversion programs funded by DSH.

With nearly 13,000 employees located across its Sacramento headquarters and five state hospitals throughout the state, every team member's effort at DSH focuses on the provision of mental health treatment in a continuum of treatment settings while maintaining the safety of patients, employees and the public. Approximately half of the Department's employees are in nursing classifications, including psychiatric technicians and registered nurses that provide care for patients in DSH's state hospitals.

DSH is funded through the General Fund and reimbursements from counties for the care of Lanterman-Petris-Short (LPS) patients. All DSH facilities are licensed through the California Department of Public Health (CDPH) and four of the five facilities (Atascadero, Metropolitan, Napa, and Patton) are accredited by The Joint Commission, an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States.

STATE HOSPITALS

DSH-Atascadero

Opened in 1954, DSH-Atascadero is located on the Central Coast of California in Atascadero (San Luis Obispo County). The hospital is a forensic mental health hospital and is a self-contained psychiatric hospital constructed within a security perimeter. The majority of the all-male patient population is remanded for treatment by county superior courts or by the California Department of Corrections and Rehabilitation (CDCR) pursuant to various sections of the California Penal Code (PC) and the Welfare and Institutions Code (WIC). DSH-Atascadero primarily serves the following four patient commitment types: Offender with a Mental Health Disorder (OMD), Coleman patients (inmates with serious mental illness) from CDCR, Incompetent to Stand Trial (IST), and Not Guilty by Reason of Insanity (NGI).

DSH-Coalinga

Opened in 2005, DSH-Coalinga is located on the western edge of Fresno County. DSH-Coalinga is a forensic mental health hospital and was created to primarily treat Sexually Violent Predators (SVP). It is a self-contained psychiatric hospital constructed with a security perimeter. CDCR provides perimeter security as well as transportation of patients to outside medical services and court proceedings. The majority of the all-male patient population is remanded for treatment by county superior courts or CDCR pursuant to various sections of the California PC and the WIC. DSH-Coalinga primarily serves the following three patient commitment types: OMD, Coleman patients from CDCR, and SVP.

DSH-Metropolitan

Opened in 1916, DSH-Metropolitan is located in Norwalk (Los Angeles County). The hospital is an "open" style campus within a security perimeter. Due to concerns raised by the community, DSH-Metropolitan maintains a formal agreement with the City of Norwalk and the Los Angeles County Sheriff not to accept patients charged with murder or a sex crime, or at high risk for escape. This agreement has limited the total number of patients that DSH-Metropolitan can treat below the licensed bed capacity. Until 2019, DSH-Metropolitan's operational bed capacity was restricted due to multiple units that were located outside of the hospital's secured treatment area (STA). The units outside of the STA were unable to house forensic patients. To provide additional capacity to serve forensic patients, a secured fence was constructed to surround the housing units located next to the existing secure treatment area. To provide additional capacity to address an ongoing system-wide forensic waitlist, the 2016 Budget Act included the capital outlay construction funding for the Increased Secure Bed Capacity project, which is now complete. DSH-Metropolitan primarily serves the following four patient commitment types: LPS, IST, OMD and NGI.

DSH-Napa

Opened in 1875, DSH-Napa is located in Napa County. Most of the hospital is a forensic mental health hospital, and the first State Hospital. DSH-Napa is the oldest California state hospital still in operation and has an "open" style campus with a security perimeter. DSH-Napa primarily serves the following four patient commitment types: LPS, IST, OMD and NGI.

DSH-Patton

Opened in 1893, DSH-Patton is located in the town of Highland in San Bernardino County. Most of the hospital is a forensic mental health hospital and has an "open" style campus with a security perimeter. Due to concerns from the community about the risk of a patient escape, CDCR correctional officers provide perimeter security and transportation at DSH-Patton. DSH-Patton primarily serves the following four patient commitment types: LPS, IST, OMD and NGI.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present an overview of the department, state hospitals system, and the proposed DSH budget.

Staff Recommendation: This is an oversight issue and therefore no action is recommended at this time.

JUSTICE INVOLVEMENT AND BEHAVIORAL HEALTH

4260 DEPARTMENT OF HEALTH CARE SERVICES
4440 DEPARTMENT OF STATE HOSPITALS
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 8: OVERSIGHT: JUSTICE INVOLVEMENT ISSUES INCLUDING INCOMPETENT TO STAND TRIAL WAITING LIST

PANEL

- **Stephanie Clendenin**, Director, DSH
- **Chris Edens**, Chief Deputy Director, Program Services, DSH
- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Toby Ewing**, Ph.D., Executive Director, OAC
- **Phebe Bell**, Nevada County Behavioral Health Director, CBHDA
- **Nina Hoang,** Finance Budget Analyst, DOF
- **Matthew Aguilera,** Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

OVERSIGHT

The purpose of this oversight issue is to give the Subcommittee an opportunity to explore the relationship between behavioral health and justice involvement, and to better understand the state's programs and initiatives to support this population.

BACKGROUND

An estimated 31% of justice involved Californians have unmet mental health needs, and the percentage of state prisoners with mental health challenges has increased by 77% over the past decade.

DSH Incompetent to Stand Trial Waiting List

Over the last decade, the State of California has seen significant growth in the number of individuals found IST on felony charges and referred to DSH for restoration of competency treatment. The year-over-year growth in IST referrals from the superior courts to DSH has outpaced the department's ability to create additional capacity. Despite recent efforts, including increased bed capacity, decreased average length of stay, and implementation of county-based treatment programs, this insufficient bed capacity has led to a large waitlist and extended wait times for IST defendants pending DSH placement. Furthermore, the impacts of the COVID-19 pandemic and infection control

measures required at DSH facilities necessitated slower admissions and reduced capacity for the treatment of felony ISTs at DSH.

In 2015, the American Civil Liberties Union filed a lawsuit against DSH (Stiavetti v. Clendenin), alleging the time IST defendants were waiting for admission into a DSH treatment program violated the IST defendants constitutional right to due process. The Alameda Superior Court ultimately ruled in 2021 that DSH must commence substantive treatment services the restore an IST defendant to competency within 28 days from transfer of responsibility to DSH which is the date of service of the commitment packet to DSH for felony IST patients, with a specified timeline for meeting that standard over the next three years. By February 27, 2024, DSH must provide substantive treatment services within 28 days of transfer of responsibility.

In 2021, the Legislature enacted the Welfare & Institutions Code (WIC) section 4147 through the passage of Assembly Bill 133 (Chapter 143, Statutes of 2021) and the Budget Act of 2021 (Chapter 69, Statutes of 2021), which charged the California Health & Human Services Agency (CalHHS) and DSH to convene an IST Solutions Workgroup (Workgroup) to identify actionable solutions that address the increasing number of individuals with serious mental illness who become justice-involved and deemed IST on felony charges. The IST Workgroup convened between August 2021 and November 2021 with various representatives and stakeholders. Per the statute, the Workgroup identified short-, medium-, and long-term solutions to advance alternatives to placement in DSH competency restoration programs.

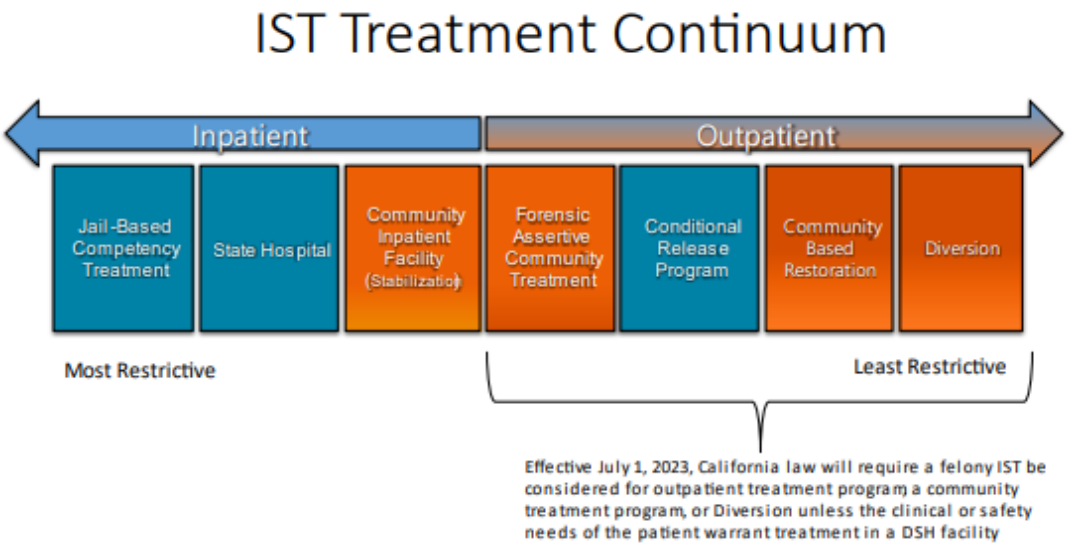
The Budget Act of 2022 appropriated DSH the following funding to implement many of the IST Solutions discussed with country partners and stakeholders:

- $535.5 million in FY 2022-23; $328.8M is one-time funding
- $482.2 million in FY 2023-24; $160 million is one-time funding
- $517.9 million in FY 2024-25; $5 million is one-time funding
- $638 million and ongoing

The components of the IST solutions provide early stabilization and care coordination, expand community-based treatment and diversion options for felony ISTs, improve IST discharge planning and coordination, implement a pilot for independent placement panels, and improve alienist training. Together, these solutions are expected to help to reverse the cycle of criminalization for individuals with serious mental illnesses and increase community transitions for state hospital patients. The Budget Act of 2022 also included an increase of $15.5 million to support expanding existing JBCT programs and associated funding for patients' rights advocacy services. Collectively, these proposals will also assist the state in meeting treatment timelines ordered by the Superior Court in Stiavetti v. Clendenin.

IST Treatment Continuum

The following chart displays the continuum of IST treatment placement options DSH continues to expand upon with the funding recently authorized. The blue boxes represent programs which have been part of DSH's continuum for a decade or more, while orange boxes represent newer placement options which have only recently begun implementation. Historically, restoration treatment options for individuals deemed IST on felony charges were primarily provided in State Hospitals and JBCT programs. In 2018, DSH was authorized to partner with counties to pilot Felony Mental Health Diversion (diversion) opportunities for individuals deemed IST on felony charges or who were likely to be found IST on felony charges. Additionally, in 2018 DSH was authorized to partner with Los Angeles County to establish the first community-based restoration of competency program for individuals from LA County who were determined to be IST on felony charges. Utilizing the recent investments made in the Budget Acts of 2021 and 2022, DSH is building upon these initial community-based programs to expand the treatment continuum serving ISTs in the least restrictive community treatment options.



IST Waitlist

Despite DSH's efforts to expand its continuum and address the IST waitlist, the number of individuals found IST on felony charges and referred by the superior courts to DSH for restoration of competency treatment has continued to increase. Furthermore, DSH has experienced significant operational impacts due to the COVID-19 pandemic which have negatively impacted the waitlist.

In February 2020, a month prior to the Governor's State of Emergency Declaration, there were 850 individuals on DSH's waitlist pending placement into a DSH IST treatment program. Since that time, and throughout the pandemic, DSH has observed seasonal fluctuations in the waitlist, with higher waitlists during winter and summer, and lower waitlists in spring and fall as DSH recovers from COVID-19 surges. ***In January 2022,***

during the COVID-19 surge fueled by the Omicron variant, the IST waitlist reached a high of 1,953.

As of December 12, 2022, the waitlist has declined to 1,473. This decline in the waitlist was achieved through new program implementation including IST Re-Evaluations, the activation of a new community-based treatment facility and implementation of Early Access and Stabilization Services in jail settings and expanding existing IST treatment programs such as DSH IST Diversion and the Los Angeles Community-Based Restoration Program. Admissions were also aided by lower infection rates following a summer surge and through November 2022 as well as an increase in DSH's operational efficiency resulting from recent changes by the Center for Disease Control and California Department of Public Health to infection control guidance

IST-Related Programs and Policies:

Early Access and Stabilization Services (EASS) – EASS, a new program funded in FY 2022-23 as part of the IST Solutions budget, provides treatment at the earliest point possible upon an individual's IST commitment to DSH, and promotes stabilization to increase community-based treatment placements.

Jail-Based Competency Treatment (JBCT) – DSH contracts with a number of California county Sheriffs' departments to provide restoration of competency treatment programs to patients committed as IST while they are housed in county jail facilities. JBCT programs are designed to treat patients presenting with lower acuity and quickly restore them to trial competency, generally within 90 days.

Community Inpatient Facilities – Community inpatient treatment facilities are being developed under the funding authorized in FY 2021-22 through the Institute for Mental Disease (IMD) and Sub-Acute Bed Capacity program. Under this program, DSH may contract with counties or private providers to develop new or renovate existing community inpatient facilities to provide alternative treatment options to state hospitals which increases the availability of IMDs, Mental Health Rehabilitation Centers (MHRC), Skilled Nursing Facilities (SNF), or other types of facilities appropriate for felony IST patients.

Expanding Felony IST Community Programing via Community Based Restoration (CBR) and Diversion – The goal of expanding CBR and the Felony Mental Health Diversion (Diversion) programs is to provide care in the most appropriate community-based setting, an alternative to placement in a DSH inpatient bed. In the 2022-23 Governor's Budget, DSH estimated 60-70% of IST commitments would be eligible for services each year in a community-based program, for a total of approximately 3,000 annual felony IST admissions, based on FY 2021-22 IST referral trends.

Community Based Restoration (CBR) – CBR programming provides intensive mental health treatment services and competency restoration training in the community. ISTs participating in this programming may receive services in locked acute, sub-acute, and unlocked residential settings, based on each defendant's treatment needs.

Diversion Program – DSH currently has Diversion contracts with 29 existing counties throughout California and continues to work to develop new or expand existing Diversion Programs. The current county programs serve individuals with serious mental illnesses diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder with the potential to be found IST on felony charges.

County Stakeholder Workgroup Grants – As part of the IST Community programming expansion, DSH has been allocated resources to support the efforts of behavioral health and criminal justice workgroups across the state. These local stakeholder workgroups are responsible for developing interventions in their communities to reduce the overall number of residents with serious mental illness (SMI) who enter the criminal justice system, many of whom may be found IST on felony charges.

IST Re-Evaluation Services – In the Budget Act of 2021-22, DSH was authorized to implement the IST Re-Evaluation Services Program as a 4-year limited-term solution to help address the IST waitlist. DSH has successfully implemented the Re-Evaluation Services for Felony ISTs program in all counties except two because these counties do not have operating jails. Under the Re-Evaluation Services program, DSH evaluators reevaluate individuals who have been deemed IST and are waiting in jail pending transfer to a DSH treatment program. In addition to the re-evaluations, this team also provides competency evaluations for newly emerging community IST treatment programs where programs do not have forensic evaluators yet available. As of December 16, 2022, DSH has completed 1,839 evaluations, of which:

- 1,256 (68%) were found not competent and continued competency restoration treatment
- 577 (31%) were found restored to competency
- <11 (<1.0%) were found unlikely to be restored to competency

DSH continues to ramp up its capacity to perform re-evaluations and will provide an update in the 2023-24 May Revision.

Care Coordination & Waitlist Management – The Patient Management Unit (PMU) was established in June 2017 to provide centralized management, oversight, and coordination of the patient preadmission processes, ensuring the placement of patients to the most appropriate setting based on clinical and safety needs. Prior to the establishment of PMU, courts were able to order commitments to any DSH hospital, creating admission backlogs and inefficiencies.

Independent Placement Panel (IPP) – In the Budget Act of 2022, DSH received resources to pilot a new independent placement determination panel to help increase the number of individuals found Not Guilty by Reason of Insanity (NGI) and Offenders with Mental health Disorders (OMD) served in the community via the Conditional Release Program (CONREP), increasing available bed capacity in the state hospitals for those on the IST waitlist.

Discharge Planning and Coordination with Counties – Patients discharged from DSH facilities may return to the community with or without supervision, transfer to other DSH facilities, or return to court, prison, or jail. Comprehensive discharge planning encompasses many components, including, but not limited to, the development of treatment goals and objectives in collaboration with interdisciplinary treatment teams and patients, coordination with available community resources, including family and social supports, and partnering with stakeholders and agencies for further treatment options. These include CONREP, county behavioral health, skilled nursing facilities, board and care facilities, California Department of Corrections and Rehabilitation (CDCR), county jails, Office of the Public Guardian, private conservators, and other community placement locations.

Alienist Training – DSH is partnering with the Judicial Council to develop statewide court-appointed IST evaluator training and workforce development programs to improve the quality of IST evaluations performed by court-appointed evaluators. These evaluations are utilized by the courts to determine a defendant's competency status and serve as the basis for a commitment to DSH as IST.

Placement Presumption – To increase consideration for the placement of IST patients in Diversion, CBR or other community IST facilities, PC Section 1370 was amended in the Budget Act of 2022 to statutorily prioritize community outpatient treatment effective July 1, 2023, unless a court, based on the recommendation of the Community Program Director or designee, finds that the clinical needs or community safety risk warrants placement in a more secure setting, such as a state hospital or JBCT program.

Felony IST Referral Growth Cap and Penalties

The Welfare and Institutions Code (WIC) section 4336 was enacted as part of the Budget Act of 2022 to establish a growth cap on the number of felony IST determinations per county, address the growing IST waitlist, and implement a penalty payment structure to be assessed if those caps are exceeded in a FY. Penalty payments to counties will commence in FY 2022-23, with the first invoices scheduled to be sent in the fall of 2023. Penalties collected will be deposited into the Mental Health Diversion Fund (Fund 3404) and redistributed back to the counties which exceeded their baseline IST determinations and remitted the payments. The funds must then be utilized to fund pre-booking diversion and reentry strategies in the county to help reduce the number of individuals who are determined to be felony IST in the future.

In December, DSH released a department letter to all counties identifying the county baseline (equal to the total number of felony IST determinations in FY 2021- 22), the penalty rate DSH will apply to FY 2022-23 IST determinations which exceed the established baseline and the counties' baseline versus the first quarter of 2022- 23 IST determinations. This initial letter reflects that overall, in the first quarter of FY 2022-23, counties have had an average of 512 felony IST determinations per month, which is 97.1 ISTs per month more than the 2021-22 monthly average of 414.9 ISTs. Additionally, 42 counties have referred more IST determinations on average per month in the first quarter of this fiscal year than last fiscal year and 15 counties have seen reductions in their average monthly IST determinations this fiscal year (one county has had no change). Going forward, DSH will notify counties of the counties' total number of determinations quarterly to allow counties to assess how they are trending in IST determinations compared to their baseline, and then to act if necessary to avoid penalties.

Mental Health Diversion Programs

The 2018 Budget Act provided funding, on a pilot basis, for DSH to contract with various counties throughout California to develop new or expand existing Diversion programs. These county programs serve individuals with a serious mental illness diagnoses such as schizophrenia, schizoaffective disorder, or bipolar disorder, who have been found or have the potential to be found Incompetent to Stand Trial (IST) on felony charges.

Funding for Existing County Programs

Of the resources provided, 99.5% was allocated by November 15, 2022, for contracts with the following 24 counties:

- Alameda
- Contra Costa
- Del Norte
- Fresno
- Humboldt
- Kern
- Los Angeles
- Marin
- Placer
- Riverside
- Sacramento
- San Bernardino
- San Diego
- San Francisco
- San Luis Obispo
- San Mateo
- Santa Barbara
- Santa Clara
- Santa Cruz
- Siskiyou
- Solano
- Sonoma
- Ventura
- Yolo

New Pilot County Program Funding

Based on the success of prior efforts, DSH received additional resources in the 2021 Budget Act to expand the Diversion pilot program. The pilot programs in new counties established under this expansion were required to follow the requirements of the original pilot. In fall 2021, DSH provided intensive technical assistance to aid counties in developing their programs, resulting in five new proposals to establish Diversion programs in the following counties:

- Madera
- Nevada
- San Joaquin
- Tulare
- Tuolumne

As of summer 2022, contracts with all five counties have been fully executed. In fall 2022, DSH began holding implementation check-in meetings with each county to assist with the activation of their diversion programs.

Expanding Existing County Programs

The 2021 Budget Act also provided resources to allow participating counties to expand their existing Diversion programs by up to 20% if they met the following criteria:

- Defendants diverted must be found felony IST
- Diagnostic criteria for entry must include any mental health diagnosis allowed under Penal Code (PC) 1001.36
- Clients must not pose an unreasonable safety risk to the community
- A connection exists between the alleged crime and the defendant's symptoms of mental illness or conditions of homelessness

Sixteen counties elected to participate in this expansion, accounting for 294 Diversion slots. Twelve of the contract amendments have been executed while the remaining four are finalizing execution. As of November 15, 2022, DSH has fully executed five new county contracts and has successfully launched and activated programs in the new counties. All expansion efforts have increased the number of contract slots, ultimately serving 1,189 felony ISTs over the course of the pilot.

Diversion Pilot Program Data Collection Efforts and Research

As of June 30, 2022, 886 eligible individuals have been diverted to a county-run program. DSH continues working one-on-one with all counties to ensure data collection quality. The following table provides a high-level snapshot of Diversion program participants:

Diversion Program Participant Descriptive Data		
Program Information	**Total Number**	**Percentage**
Total Enrolled, Eligible & Diverted as of 6/30/2022	886	100%
At risk of IST	489	55.5%
IST	392	44.5%
Removed from DSH Waitlist	186	21%
Diagnosis	**Total Number**	**Percentage**
Schizophrenia	317	35.8%
Schizoaffective Disorder	325	36.7%
Bipolar Disorder	195	22.0%
Other	49	5.5%
Ethnicity	**Total Number**	**Percentage**
White	247	27.9%
People of Color	639	72.1%
Gender	**Total Number**	**Percentage**
Male	599	67.6%
Female	280	31.6%
Other	7	0.8%
Living Situation at Arrest	**Total Number**	**Percentage**
Homeless	686	77.5%
Not Homeless	199	22.5%
Felony Charges	**Total Number**	**Percentage**
Assault/ Battery	295	33.3%
Theft	146	16.5%
Other (primarily Vandalism)	132	14.9%
Robbery	118	13.3%
Arson	74	8.4%
Criminal Threats	74	8.4%
Resisting Arrest	28	3.2%
Kidnapping	19	2.1%

DSH explains that a best practice for mental health treatment within DSH programs is utilization of Long-Acting Injectable medications (LAIs), which allows for the slow release of medicine into the blood, lasting anywhere from two to 12 weeks, which assists in stabilizing symptoms of mental illness. Based on data collected to date, DSH has observed Diversion programs have greater levels of success when participants experiencing homelessness at the time of their arrest are placed on an LAI. The following tables provide statistics on all program participants, including those who did not successfully complete the program:

Incompetent to Stand Trial WITHOUT LAI	Successful Completion Total (Percent)	AWOL/Re-incarcerated/Revoked Total (Percent)
IST	43 (48.3%)	46 (51.7%)
At risk of IST	57 (52.3%)	53 (47.7%)

Incompetent to Stand Trial WITH LAI	Successful Completion Total (Percent)	AWOL/Re-incarcerated/ Revoked Total (Percent)
IST	39 (65.0%)	21 (35.0%)
At risk of IST	35 (36.8%)	60 (63.2%)

IST and Housed at Time of Arrest	Successful Completion Total (Percent)	AWOL/Re-incarcerated/ Revoked Total (Percent)
IST	21 (61.8%)	13 (38.2%)
At risk of IST	14 (43.8%)	18 (56.3%)

IST and Homeless at Time of Arrest	Successful Completion Total (Percent)	AWOL/Re-incarcerated/ Revoked Total (Percent)
IST	69 (51.1%)	66 (48.9%)
At risk of IST	80 (44.2%)	101 (55.8%)

IST, Homeless WITHOUT LAI	Successful Completion Total (Percent)	AWOL/Re-incarcerated/ Revoked Total (Percent)
IST	29 (43.9%)	37 (56.1%)
At risk of IST	49 (53.8%)	42 (46.2%)

IST, Homeless WITH LAI	Successful Completion Total (Percent)	AWOL/Re-incarcerated/ Revoked Total (Percent)
IST	33 (63.5%)	19 (36.5%)
At risk of IST	30 (34.9%)	56 (65.1%)

DSH reports that, to date, the strongest criteria predictors of successful program completion are clients deemed IST, experiencing homelessness before arrest, and having an LAI prescription. Of participants who have exited the diversion program and met these three criteria, 63.5 percent successfully completed the program. Conversely, participants who are likely to be IST but also were homeless and prescribed an LAI have a 65.1 percent failure rate, indicating the program works best for those individuals who are determined to be IST.

DSH has a contract with Policy Research Associates to design an outcomes evaluation of the permanent, ongoing diversion program, which will follow participants over time.

Supplemental County Housing Support

In FY 2021-22, DSH released funding to participating diversion counties to support housing costs for the IST population. DSH received 17 requests from counties to participate in this opportunity. As of November 15, 2022, DSH executed 16 housing funding contracts, with one additional contract pending final execution. DSH will continue working with existing counties and provide an update in the 2023-24 May Revision

Medi-Cal and CalAIM

Over the past several years, DHCS has championed a series of policy reforms within Medi-Cal to increase access to Medi-Cal services for incarcerated or recently-incarcerated individuals. The most significant of these reforms have been through CalAIM, including PATH and the new Justice Involved Initiative (which will be discussed in more detail under issue 10 of this agenda).

MHSOAC

The Commission has undertaken a substantial amount of work, as directed by the MHSA, on the justice involved population with mental illness, including the following:

- Launched the Innovation Incubator with $5 million in one-time funding from the 2017 Budget to reduce justice involvement

- Developed multi-county learning collaboratives to reduce justice involvement

- Partnered with federal agencies to identify national best practices to bring to California

- Leveraged nearly $30 million in county innovation funding to support a range of projects
  - Expanding use of Psychiatric Advance Directives to improve response to mental health crises
  - Launched Crisis Now academy to scale evidence based practice across California
  - Strengthening county capacity to map the mental health-criminal justice nexus

- Established data infrastructure to track justice involvement, documenting 69% reduction in criminal justice involvement for Full Service Partnership (FSP) participants

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Administration and Commission provide an overview of the state's work related to justice involvement, and respond to the following:

For DSH:
Please provide the most recent assessment of progress being made with regards to the IST waitlist.

When is it reasonable to expect that DSH will have outcomes data needed to evaluate the mental health diversion program?

For the Commission:
What recommendations do you have for the state and counties to more effectively reduce justice involvement for individuals with unmet behavioral health needs?

For CBHDA:
Please share the concerns of the counties with the new ITS referral growth cap and related penalties.

Staff Recommendation: This is an oversight issue and therefore no action is recommended at this time.

ISSUE 9: DSH: DEPARTMENT OF STATE HOSPITALS CRIMINAL OFFENDER RECORD INFORMATION DATA TRAILER BILL

PANEL

- **Jaci Thomson**, Deputy Director, Hospital Strategic Planning and Implementation, DSH
- **Janna Lowder**, Research Data Officer, DSH
- **Nina Hoang,** Finance Budget Analyst, DOF
- **Matthew Aguilera,** Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

DSH proposes trailer bill to address provision of access to Criminal Offender Record Information (CORI) for purposes of Incompetent to Stand Trial solutions and other mental health policy research and program evaluations.

The proposed language can be found here:
https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/857

BACKGROUND

The Administration provided the following background information:

The Budget Act of 2022 authorized $535.5 million to implement solutions to address an increasing number of individuals who have been found incompetent to stand trial (IST) and referred to DSH for restoration of competency services. Included in these solutions is a significant expansion of community-based restoration and diversion programs and the implementation of new early access stabilization services in jail, among other solutions. The appropriation included funding for DSH to conduct outcomes evaluations of these new and expanding programs.

Existing statutory authority authorizes DSH to conduct, or contract for, research or evaluation studies that have application to mental health policy and management issues (Welfare and Institutions Code Section 4040).

The Budget Act of 2018 authorized DSH to establish an IST Diversion Pilot Program. Under this program, DSH partners with counties to implement new or expand existing diversion programs to serve individuals who are likely to be or have been found IST on felony charges. DSH is also authorized to conduct evaluation of proposals and treatment outcomes related to the IST Diversion Pilot Program (Welfare and Institutions Code Section 4361).

The Budget Act of 2021 authorized DSH to establish a new Forensic Assertive Community Treatment model within its Conditional Release Program to increase opportunities for individuals treated within DSH's state hospitals to step down into community treatment and to also provide additional community-based treatment opportunities for individuals found IST on felony charges. DSH is authorized to research the demographic profiles and other related information pertaining to persons receiving supervision and treatment in the conditional release program as well as to perform an evaluation of the program to determine its effectiveness in successfully reintegrating these individuals into the community (Penal Code Section 1617).

DSH serves individuals with serious mental illness that are engaged in the criminal justice system, including individuals found by a court to be IST, not guilty by reason of insanity, a sexually violent predator or found by the Board of Parole to be an offender with a mental health disorder, among others. These individuals are committed to DSH for treatment as a result of crimes they have committed or have been alleged to have committed. Effective evaluation of the policy that impact the programs that serve these individuals, requires understanding recidivism (re-arrest and conviction) rates and gaining understanding of the criminal charges associated with the commitments of this population. Currently, DSH is not one of the entities permitted access to CORI for research and evaluation purposes under Penal Code section 11105. Without this clear authority, DSH's access to CORI data is significantly limited and requires substantial justification and data use agreements regarding its intended use and research to be conducted. This process places significant limitations on DSH's ability to fulfill its statutory authorization to conduct research and evaluations of programs and policies.

This trailer bill language will provide DSH access to necessary CORI data to conduct research and evaluation to evaluate programs, polices, and services for individuals found IST on felony charges and other individuals committed to DSH with serious mental illnesses and engaged in the criminal justice system. This trailer bill language will increase DSH's ability to provide timely evaluation and research on criminal justice elements related to individuals with serious mental illness engaged in the criminal justice system. Further it provides DSH the ability to conduct recidivism studies for the population it serves within it state hospitals, community-based, and jail-based treatment programs to evaluate the effectiveness of the programs.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for additional discussion and consideration of the proposal.

ISSUE 10: DHCS: CALAIM JUSTICE INVOLVED INITIATIVE

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Phebe Bell**, Nevada County Behavioral Health Director, CBHDA
- **Kendra Tully,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

The Governor's Budget includes an estimated $109.7 million total fund ($39.1 million General Fund) in FY 2023-24 for the CalAIM inmate pre-release program – "Justice Involved Initiative."

The Governor's Budget also includes expenditure authority of $711.9 million ($271.2 million General Fund, $356 million federal funds, and $84.7 million special funds and reimbursements) in 2022-23 and $599.9 million ($272 million General Fund, $300 million federal funds, and $28 million special funds and reimbursements) in 2023-24 for the Medi-Cal Providing Access and Transforming Health (PATH) initiative.

BACKGROUND

DHCS provided the following background information:

People who are now, or have spent time, in jails and prisons experience disproportionately higher rates of physical and behavioral health diagnoses and are at higher risk for injury and death as a result of trauma, violence, overdose, and suicide than people who have never been incarcerated. Addressing the unique and considerable health care needs of justice-involved populations—who are disproportionately people of color, and of whom at least 80 percent are eligible for Medi-Cal—will help to improve health outcomes, deliver care more efficiently, and advance health equity. Key to that is establishing Medi-Cal enrollment processes, providing targeted Medi-Cal services to individuals while they are incarcerated immediately prior to their release, and ensuring continuity of coverage and services after incarceration as part of coordinated re-entry planning.

Medi-Cal Providing Access and Transforming Health (PATH).
The Medi-Cal PATH initiative is intended to provide a smooth transition between current 1115 Waiver pilots and statewide services and capacity building, including for effective pre-release care and coordination with justice agencies. PATH funding will support the transition from Whole Person Care pilots to Enhanced Care Management (ECM) and community supports, including funding for counties, community-based organizations, and other providers to build the capacity and infrastructure necessary for these new statewide services. In addition, PATH funding will help ensure jails and prisons are ready for service delivery for the justice-involved, including mandatory Medi-Cal applications; behavioral health referrals, linkages, and warm hand-offs from county jails to Medi-Cal managed care plans and county behavioral health departments; "in reach" services up to 90 days prior to release, and the re-entry ECM benefit available in January 2023. PATH funding will also support workforce development for the homeless and home- and community-based services systems of care, including outreach, training in evidence-based practices, information technology for data sharing, and training stipends.

DHCS has implemented pre-release Medi-Cal eligibility and enrollment processes as of January 1, 2023 and is awarding $151 million in PATH funding to support correctional agencies to collaborate with county social services departments to support planning and implementation of pre-release Medi-Cal enrollment processes. DHCS continues to seek approval of the proposed section 1115 CalAIM demonstration request to cover a targeted set of Medi-Cal services during a 90-day period prior to release to support successful community re-entry. These targeted services include care coordination; physical and behavioral health clinical consultation services including behavioral health referrals/linkages; medications for addiction treatment (MAT); medications; associated laboratory/radiology services; and for use post-release into the community a supply of medication and necessary durable medical equipment. In addition, DHCS continues to seek approval for $410 million in additional PATH funding that will support planning and implementation of pre-release and re-entry planning services in the 90 days prior to release.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present the CalAIM Justice Involved Initiative.

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for further consideration of the proposal.

HOMELESSNESS AND BEHAVIORAL HEALTH

4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 11: OVERSIGHT: HOMELESSNESS ISSUES INCLUDING: EARLY PSYCHOSIS TREATMENT, FULL SERVICE PARTNERSHIPS, BRIDGE HOUSING, AND CALAIM HOUSING SUPPORTS

PANEL

- **Tara Niendam**, Ph.D., Professor in Psychiatry, Executive Director, UC Davis Early Psychosis Programs, Director, Early Psychosis Intervention Training and Technical Assistance Program for California
- **Jonathan Porteus**, Ph.D., Chief Executive Officer, WellSpace Health
- **Phebe Bell**, Nevada County Behavioral Health Director, CBHDA
- **Toby Ewing**, Ph.D., Executive Director, OAC
- **Michelle Baass**, Director, DHCS
- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

OVERSIGHT

The purpose of this issue is for the Subcommittee to do oversight on the myriad of state and local programs aimed at meeting the behavioral health and housing needs of the homeless population.

BACKGROUND

CalAIM (Housing Supports and Transitional Rent)
CalAIM (covered in more detail in the Subcommittee's March 27th hearing agenda), the major Medi-Cal reform effort adopted through the 2021 budget, opens the door to using Medicaid funding for housing-related purposes. Specifically, CalAIM includes community supports which are services or service settings that Medi-Cal managed care plans may offer as a medically appropriate, cost-effective alternative to Medi-Cal eligible services or settings. Related to housing and homelessness, community supports include:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services

The 2023 Governor's Budget includes a proposal to add "transitional rent" as a community support, as follows: To improve the well-being and health outcomes of Medi-Cal members during critical transitions, DHCS will seek an amendment to the CalAIM waiver to authorize an additional Community Support for use by Medi-Cal Managed Care Plans. The new Community Support would allow the provision of up to six months of rent or temporary housing to eligible individuals experiencing homelessness or at risk of homelessness and transitioning out of institutional levels of care, a correctional facility, or the foster care system and who are at risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits.

Behavioral Health Bridge Housing (BHBH)

Bridge housing—also referred to as transitional housing—is housing intended to transition individuals immediately out of homelessness into a stable living environment in advance of further placement into permanent housing.

BHBH provides $1.5 billion for counties and tribes to provide BHBH Options that include behavioral health services. The 2022-23 budget package included $1 billion General Fund in 2022-23 and $500 million General Fund 2023-24 for DHCS to award grants to counties and tribes to develop transitional housing for individuals experiencing homelessness who also have serious behavioral health conditions. The administration plans three rounds of funding: (1) $908 million distributed via a formula to county behavioral health departments, (2) $50 million to tribal entities, and (3) a competitive round of grants for counties and tribes totaling $250 million.

The Governor's budget proposes to delay $250 million in BHBH funding previously budgeted for 2023-24 to 2024-25 to address the current budget problem, which will be discussed under issue #12 of this agenda.

Community Assistance, Recovery, and Empowerment (CARE) Act

SB 1338 (Umberg, Chapter 319 of 2022) established the CARE program—a new judicial process to compel individuals who meet certain criteria to engage with various behavioral health-related services. These criteria include the person being over the age of 18 as well as currently experiencing both a severe mental illness and having a diagnosis of schizophrenia or other psychotic disorders. An individual (called a "respondent") can be referred to the program by certain qualified members of the community, and a court assesses whether the respondent meets the specified criteria for admission to the program. If the court determines that the respondent meets these admission criteria, the court may order the provision of behavioral health care, stabilization medications, housing, and other supportive services, which are expected to be delivered by counties.

CARE Program Phased in Over Two Cohorts; Initial Planning and Implementation Funding Provided. SB 1338 specified that one group of counties ("Cohort 1")—which included Glenn, Orange, Riverside, San Diego, San Francisco, Stanislaus, and Tuolumne Counties—are generally required to begin CARE program operations no later than

October 1, 2023. All remaining counties ("Cohort 2") are generally required to begin CARE program operations no later than December 1, 2024. In January 2023, Los Angeles County—a member of Cohort 2—announced plans to implement the CARE program by December 1, 2023, a year earlier than required. The 2022-23 budget included $88.3 million General Fund for the CARE program, mainly for county planning and implementation costs.

2023-24 Budget Proposal Includes Multiyear Funding Across Judicial Branch and Health Entities. In 2023-24, the administration proposes a total of $52.4 million General Fund for the CARE program—$22.6 million in DHCS and $29.9 million in the judicial branch. Funding would increase to $214.6 million annually beginning in 2025-26. The following chart from the LAO shows the CARE Act funding across state government:

Entity	Purpose	2022-23	2023-24	2024-25	2025-26 and Ongoing
Judicial Branch					
Judicial Branch	Court Operations	$5.9	$23.8	$50.6	$68.5
Judicial Branch	Legal Representation	0.3	6.1	21.8	31.5
Totals, Judicial Branch		**$6.1**	**$29.9**	**$72.4**	**$100.0**
Health Entities					
CalHHS	Training	$5.0	—	—	—
DHCS	Training, Data Collection, and Other Activities	20.2	$6.1	$6.1	$6.1
DHCS	County Grants	57.0	16.5	66.5	108.5
Totals, Health Entities		**$82.2**	**$22.6**	**$72.6**	**$114.6**
Total CARE Program Funding		**$88.3**	**$52.4**	**$144.9**	**$214.6**

CARE = Community Assistance, Recovery, and Empowerment; CalHHS = California Health and Human Services Agency; and DHCS = Department of Health Care Services.

Please also see the CARE Act DHCS Budget Change Proposal under issue #13 of this agenda.

No Place Like Home

On July 1, 2016, Governor Brown signed legislation enacting the No Place Like Home (NPLH) program to dedicate up to $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who are in need of mental health services and are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness. The bonds are repaid by funding from the Mental Health Services Act (MHSA). In November 2018 voters approved Proposition 2, authorizing the sale of up to $2 billion of revenue bonds and the use of a portion of Proposition 63 taxes for the NPLH program. Key features of the program include:

- Counties will be eligible applicants (either solely or with a housing development sponsor).

- Funding for permanent supportive housing must utilize low barrier tenant selection practices that prioritize vulnerable populations and offer flexible, voluntary, and individualized supportive services.
- Counties must commit to provide mental health services and help coordinate access to other community-based supportive services.

Funds Available

- Noncompetitive Allocation ($190 million)
- Distributed by formula allocation to each county based on their 2017 homeless Point-In-Time Count with a minimum allocation per county of $500,000.

Competitive Allocation (up to $1.8 billion for multiple funding rounds)
Second Round Funding: Anticipated minimum of $622 million.

Counties compete for funding with counties of similar size, as follows:

- Los Angeles County*
- Large counties (population greater than 750,000)*
- Medium counties (population between 200,000 to 750,000)
- Small counties (population less than 200,000)

**Counties with five percent or more of the state's homeless population may be designated by the Department of Housing and Community Development (HCD) to receive and administer their own allocations of NPLH funds under their own HCD-approved method of distribution.*

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the panelists describe their programs and work related to addressing the needs of the homeless population with serious behavioral health conditions, and/or preventing homelessness by treating behavioral health conditions, and respond to the following:

1. How much of the homelessness crisis in California can be attributed to untreated behavioral health conditions?

2. How many people have been housed (permanently) by the No Place Like Home Program?

3. How successful are Full Service Partnerships?

4. How much of the homeless population statewide has access to “street medicine” services?

Staff Recommendation: This is an oversight issue and therefore no action is recommended at this time.

ISSUE 12: PROPOSED FUNDING DELAY: BEHAVIORAL HEALTH BRIDGE HOUSING AND BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE PROGRAM

PANEL

- **Michelle Baass**, Director, DHCS
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

In response to the state's fiscal condition and General Fund deficit and overall fiscal condition, the Governor's Budget proposes to delay funding for the Behavioral Health Bridge Housing Program and the Behavioral Health Continuum Infrastructure Program, as described below.

BACKGROUND

Funding Delay – Behavioral Health Bridge Housing Funding

The 2022 Budget Act provided $1 billion General Fund for Behavioral Health Bridge Housing in FY 2022-23, with another $500 million General Fund planned for FY 2023-24. The Governor's Budget delays half ($250 million) of the FY 2023-24 funding until FY 2024-25 given the state's projected General Fund revenue decline. Additionally, due to updated timelines to release funds, $50 million of the funding approved for FY 2022-23 is expected to be spent in FY 2023-24.

LAO Analysis

The LAO provided the following analysis and recommendations on the proposal to delay BHBH funding:

> "Earlier this year we assessed the Governor's Budget proposals to delay a portion of funding for two behavioral health programs. We found that the delay of funding for the Behavioral Health Continuum Infrastructure Program (BHCIP) was reasonable given the progress made in allocating funds so far, the long-term nature of the BHCIP projects, and in light of the budget condition. We suggested the Legislature defer action on the proposed delay of funding for the BHBH program until more information concerning its implementation was made available by the Administration.

DHCS has produced a Request for Applications for the first $907 million in BHBH funding that will be distributed to counties via a formula. In general, DHCS is requiring that 75 percent of the funding be used for operating, rather than expanding, bridge housing. A part of the Administration's justification for the BHBH program was to fund bridge housing options in the interim until projects funded by the BHCIP and other related efforts come online. Given that the BHBH funding will broadly be used for operating existing facilities, and that BHCIP funding would be distributed over a somewhat longer timeframe under the Governor's Budget proposal, delaying a portion of BHBH funding also seems reasonable."

Funding Delay – Behavioral Health Continuum Infrastructure Program (BHCIP) Funding

DHCS is releasing BHCIP funds through six grant rounds targeting various gaps in the state's behavioral health facility infrastructure. BHCIP Round 1: Crisis Care Mobile Units, Round 2: County and Tribal Planning Grant, Round 3: Launch Ready, and Round 4: Children and Youth projects totaling $1.22 billion, were awarded in 2021 and 2022. The request for application process in the amount of $480 million for BHCIP Round 5: Crisis and Behavioral Health Continuum is currently underway with award announcements anticipated for Spring 2023. BHCIP Round 6: Outstanding Needs Remaining is currently in the planning/stakeholder engagement process but is proposed to be delayed until FY 2024-25 and FY 2025-26, reducing costs by $480.7 million General Fund in FY 2022-23.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present these proposed funding delays and respond to the following:

1. Please describe the expected impacts of delaying the funding.

2. Given the priority that the Governor clearly places on housing the homeless with serious mental illness, does it make sense to delay these investments in housing and services for this population?

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for further discussion and consideration of these proposals.

ISSUE 13: DHCS: COMMUNITY ASSISTANCE, RECOVERY, AND EMPOWERMENT COURT (SB 1338) BUDGET CHANGE PROPOSAL

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Diana Vazquez-Luna,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS, Program Data Reporting Division (PDRD), and Quality and Population Health Management (QPHM), request 2.0 permanent positions and expenditure authority of $5,000,000 General Fund (GF) in fiscal year (FY) 2023-24 and ongoing. This request includes contract funding of $4,671,000 GF in FY 2023-24 and $4,689,000 GF in FY 2024-25 and ongoing. These resources are requested to support the implementation of Community Assistance, Recovery and Empowerment (CARE) Act Supporter Program activities pursuant to Chapter 319, Statues of 2022 (SB 1338), including:

- Training and technical assistance
- Stakeholder engagement
- Developing guidance for counties on CARE Court responsibilities relating to the Supporter Program
- Additional CARE Court technical assistance on CARE Court statute
- CARE plan services to all counties and CARE Courts
- Implementing additional processes and measures to support ongoing data collection, validation, and reporting
- Additional support of the CARE Court evaluation activities.

BACKGROUND

The Administration provided the following background information:

The CARE Act is a new civil court process to deliver community-based behavioral health services and supports to Californians living with untreated schizophrenia spectrum or other psychotic disorders. CARE is intended to serve as an upstream intervention for the most severely impaired Californians to prevent avoidable psychiatric hospitalizations, incarceration, and Lanterman-Petris-Short Mental Health Conservatorship. CARE connects a person in crisis with a court-ordered care plan for up to 12 months, with the possibility to extend for an additional 12 months. If a participant cannot successfully

complete a CARE plan, the Court may utilize existing authority under current law to ensure the participants safety. The court will notify the county behavioral health agency and the Office of the Public Conservator and Guardian if the court utilizes that authority.

DHCS will provide training and technical assistance to county behavioral health agencies to support the implementation of CARE including training regarding the CARE process, CARE agreement and plan services and supports, supported decision-making, the supporter role, trauma-informed care, elimination of bias, psychiatric advance directives, family psychoeducation, and data collection.

DHCS is further responsible for administering technical assistance and training activities for volunteer supporters on the CARE Court process (hereafter referred to as "Supporter Program") described in California Welfare and Institutions Code § 5980. The Supporter Program is a critical on-going component to the CARE Act process to deliver mental health and substance use disorder (SUD) services to the most severely impaired Californians who too often languish – suffering in homelessness or incarceration – without the treatment they need.

DHCS is responsible, in consultation with disability rights groups, county behavioral health and aging agencies, individuals with lived expertise, families, racial justice experts, and other appropriate stakeholders, for providing optional training and technical resources for supporters on CARE Act proceedings, community services and supports, supported decision making, people with behavioral health conditions, trauma-informed care, family psychoeducation, and psychiatric advance directives. A Supporter is an individual that assists the participant to understand, consider, and communicate decisions, and give the participant the tools to make self-directed choices to the greatest extent possible. This newly established Supporter Program is intended to assist each participant and their clinical team to reach the participant's Care Plan goals. The Care Plan provides coordinated supports and services, including housing, focused on the individual needs of the participant. DHCS may consult with other state and national public and nonprofit agencies and organizations and the Judicial Council to align supported decision-making training with best practices for persons with mental illnesses, intellectual and developmental disabilities, other disabilities, and older adults.

DHCS is also responsible, in consultation with the Judicial Council, county behavioral health agencies, other relevant state or local government entities, disability rights groups, individuals with lived experience, families, counsel, racial justice experts, and other appropriate stakeholders, to develop an annual CARE Act report. The annual report is required to include process measures to examine the scope of impact and monitor the performance of CARE Act model implementation; include, at a minimum, information on the effectiveness of the CARE Act model in improving outcomes and reducing disparities, homelessness, criminal justice involvement, conservatorships, and hospitalization of participants; and include 18 separate elements as specified in the statute.

In addition, DHCS is obligated to retain an independent, research-based entity retained by the department to develop an independent evaluation of the effectiveness of the CARE Act, in consultation with county behavioral health agencies, county CARE courts, racial justice experts, and other appropriate stakeholders. The independent evaluation is required to employ statistical research methodology and include a logic model, hypotheses, comparative or quasi-experimental analyses, and conclusions regarding the extent to which the CARE Act model is associated, correlated, and causally related with the performance of the outcome measures included in the annual reports. DHCS is required to produce a preliminary and final report based on the evaluation.

While the civil CARE Court is similar to collaborative drug courts, California has never had a statewide requirement for court-ordered treatment outside the criminal justice system. Implementation is complex, and requires collaboration across many agencies, departments, and stakeholders. In order to effectively collect, monitor, and report data for the CARE Act, including for Supporter Program activities, funding for contracts and state positions are necessary. Positions will be in the QPHM and PDRD to support and oversee data collection, reporting, and evaluation work to be performed by contractors.

Supporter Program

Chapter 45, Statutes of 2022 (2022 Budget Act Budget Bill Jr 1) included $15,178,000 General Fund in FY 2022-23 and $1,065,000 General Fund in FY 2023-24 and ongoing for DHCS CARE Court state operations. In August 2022, Chapter 249, Statutes of 2022 (2022 Budget Act Budget Bill Jr 2), provided additional $5 million one-time General Fund to reflect DHCS administration of the Supporter Program and other workload. This proposal reflects the ongoing funding for DHCS to implement the Supporter Program and other workload. Specifically, SB 1338 requires DHCS to collect validate, and report data related to volunteer supporters, including the number, rates, and trends of supporters. Additional resources are required to include data, reporting, and evaluation of the Supporter Program.

Data Collection, Reporting, and Evaluation

DHCS is the state department responsible for creating and reporting CARE Court data outcomes for the CARE Act. Counties are required to collect, compile, and submit aggregate quantitative and qualitative data detailing CARE Act processes. These activities include, but are not limited to: creating and implementing a standardized data collection process for all 58 counties and courts, statewide data management, extraction and analysis, developing performance measures, and reporting CARE Court data outcomes. DHCS is also required to develop an independent evaluation of the effectiveness of the CARE Act and would require the department to produce a preliminary and final report based on that evaluation.

DHCS staff will be responsible for interfacing with and overseeing the contractors responsible for collecting, aggregating, and evaluating all submitted data from all 58 counties. DHCS staff will be responsible for supporting the analysis of CARE Court program data to be performed by the contractor for the purpose of identifying statewide trends and program outcomes, as well as overseeing the contractor in compiling the annual report. Staff will be required to spend substantial time working with the contractor as it conducts outreach and communication to counties and CARE Courts, as well as working with the contractors, to facilitate data submissions and problem-solve any data collection issues.

DHCS explains that additional staffing resources are required, as DHCS's previous approved BCP (4260-217-BCP2022-MR) did not reflect the full extent of the annual reporting and evaluation requirements of the CARE Court program that were later included in SB 1338.

Complementing the $57 million one-time General Fund included in the 2022 Budget Act, the budget includes $16.5 million General Fund in FY 2023-24 for CARE Act related county costs. In October 2022, the Department allocated the $57 million for one-time administrative CARE Act startup costs to cover information technology infrastructure costs and planning and preparation activities. The budget assumes the counties of Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne and the City and County of San Francisco implement the program beginning October 1, 2023. The budget assumes county behavioral health costs for these counties in FY 2023-24 associated with clinical assessments and time spent in court by county reimbursed-behavioral health providers. DHCS assumes the remaining counties implement the provisions of this act no later than December 1, 2024. The Administration will continue to work with counties and stakeholders to refine the ongoing program cost estimate.

LAO Recommendation

The LAO recommends approving of just one year of funding given uncertainties around participation levels.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 14: DHCS: ENHANCED LANTERMAN-PETRIS SHORT ACT DATA AND REPORTING (SB 929) TRAILER BILL

PANEL

- **Tyler Sadwith**, Deputy Director Behavioral Health, DHCS
- **Michelle Cabrera**, Executive Director, CBHDA
- **Diana Vazquez-Luna,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez**, Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS proposes trailer bill to expand Lanterman-Petris-Short (LPS) Act data reporting requirements primarily by: 1) requiring counties to collect and report data quarterly to DHCS from their local entities implementing LPS involuntary holds rather than those entities reporting directly to DHCS, and 2) authorizing DHCS to levy civil money penalties against facilities and counties for failure to submit data timely. The civil money penalties would be subject to an appeals process and penalty revenue would be deposited into a new continuously appropriated special fund to support DHCS implementation of SB 929 (Eggman, Chapter 539, Statutes of 2022).

The proposed language can be found here:
https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/838

BACKGROUND

The Administration provided the following background information:

The California State Auditor's July 2020 report: *Lanterman-Petris-Short Act California Has Not Ensured That Individuals With Serious Mental Illnesses Receive Adequate Ongoing Care* made recommendations to the Legislature for improvements to the reporting requirements for LPS Act holds and to ensure that counties can access existing state-managed data about the specific individuals placed on holds. In part, the report noted that counties have difficulty accessing information about when individuals are placed on involuntary holds and the treatment facilities who serve these individuals do not always share information about involuntary holds with county behavioral health departments. Furthermore, existing law requires DHCS to annually collect and publish quantitative data concerning the number of persons admitted and treated involuntarily (WIC Section 5402). However, state law does not permit DHCS to collect information on the number of instances for which a person was detained and admitted for evaluation and treatment. In addition, existing law allows non-designated facilities, as well as designated members of

a mobile crisis team and county-designated professional persons, to involuntarily detain an individual for up to 72 hours for assessment, evaluation and crisis intervention under the LPS ACT (WIC Section 5150(a)). DHCS does not have oversight of these entities and does not have the authority to collect information from these non-designated entities. For that reason, the auditor's report stated that DHCS data collection does not provide county behavioral health departments with sufficient and timely information regarding LPS holds for their residents so that they can effectively intervene and proactively support individuals who are at risk of more restrictive holds/placement.

SB 929: 1) requires DHCS to collect data quarterly and publish, on or before May 1 of each year, a report including quantitative, de-identified information relating to persons admitted or detained pursuant to the LPS Act; 2) requires the Judicial Council to provide DHCS by October 1 of each year, specified data from each superior court that is necessary for DHCS to complete the report: 3) requires each county behavioral health director or other entity involved in implementing the provisions to provide data as prescribed by DHCS; and 4) authorizes DHCS to impose a plan of correction against a facility or county that fails to submit data timely or as required.

DHCS believes that SB 929 was an incremental first step to assist in identifying LPS Act hold trends, which will improve treatment and service outcomes. However, DHCS does not have authority over all entities which initiate these types of holds. DHCS proposes to clarify that data should flow from facilities and other entities to counties and from counties to DHCS. The proposed trailer bill would require counties to collect and report data quarterly to DHCS from their local designated and approved facilities, along with other entities implementing involuntary holds pursuant to the LPS Act. Pursuant to existing law, DHCS will publish a de-identified annual report to enable counties to develop program services for individuals placed on involuntary holds under the LPS Act and to connect these individuals with services that would support their ongoing behavioral health needs.

The proposal authorizes counties to establish policies and procedures in order to provide accurate and complete data to DHCS. Furthermore, without the ability to impose civil money penalties for non-compliance related to either late or inaccurate/incomplete data reporting, there may be challenges to successfully enforce compliance, which could lead to difficulties with implementation of the bill. The proposed trailer bill includes the ability for facilities and counties to submit written appeals and request a formal hearing for any civil money penalties levied against them, as well as establish the LPS Act Oversight Data and Reporting Oversight Fund as the repository of these funds. DHCS has communicated to the author the need for clean-up language to clarify the flow of data and to levy monetary penalties. Where appropriate, against facilities and counties for failure to submit accurate or timely information.

DHCS states that this proposal:

- Clarifies the roles and responsibilities of data reporting among the state, county and providers in the LPS system.
- Provides DHCS the ability to levy civil money penalties against facilities and counties for failure to submit data timely.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal, respond to the concerns raised by CBHDA, and respond to the following:

1. For what reasons is this language not being proposed through a policy bill, given that it amends a 2022 policy bill?

2. Has the Administration negotiated this language with Senator Eggman, and the policy and Appropriations Committees in both houses?

Staff Recommendation: Subcommittee staff recommends holding this issue open for further discussion and consideration, and also recommends urging the Administration to move this language into a policy bill.

BEHAVIORAL HEALTH WORKFORCE

4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION
4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 15: OVERSIGHT: BEHAVIORAL HEALTH WORKFORCE ISSUES INCLUDING: CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE AND EARLY PSYCHOSIS TREATMENT

PANEL

- **Janet Coffman**, Associate Director, UCSF Institute for Health Policy Studies
- **Tara Niendam**, Ph.D., Professor in Psychiatry, Executive Director, UC Davis Early Psychosis Programs, Director, Early Psychosis Intervention Training and Technical Assistance Program for California
- **Le Ondra Clark Harvey**, Ph.D., CEO, California Council of Community Behavioral Health Agencies
- **Michelle Cabrera**, Executive Director, CBHDA
- **Caryn Rizell**, Deputy Director, Health Workforce Development, Department of Health Care Access and Information
- **Joseph Donaldson**, Finance Budget Analyst, DOF
- **Matthew Aguilera**, Principal Program Budget Analyst, DOF
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

OVERSIGHT

The purpose of this issue is for the Subcommittee to engage in oversight over the state's initiatives and efforts to respond to the state's behavioral health workforce shortage.

BACKGROUND

CBHDA Study on California's Behavioral Health Workforce – February 2023

The report, Building the Future Behavioral Health Workforce: Needs Assessment, authored by two researchers from Healthforce Center at the University of California, San Francisco (UCSF), sheds light on the workforce crisis impacting California's delivery of vital behavioral health services to safety net clients and the implementation of sweeping new behavioral health initiatives the state has launched in recent years. The message of the report is that California must increase investments and adopt new strategies to equip counties and their community-based organization partners to recruit and retain significantly more behavioral health professionals who reflect California's diversity and to fuel the various new mental health and substance use disorder initiatives rolled out by the state in recent years.

Key findings include:

- California is not graduating enough behavioral health professionals to replace those nearing retirement age, and in some cases the pipeline of new professionals is narrowing. For example, graduates of certificate and associate degree programs for SUD counselors decreased by 21 percent between 2015 and 2020.
- Compounding the crisis, many current behavioral health professionals are near retirement age. Thirty-one percent of psychiatrists and 27 percent of clinical and counseling psychologists are age 65 or older.
- California's county behavioral health departments are facing significant recruitment and retention challenges, from the inability to offer competitive pay, to lengthy hiring processes. More than 90% of counties reported difficulty recruiting Licensed Clinical Social Workers, Licensed Marriage and Family Counselors, and psychiatrists. Most counties also had difficulty recruiting substance use disorder counselors. It is even more difficult for counties to hire professionals with specialties such as working with adolescents or people with criminal justice system involvement.
- Behavioral health professionals do not match the racial/ethnic or linguistic diversity of the clients served.

The report recommends a series of actions at both the state and county level to meet California's future behavioral health needs. These include:

- Supporting higher education institutions to expand their educational capacity for behavioral health professions,
- Financial assistance to support a diverse pipeline of students who commit to work in the county behavioral health safety net after graduation,
- Increasing the rates the state pays to counties to serve the Medi-Cal population to enable counties to be more competitive on salary and compensation, and
- Streamlining documentation requirements so professionals spend more time with clients rather than paperwork.

The needs assessment provides baseline information on the capacity of counties and contracted community-based organizations as California is significantly transforming mental health and substance use delivery through several sweeping state initiatives:

- Substantial, additional workforce capacity will be required to meet the goals of CalAIM, the state's Medi-Cal transformation: more quickly connecting clients to mental health and substance use disorder services, offering intensive, community-based care coordination for clients, and expanding services offered to children and families.
- The Children and Youth Behavioral Health Initiative imagines school-linked and school-based behavioral health services for all students, and an expanded workforce focused on prevention, including counselors and coaches.

- The state's new mobile crisis benefit, which will scale statewide access to 24/7 mobile crisis services for the 1 out of 3 Californians with Medi-Cal insurance coverage.
- Care teams implementing individualized care plans and services for clients struggling with schizophrenia and psychotic disorders central to California's new CARE Court initiative.

HCAI Behavioral Health Workforce Programs

Children and Youth Behavioral Health Initiative ($800 Million) – the initiative includes $800 million over 2021-22 through 2023-24 to increase behavioral health workforce capacity targeted at children and youth ($427 million) and develop a state behavioral health counselor and coach workforce ($338 million).

Licensed Mental Health Services Provider Education Program – increases the number of appropriately trained mental health professionals providing direct client care in a qualified facility in California.

Train New Trainers Primary Care Psychiatry Fellowship Scholarship – a scholarship program for primary care physicians who have been accepted into the UC Irvine/UC Davis Train New Trainers Primary Care Psychiatry Fellowship.

Primary Care – Training and Education in Addiction Medicine Fellowship Scholarship Program – a scholarship program for primary care physicians who have been accepted into the UC Irvine Primary Care – Training and Education in Addiction Medicine Fellowship.

Behavioral Health Scholarship Program – increases the number of appropriately trained allied and advanced behavioral health professionals providing direct patient care in California. There are scholarships available for individuals pursuing behavioral health careers in reproductive health settings.

Golden State Social Opportunities Program – increases the number of appropriately trained licensed behavioral health professionals providing direct patient care in California. This scholarship gives priority to those who have experienced foster care and/or homelessness as well as Community-Based Organization employees.

Behavioral Health Grant Programs:

1. Peer Personnel Training and Placement Program
2. Substance Use Disorder/Justice System-Involved Youth (SUD/JSIY) Training Request for Information
3. Substance Use Disorder Earn and Learn Grant Program
4. Community-Based Organization Behavioral Health Workforce Grant Program
5. Social Work Education Capacity Expansion Grant Program
6. Peer Personnel Training and Placement

7. Psychiatric Education Capacity Expansion (PECE) Psychiatric Mental Health Nurse Practitioners Grant Program
8. PECE Psychiatry Residency Grant Program
9. Regional Partnership
10. Mental Health Services Act Workforce Education and Training (WET) Program

The 2022-23 Budget included a substantial health care workforce package of investments, including the following specific to behavioral health:

2022-23 Health Workforce Package – Behavioral Health
(GF Dollars in Millions)

Initiative	2022-23	2023-24	Totals
Masters in social work programs	$30	$30	$60
Behavioral health training programs	$26	$26	$52
Addiction psychiatry and medicine graduate medical education	$25	$25	$50
Culturally Diverse Future Behavioral Health Workers	$13	$13	$26
Psychiatry loan repayment (State Hospitals)	$7	$7	$14
Psychiatry loan repayment (local behavioral health programs)	$7	$7	$14
Psychiatry graduate medical education	$5	$5	$10

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the panelists provide insight and expertise on the state's behavioral health workforce challenges, and recommendations on addressing these challenges.

Staff Recommendation: This is an oversight issue and therefore no action is recommended at this time.

ISSUE 16: PROPOSED FUNDING DELAY: BEHAVIORAL HEALTH WORKFORCE INVESTMENTS

PANEL

- **Joseph Donaldson**, Finance Budget Analyst, DOF
- **Matthew Aguilera**, Principal Program Budget Analyst, DOF
- **Michelle Cabrera**, Executive Director, CBHDA
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

The 2022 budget includes a substantial investment in health care workforce development programs across many state government departments and agencies. The 2023 Governor's budget proposes delays to various components of the 2022 health care workforce package, for purposes of addressing the 2023-24 General Fund shortfall. Most of these delays were discussed at the Subcommittee's hearing on March 13, 2023, and this issue specifically covers the proposed delays to funding for *behavioral health* workforce programs, which can be seen in the LAO's chart below.

Proposed Reductions and Delays in 2023-24 Governor's Budget

General Fund (In Millions)

	2022-23	2023-24	2024-25	2025-26	Totals
Proposed Delays at HCAI[a]					
Home and Community Care					
Community health workers	—	-$130	$65	$65	—
Nursing initiative	-$15	-55	35	35	—
Social Work initiative	-4	-48	26	26	—
Behavioral Health					
Master's in social work programs	—	-$30	$15	$15	—
Behavioral health training programs	-$26	-26	26	26	—
Addiction psychiatry and medicine graduate medical education	-24	-25	24	24	—
Song Brown					
Nurses	—	-$15	$8	$8	—
Totals	**-$68**	**-$329**	**$199**	**$199**	—

BACKGROUND

The LAO included the following background information in their report: "*The 2023-24 Budget: Health Workforce Budget Solutions*." The full LAO report can be accessed here: https://lao.ca.gov/Publications/Report/4691

California Has Sizable Health Workforce. In 2021, around 2 million Californians worked as physicians, nurses, health care technicians, home health workers, behavioral health counselors, epidemiologists, and many other related health occupations. Based on data from the Employment Development Department (EDD), we estimate health occupations comprised 13 percent of the state's overall workforce in 2021.

Health Workforce Education, Training, and Development Is Supported From Many Sources. Both public and private institutions educate, train, and develop California's health workforce. The state departments that play a key role in health workforce development include the Department of Health Care Access and Information (HCAI), the state's workforce development departments, and the state's higher education segments, among others. Though estimates of total spending across all fund sources in California are not readily available, a likely substantial portion of health workforce education, training, and development is supported by non-state sources at both public and private programs. For example, the University of California's medical schools rely on a mix of state support, student tuition and fee revenue, and faculty clinical revenue to support their operations.

Three Key Issues Regarding California's Health Workforce. In recent years, researchers and stakeholders have identified a number of issues regarding the state's health workforce. Below, we describe three key issues.

Inadequate Statewide Supply for Certain Occupations. Past research suggests the supply of workers in some health occupations may not keep pace with demand for their services in future years, whereas supply and demand for other health occupations may be more balanced. For example, past studies have projected statewide shortfalls of primary care and behavioral health providers over the next several years in California. By contrast, recent research estimates an existing shortfall of nurses in California, but projects that statewide supply will align with demand over time due to anticipated increases in higher education nursing enrollments. For some health occupations, limited data make it difficult to fully quantify supply and demand. For example, the number of graduates with public health degrees has grown considerably over the last few decades, but we are not aware of research that fully quantifies how this trend will impact future supply and demand for public health employees in California.

Regional Disparities. The supply of providers relative to population varies considerably across the state. For example, the relatively wealthy coastal regions (such as the Bay Area) tend to have higher numbers of providers per population relative to less wealthy inland regions (such as the Central Valley and the Inland Empire). The federal government has designated hundreds of areas in California (for the most part, small subdivisions of counties) as having shortfalls of primary care, mental health, and dental providers. The state also has designated 38 out of 72 areas in California as having high or medium shortfalls of nurses.

Disparate Representation in Certain Occupations. The composition of many health occupations does not match the demographics of the state. For example, relative to their share of California's population, Latinos are underrepresented among physicians, nurses, and many other providers, but overrepresented among certain health support occupations.

Health Workforce Package Adopted in 2022-23 Budget

General Fund (In Millions)

	2022-23	2023-24	2024-25	2025-26	Totals
Health Care Access and Information					
Health and Home Care Initiatives					
Community health workers	$20	$130	$131	—	$281
Nursing initiative	25	55	140	—	220
Social Work initiative	8	48	70	—	126
Behavioral Health Initiatives					
Master's in social work programs	$30	$30	—	—	$60
Behavioral health training programs	26	26	—	—	52
Addiction psychiatry and medicine graduate medical education	25	25	—	—	50
Culturally Diverse Future Behavioral Health Workers	13	13	—	—	25
Psychiatry loan repayment (State Hospitals)	7	7	—	—	14
Psychiatry loan repayment (local behavioral health programs)	7	7	—	—	14
Psychiatry graduate medical education	5	5	—	—	10
Song Brown (Primary Care) Initiatives					
Nurses	$20	$15	$15	—	$50
Physicians	10	10	10	—	30
Nurse practitioners	4	—	—	—	4
Physician assistants	1	—	—	—	1
Nurse midwives	1	—	—	—	1
Other Initiatives					
Reproductive health clinical infrastructure	$20	—	—	—	$20
California Reproductive Health Service Corps	20	—	—	—	20
Health information technology training	15	—	—	—	15
Public health nurse certification fee waivers	3	$3	$3	—	10
Totals	**$259**	**$374**	**$370**	—	**$1,003**

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DOF present this proposal.

Staff Recommendation: Subcommittee staff recommends holding this issue open.

ISSUE 17: DSH: PSYCHIATRY WORKFORCE PIPELINE, RECRUITMENT, HIRING AND RETENTION BUDGET CHANGE PROPOSAL

PANEL

- **Brent Houser**, Chief Deputy Director, Operations, DSH
- **Dr. Katherine Warburton**, Statewide Medical Director, DSH
- **Nina Hoang,** Finance Budget Analyst, DOF
- **Matthew Aguilera,** Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

DSH requests a total of 7.0 positions in fiscal year (FY) 2023-24 and ongoing; and General Fund (GF) of $6.5 million in FY 2023-24, $7.1 million in FY 2024-25, $7.3 million in FY 2025-26, $7.7 million in FY 2026-27 and $8.3 million in FY 2027-28 and ongoing for the development and implementation of pipeline, recruitment, and retention initiatives to sustain and grow DSH's psychiatric workforce.

BACKGROUND

The Administration provided the following background information:

A multitude of academic articles, policy studies, and other sources of information have revealed generalized shortages of psychiatrists at the national and statewide level and the extent to which they have worsened over time. These shortages hinder the ability for psychiatrist employers around the country to hire the desired number of psychiatrists. There are currently about 45,000 psychiatrists in the United States (U.S.), but an additional 2,800 psychiatrists (6% of the workforce) are needed to alleviate acknowledged shortages. Studies also predict the psychiatry shortage will worsen and reach a deficit of 25% of the workforce by 2025. Nationwide, the median ratio of psychiatrists per 100,000 residents has declined by 10% between 2003 and 2013. The decline is stark when compared to other specialties where national shortages also exist. For example, the pool of neurologists increased by 15% and the pool of primary care physicians increased by 1.3% per 100,000 residents between 2003 and 2013. The factors that drive a worsening psychiatrist shortage include both an increase in demand for mental health services and a diminishing supply of psychiatrists nationwide. The growing demand for psychiatrist services nationwide is attributed to several factors, including but not limited to a high incidence of mental illness and substance abuse, patients' increased awareness of mental health conditions, and improvements in insurance coverage for mental health treatment related to the Affordable Care Act (ACA).

Further highlighting the need to develop pipeline, recruitment, and retention strategies focused on psychiatry is the limited supply of psychiatrists is likely to become more constrained over the next few years as almost 60% of practicing psychiatrists are over 55 years old and more than a quarter are over 656. The psychiatry workforce is aging, more so than the overall physician population, where about 40% of active physicians are over 55 and 14% are over 656. Younger psychiatrists are not completing residency programs and joining the workforce at a sufficient pace to replace the older generation, let alone to meet the increasing demand. According to the American Psychiatric Association (APA) Resident Census for 2013-2014, a total of about 6,000 residents were expected to finish graduate programs between 2014 and 2017, a graduation rate that is potentially insufficient to replace the large volume of imminent retirements6. Between 1995 and 2013, the total number of physicians has experienced 45% growth, while the U.S. population has grown by 21%, but the number of psychiatrists has only increased by 12%7. In its most recent update, the HRSA (Health Resources and Services Administration) found that as of June 30, 2018, the number of psychiatrists needed to alleviate all mental health professional shortage areas in the country had already reached almost 6,000 full-time equivalents (FTEs). This is more than twice the baseline shortage identified in 20138.

Within the DSH system of care, psychiatrists function as the lead of the interdisciplinary treatment team and are responsible for making sure the full team is advancing in the development of an integrated treatment plan, reviewing serious incident reports, obtaining information related to treatment noncompliance, and responsible for writing a detailed discharge summary along with medication information. Psychiatrists in DSH's hospitals continuously collect and analyze patient information through face-to-face meetings, observations and record review to make diagnostic decisions, prescribe or assess the effectiveness of medication, identify if medications need to be changed or adjusted, and ultimately to assess the progression of a patient.

Historically, recruitment and retention pose a significant challenge for DSH and has been further exacerbated during the COVID-19 pandemic. While DSH is not alone in its staffing challenge for healthcare workforce, DSH does present unique challenges for recruitment and retention due to multiple factors. The individuals DSH serves have some of the most difficult to treat behavioral health conditions, many with a significant violence risk level. This, coupled with the geographic locations of DSH facilities and nationwide shortages for the healthcare workforce DSH employs, makes recruitment and retention challenging. Due to these factors, DSH has implemented a multi-faceted approach in an effort to recruit and retain staff.

DSH conducts a significant amount of outreach and marketing to attract a talented workforce across many disciplines. DSH attended multiple conferences and career fairs in 2021, contracted with advertising firms and platforms to publicize job vacancies, utilized social media, created and established a recruitment unit, and established partnerships with business professional journals to advertise to a broad audience nationwide. DSH

currently provides limited post-residency training in forensic psychiatry and has established one psychiatric residency program and DSH-Napa. Despite these significant endeavors to increase DSH's recruitment and retention efforts of psychiatrists, additional efforts and resources are needed to sustain and grow DSH's workforce to meet the demand for behavioral health services.

One key area of opportunity is related to developing the pipeline of psychiatrists through training programs. The California Future Health Workforce Commission estimated that California would need to train 527 additional first-year psychiatry residents per year from 2025 to 2029 to alleviate 56% of the projected shortage of psychiatrists. Currently, there are approximately 198 first-year resident student positions in California. During every year of the past decade, 98% to 100% of first-year psychiatry residency positions in California that were offered through the match were filled. According to the Association of American Medical Colleges' 2019 Report on Residents9, more than half (54.6%) of the individuals who completed residency training from 2009 to 2018 are practicing in the state where they did their residency training. For psychiatry, this figure is 64.5%. DSH recognizes the overall shortage of psychiatrists and therefore a critical focus must be on the pipeline/earlier interventions to increase the overall supply of psychiatrists. Below are proposed solutions for development and implementation of an academic pipeline to sustain and grow DSH's psychiatric workforce.

Pipeline Solutions: Development and Expansion of Residency, Fellowship and Rotation Opportunities

Based on available research and DSH's experience, a critical solution to the psychiatry shortage is expanding training programs. According to the National Resident Matching Program (NRMP) in 2021, 9.4% of senior Doctor of Medicine (MDs) who applied for a psychiatry residency slot did not get one, as did 26.5% of senior Doctor of Osteopathic Medicine (DOs) and 57.5% of international medical graduates, resulting in 480 medical students who wanted to become psychiatrists being denied a training slot in 2021. As a result, DSH endeavors to expand the potential number of future psychiatrists in DSH by proposing to increase the pipeline from graduate medical school to employment through three strategies: 1) Development of an additional residency program; 2) Expanding the number of psychiatry fellowship slots; 3) Increasing the number of psychiatry residents rotating at a state hospital clinical site.

New Residency Program – 3.0 Positions and $1.4 million in BY and ongoing

Upon completion of medical school, specialty training in psychiatry is accomplished through a four- or five-year (variations depending on program and special qualifications) residency training program. Residents practice with a limited license under direct supervision by an attending physician, completing rotations defined as requirements by the Accreditation Council for Graduate Medical Education (ACGME). Successful completion of a residency program is required to be able to practice clinical medicine in the United States. The total number of residency programs, and slots within them, are

largely defined or limited by ACGME requirements of the sponsoring institutions, as well as the federal funding they may be eligible for.

Leveraging DSH's successful experience at DSH-Napa, which is in the second year of its residency program and now has two cohorts of seven residents each in rotations, in establishing an accredited residency program, DSH will collaborate with Eisenhower Medical Center to develop an on-site psychiatry training program for residents who will perform duties and responsibilities associated with that of an inpatient psychiatry resident. DSH-Patton will collaborate with Eisenhower Medical Center to become an accredited program; and DSH estimates the program could be for total of 20 resident positions with four residents per year starting in 2024 for postgraduate year one (PGY1). The resource request entails 1.0 Senior Psychiatrist Supervisor, 1.0 Hospital Administrative Resident II, 1.0 Associate Governmental Program Analyst and the associated funding for the operating expenses to be the co-sponsoring institution of the program and for DSHs portion of the annual residency salaries.

Psychiatric Fellowships – $3.6 million in BY and ongoing

Fellowships, in contrast, constitute post-doctoral training. Upon completion of a residency program (as defined above), a physician specialized in psychiatry may opt for further training and qualifications in a subspecialty of the field. Physicians in fellowship training are fully licensed to practice independently should they choose to do so; subspecialty training is not a requirement to practice medicine or psychiatry. Fellowship subspecialties and their requirements are also defined by the ACGME and may be of one or two years duration. Much fewer fellowship programs exist, they are characteristically much smaller in program size (i.e. trainee slots), do not follow a "Match" program (automatic system for matching candidates with programs once applications and interviews are completed), and are often not eligible for funding sources offered to residencies. Fellowship programs offer an opportunity to focus on a specific area of interest, with intensive exposure to educational sites and opportunities that contain it.

DSH proposes to expand or develop fellowship programs in association with the following institutions, to provide new psychiatrists with specialized training that focuses on the unique needs of state hospital populations. Forensic fellowships provide invaluable opportunities to gain experience evaluating, authoring reports and testifying on a wide variety of criminal and civil matters, such as civil commitment, competency to stand trial, criminal responsibility, evaluations of Offenders with Mental Health Disorders (OMD) and Sexually Violent Predators (SVP), and violence/dangerousness risk assessments. DSH currently partners with UC Davis to provide training to four forensic fellows a year at DSH-Napa. In addition to the forensic fellowships, this proposal includes the establishment of geriatric psychiatry fellowships to provide the specialized training needed to serve the aging population of DSH patients. These fellowships would establish training sites at DSH-Napa and eventually also DSH-Metropolitan, the two facilities that operate skilled nursing facilities (SNF). Finally, given that a significant percentage of the patient population has a co-occurring substance use disorder, the addition of an addiction

psychiatry fellowship at DSH-Napa will establish a pipeline of psychiatrists prepared to treat dual diagnoses. This proposal will enable the potential expansion of DSH fellowship offerings by establishing or expanding partnerships with the following programs to sponsor and train two fellows per program per year:

- Forensic Psychiatry
  - Stanford University (at DSH-Coalinga)
  - UC Riverside (at DSH-Patton)
  - UC Los Angeles (UCLA) and University of Southern California (USC) (at DSH-Metropolitan)
  - Santa Clara/San Mateo (at DSH-Atascadero and DSH-Coalinga)
- Geriatric Psychiatry
  - Saint Joseph's Medical Center (SJMC)-Dignity Health (at DSH-Napa)
- Addiction Psychiatry
  - SJMC-Dignity Health (at DSH-Napa)

Resident Rotations – $900,000 in FY 2023-24 and ongoing

In addition to the strategies above, DSH proposes to increase the amount of rotation sites to residents. This increases the possibility of attracting future physicians with specific training not just in areas of specific interest given our population, but also, specific exposure to the DSH system and the application of that subspecialty knowledge in a large public sector health system.

A larger number of residency programs and residents exist, but many of them disperse to subspecialty training or post training relocation. Subspecialty psychiatrists are lower in number and seek opportunities that incorporate a more advanced skillset. Both are in high demand and will negotiate highly competitive offers upon graduation. Hence, exposure to opportunities within DSH must begin during training.

Clinical rotations provide safe space to care for patients, providing residents competency and confidence while working with medical teams providing supervised care. Expanding rotations increase the existing trainees on campus, resulting in increased exposure for future psychiatrists to the DSH population. Additionally, adding new partnerships will increase the number of resident rotations on DSH campuses. DSH proposes 15 permanent and ongoing sponsorships.

Overall, it is critical that DSH connects with trainees at each stage of professional development. Since the establishment of a Residency Program sponsored or co-sponsored directly by DSH has extensive procedural and resource requirements, only one is being petitioned at this time (for a total of two within the DSH system: a Northern CA one based in Napa, and a Southern CA based in Patton). However, additional reach can be attained by sponsoring residency slots in established programs throughout the state without incurring in the establishment of a new program.

Retention: Office of Continuing Education and Medical Advancement (CEMA)

Psychiatrists working in the public sector, and especially in state hospitals, often feel academically isolated. There is a perception that practice within public institutions is lower quality than academic centers, and many psychiatrists leave (or never join) public systems for this reason. DSH has endeavored to implement academic programs, such as psychopharmacology consulting service, research partnerships and teaching programs, to combat academic isolation and maintain a high sense of professional pride and morale among DSH psychiatrists and its other clinicians. Continuing Medical Education (CME) is a primary academic platform. CME is the educational requirement for psychiatrists to maintain licensure. Additionally, CME is now a critical component of maintaining board certification for psychiatrists because the American Board of Psychiatry and Neurology (ABPN) recently changed the Maintenance of Certification (MOC) requirement from testing to focus it on CME. Therefore, any applicants or incumbents who are board certified, or wishing to become board certified, will pay attention to CME related opportunities. CME activities provide an opportunity for collegial cohesion, where psychiatrists working independently from one another may come together to learn from one another, provide peer review and mentorship, and discuss matters of the field with like-minded colleagues.

CME activities, benefits and opportunities are widely offered in competing employment opportunities in today's market. In order to attract candidates away from those opportunities and keep incumbents in the public system, this aspect must be comparable or superior. CME activities ignite ideas for research, presentations and publications. CME activities promote best practices and physicians feel pride of practicing at their maximum potential and by being surrounded by physicians who do as well. When institutions practice at the cutting edge of scientific knowledge and skill, it promotes attachment to that facility among the psychiatry workforces. For all of these reasons, a robust CME program promotes positive morale among psychiatrists and can lead to better retention.

DSH has been piloting a university quality statewide CME program for several years focused on psychopharmacology and forensic topics. The workload associated with the peer review necessary to certify CME and the workload required to issue the credits are onerous. For that reason, this proposal includes 1.0 Staff Services Manager II and 3.0 Associate Governmental Program Analysts to process and issue credits for all continuing medical education for DSH.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Subcommittee staff recommend holding this issue open for further discussion and consideration.

MANAGED CARE AND BEHAVIORAL HEALTH

4150 DEPARTMENT OF MANAGED HEALTH CARE
4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 18: OVERSIGHT: MANAGED CARE BEHAVIORAL HEALTH SERVICES

PANEL

- **Rachel Hotz**, Peer Advocate
- **Bonnie Hotz**, Family Advocate
- **Toby Ewing**, Ph.D., Executive Director, OAC
- **Michelle Cabrera**, Executive Director, CBHDA
- **Jedd Hampton**, Director of Legislative Affairs, California Association of Health Plans
- **Mary Watanabe**, Director, DMHC
- **Dan Southard**, Chief Deputy Director, DMHC
- **Michelle Baass**, Director, DHCS
- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Joseph Donaldson**, Finance Budget Analyst, DOF
- **Matthew Aguilera**, Principal Program Budget Analyst, DOF
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

OVERSIGHT ISSUE

The purpose of this issue is to give the Subcommittee an opportunity to provide oversight on the state's programs and policies that seek to improve the quality and accessibility of behavioral health services provided by both commercial and public managed care plans. The Department of Managed Health Care (DMHC) has the primary role in this space, while the Department of Health Care Services (DHCS) oversees and enforces Medi-Cal managed care contracts.

BACKGROUND

DMHC provided the following background on their roles and responsibilities specific to behavioral health care:

DMHC protects consumers' health care rights and ensures a stable health care delivery system. It does this through the regulation of 140 health plans, including 94 full-service[1]

[1] A full-service plan must provide all basic health care services to plan enrollees.

licensed health care service plans and 46 specialized health care service plans.[2] These plans cover 96% of commercial and public health plan enrollment in California.

Effective January 1, 2021, pursuant to SB 855 (Wiener, Chap. 151, Stats. 2020) health plans are required to cover medically necessary treatment of all behavioral health conditions recognized by the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, regardless of age or product type.

DMHC's Oversight of Behavioral Health Services

Ensuring consumers have access to mental health services in compliance with the law is a high priority for the DMHC. The DMHC ensures plans comply with the law in a variety of ways:

- Licensure of Plans: In order to receive and maintain a license, plans are required to comply with applicable laws. Additionally, plans may be required to regularly report on operational measures to ensure ongoing compliance. For example, plans are required to submit their Evidence of Coverage (EOC) documents for review and approval.
- Network Review: The DMHC reviews health plan networks upon initial licensure and annually for compliance with geographic and provider-to-enrollee ratio requirements. The DMHC also reviews health plan networks when there is a 10% or greater change in the names of providers in a network or when a health plan wants to expand or contract their service area.
- Timely Access: The Timely Access Regulation requires health plans to submit annual reports detailing compliance with the timely access standards, which include standards for initial appointment wait times. As part of this reporting, health plans survey a statistically relevant sample of specific provider types within the plans' networks, including psychiatrists and non-physician mental health providers to determine whether they have appointments available within the time-elapsed standards.

  Starting July 1, 2022, plans are required to offer follow-up appointments with non-physician mental health or substance use disorder providers within 10 business days of the prior appointment, or beyond 10 business days if the treating provider determines a longer wait time will not have a detrimental impact on the health of the enrollee.

  In addition, the recently amended timely access regulation set a compliance threshold of 70 percent for urgent and non-urgent appointments at the network level. The DMHC will begin enforcing these rates of compliance in 2024 for measurement year 2023.

[2] Specialized plans are limited to providing dental, vision, acupuncture, chiropractic, and/or behavioral health services.

The annual Timely Access Reports, including the most recent report for Measurement Year 2021 and the Timely Access Fact Sheet are available on the DMHC's website.

- Plan Surveys: The DMHC ensures compliance with the Knox-Keene Act through medical surveys (e.g., audits) of health plan operations. The surveys examine health plan practices related to access, utilization management, quality improvement, continuity and coordination of care, language access, and enrollee grievances and appeals. The DMHC may also conduct a non-routine survey when a specific issue or problem requires a focused review of a health plan's operations.
- Help Center: The DMHC ensures consumers receive access to behavioral health services through the DMHC Help Center's complaint and Independent Medical Review (IMR) processes. The Help Center's complaint process addresses enrollee complaints with respect to, among other things, plans' denial of coverage for services based on the plans' assertions the services are not a covered benefit. The IMR process is available to consumers if a health plan denies, modifies, or delays a service because the plan determined the requested service is not medically necessary or is experimental or investigational. If the IMR is decided in the consumer's favor, the health plan must authorize the treatment within five business days. Every IMR decision is reported on the DMHC website with a summary of the issue and outcome.
- Enforcement Actions: The DMHC takes enforcement actions against plans that violate the law. These violations are often discovered by the DMHC Help Center, which educates consumers about their health care rights, resolves consumer complaints, and ensures consumers receive timely access to appropriate health care services.

Compliance with Federal Mental Health Parity Law

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, requires full-service health plans to provide services to treat mental health and substance use disorders (MH/SUD) in parity with services to treat physical or medical conditions. Following the release of the final federal rules for MHPAEA in 2013, the DMHC required health plans to conform to the new federal requirements. To ensure compliance with MHPAEA, the DMHC undertook a two-phased approach.

During Phase 1, which occurred from 2014 to 2015, the DMHC conducted comprehensive reviews of 25 full-service commercial health plans' benefit designs and their plan policies and procedures to verify whether they were compliant with MHPAEA in three broad areas:

1. Financial requirements: The DMHC reviewed parity in cost-sharing, such as copayments, coinsurance, deductibles and out-of-pocket maximums, to make sure the cost-sharing to treat a behavioral health condition is not higher than the most common cost-sharing for treating substantially all medical conditions, on an inpatient basis or on an outpatient basis.

2. Quantitative treatment limits (QTLs): The DMHC reviewed limits on the scope and/or duration of benefits, such as day or visit limits.
3. Non-quantitative treatment limits (NQTLs): The DMHC reviewed policies and procedures such as utilization management standards, provider credentialing, and other limits on the scope or duration of benefits.

During Phase 2, which occurred in 2016 and 2017, the DMHC conducted focused medical surveys to assess whether the health plans were operating consistently with the policies and procedures the plan previously filed with the Department.

As a result of the focused compliance review, many health plans were found to not be following the policies and procedures previously filed and approved by the DMHC. The focused medical surveys found 14 of the 25 commercial health plans subject to MHPAEA were non-compliant in areas related to treatment limitations (e.g., visit limits were more restrictive for mental health/substance use disorder services compared to medical/surgical visit limits), or financial requirements (e.g., copays), or both. Specifically, seven health plans incorrectly applied cost-sharing to mental health and substance use disorder services causing enrollees to overpay for these services. The DMHC required the health plans to recalculate the applicable cost-sharing and reimburse roughly 5,000 enrollees a total $517,375. Additionally, the DMHC required some health plans to eliminate impermissible day and visit limits and revise prior authorization requirements that were more restrictive for mental health services.

Since the initial compliance review, the DMHC has incorporated compliance and enforcement of mental health parity into our day-to-day work. This includes reviewing compliance during our routine medical surveys, reviewing help center complaints, taking enforcement action, and the on-going review of MHPAEA compliance when plans make changes to policies or when we license new plans.

Other Behavioral Health Initiatives:

In addition to the DMHC's routine oversight activities, there are a number of other initiatives related to behavioral health or implementation of recent legislation which are summarized below.

Focused Behavioral Health Investigations

Notwithstanding DMHC's rigorous oversight of access to behavioral health services and mental health parity compliance, many enrollees continue to experience difficulty accessing timely behavioral health care services. Enrollees often experience challenges finding in-network providers that are accepting new patients and scheduling timely initial and follow-up appointments. Even when an enrollee successfully connects with a provider, the enrollee may face additional obstacles in obtaining care due to health plan or health plan delegate clinical guidelines that may limit or delay initial authorizations, treatment durations or covered services. As a result, many enrollees abandon their efforts

to seek in-network care and may subsequently pay out-of-pocket for behavioral health services with an out-of-network provider, seek costly care in hospital emergency rooms or county inpatient centers, or at worst, enrollees may not obtain medically necessary behavioral health care.

Health plans are required to facilitate access to behavioral health services, assist enrollees with navigating the health care system and remove unnecessary restrictions such as those described above. The volume of mental health complaints to the Help Center increased 86% from 2013 to 2019. Additionally, anecdotal data from stakeholders including consumer groups and providers suggests an upward trend and indicate that not all complaints are filed with the DMHC for resolution.

To further understand the enrollee experience and the barriers enrollees face when attempting to access behavioral health services, beginning in FY 2020-21, the DMHC received funding to conduct focused behavioral health investigations of 25 full service, commercial health plans (averaging five investigations per year) over 5 years. The investigations will focus on every aspect of the health plans' behavioral health service delivery system, with a focus on the enrollee experience. These investigations will cover the full service, commercial health plan as well as any subcontracted behavioral health plans.

The investigations may include, but are not be limited to, the review of health plan and health plan delegate consumer assistance centers and their policies, procedures and protocols; provider reimbursement; provider/enrollee experience; coordination of care; utilization management policies and procedures; utilization data; clinical guidelines; timely access standards; quality assurance; network adequacy for behavioral health providers; appointment availability; health plan and provider scheduling systems; and review of specific enrollee medical and scheduling records to identify significant barriers in accessing timely and appropriate diagnosis and treatment.

In response to any identified deficiencies, the DMHC may take enforcement action, including assessing financial penalties and requiring corrective actions to bring deficient health plans into compliance. The results of these investigations may also lead to recommendations to health plans to improve health plan practices and eliminate barriers to care. The results may identify whether additional legislative or regulatory action is necessary.

Children and Youth Behavioral Health Initiative (CYBHI)

Beginning January 1, 2024, plans will be required to cover behavioral health services provided at schools, regardless of whether the plan has a contract with the school or health care provider. Health plans will reimburse the schools for services provided to students at the greater of the contracted rate, if they have a contract with the school or facility, or the rate set by the Department of Health Care Services (DHCS) for Medi-Cal enrollees (fixed rate fee schedule). The services provided in schools will not be subject

to any form of cost sharing, such as copays, coinsurance or deductibles and health plans are prohibited from requiring prior authorization and would only be allowed to deny a claim if they reasonably believe the student was not enrolled in the health plan, the services were never performed, or they were not provided by a health care provider appropriately licensed to provide the services.

The DMHC is working in collaboration with DHCS, who will publish the all-payer fee schedule. The DMHC is participating in weekly meetings with DHCS and assists in staffing the bi-monthly Fee Schedule Working Group, which is comprised of commercial and Medi-Cal health plan representatives, behavioral health providers, education and consumer advocates. In addition to the larger Fee Schedule Working Group, the DMHC has participated in smaller, targeted stakeholder group meetings with education and health plan stakeholders to discuss policy and operational concerns of the CYBHI. The DMHC will issue guidance to commercial plans on implementation of the fee schedule by December 31, 2023.

SB 855 (Wiener, 2020)
On September 25, 2020, Governor Newsom signed SB 855 (as cited above), which significantly revised and expanded California state law regarding health plan coverage of behavioral health treatment. First, the bill expanded the Knox-Keene Act requirements for coverage, requiring that all full-service commercial health plans, in both individual and group markets, provide medically necessary treatment for all behavioral health conditions identified in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, regardless of the age of the enrollee. Second, SB 855 established a statutory definition of "medically necessary treatment" for purposes of mental health and substance use disorder treatment and prescribes standards for the use of clinical criteria health plans are required to utilize when making medical necessity determinations. In essence, the bill disallows the use of clinical guidelines that vary from the generally accepted standards of treatment recognized by the relevant clinical specialties.

The DMHC is in the process of promulgating regulations related to the implementation of SB 855. The first comment period of the formal rulemaking process began on December 16. 2022 and closed on January 30, 2023. Staff are reviewing all comments and will determine whether additional comment period(s) are needed.

SB 221 (Wiener, 2021)
On October 8, 2021, Governor Newsom signed SB 221 (Wiener, Chapter 724, Statutes of 2021), which placed some of the timely access standards adopted in regulation by the DMHC into the Health and Safety and Insurance Code. SB 221 requires health plans, as of July 1, 2022, to ensure that its contracted provider network can offer non-urgent follow-up appointments with a non-physician mental health care or substance use disorder provider within 10 business days of the prior appointment, or longer if the treating provider determines a longer wait time will not have a detrimental impact on the health of the enrollee. Additional consumer protections in SB 221 include:

- Requiring interpreter services with scheduled appointments for health care services, without delaying the scheduling of the appointment.
- Requiring health plans that use a tiered network to demonstrate compliance with the timely access standards at the lowest cost-sharing tier.
- Requiring a health plan to arrange coverage outside of the plan's contracted network if medically necessary treatment of mental health or substance use disorder is not timely available with an in-network provider.

To implement SB 221, the DMHC is promulgating a timely access regulation to clarify requirements and standards for follow-up appointments with non-physician mental health care and substance use disorder providers, set forth parameters and standards for adequate capacity, availability and sufficiency of the provider types subject to timely access standards, revise the DMHC's methodology for health plan reporting to include a the average waiting time for each class of appointment, develop standardized methodologies for health plan reporting that shall be used by health plans to demonstrate compliance with SB 221. This regulation is currently under review with the Office of Administrative Law. The DMHC expects the rule will be approved by the end of April 2023. Lastly, the DMHC will investigate and take enforcement action against health plans that are not compliant with SB 221.

Health Plans are required to survey their providers annually and submit compliance reports to the DMHC to demonstrate compliance and performance with the timely access standards. The new requirements of SB 221 have been incorporated into the annual compliance filing.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests panelists provide information, experience, and expertise related to behavioral health services in managed care, and respond to the following:

For DMHC:

- What is your assessment of the effectiveness of the myriad of state and federal parity and access laws? Do any of them meaningfully improve access to behavioral health services in managed care?

For DHCS:

- How do you hold Medi-Cal managed care plans accountable and enforce state law and Medi-Cal contractual requirements?

For the California Association of Health Plans:

1. What initiatives is the managed care industry undertaking to improve the quality of, and access to, behavioral health services?

2. What is the industry's response to the well-known anecdotal information about parents quitting their jobs in order to qualify for Medi-Cal so that their child with serious mental health needs can access Medi-Cal Specialty Mental Health Services?

Staff Recommendation: This is an oversight issue and therefore no action is recommended at this time.

ISSUE 19: DMHC: AUGMENT BEHAVIORAL HEALTH FOCUSED INVESTIGATIONS WORKLOAD, SPRING FINANCE LETTER ISSUE 42

PANEL

- **Mary Watanabe**, Director, DMHC
- **Dan Southard**, Chief Deputy Director, DMHC
- **Joseph Donaldson**, Finance Budget Analyst, DOF
- **Matthew Aguilera**, Principal Program Budget Analyst, DOF
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

DMHC requests that Item 4150-001-0933 be increased by $2,981,000 from the Managed Care Fund and 8 positions in 2023-24, decreasing to $2,900,000 in 2024-25 and ongoing to complete focused behavioral investigations and incorporate long-range behavioral health focused assessments into the routine medical survey process.

This request includes consulting funding of $52,000 in 2023-24, $35,000 in 2024-25 and annually thereafter for a statistical consultant to assist in identifying behavioral health compliance issues and $1,259,000 annually for a clinical consultant to assist in conducting investigations.

BACKGROUND

The Administration provided the following background information:

The DMHC's Office of Plan Monitoring (OPM) performs routine medical surveys every three years for every DMHC licensed health, behavioral and specialized plan. Currently, the DMHC performs approximately 50 medical surveys per year. The behavioral health focused investigations assess areas of health plan delivery systems that are not commonly assessed during a routine medical survey. Health and Safety Code section 1380 requires the DMHC to conduct periodic, onsite medical surveys of the health delivery system of each health plan. These surveys include a review of the procedures for obtaining health services, the procedures for regulating utilization, peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the health plan in providing health care benefits and meeting the health needs of the subscribers and enrollees.

In 2020-21, the DMHC received approval and funding to conduct focused investigations of 25 full-service commercial health plans regulated by the DMHC to assess whether enrollees have consistent access to medically necessary behavioral health care services. The DMHC's Office of Plan Monitoring (OPM), Division of Plan Surveys (DPS) received 1.0 permanent Attorney IV, 1.0 permanent Health Program Specialist II (HPS II) and $1,248,000 for managed care clinical consulting services through the 2020-21 Behavioral Health Focused Investigations Budget Change Proposal (BCP). The DMHC anticipated conducting the investigations over a period of five years, by investigating five health plans per year.

The DMHC began conducting the behavioral health investigations of the DMHC licensed, full-service commercial health plans in 2021, anticipating the investigation of five of the twenty-five full-service health plans in the first year. During this process, the DMHC has identified three additional health plans (for a total of 28 health plans) meeting investigation eligibility criteria. Several factors have increased the complexity, difficulty and volume of work associated with this investigation. Those factors include:

1. The DMHC expanded the scope of the investigations to incorporate a review and analysis of the health plans' non-quantitative treatment limitation comparative analyses in accordance with federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requirements. The original BCP was prepared in April of 2020 and subsequently the Federal law pertaining to NQTLS passed in December of 2020, requiring health plans to make their prepared NQTL comparative analyses available to States beginning February 10, 2021. Therefore, this component of the investigation was not considered as part of the original proposal and requires ongoing resources for reviewing legal requirements, evaluating health plan documents, analyzing vendor work product and coordinating with the vendor on issues related to this component of the investigations. The complexity of the work requires significant attorney time and expertise.

2. The investigations require health plans to submit documents, data and information not otherwise requested as part of the health plans' routine surveys. The volume of documents to be submitted is immense. Reviewing this documentation requires significant time and coordination between the DMHC and the contractor to review for completeness, accuracy and responsiveness. This also requires frequent and ongoing communication with the health plans to identify, track and ensure all required documentation is submitted.

3. A significant amount of time is also spent coordinating with the special investigators in the DMHC's Office of Enforcement who have been conducting enrollee and provider interviews to determine barriers to obtaining and providing behavioral health services.

Due to the significant impact of the factors identified above, the DMHC is unable to timely complete the focused investigations without the additional requested resources. Because of the complexity and expansion of the investigations, the time required to obtain the needed health plan documents, the ongoing coordination and guidance with the contractor, and conducting all required tasks with the current resources, the overall process is taking longer than anticipated and has resulted in the DMHC not being able to meet the initially developed timeline of conducting five behavioral health investigations per year.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for additional consideration of this request.

CALAIM BEHAVIORAL HEALTH

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 20: OVERSIGHT: CALAIM BEHAVIORAL HEALTH

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Michelle Cabrera**, Executive Director, CBHDA
- **Diana Vazquez-Luna,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

The purpose of this issue is for the Subcommittee to provide oversight over the behavioral health components of CalAIM. The rest of CalAIM was discussed at the Subcommittee's hearing on March 27, 2023.

The Governor's January budget includes General Fund expenditure authority of $45.4 million in 2022-23 and $19.5 million in 2023-24 to support the Behavioral Health Quality Improvement Program (BH-QIP).

BACKGROUND

Behavioral Health Payment Reform

CalAIM seeks to reform behavioral health payment methodologies in a multi-step process from the current cost-based reimbursement process to a rate-based and value-based structure using intergovernmental transfers to fund the non-federal share of services. The first step in the process, supported by the BH-QIP, will transition behavioral health services from the current claims coding system, Healthcare Common Procedure Coding System (HCPCS) Level II, to HCPCS Level I. According to DHCS, this transition would allow for more granular claiming and reporting of services provided, as well as more accurate reimbursements.

DHCS expects that, concurrent with the transition to HCPCS Level I, DHCS will transition to a rate-setting process for behavioral health services by peer groups of counties with similar costs of doing business. The non-federal share of rates would be provided by counties via intergovernmental transfer (IGT), rather than the current, cost-based certified public expenditure reflects the costs of providing services. DHCS would, at first, make

payments to counties on a monthly basis, and would eventually transition to a quarterly payment schedule.

Medical Necessity

CalAIM also seeks to modify the existing medical necessity criteria for behavioral health services to ensure behavioral health needs are being addressed and guided to the most appropriate delivery system as well as provide appropriate reimbursement to counties. These changes will separate the concept of eligibility for services from that of medical necessity, allow counties to provide services to meet a beneficiary's behavioral health needs prior to diagnosis of a covered condition, clarify that treatment in the presence of a co-occurring substance use disorder is appropriate and reimbursable when medical necessity is met, implement a standardized screening tool to facilitate accurate determinations of which delivery system (specialty mental health, Medi-Cal managed care, or Medi-Cal fee-for-service) is most appropriate for care, implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system in which they seek care, and make other revisions and technical corrections. These changes will ensure that eligibility criteria, largely being driven by level of impairment as well as diagnosis or a set of factors across the bio-psycho-social continuum, will be the driving factor for determining the delivery system in which a beneficiary should receive services.

The implementation of behavioral health payment reform has the potential to significantly simplify how county behavioral health departments pay providers for the services they provide to Medi-Cal beneficiaries. Instead of requiring strict documentation of every unit of service provided, behavioral health providers would be compensated on a fee-for-service basis, reducing the "document burden" on providers. The changes in medical necessity determinations and the "no wrong door" approach likewise should improve the timeliness and appropriateness of care for Medi-Cal beneficiaries.

Please also see issue #22 of this agenda for information on the Administration's proposed trailer bill related to behavioral health payment reform as well as proposed cash-flow funding for counties.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS provide an overview of, and implementation updates on, the behavioral health components of CalAIM, and requests CBHDA share their perspectives on the potential benefits and challenges of CalAIM.

Staff Recommendation: This is an oversight issue and therefore no action is recommended at this time.

ISSUE 21: CALIFORNIA'S BEHAVIORAL HEALTH COMMUNITY-BASED CONTINUUM (CALBH-CBC) WAIVER

PANEL

- **Tyler Sadwith**, Deputy Director Behavioral Health, DHCS
- **Michelle Cabrera**, Executive Director, CBHDA
- **Diana Vazquez-Luna,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

As a part of the CalAIM transformation, DHCS will seek approval of a new proposed Medicaid Section 1115 demonstration, titled California's Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration, to expand access and strengthen the continuum of mental health services for Medi-Cal members living with serious mental illness (SMI) and serious emotional disturbance (SED), through a staged implementation beginning no sooner than January 1, 2024. The fiscal impact for the DHCS and Department of Social Services over the five years of the waiver is estimated to be $6.1 billion total funds ($314 million General Fund). The DHCS budget includes $5.7 million total funds ($0.31 million General Fund) in FY 2023-24 for the waiver.

Please see the chart below for detailed fiscal information on the CalBH-CBC.

California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration
2023-24 Governor's Budget
(Thousands)

Dept	Demonstration Activity	Statewide or Opt-In	Estimate	FY 2023-24					FY 2027-28					Five Year Total				
				Total Fund	General Fund	Mental Health Services Fund	Federal Fund	Medi-Cal County BH Fund	Total Fund	General Fund	Mental Health Services Fund	Federal Fund	Medi-Cal County BH Fund	Total Fund	General Fund	Mental Health Services Fund	Federal Fund	Medi-Cal County BH Fund
DHCS	Multi-Systemic Therapy	Statewide	PC 243	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Functional Family Therapy	Statewide	PC 243	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Parent-Child Interaction Therapy	Statewide	PC 243	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Activity Stipends for Children in Child Welfare	Statewide	PC 243	-	-	-	-	-	47,630	23,815	-	23,815	-	166,706	83,353	-	83,353	-
	Initial Child Welfare-Mental Health Plan Assessment at Entry Point Into Child Welfare	Statewide	PC 243	274	137	-	137	-	12,560	6,280	-	6,280	-	50,514	25,257	-	25,257	-
	Housing Transitions	Statewide	PC 243	-	-	-	-	-	1,778	889	-	889	-	6,224	3,112	-	3,112	-
	Intensive Pre-Discharge Care Coordination	Statewide	PC 243	-	-	-	-	-	2,666	1,333	-	1,333	-	9,332	4,666	-	4,666	-
	Contract Post-Discharge	Statewide	PC 243	-	-	-	-	-	1,407	538	-	889	-	4,994	1,882	-	3,112	-
	Screen and Address Comorbid Conditions	Statewide	PC 243	-	-	-	-	-	766	383	-	383	-	2,682	1,341	-	1,341	-
	Assertive Community Treatment	Opt-In	PC 243	1,154	-	-	769	384	133,831	-	-	89,238	44,593	433,842	-	-	289,285	144,557
	Forensic Assertive Community Treatment	Opt-In	PC 243	-	-	-	-	-	147,569	-	-	98,399	49,170	368,992	-	-	246,044	122,948
	Supported Employment	Opt-In	PC 243	-	-	-	-	-	595,623	-	-	397,161	198,462	1,489,340	-	-	993,091	496,249
	Coordinated Specialty Care for First Episode Early Psychosis	Opt-In	PC 243	66	-	-	44	22	7,547	-	-	5,049	2,498	24,465	-	-	16,368	8,097
	Community Health Worker Services	Opt-In	PC 243	802	-	-	535	267	93,002	-	-	62,014	30,988	301,487	-	-	201,032	100,455
	Rent/Temporary Housing (6 Months)	Opt-In	PC 243	-	-	-	-	-	58,713	-	-	39,150	19,563	146,810	-	-	97,892	48,917
	IMD Reimbursable Services	Opt-In	PC 243	1,800	-	-	1,302	498	208,798	-	-	151,070	57,728	676,865	-	-	489,728	187,138
	Assessment Tool	Opt-In	PC 243	-	-	-	-	-	2,908	-	-	1,454	1,454	7,273	-	-	3,636	3,637
	CalBH-CBC Non-Administrative Total			$ 4,095	$ 137	$ -	$ 2,787	$ 1,171	$ 1,314,818	$ 33,238	$ -	$ 877,154	$ 404,456	$ 3,689,527	$ 119,611	$ -	$ 2,457,917	$ 1,111,999
DHCS	Statewide County Incentive Program: Specialty Mental Health	Statewide	OA 89	-	-	-	-	-	245,000	-	-	122,500	122,500	980,000	-	-	490,000	490,000
	Statewide County Incentive Program: Drug Medi-Cal	Statewide	OA 89	1,252	-	-	626	626	57,544	-	-	28,772	28,772	231,428	-	-	115,714	115,714
	Cross-Sector Incentive Pool	Statewide	OA 89	-	-	-	-	-	50,000	-	50,000	-	-	175,000	-	175,000	-	-
	Centers of Excellence	Statewide	OA 89	65	65	-	-	-	3,000	3,000	-	-	-	12,065	12,065	-	-	-
	Bed Tracking	Statewide	OA 89	217	109	-	108	-	10,000	5,000	-	5,000	-	40,217	20,109	-	20,108	-
	Utilization Review	Statewide	OA 89	-	-	-	-	-	16,404	8,202	-	8,202	-	57,413	28,706	-	28,707	-
	Opt-In County Incentive Program: Specialty Mental Health	Opt-In	OA 89	-	-	-	-	-	234,906	-	-	117,453	117,453	759,474	-	-	379,737	379,737
	Children and Youth	Opt-In	OA 89	-	-	-	-	-	564	-	-	282	282	1,408	-	-	704	704
	Emergency Department Strategy	Opt-In	OA 89	22	-	-	11	11	2,558	-	-	1,279	1,279	8,293	-	-	4,147	4,146
	CalBH-CBC Administrative Total			$ 1,556	$ 174	$ -	$ 745	$ 637	$ 619,976	$ 16,202	$ 50,000	$ 283,488	$ 270,286	$ 2,265,299	$ 60,880	$ 175,000	$ 1,039,117	$ 990,302
	DHCS Total [1]			**$ 5,651**	**$ 311**	**$ -**	**$ 3,532**	**$ 1,808**	**$ 1,934,794**	**$ 49,440**	**$ 50,000**	**$ 1,160,642**	**$ 674,742**	**$ 5,954,825**	**$ 180,491**	**$ 175,000**	**$ 3,497,034**	**$ 2,102,300**
CDSS	Child and Family Teams for Family Maintenance Cases	Statewide	CalBH-CBC	14,457	10,554	-	3,903	-	28,914	21,107	-	7,807	-	130,113	94,982	-	35,131	-
	Joint Home Visits	Statewide	CalBH-CBC	-	-	-	-	-	7,199	5,255	-	1,944	-	25,197	18,393	-	6,804	-
	Activity Stipends Administration	Statewide	CalBH-CBC	-	-	-	-	-	8,499	6,204	-	2,295	-	27,622	20,163	-	7,459	-
	DSS Total [2]			**$ 14,457**	**$ 10,554**	**$ -**	**$ 3,903**	**$ -**	**$ 44,612**	**$ 32,566**	**$ -**	**$ 12,046**	**$ -**	**$ 182,932**	**$ 133,538**	**$ -**	**$ 49,394**	**$ -**
	DHCS and CDSS Combined Totals			**$ 20,108**	**$ 10,865**	**$ -**	**$ 7,435**	**$ 1,808**	**$ 1,979,406**	**$ 82,006**	**$ 50,000**	**$ 1,172,688**	**$ 674,742**	**$ 6,137,757**	**$ 314,029**	**$ 175,000**	**$ 3,546,428**	**$ 2,102,300**

Footnotes:
[1] DHCS Cost Estimate: https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2022_November_Estimate/N22-Medi-Cal-Local-Assistance-Estimate.pdf
[2] CDSS Cost Estimate: https://cdss.ca.gov/Portals/9/Additional-Resources/Fiscal-and-Financial-Information/Local-Assistance-Estimates/2023-24/23-24-estimate-methodologies.pdf

BACKGROUND

DHCS provided the following background information:
CalBH-CBC will expand behavioral health services from prevention, wellness, outpatient and recovery to crisis, inpatient, and residential services statewide, with a focus on children and youth, people experiencing or at risk of homelessness, and justice-involved individuals. The CalBH-CBC Demonstration complements and amplifies the state's current and planned initiatives to build out the behavioral health continuum of care, such as the Community Assistance, Recovery and Empowerment (CARE) Act, Children and Youth Behavioral Health Initiative, Behavioral Health Continuum Infrastructure Program, Bridge Housing, peer and recovery services, and mobile crisis, to name a few. Building off these critical investments, the CalBH-CBC Demonstration will:

- Strengthen the continuum of community-based services that reduce the need for institutional care by expanding coverage for evidence-based therapies and home-based services for children and families, Assertive Community Treatment (ACT), Forensic ACT, Coordinated Specialty Care for First-Episode Psychosis, Supported Employment Services, Rent/Temporary Housing, and Community Health Worker services in the county behavioral health delivery system;
- Improve integrated medical, behavioral health and social services for foster children and youth;
- Build statewide centers of excellence in behavioral health services to support statewide practice transformations;
- Enhance quality of care and pre-discharge care coordination in psychiatric hospitals and residential settings;
- Implement strategies to decrease lengths of stay in emergency departments; and
- Provide coverage for short-term inpatient psychiatric and residential mental health treatment in facilities that meet the federal criteria for an institution for mental disease (IMD).

In November, 2022, DHCS released a concept paper on this initiative which can be found here:
CalBH-CBC Demonstration External Concept Paper 11.14.22_Final

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and requests CBHDA share their perspectives on the proposal.

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for additional discussion and consideration of the proposal.

ISSUE 22: BEHAVIORAL HEALTH PAYMENT REFORM TRAILER BILL AND CASH FLOW FUNDING

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Michelle Cabrera**, Executive Director, CBHDA
- **Diana Vazquez-Luna,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

Trailer Bill
DHCS proposes trailer bill to establish a continuously appropriated special fund, titled Medi-Cal County Behavioral Health Fund, to support the non-federal share of behavioral health services provided by counties under the implementation of the CalAIM Behavioral Health Payment Reform initiative which transitions county behavioral health plans from a certified public expenditure (CPE) protocol to intergovernmental transfers (IGT).

The proposed language can be found here:
https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/860

Cash Flow Funding
The proposed budget includes $375 million General Fund one-time in FY 2023-24 to initially fund the non-federal share of behavioral health-related services at the start of the CalAIM Behavioral Health Payment Reform. These funds will mitigate a significant cash flow issue for counties as they transition from cost-based reimbursement to fee-schedule.

BACKGROUND

The Administration provided the following background information:

Trailer Bill
Under the CalAIM initiative, and pursuant to Welfare and Institutions Code Section 14184.403(b), DHCS will replace the current CPE reimbursement methodology with an IGT reimbursement methodology beginning July 1, 2023.

In order to appropriately transfer, track, and report IGT funding on a monthly basis to 56 county behavioral health plans, DHCS requests the creation of the "Medi-Cal County Behavioral Health Fund" to receive funds voluntarily provided by counties through IGTs to be used for the non-federal share amount to claim federal financial participation

associated with CalAIM Behavioral Health Payment Reform. Given the volume of transactions, magnitude of the dollar amount, and the number of entities to be paid from this fund it is prudent to track and distribute this funding via a special fund and not through revenue codes or other mechanisms.

Sources for the IGTs include, but are not limited to:

1. The Behavioral Health Subaccount in the Support Services Account in the Local Revenue Fund 2011;
2. The Mental Health Subaccount in the Sales Tax Account, in the Local Revenue Fund;
3. The Mental Health Services Fund; and
4. County General Fund.

DHCS states that the trailer bill:

- Creates a new special fund aids the successful implementation of the CalAIM Behavioral Health Reform.
- Allows counties to elect to authorize the California State Controller to transfer certain Mental Health Services Fund and Realignment funding into the Medi-Cal County Behavioral Health Fund, allowing for reduced administrative burdens to counties.

Cash Flow

The Governor's Budget includes General Fund expenditure authority of $375 million in 2023-24 to support the non-federal share of behavioral health services provided by counties under payment reform. While behavioral health services are realigned programs, with the non-federal share typically supported by county funding, the budget proposes to use General Fund resources to fund the first year of services under payment reform, with counties reimbursing the state through intergovernmental transfers deposited in a special fund. Because Medi-Cal operates on a cash basis of accounting, this one-time General Fund expenditure will not be recouped unless the state discontinues the intergovernmental transfer arrangement for payment reform.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present these proposals and requests CBHDA share their perspectives on the proposals.

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for additional discussion and consideration of the proposals.

ISSUE 23: SACRAMENTO AND SOLANO COUNTIES KAISER SPECIALTY MENTAL HEALTH CARVE-OUT

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director Health Care Programs, DHCS
- **Ryan Quist**, Behavioral Health Director, Sacramento County
- **Emery Cowan**, LPCC, LMHC, Chief Deputy, Behavioral Health Director, Solano County Department of Health & Social Services
- **Diana Vazquez-Luna,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS proposes to shift $19 million in realignment funds ($57 million total funds) to Sacramento and Solano Counties from the other 56 counties. This funding shift is proposed in order to end the long-standing carve-out in these two counties that currently relies on Kaiser to provide Specialty Mental Health Services (SMHS) to individuals with serious mental illness (SMI), who are enrolled in Kaiser, rather than these two counties providing these services as they do for all other individuals with SMI, but not enrolled in Kaiser.

BACKGROUND

Since the 2011 realignment, 56 of the State's 58 counties already serve, and were provided funding for, patients receiving SMHS in their counties. But under a long-standing agreement between the State and Kaiser, which existed pre and post-realignment, the State continues to pay Kaiser to provide SMHS in Sacramento and Solano Counties. As a result, neither county receives realignment funding for this population. Now, in furtherance of CalAIM, the State seeks to end its agreement with Kaiser and transition 7,000 SMHS patients to Sacramento and Solano Counties for their SMHS.

Sacramento County states that it will need approximately $36 million and Solano County states that it needs $16.7 million in annual ongoing funding in order to serve this population, for a total of $52.7 million for both counties. These two counties are also requesting a phased transition of these patient populations, so that they are not assuming responsibility for the entire population on one day.

DHCS states that these counties could make arrangements with Kaiser to:

- Implement a phased transition;
- Contract with Kaiser so that this population continues to receive care from Kaiser; or
- Both (i.e., contract with Kaiser until a phased transition is complete).

According to DHCS, the state's contract with Kaiser for the SMHS for these populations costs $22.6 million total funds. Sacramento and Solano Counties explain that their costs will be significantly higher than Kaiser's.

DHCS had planned to effectuate this transition on July 1, 2023, but has cancelled this transition in light of the objections of Sacramento and Solano Counties. DHCS also warned that they intend to evaluate whether Sacramento and Solano County actions constitute a failure, or risk of failure, to perform Mental Health Plan functions, thereby justifying sanctions and/or other additional state action.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS explain their proposal to transition this population from Kaiser to these two counties, and requests Sacramento and Solano Counties provide their perspective on the challenges and needs of the counties to be able to effectuate this transition in a way that properly protects the population.

For DHCS:

- How did you calculate the proposed $19 million (to shift from the other counties to Sacramento and Solano Counties)?

- Are you insisting on transferring these populations all on one day?

- Have you done transition planning with Sacramento and Solano Counties?

- What will be the impact on the other 56 counties of losing $19 million in realignment funds?

For Sacramento and Solano Counties:

- In your letter to the Legislature, you state: "These patients, who are a new population never served by either county, have significant impairment due to a mental health disorder(s), and need specialty care that is more intensive than the mental health services covered by standard managed care plans." Are you saying that Kaiser currently is not providing the level of services needed and warranted, or that they have efficiencies that allow them to provide the same level of service at a lower cost?

- For what reasons do you not want to, or believe that it's not possible or not appropriate, to enter into contracts with Kaiser to continue providing care to this population, either long-term or short term (associated with a phased transition to the counties)?

Staff Recommendation: Subcommittee staff recommends holding this issue open and also recommends urging DHCS and these counties to engage in more communication and collaboration in order to reach an agreed upon course of action that is acceptable to both.

SUBSTANCE ABUSE DISORDERS PREVENTION AND TREATMENT

4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE 24: OVERSIGHT: SUBSTANCE USE DISORDER PREVENTION AND TREATMENT ISSUES

PANEL

- **Laura Thomas**, MPH, MPP, Senior Director, HIV and Harm Reduction Policy, San Francisco AIDS Foundation (*Remote Speaker*)
- **Michelle Cabrera**, Executive Director, CBHDA
- **Michelle Baass**, Director, DHCS
- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Toby Ewing**, Executive Director, OAC
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

OVERSIGHT

The purpose of this issue is for the Subcommittee to engage in oversight over the state's programs and policies designed to prevent and treat substance use disorders. As with Specialty Mental Health Services, substance use disorder services in Medi-Cal were realigned to counties.

BACKGROUND

The following background information is contained in a California Health Care Foundation Report: *Substance Use in California, 2022: Prevalence and Treatment*, including the following key findings:

- The death rate from fentanyl increased 10-fold from 2015 to 2019. The rate of prescription opioid deaths fell 30% from 2011 to 2019.
- The number of amphetamine-related emergency department visits increased nearly 50% between 2018 and 2020. The number of non-heroin-related opioid ED visits more than doubled in the same period.
- California's Drug Medi-Cal Organized Delivery System pilot program has been implemented in 37 counties, which represent 96% of the state's Medi-Cal population.

- Between 2017 and 2019 the number of facilities offering residential care for substance use treatment grew by 68%, and the number of facilities offering hospital inpatient care more than doubled.
- Approximately 40% of commercial HMO and PPO health plan members with an alcohol or other drug dependence diagnosis received care that met the national quality standard of an initial treatment visit within 14 days of diagnosis.

California's Public Substance Use Disorder Treatment System

	Primary Public Programs for SUD Treatment			
	COUNTY SUD PROGRAMS			
	STANDARD DRUG MEDI-CAL STATE PLAN	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)	PROGRAMS FUNDED THROUGH SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT	MEDI-CAL MANAGED CARE AND FEE-FOR-SERVICE
Payer	Medi-Cal (federal and state/local)	Medi-Cal (federal and state/local)	Substance Abuse and Mental Health Services Administration	Medi-Cal (federal and state/local)
People Served	Medi-Cal enrollees with SUD	Medi-Cal enrollees with SUD	People with SUD who are either uninsured or are Medi-Cal enrollees (for services not covered by Medi-Cal)	Medi-Cal enrollees needing preventive services, addiction medication management, or inpatient withdrawal management
Services Provided	Outpatient and intensive outpatient SUD services, perinatal residential SUD treatment, narcotic treatment programs	Standard Drug Medi-Cal benefit plus target case management, residential SUD treatment (not limited to perinatal), withdrawal management continuum, recovery services, physician consultation, and at county option, additional medication-assisted treatment and partial hospitalization	Nonresidential treatment, residential treatment, ancillary services, and recovery support services	Prevention and early intervention; Screening, Brief Intervention, and Referral to Treatment (SBIRT); medication-assisted treatment provided in medical settings; inpatient withdrawal management in general and freestanding facilities

Drug Medi-Cal Organized Delivery System (DMC-ODS)

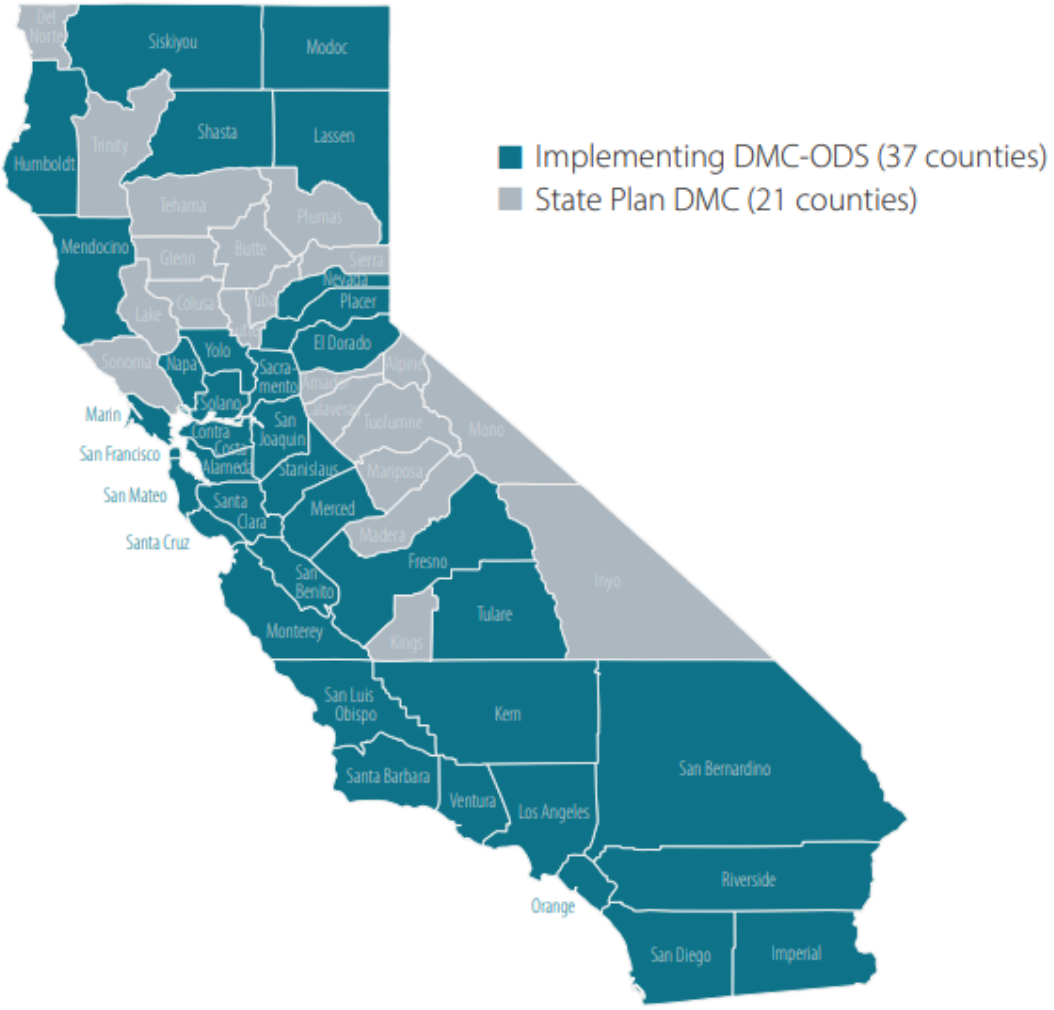
Under the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot program, established under California's Medicaid Section 1115 waiver in 2015 and extended through 2026 under California's 1915b waiver in 2021, a broad spectrum of substance use disorder services is provided through county-based managed care plans. The DMC-ODS represents a major expansion of benefits compared to the standard Drug Medi-Cal program.

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is California's effort to expand, improve, and reorganize treatment of substance use disorders in Medi-Cal. As of August 2020, 37 counties were implementing DMC-ODS, representing 96% of the state's Medi-Cal population.

California's Drug Medi-Cal Organized Delivery System

STANDARD DRUG MEDI-CAL STATE PLAN SERVICES	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER SERVICES
Providers contract with: counties or state	**Providers contract with:** counties
Services • Outpatient drug-free treatment • Intensive outpatient treatment • Residential substance use disorder (SUD) services for perinatal women only (limited to facilities with up to 16 beds) • Naltrexone treatment • Narcotic treatment programs (methadone only)	**Services** All services provided in the standard Drug Medi-Cal program, plus: • Multiple levels of residential SUD treatment (not limited to perinatal women or to facilities with up to 16 beds) • Narcotic treatment programs expanded to include buprenorphine, disulfiram, and naloxone • Withdrawal management (at least one ASAM level*) • Recovery services • Case management • Physician consultation **Optional** • Partial hospitalization • Additional medication-assisted treatment

Drug Medi-Cal Organized Delivery System (DMC-ODS)
by County, California, 2020



The Administration provided the following background information specific to the opioid epidemic:

The opioid epidemic has greatly impacted California communities and families. In recent years, morbidity and mortality are largely driven by synthetic opioids, such as fentanyl, stimulants, such as methamphetamine and by polysubstance use. While California has made significant public health progress to reduce the number of overdose deaths due to prescription opioids, the unpredictability of the illicit drug market shadows these state efforts as opioid overdoses and deaths are significantly increasing. Among Californians, there were 16,537 Emergency Department (ED) visits related to any opioid non-fatal overdose in 2020, an 87 percent increase since 2018 (8,832 ED visits). In terms of fatal overdoses, there were 5,502 any opioid-related overdose deaths in 2020 among Californians, a 127 percent increase since 2018 (2,428 deaths).

An analysis of the costs of opioid use disorder and fatal opioid overdose deaths in 2017 found that in California, the cost of fatal opioid overdoses was $25 billion, and the cost of opioid use disorder was $36 billion.3 Per capita, the cost of a fatal opioid overdose was $642, and the cost of opioid use disorder was $923. Within CHC, the Substance Abuse Prevention Branch (SAPB) aims to reduce individual, social, and environmental harm from addiction and substance use through research-driven prevention, education, and treatment. CDPH-SAPB currently has four primary programmatic areas: (1) overdose surveillance and prevention; 2) alcohol use research and harms prevention; 3) problem gambling education, prevention, and treatment; and (4) cannabis surveillance and youth cannabis prevention and education. CDPH-SAPB is an appropriate and logical home for a grant program aimed at reducing fentanyl overdoses and use throughout the state.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests SFAF to provide expertise on harm reduction related to SUDs, and share any recommendations they may have related to the state's efforts to prevent, as well as treat, SUDs.

The Subcommittee requests DHCS and CBHDA provide an overview of the Drug Medi-Cal program, including the ODS Waiver, and highlight significant unaddressed challenges associated with providing Medi-Cal SUD treatment services. Please also provide an overview of the accessibility of both community-based and residential SUD treatment services specifically for youth.

The Subcommittee requests CDPH provide an overview of all of the department's substance abuse prevention programs.

The Subcommittee requests the Commission provide an overview of the role of the MHSA in counties' response to SUDs, as well as on the Commission's work related to SUDs.

Staff Recommendation: This is an oversight issue and therefore no action is recommended at this time.

ISSUE 25: DHCS: OPIOID SETTLEMENTS FUND STATE DIRECTED PROGRAMS BUDGET CHANGE PROPOSAL

PANEL

- **Tyler Sadwith**, Deputy Director Behavioral Health, DHCS
- **Michelle Cabrera**, Executive Director, CBHDA
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS, Community Services Division (CSD), requests four-year limited-term (LT) expenditure authority of $32,000,000 Opioid Settlements Fund (OSF) in fiscal year (FY) 2023-24, $23,000,000 OSF in FY 2024-25, and $12,000,000 OSF in FY 2025-26 through FY 2026-27 to support the Naloxone Distribution Project (NDP).

Proposal (dollars in thousands)	2023-24	2024-25	2025-26	2026-27
Project Proposals				
NDP	$32,000	$23,000	$12,000	$12,000
Total State-Directed OSF Proposed Expenditures	**$32,000**	**$23,000**	**$12,000**	**$12,000**

BACKGROUND

The Administration provided the following background information:

The opioid epidemic has caused devastation across the nation. From 1999 to 2020, nearly 841,000 people died from a drug overdose, with prescription opioids serving as a factor in nearly 247,000 of those deaths. Overdose deaths involving opioids have increased six-fold since 1999. More than 108,000 people in the United States died from a drug overdose in the past year, with nearly 80 percent of the deaths attributed to fentanyl. In 2021, there were more than 6,800 opioid overdose deaths in California, more than 5,700 of them related to fentanyl. Also, 224 fentanyl-related overdose deaths were among teens 15–19 years of age. Most opioid overdose deaths are prescription drug-related followed by heroin-related and fentanyl-related overdose deaths. Opioid overdose death rates vary by gender, with males having higher rates than females, and by ethnicity, with much higher rates among American Indian and Alaska Native populations.

Opioid overdose can be due to many factors. For example, overdose can occur when an individual deliberately misuses a prescription, uses an illicit opioid (such as heroin or fentanyl), or uses an opioid contaminated with other even more potent opioids (such as fentanyl). Overdose can also occur when a patient takes an opioid as directed but the prescriber miscalculated the opioid dose, when an error was made by the dispensing pharmacist, or when the patient misunderstood the directions for use. It can also occur when opioids are taken with other medications—for example, prescribed medications such as benzodiazepines or other psychotropic medications that are used in the treatment of mental disorders—or with illicit drugs or alcohol that may have adverse interactions with opioids. At particular risk are individuals who use opioids and combine them with benzodiazepines, other sedative hypnotic agents, or alcohol, all of which cause respiratory depression.

Emergency medical personnel, health care professionals, people who use drugs, and other community members who may witness and respond to an overdose are being trained in the use of the opioid antagonist medication naloxone, which can reverse the potentially fatal respiratory depression caused by opioid overdose. Naloxone is a medication approved by the Food and Drug Administration designed to rapidly reverse opioid overdose. It is an opioid antagonist—meaning that it binds to opioid receptors and can reverse and block the effects of other opioids, such as heroin, morphine, and oxycodone. Administered when an individual is showing signs of an opioid overdose, naloxone is a temporary treatment and its effects do not last long. Therefore, it is critical to obtain medical intervention as soon as possible after administering/receiving naloxone. The medication can be given by intranasal spray (into the nose), intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection. Naloxone is effective if opioids are misused in combination with other sedatives or stimulants. It is not effective in treating overdoses of benzodiazepines or stimulant overdoses involving cocaine and amphetamines.

In October of 2018, the DHCS created the NDP in response to the rising deaths in California due to opioid overdoses. The NDP aims to reduce opioid overdose deaths through the provision of free naloxone in the form of a spray that can be used by laypeople. The intranasal formulation was chosen by DHCS as many individuals utilizing the naloxone are not health professionals and are uncomfortable utilizing a needle to administer the medication. Currently, DHCS utilizes the 4 mg Narcan kit with two doses at a cost of $47.50 (which includes shipping). DHCS also utilizes the .5 mg vials of intramuscular for harm reduction organizations at a cost of $3 (which includes shipping). As new formulations of naloxone become available, DHCS will continue to research the benefits of adding them to the NDP. DHCS will review available data, research studies, efficacy, feasibility, cost, direct shipping to applicants, and other factors before adding new formulations to the NDP.

Eligible entities (applicants) apply to DHCS to have naloxone shipped directly to their address. Applicants complete and submit the NDP application along with a prescription or utilize the standing order issued by the California Department of Public Health (CDPH). The NDP application, prescription or standing order, and the applicant's naloxone distribution plan, are submitted to the DHCS NDP. Entities must also attest that they have completed training on how to utilize the naloxone in an overdose event. Once approved, the naloxone is shipped directly to the entity.

Since inception, the NDP has reviewed over 7,200 applications. Eligible entities include law enforcement such as police departments, county jails and probation, fire, emergency medical services, and first responders, schools and universities, county public health and behavioral health departments, and community organizations such as harm reduction organizations or community opioid coalitions.

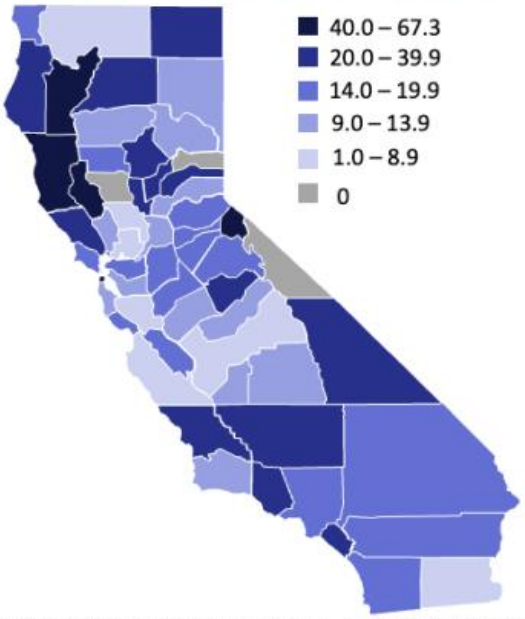
In response to the opioid epidemic, several lawsuits have reached settlement agreements which impact California, and there may be more settlements in the future. In the first settlement agreement, the Attorney General settled claims against McKinsey related to services it provided to the opioid industry. Second, nationwide settlement agreements with Janssen Pharmaceuticals (Janssen's parent company is Johnson & Johnson) and distributors, McKesson, Cardinal Health and AmerisourceBergen, have recently been finalized. Under these settlements, California and its cities and counties could receive approximately $2.2 billion over nearly two decades for substance use prevention, harm reduction, treatment, and recovery activities pursuant to the List of Opioid Remediation Uses specified in the settlement agreements. Under an agreement between the State and litigating local governments, fifteen percent of the funds are allocated to the State and must be utilized for State determined priorities that pertain to opioid remediation. The purchase and distribution of naloxone is an allowable use of opioid settlement funding.

Through November 2022, the NDP has distributed more than 1,700,000 units of naloxone to all 58 counties in the state, with the highest rates of naloxone distributed to counties and regions with the highest rates of opioid deaths. As of December 2022, more than 112,000 opioid overdose reversals have been reported to DHCS through the NDP. Due to naloxone being widely spread throughout California through the NDP, this figure is likely significantly underreported.

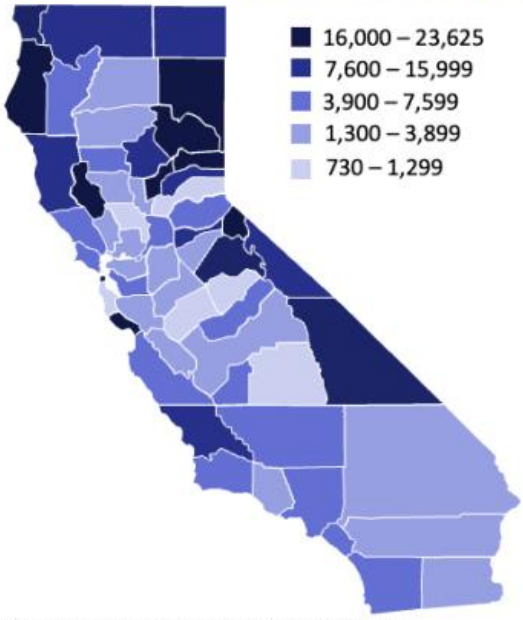
The following figure demonstrate where naloxone has been provided through the NDP compared to overdose rates:

DHCS

Opioid Overdoses per 100,000 Residents, 2021



Approved Naloxone Units per 100,000 Residents, 2018-2022

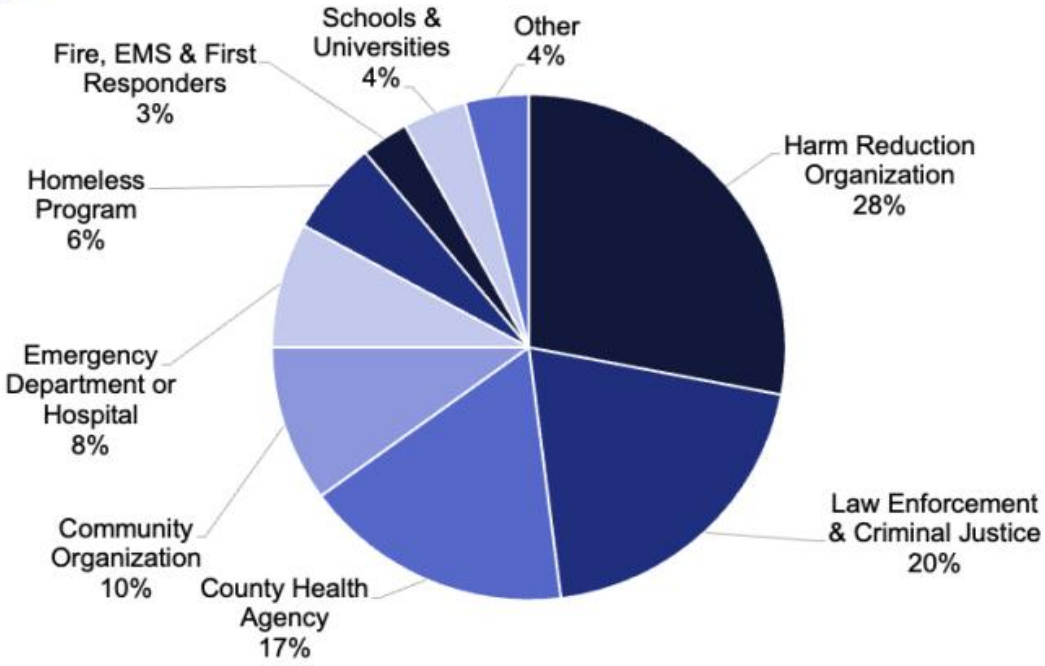


SOURCES: Any Opioid-Related Overdose Deaths – California Department of Public Health, "California Opioid Overdose Surveillance Dashboard"; accessed October 2022. Population data - State of California Department of Finance, "E-1 Cities, Counties, and the State Population Estimates with Annual Percent Change – January 1, 2021 and 2022"; accessed October 2022. Naloxone units as of December 9, 2022.

2

DHCS

Naloxone Units by Type of Organization



Units Approved: 1,764,504

NOTE: Naloxone units as of December 9, 2022.
Other category includes: SUD treatment facilities, libraries, veterans organizations, religious entities, and state agencies.

6

The NDP has recently received ongoing funding through the General Fund (GF) beginning in FY 2022-23 after solely being funded through one-time federal grants since the NDP's creation in 2018. For FY 2022-23, the NDP has $61 million in funding available; however, $25.5 million of this is one-time funds which will be fully expended by June 30, 2023. The one-time grants were from federal stimulus funds provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) through the Substance Abuse Block Grant (SABG) Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA) and the American Rescue Plan Act (ARPA), and one-time opioid settlement funds. For the FY 2023-24, the NDP has $35.5 million in ongoing GF, but there remains an increasing demand for access to naloxone and the NDP.

Table 2: Funding for the NDP in FY 2022-23

Funding Source	Naloxone Formulation	Eligible Organizations	Funding Amount
SABG ARPA	Intramuscular (injectable)	Syringe Services Providers	$1,500,000
OSF	Intranasal (Narcan 4mg Nasal spray)	Homeless Services Providers	$14,750,000
GF	Intranasal (Narcan 4mg Nasal spray)	All other NDP Applicants	$35,753,000
SABG CRRSAA	Intranasal (Narcan 4mg Nasal spray)	All other NDP Applicants	$9,000,000
Total			**$61,003,000**

Table 3: Currently Available Funding for the NDP in FY 2023-24

Funding Source	Naloxone Formulation	Eligible Organizations	Funding Amount
GF	Intramuscular (injectable)	Syringe Services Providers	$1,500,000
GF	Intranasal (Narcan 4mg Nasal spray)	All other NDP Applicants	$34,000,000
Total			**$35,500,000**

DHCS is requesting to utilize OSF to assist in meeting the increased demand for naloxone requested through the NDP.

Opioid Settlements Fund (OSF) Proposed Expenditures at 2023 Governor's Budget

Dollars in thousands

Department	Investment	2022-23	2023-24	2024-25	2025-26	2026-27
Authorized by the 2022 Budget Act						
DHCS	OSF Oversight	$2,716	$2,617	$2,617	$2,617	$2,617
	Naloxone Distribution Project Augmentation[1/]	$15,000				
	SUD Provider Workforce Training[1/]	$51,113				
	ATLAS Platform Operation and Outreach Campaign[1/]	$7,500				
	Shatterproof Statewide Anti-Stigma Campaign[1/]	$1,700				
CDPH	Fentanyl Education and Awareness Campaigns[1/]	$40,800				
	Opioid Overdose Data Collection and Analysis[1/]	$5,000				
DOR	Integrating Employment in Recovery Pilot Project[1/]	$4,000				
Proposed at the 2023 Governor's Budget						
DHCS	Naloxone Distribution Project Augmentation		$32,000	$23,000	$12,000	$12,000
CDPH	Support the Implementation of AB 2365 Fentanyl Program Grants[2/, 3/]		$5,000	$3,000	$1,000	$1,000
	Strips and Naloxone More Widely Available[2/]		$2,500	$500	$500	$500
Total State-Directed Proposed OSF Expenditures		**$127,829**	**$42,117**	**$29,117**	**$16,117**	**$16,117**
Total State-Directed Projected OSF Revenue Transfer		**$127,829**	**$42,174**	**$29,090**	**$16,094**	**$16,214**
Difference		*$0*	*$57*	*($27)*	*($23)*	*$97*

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal, and requests CBHDA share the experiences of counties in responding to the opioid epidemic as well as any recommendations with regards to the state's response and use of OSF.

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for additional discussion and consideration.

ISSUE 26: CDPH: FENTANYL PROGRAM GRANTS (AB 2365) AND INNOVATIVE APPROACHES TO MAKE FENTANYL TEST STRIPS AND NALOXONE MORE WIDELY AVAILABLE BUDGET CHANGE PROPOSAL

PANEL

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Alessandra Ross**, Harm Reduction Unit Chief, Office of AIDS, Center for Infectious Disease, CDPH
- **Laura Thomas**, MPH, MPP, Senior Director, HIV and Harm Reduction Policy, San Francisco AIDS Foundation (*Remote Speaker*)
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH, Center for Healthy Communities (CHC) and Center for Infectious Diseases (CID) requests $7.5 million from the Opioid Settlements Fund (Fund 3397) in 2023-24, $3.5 million in 2024-25, and $1.5 million in 2025-26 and 2026-27 with provisional language extending encumbrance or expenditure authority through June 30, 2027. Funding will be used to support six one-time competitive grants to reduce fentanyl overdoses and use per the requirements of AB 2365 (Patterson, Chapter 783, Statutes of 2022), and two one-time competitive grants to support innovative approaches to make fentanyl test strips and naloxone more widely available.

BACKGROUND

The administration provided the following background information:

The opioid epidemic has greatly impacted California communities and families. In recent years, morbidity and mortality are largely driven by synthetic opioids, such as fentanyl, stimulants, such as methamphetamine and by polysubstance use. While California has made significant public health progress to reduce the number of overdose deaths due to prescription opioids, the unpredictability of the illicit drug market shadows these state efforts as opioid overdoses and deaths are significantly increasing. Among Californians, there were 16,537 Emergency Department (ED) visits related to any opioid non-fatal overdose in 2020, an 87 percent increase since 2018 (8,832 ED visits).1 In terms of fatal overdoses, there were 5,502 any opioid-related overdose deaths in 2020 among Californians, a 127 percent increase since 2018 (2,428 deaths).

An analysis of the costs of opioid use disorder and fatal opioid overdose deaths in 2017 found that in California, the cost of fatal opioid overdoses was $25 billion, and the cost of opioid use disorder was $36 billion.3 Per capita, the cost of a fatal opioid overdose was $642, and the cost of opioid use disorder was $923. Within CHC, the Substance Abuse Prevention Branch (SAPB) aims to reduce individual, social, and environmental harm from addiction and substance use through research-driven prevention, education, and treatment. CDPH-SAPB currently has four primary programmatic areas: (1) overdose surveillance and prevention; 2) alcohol use research and harms prevention; 3) problem gambling education, prevention, and treatment; and (4) cannabis surveillance and youth cannabis prevention and education. CDPH-SAPB is an appropriate and logical home for a grant program aimed at reducing fentanyl overdoses and use throughout the state.

To respond to the overdose crisis, CDPH-SAPB works to reduce individual, social, and environmental harm from addiction and substance use through research-driven prevention, education, and treatment. CDPH-SAPB houses the Overdose Prevention Initiative (OPI) which collaborates with partners throughout the state to monitor and address current overdose trends at the statewide and local level. OPI focus areas include:

- **Public Awareness and Education**. Provides opioid misuse prevention, education, and awareness, tailored towards California youth; and fentanyl education, awareness, and harm reduction strategies tailored toward California adults.
- **Building Local Capacity and Engaging Stakeholders**. Funds 21 local Overdose Prevention Coalitions that promote safe prescribing practices, expand access to medication assisted treatment, distribute naloxone and fentanyl test strips, increase overdose prevention public awareness and education, develop local opioid policies and procedures, and promote harm reduction practices.
- **Policy, Systems, and Environmental Change**: Works with statewide partners to establish and amplify policy changes at the state and local level. Policy and systems changes include inter-agency coordination, harm reduction strategies, naloxone access policies, improving pathways to treatment, and adoption of community-centered approaches to substance misuse prevention and overdose prevention.
- **Research and Surveillance**: Monitors fatal and non-fatal opioid-related overdose trends over time in California, by sex, age, race/ethnicity, location, and substance type. Data are available on the California Overdose Surveillance Dashboard (https://skylab.cdph.ca.gov/ODdash/?tab=Home). OPI also collects and analyzes data on overdose risk factors and substance use/misuse behaviors.

Current CDPH funding for overdose prevention efforts is supported by federal funds awarded by the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA), via state interagency agreement with the Department of Health Care Services (DHCS). Funding to support

local efforts to prevent overdose through the Overdose Prevention Coalitions is approximately $2.3 million per year, inclusive of grants ($1.5 million) and state operations ($800,000).

In 2022-23, CDPH received a one-time appropriation of $45.8 million, available through 2024- 25, to support two priority projects, the Overdose Public Awareness Campaign and Improved Surveillance:
(https://esd.dof.ca.gov/Documents/bcp/2223/FY2223_ORG4265_BCP5435.pdf)

The current proposal is complementary to these efforts; there is no duplication or overlap of scope, services, or scope.

CDPH works closely with DHCS as part of the broader state response to address drug overdoses. In 2022-23, DHCS was established as the fund administrator for California's Opioid Settlements Fund. As part of the opioid settlement agreement, local governments who sign on to the agreement will receive funding directly from the state to prevent and respond to opioid use, including fentanyl. About 95 percent of local governments have signed on, representing approximately 99 percent of California's population. DHCS also receives the SAMHSA State Opioid Response (SOR) grant to address the opioid crisis by increasing access to treatment; reducing unmet treatment need; and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorder. SOR funds are used to support overdose response at the local and regional level across the state.

The opioid epidemic is also linked to significant increases in Hepatitis C Virus (HCV) infection in California as well as risk of Human Immunodeficiency Virus (HIV) infection. Researchers have documented that as the supply of opiate medications such as oxycodone were cut off by new medical guidelines and laws to prevent diversion, people increasingly turned to injecting heroin, and later fentanyl, which now dominates the illicit opiate market. Rates of newly reported chronic hepatitis C infections and opiate-related emergency department visits among young adults (25 to 29 years of age) increased together at a similar rate. Between 2012 and 2016, rates of newly reported cases of chronic hepatitis C increased 159 percent and opiate-related emergency department visits increased 139 percent respectively, likely due to increases in injection drug use. Nationally and in California there is no evidence of an increase in HIV among people who inject drugs, but transmission through unsterile injection drug use often accompanies increases in HCV infection, as was seen in the Scott County Indiana HIV outbreak. In 2015, rural Scott County experienced an unprecedented HIV outbreak, with 181 new HIV infections identified in three months; most of those diagnosed were found to have pre-existing HCV infection. Since that time, outbreaks of injection-mediated HIV infection have been documented in Boston, Northern Kentucky, Cincinnati, Seattle, and West Virginia. California has increased funding for Syringe Services Programs (SSPs) in recent years to protect against outbreaks and bring wrap-around services to people experiencing addiction. The CDPH Office of AIDS (OA) Harm Reduction Unit oversees these efforts

and collaborates closely with colleagues within in CID to expand the services SSPs are able to offer.

CID works to prevent transmission of infectious diseases and assist those living with an infectious disease to access healthcare, medications, and support services. It does this through four Divisions/Offices, among which are the Division for Communicable Disease Control (DCDC) and OA.

As designated by California Health and Safety Code (HSC) section 131019, OA has lead responsibility for coordinating state programs, services, and activities relating to HIV and AIDS. OA is made up of a Division Office and six branches, including the HIV Prevention Branch, which includes the Harm Reduction Unit. OA also works closely with the DCDC/STD Control Branch on comprehensive prevention, diagnosis, and treatment services for sexually transmitted diseases, HCV, and HIV.

The Harm Reduction Unit prevents HIV transmission and supports whole-person care for people who inject drugs by authorizing new SSPs in areas of California at risk of outbreaks of HIV or HCV or increases in opiate overdose. The Harm Reduction Unit integrated overdose prevention and response into its core mission in 2015 as part of efforts to prioritize the identified needs of people who use drugs, who experience overdose and overdose fatalities in high numbers.

The number of SSPs in CA has grown significantly in the past five years, from 35 to 65 programs, due in part to the opioid crisis and local organizing efforts in response, as well as funding to expand OA's technical assistance to new programs. Currently, OA funds supplies for the 65 SSPs in California, funds staffing at 38 SSPs, and provides technical assistance to organizations interested in adding overdose education, naloxone distribution, and infectious disease prevention to their existing services.

In 2021 the DHCS Naloxone Distribution Project (NDP) provided at least 159,300 two-pack naloxone kits to SSPs, representing the majority of naloxone distributed to community members. This volume of distribution was approximately equal to naloxone acquired by law enforcement, fire/EMS services, emergency departments, and homeless services organizations combined.4 The friends and families of people who use drugs continue to be those most likely to witness and respond to an overdose.

AB 2365 Fentanyl Program Grants

AB 2365 requires the CDPH-SAPB to establish a grant program to reduce fentanyl overdose and use throughout the state to increase local efforts in education, testing, recovery, and support services. Six, one-time grants will be awarded as part of this pilot, allocated by region: two in Northern California, two in the Central Valley, and two in Southern California.

Grant activities will include any of the following: (1) education programs in local schools; (2) increasing testing abilities for fentanyl; (3) overdose prevention and recovery programs, including making naloxone or other overdose recovery drugs more available in the community; and (4) increasing social services and substance use recovery services to those addicted to fentanyl or other opioids.

Grantee awards are estimated at an average of $427,000 per year over three years, meaning a total of $1,281,000 per grantee over the three-year period beginning in January 2024. Actual amounts awarded may vary, based on the scale of the population served (accounting for regional/geographic reach and population size) and specific strategies identified by grantees.

CDPH-SAPB will also engage an external partner via Interagency Agreement with a State College or University to support grantee success. The external partner will be responsible for establishing a data collection framework to support evaluation of the efficacy of each program, providing technical assistance to grantees on evaluation, and providing CDPH-SAPB with the data and information to evaluate program success. The program evaluator will be a resource to the grantees, as local partners are not anticipated to have sufficient evaluation capacity in-house.

Through this proposal, CDPH-SAPB will administratively establish one Associate Governmental Program Analyst (AGPA) and two Health Program Specialist I (HPS I) positions to establish and implement the program, including developing the request for applications (RFA) to determine the jurisdictions that will receive funding, executing agreements, monitoring grantee progress, working with the external partner on grantee data and evaluation, developing and submitting the final report to the Legislature and the Governor’s office, and preparing and developing final comprehensive grantee program report for the public.

CDPH-SAPB will also provide a comprehensive final report on all grantee outcomes, following the close of the grant period. This proposal will support public health by providing funding directly to local jurisdictions to respond to fentanyl and providing critical data and information to the Legislature on potential successes of the fentanyl grant pilot program.

The fentanyl grant pilot program will be similar to OPI’s Local Overdose Prevention Coalition program. An RFA was released in September 2019; in April 2020, 23 coalitions7 received funding to implement strategies to address overdose at the local level. CDPH-SAPB will use the coalition grant program as a model for the fentanyl grant pilot program; requirements of the fentanyl grant pilot program RFA will be tailored to meet the stipulations of AB 2365, the scope of the project, and the timeline described under the implementation plan.

Innovative Approaches to Make Fentanyl Test Strips and Naloxone More Widely Available

Syringe Services Programs are the primary vehicle for reaching people at greatest risk of experiencing or witnessing an overdose with overdose education and naloxone distribution services. State data show SSPs have received a third of the naloxone shipments in this fiscal year, but account for two-thirds of the reported reversals. Unlike many other types of types of programs that order naloxone through the DHCS Naloxone Distribution Project and keep it available in case of onsite emergencies, SSPs actively work to distribute naloxone to people who use drugs – their program participants -- then train them in its use and serve as sources of emotional support after they reverse an overdose. A 2022 CDPH-supported survey of 1,500 SSP participants found that 65 percent of respondents had witnessed an overdose in the previous six months, and 54 percent had used naloxone on someone to reverse an overdose. Although most of California's SSPs participate in the NDP, many also supplement their naloxone orders through other sources.

Recent changes to California law as a result of AB 1598 (Davies, Chapter 201, Statutes of 2022) exempted testing equipment designed, marketed, intended to be used, or used, to test a substance for the presence of fentanyl, ketamine, gamma hydroxybutyric acid, or any analog of fentanyl from being considered "drug paraphernalia." AB 1598 goes into effect as of January 1, 2023, and as of that date, service providers throughout California may seek to distribute fentanyl test strips to their clients and patients to prevent overdose. Fentanyl test strips are a form of inexpensive drug testing technology that was originally developed for urinalysis, but which have been shown to be effective at detecting the presence of fentanyl in drug samples prior to ingestion. A study involving a community-based program in North Carolina found that 81 percent of those with access to fentanyl test strips routinely tested their drugs before use. Those with a positive test result were five times more likely to change their drug use behavior to reduce the risk of overdose.8 In a Rhode Island study of young adults who reported using heroin, cocaine, or illicitly obtained prescription pills, "receiving a positive [fentanyl] result was significantly associated with reporting a positive change in overdose risk behavior."9 Increasing access to fentanyl test strips, potentially through the Naloxone Distribution Project, will assist many organizations looking to better serve the needs of their clients.

To address these challenges and opportunities, CDPH-OA proposes to use the Request for Information (RFI) process to gather information to: 1) Expand access to fentanyl test strips and establish a low-cost naloxone supply bank to potentially supplement the DHCS Naloxone Distribution Project and provide naloxone to the community-based programs, predominantly SSPs, that have already demonstrated the greatest efficiency in reversing overdoses; and 2) Issue a Request for Proposals (RFP) to manufacturers and distributors of fentanyl test strips and naloxone in order to expand access to both services through innovative and cost effective ways. The resulting contracts may potentially support the Naloxone Distribution Project with additional naloxone supply and alternative naloxone formulations and expand its scope by supplying fentanyl test strips. CDPH-OA may

establish an inter-agency agreement with DHCS to administer one or more contracts with manufacturers and distributors of both products.

OA will issue an RFI to solicit information from manufacturers and distributors of both products and use the information to develop and issue an RFP from vendor(s) prepared to supply one or both products. CDPH-OA will engage an external partner (interagency agreement with a state college or university) to provide subject matter expertise concerning which formulation of naloxone to purchase, evaluate strengths and weaknesses of the products, and assess acceptability to the products' end users, including both individuals and institutions. The external partner will also be responsible for assessing areas of high need for naloxone, taking into account racial and ethnic disparities in overdose rates and naloxone access, as well as regional disparities. The subject matter expert will also evaluate gaps and overlaps in naloxone distribution by key sectors, including jails, emergency departments and homeless service providers, and provide technical assistance to agencies that have not yet begun to offer overdose education and naloxone distribution at the conclusion of the RFI process.

CDPH-OA will also administratively establish one Health Program Specialist I (HPS I) position to establish and implement the program, including developing the RFI and RFP(s), executing agreements, monitoring progress, working with the external partner and convening key partners, including CDPH colleagues, DHCS and Aurora Health staff who oversee the Naloxone Distribution Project, and outside stakeholders invested in improved naloxone distribution as a way to address the overdose fatality crisis.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal, and requests SFAF provide expertise and recommendations related to harm reduction and opioid use.

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for additional discussion and consideration.

ISSUE 27: CDPH: FENTANYL PROGRAM GRANTS REPORTING REQUIREMENTS (AB 2365) TRAILER BILL

PANEL

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Alessandra Ross**, Harm Reduction Unit Chief, Office of AIDS, Center for Infectious Disease, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH proposes changes to the reporting requirements and timeline of AB 2365 (Patterson, Chapter 783, Statutes of 2022) to support the implementation of a grant program to reduce fentanyl overdoses and use through the state and the development of a comprehensive report, including all data and information as defined in Welfare and Institutions Code (WIC) section 3201(a). The proposed amendments also define CDPH, rather than California Health and Human Services (CalHHS) Agency, as being responsible for grant implementation and reporting.

BACKGROUND

The Administration provided the following background information:

AB 2365 requires CalHHS Agency to implement a fentanyl grant program and report on the outcomes of the program. Two issues have been identified that were not addressed in AB 2365: (1) there is no department identified within CalHHS to administer the fentanyl program grants and mandated reporting, and (2) the timeframe for reporting to the Legislature and Governor's Office did not account for the time necessary for CDPH to develop the grant program, for grantees to implement activities, and for grantees and CDPH to report on outcomes of the fentanyl grant programs.

Because some of the required information (hospitalization data and mortality data) is only available after several months, the reporting timeline needs to be adjusted. Hospitalization data are reported every 6 months and information is only available approximately 6-9 months after each reporting period. Preliminary overdose mortality data are reported quarterly and is available approximately 5-7 months after the end of the quarter.

In addition, the Governor's Budget proposes $10 million Opioid Settlements Fund over four years to support a fentanyl grant program consistent with the requirements of AB 2365. The proposed reporting timeline will align with the availability of funding.

CDPH states that the proposed amendments will allow CDPH to incorporate the most updated fentanyl program grant data while also meeting the intent of the original statute.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to the following:

1. For what reasons is this language not being proposed through a policy bill, given that it amends a 2022 policy bill?

2. Has the Administration negotiated this language with Assemblymember Patterson, and the policy and Appropriations Committees in both houses?

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for additional discussion and consideration.

ISSUE 28: DHCS: STRENGTHENING OVERSIGHT FOR SUBSTANCE USE DISORDER LICENSING AND CERTIFICATION BUDGET CHANGE PROPOSAL AND TRAILER BILL

PANEL

- **Michelle Baass**, Director, DHCS
- **Robb Layne**, Executive Director, California Association of Alcohol and Drug Program Executives, Inc.
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS, Licensing and Certification Division (LCD) and Offices of Legal Services (OLS), request approval to increase the Residential and Outpatient Program Licensing Fund (ROPLF) fees for residential and outpatient recovery and treatment programs effective July 1, 2023. A fee increase is required to cover expenditures associated with residential and outpatient licensing activities as the current rate of collection is not sufficient. Additionally, upon approval of the proposed fee increase, DHCS requests 12.0 permanent positions and expenditure authority of $2,012,000 ROPLF in FY 2023-24 and $1,904,000 ROPLF in FY 2024-25 and ongoing, and corresponding statutory changes, to strengthen compliance oversight and establish a new mandatory certification for outpatient substance use disorder programs.

BACKGROUND

The Administration provided the following background information:

DHCS has the sole authority to license, certify, and monitor Substance Use Disorder (SUD) recovery or treatment facilities to support the health and safety of program clients (Health and Safety Code, Division 10.5, Chapter 7.5, Sections 11830.1, 11834.01 and 11834.30). DHCS is responsible for all activities associated with facility licensure and/or certification, compliance with statutory and regulatory requirements, and client-related health and safety issues. These activities include, but are not limited to, initial facility application and on-site reviews, renewal processes, on-site monitoring compliance reviews, and complaint investigations of facilities, counselors, and client deaths. There are 879 licensed SUD recovery or treatment facilities.

Licensure: Licensed SUD recovery or treatment facilities provide residential non-medical services to individuals seeking treatment for an SUD. Licensure is required when one or more of the following treatment services is provided in a residential setting: incidental

medical services, detoxification, individual sessions, group sessions, educational sessions, or alcoholism or SUD treatment or recovery planning. These services can be offered by a variety of providers such as SUD counselors, mental health therapists, social workers, psychologists, nurses, and physicians. Under current statute, licensure is not required for non-residential SUD treatment facilities, including outpatient SUD treatment facilities.

Certification: DHCS also offers a voluntary facility certification to both residential and nonresidential programs. Facilities that hold a DHCS voluntary certification are required to exceed minimum levels of service quality and must be in substantial compliance with State program standards, specifically the Alcohol and/or Other Drug Certification Standards. These Certification Standards were last revised in February 2020 and took effect on July 1, 2020. A majority of DHCS licensed residential facilities also hold the voluntary certification and some counties also require providers to receive the voluntary facility certification to receive state and federal funds. There are currently1,343 facilities that have a voluntary certification.

Complaints: DHCS has the responsibility to investigate complaints against both licensed SUD residential programs and all SUD facilities with a voluntary DHCS certification, which includes both licensed SUD treatment facilities and outpatient SUD treatment facilities. Complaints are triaged based on priority; after a case has been assigned either high, medium, or low status, it is assigned to a complaint analyst by a supervisor. Assignment depends on the nature of the complaint with deaths, allegations of imminent danger to clients and counselor investigations given the highest priority. Medium level complaints include unethical counselor conduct, unlicensed activity, or overconcentration concerns. Low-level complaints include dissatisfaction with meals, pest control issues or anonymous complaints filed with minimal information. While complaints are initially categorized based on priority, depending on the course of the investigation, the priority level can change. Each complaint can vary in length of time to complete, from 30 days to up to two years. There are different variables involved before a complaint can be closed. For example, some complaints are involved in litigation, which is cause for a complaint to remain open for two years as it moves through the court process. Over the past few years, DHCS has improved processes to streamline the review and completion of complaints. The average time to close a complaint has dropped almost in half in the last two years, from 245 days to 114 days. However, additional resources are needed to continue DHCS' efforts to strengthen compliance oversight to protect patient safety and ensure high quality of care.

Residential and Outpatient Program Licensing Fund: SB 84 (Chapter 177, Statutes of 2007) created the ROPLF, consisting of specified fees, fines, and penalties collected from SUD treatment facilities seeking licensure and certification. The revenues are intended to support and maintain the resources necessary for continued provider oversight by DHCS. The fees for SUD facilities were last increased in 2014 through Mental Health SUD Information Notice 14-022. Since 2018, the ROPLF has experienced

a steady decline of revenue due to program closures and the COVID-19 pandemic. This loss of revenue has caused the ROPLF to become insufficient to sustain existing staff resources. If DHCS is unable to fund staff resources for licensing and certification activities, DHCS must pursue an increase to the fees. In January 2022, DHCS requested to increase the licensure fees that fund ROPLF by 63 percent. However, in July 2022, instead of a ROPLF fee increase the 2022 Budget Act includes $3,577,000 one-time General Fund to support DHCS licensing and certification workload.

DHCS Licensing and Certification Division: DHCS' LCD has two sections, the Licensing and Certification Section (LCS) and the Complaints Section (CS), that are responsible for verifying the compliance of SUD treatment facility laws, regulations, and standards. Throughout the last several years, new legislation has been implemented related to licensing and certification activities. This legislation includes adding Incidental Medical Services as an available service, patient brokering laws that prohibit remuneration for individuals or entities that refer patients to SUD treatment providers, the requirement for residential facilities to have a DHCS level of care designation, and facility requirements to hold various insurance policies. DHCS continues to receive nearly 600 complaints per year against SUD facilities and allegations of unlicensed activity. Staff solely located in Sacramento are responsible for quick and thorough investigations. However, a majority of complaints emanate from southern California, requiring Sacramento-based staff to travel to southern California to conduct on-site investigations. This travel creates inefficiencies in the investigation and enforcement process, and could lead to delays in enforcement action.

Enhanced Oversight and Transparency in Southern California

LCD staff have historically been located in a Sacramento based office to oversee SUD facilities statewide. Over the last three fiscal years, Orange, Los Angeles, and San Diego counties have had the highest number of SUD facility-related complaints in the state of California. In response, DHCS recently redirected three AGPAs from the Sacramento office to the DHCS Santa Ana office in an effort to more promptly investigate high priority complaints on an ongoing basis. Between FY 2017-18 through FY 2021-22, DHCS averaged 595 complaints annually for about 1,750 SUD treatment facilities and the typical caseload a complaint analyst can address is about 30 complaints per year.

However, this does not take into account that there are complaints that can take months to investigate and possibly result in a licensing action and litigation. LCD has also received an increased number of allegations specific to patient brokering and patient trafficking cases in the southern California region, which are more intensive by nature than general complaint investigations, requiring more in-depth analysis of patient records and program contracts. Staff review records and conduct interviews to find evidence of client payoffs, records manipulation, and other patient brokering practices.

Having additional staff focused on complaint investigation located in southern California will improve the LCD response time and allow staff to quickly obtain conclusive evidence of patient brokering and patient trafficking through client/broker/program digital communications (text, e-mail) and seek corroborating evidence from client files, shift notes, invoices, etc. within the program itself. Having staff locally in the southern California region will also improve coordination with other agencies, which is frequently required for high-level complaints relating to patient brokering and patient trafficking, due to the complexity and serious nature of the complaint. This proposal will improve and strengthen DHCS' compliance oversight by reducing analyst caseloads, creating a quicker response time to complaints, and allowing more opportunity for necessary follow-up site visits. DHCS is requesting staffing to build out a full southern California based team and backfill the Sacramento positions that were redirected. This is a targeted request to respond to the most complex and resource-intensive complaints involving patient brokering and patient trafficking so that LCD can successfully support safety for vulnerable patients.

In an effort to enhance transparency of DHCS' licensing and certification compliance reviews, DHCS will be posting all complaint and compliance reports on the DHCS website. The online posting of DHCS' reports is the first step of working towards the future goal of creating a more robust online database. LCD is exploring long-term enhanced solutions through implementation of the Behavioral Health Modernization project.

Improve the ROPLF Fee Processes

Due to the loss in revenue in the ROPLF, which is insufficient to sustain existing staff resources, and given the subsequent denial of the requested fee increase, the 2022 Budget Act includes $3.5 million one-time General Fund to support DHCS LCD's SUD licensing and certification functions for FY 2022-23. However, the General Fund is not a reliable mechanism to support the resources needed to maintain oversight and compliance monitoring of SUD providers on an ongoing basis. Therefore, in an effort to build a more sustainable fee-supported program, DHCS proposes statutory changes to authorize ROPLF fee changes in such a way that does not overly burden the provider network and allows more predictable planning and budgeting for providers.

DHCS anticipates that it will need to increase the ROPLF fees by 75 percent. The projected increase reflects an additional revenue collection of $5,355,950.25 in FY 2023-24. DHCS performed a fee analysis and reviewed the health of the ROPLF based on actual expenditures and fees collected for FY 2021-22 and determined the current fee rate to be substantially insufficient to cover current, and future operating costs.

DHCS would have to increase funds by 75 percent to cover the newly requested BCP positions, and existing operations.

DHCS' fee collection fluctuates biennially as providers renew licensure or certification every two years on the provider's anniversary date. DHCS classifies these fluctuations in

fee collection revenue as "high" or "low" years and DHCS' fee projection methodology must factor this in when projecting increases. Data shows that fees collected on a low year generate 68 percent of the revenue collected on a high year, therefore DHCS must increase fees by a percentage high enough to offset the reduction of revenue generated on a low year. Although any fee increases are sensitive, this "smoothing" tends to be preferred by fee payers as it eliminates large fluctuations and improves predictability of and planning for paying fees.

The following chart shows the impact of a 75 percent increase in fees for each residential licensure application type:

APPLICATION TYPE		75% INCREASE	
RESIDENTIAL LICENSURE	CURRENT FEE	INCREASE	NEW FEE
Initial Residential Licensure Application	$3,050	$2,288	$5,338
Initial Biennial Residential Licensure	$324 (per bed)	$243	$567
Biennial Residential Licensure Extension	$324 (per bed)	$243	$567
Adolescent Waiver Application	$1,507	$1,130	$2,637
Dependent Children Application (if not requested during initial licensure application)	$1,054	$791	$1,845
Supplemental Application (Increase or Decrease in Bed Capacity, Target Population change, Program Name change, Removal of Address or Suite, Legal Entity Name change, Addition or Removal of Services - i.e., Incidental Medical Services, Detoxification, Co-ed.)	$1,034	$776	$1,810
Facility Address Update (Facility Relocation, Adding Additional Address or Suite number(s))	$1,008	$756	$1,764
CERTIFICATION	CURRENT FEE	INCREASE	NEW FEE
Initial Outpatient Certification Application	$2,931	$2,198	$5,129
Initial Biennial Outpatient Certification	$3,798	$2,849	$6,647
Biennial Outpatient Certification Extension	$3,798	$2,849	$6,647
Biennial Residential Certification (for facilities having a residential license issued by another State Department). The maximum fees for beds will not exceed the biennial certification fee	$324 (per bed, with a maximum of $3,798)	$243	$567 (per bed, with a maximum of $6,647)
Supplemental Application (Target Population change, Program Name change, Removal of Address or Suite, Legal Entity Name change, Addition or Removal of Services - i.e., Intensive Outpatient, Outpatient, Residential, Detoxification)	$1,034	$776	$1,810
Facility Address Update (Facility Relocation, Adding Additional Address or Suite number(s))	$1,008	$756	$1,764
COMBINED RESIDENTIAL LICENSURE AND CERTIFICATION	CURRENT FEE	INCREASE	NEW FEE
Initial Combined Residential Licensure and Certification Application	$4,068	$3,051	$7,119
Initial Biennial Combined Residential Licensure and Certification	$324 (per bed)	$243	$567
Biennial Combined Residential Licensure and Certification Extension	$324 (per bed)	$243	$567

DHCS states that with more predictable ROPLF funding levels, DHCS will be able to better support the operation and oversight of SUD facilities. In addition, with the creation of a mandatory certification for outpatient SUD programs, DHCS will establish a mandatory fee structure for certification, similar to the current fee structure for voluntary certification, which would help to support the oversight responsibilities associated with the new mandatory certification.

Mandatory Certification for Outpatient Programs

California patients, their families, and those paying for treatment need assurance that all SUD treatment programs and facilities are delivering treatment that is effective, efficient, safe, and high-quality. Individual treatment outcomes depend on the extent and nature of the patient's problems, the appropriateness of treatment and related services used to address those problems, and the quality of interaction between the patient and his or her treatment providers. Because the quality and appropriateness of addiction treatment is critical to the success of addiction treatment, mandatory oversight of outpatient SUD programs is critical at this juncture.

Currently, DHCS only licenses residential SUD facilities. In addition, DHCS offers a voluntary certification of both residential and nonresidential SUD facilities if they exceed minimum levels of service quality and comply with the requirements outlined in the Alcohol and/or Other Drug Certification Standards. Currently, outpatient certification is voluntary; many treatment programs provide outpatient SUD treatment services without seeking voluntary certification. These outpatient SUD treatment facilities are not subject to any governmental oversight, leading to unregulated facilities, poor quality of care, and patient safety risks. Previously, the following bills proposed to establish requirements for mandatory licensure or certification for outpatient SUD facilities, SB 325 (Hill, 2019), AB 920 (Petrie-Norris, 2019), AB 77 (Petrie-Norris, 2021), however those bills were unsuccessful. In addition, during Legislative oversight hearing in December 2021, DHCS was asked to increase their oversight of the SUD field.

DHCS recognizes the gap in oversight that exists with the current voluntary outpatient certification program. Therefore, DHCS proposes statutory changes to change the voluntary outpatient certification program to a mandatory certification to provide outpatient SUD services. However, DHCS would maintain the voluntary certification for residential programs and facilities licensed by other departments that choose to include minimum levels of service quality for their SUD treatment services. Although DHCS does not have authority to impose a mandatory certification on providers who are licensed by other departments, maintaining a voluntary certification, for this provider group only, would allow those providers to continue to meet County or insurance carrier requirements. Mandatory certification and oversight for outpatient SUD facilities would grant DHCS with the necessary statutory and regulatory authority to verify facility compliance with applicable laws and would establish robust oversight mechanisms germane to licensure and in place today for residential SUD licensure requirements, such as criteria for acceptable facility performance, application and licensing requirements, structural

requirements, program inspections, administrative actions such as certification termination, revocation or denial, and program appeal rights.

Mandatory certification for SUD outpatient programs would close a major gap in oversight of California's SUD treatment system by providing DHCS the appropriate authority to further ensure quality of care and patient safety across the entire SUD treatment continuum of care. However, if the resources and fee increases proposed in this BCP are denied, DHCS will be unable to implement these new requirements and strengthen oversight and compliance.

STAFF COMMENTS/QUESTIONS

The 2022 Governor's Budget included a similar proposal to increase the licensing rates for SUD facilities, and it was not supported by the Legislature due to concerns about the financial impact the fee increase would have on many struggling facilities. The Legislature urged DHCS to work with providers to develop a sustainable, long-term financing system that is not likely to put providers out of business, thereby further reducing access to SUD services.

The Subcommittee requests DHCS present this proposal and requests CAADPE share the concerns of providers. Please also respond to the following:

1. What impact will the proposed 75% increase in licensing fees have the quantity of SUD providers?

2. Is DHCS concerned about the potential reduction in the number of providers that may result from a 75 percent licensing fee increase?

3. Has DHCS collaborated with providers to develop this proposal?

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for additional discussion and consideration, and recommends urging DHCS to consider a phased increase in licensing fees along with alternative financing schemes for this program.

ISSUE 29: DHCS: DRUG MEDI-CAL CLAIMING TIMELINES TRAILER BILL

PANEL

- **Tyler Sadwith**, Deputy Director Behavioral Health, DHCS
- **Michelle Cabrera**, Executive Director, CBHDA
- **Nathanael Williams,** Finance Budget Analyst, DOF
- **Guadalupe Manriquez,** Assistant Program Budget Manager, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS proposes to change the Drug Medi-Cal claim timeliness from six months to twelve months to create parity and be consistent with the claim timeliness requirements for Medi-Cal fee-for-service (FFS), Specialty Mental Health Services (SMHS) and federal regulations.

The proposed language can be found here:
https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/831

BACKGROUND

The Administration provided the following background information:

Existing law requires claims for reimbursement of Drug Medi-Cal services to be submitted within six months after the date of service (Welfare and Institutions Code (W&I Code), Section 14021.6(g)). DHCS allows the submission of Drug Medi-Cal claims after six months if they meet the good cause criteria as outlined in state regulations (California Code of Regulations, Title 22, Section 51008.5). If a Drug Medi-Cal provider needs additional time, the following steps would occur: 1) the provider would submit a request to DHCS; 2) DHCS would review and approve the request; 3) upon approval, DHCS would issue a delay reason code to the provider; and 4) the provider would submit the claim with the delay reason code. This time intensive review process further delays reimbursement of claims.

Federal regulations require providers to submit claims within twelve months (Code for Federal Regulations (CFR), Title 42, Section 447.45(d)). Claiming requirements for Medi-Cal FFS and SMHS currently allow claims to be submitted within 12 months after the date of service.

DHCS is proposing to allow providers to submit claims for Drug Medi-Cal services within twelve months instead of six months after the date of service to create parity and be consistent with the claim timeliness requirements for Medi-Cal FFS, SMHS and federal regulations, which would provide Drug Medi-Cal providers additional time to submit claims and reduce DHCS and county workload associated with late claim approval requests.

DHCS states that:

- The proposal provides additional time to Drug Medi-Cal providers to submit claims eliminating or greatly reducing delays.

- The proposal reduces DHCS workload because the review and approval process for delayed claims would be reduced.

- The proposal aligns the Drug Medi-Cal Delivery system claim timeliness policy with Medi-Cal FFS, SMHS, and federal regulations which creates parity.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal, and requests CBHDA share any county concerns with this proposal.

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for additional discussion and consideration.

NON-PRESENTATION ITEMS

THERE ARE NO PANELS FOR NON-PRESENTATION ITEMS, HOWEVER ANY ITEM CAN BE MOVED TO PRESENTATION AT ANY TIME BEFORE OR DURING THE HEARING BY ANY MEMBER. AT THE END OF THE HEARING, PUBLIC COMMENT IS WELCOME ON ALL ITEMS ON THE AGENDA, INCLUDING THE NON-PRESENTATION ITEMS.

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 30: HEALTH CARE COVERAGE: MENTAL HEALTH AND SUD: PROVIDER CREDENTIALS (AB 2581) BUDGET CHANGE PROPOSAL

PROPOSAL

DMHC requests 0.5 position and $27,000 in 2023-24, $186,000 in 2024-25, $177,000 in 2025-26 and annually thereafter from the Managed Care Fund to address the requirements of AB 2581 (Salas, Chapter 533, Statutes of 2022).

This request includes consulting funding of $27,000 in 2023-24, $47,000 in 2024-25 and annually thereafter for a clinical consultant to assist in reviewing e-file and routine survey activities related to AB 2581 requirements.

This request also includes $1,000 annually for annual software licensing costs for access to the Necessary Infrastructure Modernization for Business Unified Services (NIMBUS) platform for the new position included in this proposal.

BACKGROUND

The Administration provided the following background information:

AB 2581 adds a new statute to the Knox-Keene Act, Health and Safety Code (HSC) section 1374.197, which requires health plans that provide coverage for MH/SUD treatment and credential health care providers, to complete the credentialing process within 60 days of receiving a completed provider credentialing application. AB 2581 also specifies that a health plan must notify the credentialing applicant within seven days to verify receipt of the application and confirm that their application is complete. The bill also stipulates that the 60-day timeline shall apply only to the credentialing process and does not include contracting completion. All full service health plans and specialized behavioral health plans provide MH/SUD treatment and the bill applies only to the credentialing of providers of those services. The purpose of the bill is to require timely review of mental health providers' qualifications so that health plans and insurers can more quickly add them to their provider networks.

The DMHC shall:

- Annually review health plan documents to ensure compliance with the provisions of AB 2581
- Modify existing plan survey methodologies and tools to meet the requirements of AB 2581
- Revise policies and procedures for compliance with AB 2581

AB 2581 applies to all the full-service DMHC licensed health plans and specialized behavioral health plans that provide MH/SUD treatment and the credentialing of providers of those services. To ensure compliance with the requirements of AB 2581, the DMHC will need to conduct legal research, review provider contracts and policies and procedures, draft formal legal memoranda and review MH/SUD health plan documents to ensure compliance with the provisions of AB 2581.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 31: CARE COORDINATION FOR INDIVIDUALS EXITING TEMPORARY HOLDS OR CONSERVATORSHIPS (AB 2242) BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS, Licensing and Certification Division (LCD), requests 2.0 permanent positions and expenditure authority for $304,000 ($152,000 General Fund (GF) and $152,000 Federal Fund (FF)) for fiscal year (FY) 2023-24 and $286,000 ($143,000 GF and $143,000 FF) for FY 2024-25 and ongoing to implement AB 2242 (Santiago, Chapter 867, Statutes of 2022). These resources will allow DHCS to develop a statewide model care coordination plan (CCP) for implementation by all facilities designated by the counties and approved by DHCS, for the involuntary detainment, evaluation and treatment of adults or minors. Resources will also permit DHCS to coordinate the stakeholder process and provide ongoing technical assistance.

BACKGROUND

The Administration provided the following background information:

DHCS is responsible for the approval of facilities designated by counties throughout the State of California for the purpose of 72-hour treatment and evaluation under the LPS Act and the Children's Civil Commitment and Mental Health Treatment Act of 1988, and Welfare and Institution (W&I) Code sections 5585.50/5585.55, for individuals with mental health conditions.

The LPS Act provides guidelines for handling involuntary civil commitment and treatment of individuals with specified mental health disorders. It authorizes the use of a 72-hour involuntary psychiatric hold in a facility designated by the county and approved by DHCS, of an individual determined to be a danger to themselves or others, or gravely disabled, at the discretion of a designated professional. It also sets forth an existing conservatorship practice under which a conservator can be appointed to a person who is deemed gravely disabled by the court and unable to meet their basic needs for food, clothing, and shelter. Under the current LPS Act conservatorship process, an appointment of a conservator is subject to certain requirements, which may include consideration of the protection of the public, as well as treatment of the person conserved.

Under current law, individuals placed on LPS Act holds receive services including assessment and clinical evaluation, ongoing crisis intervention, or placement for intensive evaluation and treatment. Evaluation consists of multidisciplinary professional analyses of a person's medical, psychological, educational, social, financial, and legal conditions

that may require referrals and linkages to local support systems. Although existing law requires LPS-designated and approved facilities to develop referral plans and aftercare services for individuals exiting a temporary hold or a conservatorship, the legislature has repeatedly proposed legislation to address the lack of coordination among the treatment facilities, county behavioral health departments, courts, and public conservators around the care and treatment provided to individuals detained on involuntary holds and post-holds.

To facilitate adequate continuity of care, AB 2242 was enacted to improve coordination of care and ensure that individuals being released from inpatient services are appropriately transitioned to outpatient services and supports.

AB 2242 requires DHCS to convene a stakeholder group, on or before December 1, 2023, to create a model CCP for the coordination of care for individuals held under a temporary hold or a conservatorship

AB 2242 also requires the model CCP developed by the workgroup be implemented by all LPS-designated and approved facilities. DHCS will need to provide technical assistance and oversight to ensure counties and all statewide LPS-designated and approved facilities successfully implement the provisions stipulated in AB 2242, which will result in a significant increase in workload.

There are currently 190 LPS-designated and DHCS-approved facilities (total beds: 7,133) in California, which include General Acute Care Hospitals, Acute Psychiatric Hospitals, Psychiatric Health Facilities, Crisis Stabilization Units, Skilled Nursing Facilities with Special Treatment Programs, Mental Health Rehabilitation Centers, Correctional Treatment Centers, County Jail Inpatient Units and Veterans' Administration Hospitals.

These resources will allow DHCS to develop a statewide model care coordination plan (CCP) for implementation by all facilities designated by the counties and approved by DHCS, for the involuntary detainment, evaluation and treatment of adults or minors.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 32: ENHANCED LANTERMAN-PETRIS SHORT ACT DATA AND REPORTING (SB 929) BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS requests 10.0 permanent positions and expenditure authority of $2,400,000 ($1,200,000 General Fund (GF); $1,200,000 Federal Fund (FF)) in fiscal year (FY) 2023-24 and $1,560,000 ($780,000 GF; $780,000 FF) in FY 2024-25 and ongoing to implement SB 929 (Eggman, Chapter, 539, Statutes of 2022).

BACKGROUND

The Administration provided the following background information:

DHCS is responsible for the approval of facilities designated by counties throughout the State of California for the purpose of 72-hour treatment and evaluation under the LPS Act and the Children's Civil Commitment and Mental Health Treatment Act of 1988, and Welfare and Institutions (W&I) Code sections 5585.50/5585.55 for individuals with mental health conditions. The LPS Act established several types of short-term holds, including a 72-hour hold that is commonly referred to as a "5150" hold (based on the authorizing W&I Code Section 5150) that allows a peace officer or other specified individual to commit a person for an involuntary detention of up to 72 hours for evaluation and treatment in an LPS designated facility, if that person is determined to be, as a result of a mental health disorder, a danger to self or others, or gravely disabled. The peace officer or other specified individual, who initially detains the individual, must determine and document that the individual meets this standard.

Once the initial 5150 assessment is completed, and the determination is made that an individual should be transported to an LPS designated facility for further evaluation and treatment, a second assessment (5151 assessment) must be performed by the professional in charge of the facility, or his or her designee, to determine whether the initial determination of the 5150 hold is valid and whether the person should in fact be admitted for evaluation and treatment. During the 5151 assessment, it is also determined whether the individual is willing and able to consent to evaluation and treatment, or whether the person should be held involuntarily under the 72-hour/5150 hold. Under the LPS Act, when a person, as a result of a mental health disorder, is a danger to others, or to themselves, or gravely disabled, they may be involuntarily detained for assessment, evaluation, or treatment. The LPS Act allows for additional involuntary holds pursuant to 5250, 5260, 5270, 5300 and 5352 if the individual meets specified criteria and may result in the establishment of a conservatorship. Collectively, these holds are referred to as LPS Act holds.

SB 929 mandates the collection of additional comprehensive data to determine what is working well and help identify best practices pertaining to the implementation of the LPS Act. SB 929 also identifies what is not working well. Additionally, SB 929 imposes the collection of data to provide helpful information in evaluating the services and strategies currently utilized and allow the state to improve outcomes for those who are served.

The intent of SB 929 is to expand existing DHCS data collection and reporting requirements to address data deficiencies in the collection of critical information pertaining to involuntary detentions under the Lanterman-Petris-Short (LPS) Act. Key changes to LPS data collection and the required annual report includes the requirement for each entity involved in implementing Section 5150 to provide the required data elements and for DHCS to conduct an analysis and evaluation of the data submitted to determine if it is in alignment with legislative intent.

SB 929 mandates the collection of additional comprehensive data to determine what is working well and help identify best practices pertaining to the implementation of the LPS Act. SB 929 also identifies what is not working well. Additionally, SB 929 imposes the collection of data to provide helpful information in evaluating the services and strategies currently utilized and allow the state to improve outcomes for those who are served.

DHCS will collect and analyze LPS Act data and work towards meeting the goals set forth by SB 929 by:

- Ensuring that the criteria for involuntary detention for those who are a danger to self or others or gravely disabled, due to a mental health condition, and criteria for conservatorship, are consistently implemented by counties;
- Identifying different approaches between counties in implementing the LPS Act;
- Determining funding sources utilized for involuntary holds and whether funding is a barrier to implementing the LPS Act; and,
- Determining the availability of treatment resources in each county.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 33: CHILDREN'S PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (AB 2317) BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS requests 15.0 permanent positions, and expenditure authority of $2,565,000 ($1,223,000 General Fund (GF) and $1,342,000 Federal Funds (FF)) in Fiscal Year (FY) 2023-24, $2,639,000 ($1,262,000 GF and $1,377,000 FF) in FY 2024-25 and ongoing, and corresponding statutory changes to implement AB 2317 (Ramos, Chapter 589, Statutes of 2022).

BACKGROUND

The Administration provided the following background information:

AB 2317 requires DHCS to establish and oversee a new licensing category, Psychiatric Residential Treatment Facility (PRTF), for children and youth requiring inpatient psychiatric services in order to promulgate regulations and to develop and requires DHCS to implement policies and processes related to the PRTF licensing on-site review operations, clinical practice standards, treatment modalities and provide legal consultation and opinion.

Over the last several years, the legislature has repeatedly proposed legislation to address the need for greater PRTF service options for children and youth. In 2015, former Governor Brown directed California Department of Social Services (CDSS) and DHCS to work with county behavioral health directors and children's advocates to develop a more viable solution to the acute shortage of residential programs that provide psychiatric treatment services for children and youth. The outcome of that collaboration resulted in establishing the Short-term Residential Therapeutic Program (STRTP) licensure category.

However, the Centers for Medicare & Medicaid Services (CMS) determined that STRTPs cannot be exempted from Institute for Mental Disease (IMD) determination and required DHCS to conduct IMD determination reviews of all STRTPs by December 31, 2022, to determine whether STRTPs are eligible to claim federal financial participation (FFP). DHCS anticipates some STRTPs in California may be categorized as IMDs. Once an STRTP is designated as an IMD, it will result in a complete loss of Medi-Cal funding for any children placed in those facilities. This funding loss is anticipated to result in the closure of STRTP facilities and cause a severe shortage of residential treatment options for children with the most significant psychiatric needs. The IMD exclusion does not apply to inpatient psychiatric services provided to people under age 21, and the establishment of the PRTF licensure category can provide children and youth with the greatest needs will have sufficient access to inpatient psychiatric services in a non-hospital setting.

According to CMS, a PRTF is any non-hospital facility with a provider agreement with a state Medicaid agency that provides inpatient services benefit to Medicaid-eligible individuals under the age of 21. The facility must be accredited by the Joint Commission or any other accrediting organization with comparable standards recognized by the state.

AB 2317 establishes PRTFs as a new category of publicly or privately owned residential health facilities licensed by DHCS. PRTFs would be required to have a provider agreement with a state Medicaid agency to provide active treatment in an inpatient level of care to individuals under 21 years of age in a residential setting. AB 2317 requires DHCS to collaborate with CDSS and other stakeholders to establish regulations and certifications consistent with Medicare and Medicaid regulations to maximize FFP. Additionally, AB 2317 requires PRTFs to conform with existing laws pertaining to aftercare plans, confidential information sharing, background checks, seclusion and restraint, serious and unusual occurrences, and judicial review of placement of patients in PRTFs.

PRTFs will provide inpatient psychiatric treatment services to vulnerable children and youth requiring active treatment in an inpatient level of care. Until now, children and youth in mental health crisis have primarily turned to emergency rooms, where they have long stays due to lack of placement options or transfer to distant facilities for treatment.

With the proper resources to implement AB 2317, DHCS can verify a comprehensive array of services to the continuum of care available for children, including foster youth, who need such services in a residential setting. The addition of PRTFs in California expands access to treatment for high-need children, including foster youth, requiring active treatment in an inpatient level of care resulting in an increase in mental health bed capacity. Per CMS, inpatient psychiatric services for individuals under 21 is a Medicaid benefit as provided by the Social Security Act section 1905(a)(16). The provision of these services is an optional benefit for individual states. Although a state may choose whether to offer these services in a PRTF, the benefit must be provided in a PRTF by all states to those individuals who are determined, during the course of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), to need inpatient psychiatric care in a PRTF. Under the EPSDT provisions in the Social Security Act section 1905(r)(5), states must provide any service listed in section 1905(a) that is needed to correct or ameliorate defects and physical and mental conditions discovered by EPSDT screening services, whether or not the service is covered under the state plan. The treatment services offered by PRTFs will strengthen local capacity to stabilize and treat individuals with mental illness.

DHCS proposes to begin implementation of the licensing PRTF requirements no later than July 1, 2023. In order to meet this implementation date, DHCS will need to establish PRTF licensing programmatic standards through information notices, all-county letters, or similar instructions until regulations are developed, on or before December 31, 2027.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 34: SPECIALTY MENTAL HEALTH SERVICES: FOSTER YOUTH PRESUMPTIVE TRANSFER (AB 1051) BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS Medi-Cal Behavioral Health Division (MCBHD), and Data Analytics Division (DAD) request 5.0 permanent positions and expenditure authority of $764,000 ($382,000 General Fund (GF); $382,000 Federal Fund (FF)) in fiscal year (FY) 2023-24, and $719,000 ($360,000 GF; $359,000 FF) in FY 2024-25 and ongoing, to implement AB 1051 (Bennett, Chapter 402, Statutes of 2022).

BACKGROUND

The Administration provided the following background information:

AB 1051 seeks to assist foster children placed in a group home, community treatment facilities (CTFs), Children's Crisis Residential Programs (CCRPs), or short-term residential therapeutic programs (STRTP) outside of their county of original jurisdiction, access Specialty Mental Health Services (SMHS) in a timely manner, consistent with their individual strengths and needs, and with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and SMHS requirements, as required by AB 1051.

Pursuant to Welfare and Institutions Code (WIC) Section 14717.1, it is the intent of the Legislature to secure that foster children who are placed outside of their county of original jurisdiction are able to access SMHS in a timely manner, consistent with their individual strengths and needs and the requirements of federal EPSDT services.

WIC Section 14717.1 defines "Presumptive transfer" as the requirement that, absent any exceptions as established by current law, responsibility for providing or arranging for SMHS promptly transfer from the county of original jurisdiction to the county in which the foster child resides, under certain conditions, as specified.

Under existing law, responsibility to authorize and pay for SMHS provided to all foster youth placed outside of their county of original jurisdiction is presumptively transferred from the Mental Health Plan (MHP) in the county of original jurisdiction to the MHP in the county of residence, unless presumptive transfer is waived.

When presumptive transfer occurs, the MHP in the county of original jurisdiction may make payments to the out-of-county provider under an existing contract, or the county may enter into a comprehensive contract with the out-of-county provider. However, if the MHP in the county of original jurisdiction and the out-of-county SMHS provider do not have a contract, and do not agree to enter into a comprehensive contract, the MHP in the county of original jurisdiction and the MHP in the county of residence may enter into an

agreement through which the MHP in the county of residence would reimburse the SMHS provider through an existing contract and the MHP in the county of original jurisdiction would reimburse the MHP in the county of residence the non-federal share of those payments.

The differences between the presumptive transfer requirements that MHPs are currently held to, and those pursuant to AB 1051, are as follows:

- AB 1051 defines "foster child" to mean Medi-Cal eligible children up to 21 who have been placed in foster care.
- AB 1051 prohibits presumptive transfer for SMHS provided to foster children placed in group homes, CTFs, CCRPs, or STRTPs outside of their counties of original jurisdiction, unless a specified exception is invoked.
- AB 1051 specifies a 30-day timeframe for the MHP in the county of original jurisdiction and the MHP in the county of residence to enter into an agreement for payment of services should no contract or payment agreement exist between the MHP in the county of original jurisdiction and the SMHS provider.
- AB 1051 requires DHCS to promulgate regulations by July 1, 2027.
- AB 1051 requires DHCS, if necessary, to seek approval from the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) before implementing the provisions of this bill. If DHCS finds it is necessary to seek federal approval, DHCS would be permitted to work with CMS to make any initial federal requests and is required to do so by July 1, 2024.
- AB 1051 requires DHCS and CDSS to collect specified information on the receipt of SMHS by foster children placed out-of-county and requires that this information be included in DHCS' Medi-Cal SMHS performance dashboard, in compliance with state and federal confidentiality laws.

The requested resources are needed to lead policy development related to the bill's updated presumptive transfer law that ensures that foster children who are placed outside of their county of original jurisdiction for a short time-limited placement are able to access SMHS in a timely manner. The requested resources will also help ensure timely access and transition of care/continuity of care requirements, provide technical assistance to Managed Care Plans (MCP) as needed, and track and monitor the receipt of SMHS by foster children who are placed outside of their county of original jurisdiction.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 35: HEALTH CARE COVERAGE: MATERNAL AND PANDEMIC-RELATED MENTAL HEALTH CONDITIONS (SB 1207) BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS, Managed Care Quality and Monitoring Division (MCQMD) requests 2.0 permanent positions of $310,000 ($155,000 General Fund (GF); $155,000 Federal Fund (FF)) in fiscal year (FY) 2023-24 and $292,000 ($146,000 GF; $146,000 FF) in FY 2024-25 and ongoing to implement the provisions of SB 1207 (Portantino, Chapter 618, Statutes of 2022).

BACKGROUND

The Administration provided the following background information:

Pursuant to the Affordable Care Act, MCPs are federally required to cover preventive services, including those related to maternal mental health, in accordance with United States Preventive Services Taskforce (USPSTF) grade A or B recommendations, without cost sharing. The USPSTF has currently assigned a grade of B to the following depression screening recommendation, which includes pregnant and postpartum women:

- The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to verify accurate diagnosis, effective treatment, and appropriate follow-up.

Another USPSTF grade B recommendation is for preventive interventions for perinatal depression, and also includes pregnant and postpartum women:

- The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.

In addition, the California Medicaid State Plan requires the coverage of additional preventive services for women as recommended in the federal Health Resources & Services Administration-supported Women's Preventive Services Guidelines. This coverage is a federally mandated essential health benefit under the Medi-Cal program. Current recommendations related to maternal mental health include screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, as well as screening and counseling for interpersonal and domestic violence.

Prior to this bill, the maternal mental health program requirements outlined in Health and Safety Code Section 1367.625 only applied to Knox-Keene licensed health plans and were implemented, overseen and regulated by the Department of Managed Health Care (DMHC). This bill expanded the requirements, making them applicable to all MCPs, including County Organized Health Systems (COHS), to the extent they are federally permissible, thereby resulting in new implementation and oversight activities for DHCS. DHCS needs staffing resources to develop the requirements for the new maternal mental health program, consistent with current federal requirements for preventive care, to verify continued receipt of federal approvals and federal financial participation; provide policy guidance and technical assistance to MCPs; develop any necessary monitoring tools; and to conduct initial and ongoing monitoring to verify MCPs are meeting, and continue to meet the requirements of SB 1207.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 36: MEDI-CAL MANAGED CARE PLANS: MENTAL HEALTH BENEFITS (SB 1019) BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS, Quality and Population Health Management (QPHM) requests 5.0 permanent full time positions and expenditure authority of $1,443,000 ($722,000 General Fund (GF); $721,000 Federal Fund (FF)) in fiscal year (FY) 2023-24 and $2,098,000 ($1,049,000 GF; $1,049,000 FF) in FY 2024-25 and ongoing to meet the expanded workload created by SB 1019 (Gonzalez, Chapter 879, Statutes of 2022).

BACKGROUND

The Administration provided the following background information:

As part of SB 1019, starting no later than January 1, 2025, Medi-Cal Managed Care Plans (MCPs) are required to conduct annual outreach and education to members regarding mental health benefits covered by the MCP, pursuant to existing law. This service will be based on a plan that the MCP develops and submits to DHCS, upon approval of the MCP's Population Needs Assessment (PNA). The outreach and education plan shall be informed by the MCP's stakeholder engagement, the MCP's PNA, and an assessment of utilization of covered mental health benefits by race, ethnicity, language, age, sexual orientation, gender identify, and disability. SB 1019 requires that the MCP submit this utilization assessment to DHCS, and requires each MCP to publicly post, on its internet website and in an accessible manner, its approved outreach and education plan, as well as its utilization assessment, excluding any personally identifiable information.

DHCS is required to review the annual outreach and education plans submitted by each MCP and approve or modify each plan, within 180 calendar days of submission, to verify standards are met and subject to the department's approval. SB 1019 requires DHCS, once every three years, to assess member experience with MCP-covered mental health benefits.

DHCS must consult with stakeholders, which are representative of diverse racial and ethnic communities, to develop the standards by which outreach and education plans are reviewed and approved.

SB 1019 requires DHCS, once every three years, to assess enrollee experience with mental health benefits covered by MCPs. Starting no later than January 1, 2025, DHCS shall adopt survey tools and methodologies.

DHCS is required to post the first triannual report on consumer experience with MCP-covered mental health benefits in April 2026, and once every three years thereafter. DHCS plans to report the 2025 ECHO survey data in the 2024-2025 External Quality Review Technical Report that will be published by April 30, 2026.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 37: ATASCADERO: SEWER AND WASTEWATER TREATMENT PLANT BUDGET CHANGE PROPOSAL

PROPOSAL

DSH requests $1,038,000 General Fund for the working drawings phase to provide upgrades to the sewer collection system, installation of a screening system, and connection to the City of Atascadero's wastewater treatment system. DSH-Atascadero's existing Wastewater Treatment Plant (WWTP) currently serves approximately 1,150 patients and approximately 2,000 employees. Total project costs are estimated at $15,331,000, including preliminary plans ($4,069,000), working drawings ($1,038,000), and construction ($10,224,000). The construction amount includes $8,142,000 for the construction contract, $570,000 for contingency, $783,000 for architectural and engineering services, and $729,000 for other project costs. The current project schedule estimates preliminary plans will be completed in March 2024. Working drawings are scheduled to begin in April 2024 and will be completed in December 2025. Construction is scheduled to begin in January 2026 and will be completed in June 2027.

BACKGROUND

The Administration provided the following background information:

DSH-Atascadero has not made significant improvements to its sewer collection and wastewater treatment plant (WWTP) since its commissioning in the early 1950s. After a condition assessment of the WWTP and analysis of the new Central Coast Regional Water Quality Control Board (CCRWQCB) General Order for Waste Discharge Requirements (WDR), it was determined the existing 70-year-old WWTP treatment processes will not comply with the mandates of the new WDR. Other WWTP deficiencies include improper flow rates, complicated by inadequate treatment capabilities.

The existing WWTP is unable to meet the requirements of the WDR, which limits the effluent (liquid waste) discharge to settling ponds. The contractor performing the study made several site visits to observe, evaluate and document the physical condition of the entire WWTP facility, including the site infrastructure, buildings, concrete structures, instruction, and equipment.

Historic WWTP daily and hourly flows were analyzed to develop the existing and future collection system flows and peaking factors and were used to evaluate infiltration and inflow (I/I) in the collection system. The Annual Average Daily Flow (AADF) is currently 0.169 and the Future Flow is 0.202 million gallons per day.

Additionally, the State Water Resources Control Board has the authority to shut down the WWTP until DSH complies with the requirements. The discharge of waste is a privilege, not a right, and authorization to discharge is conditional upon compliance with the provisions of Division 7 of the California Water Code as well as any more stringent effluent limitations necessary to implement water quality control plans, to protect beneficial uses, and to prevent nuisance. Completion of this project would comply with this order and would mitigate any potential adverse changes in water quality or fines imposed. Due to the many existing 70-year-old WWTP deficiencies summarized above, complicated by inadequate treatment capabilities, upgrading the existing WWTP to meet the new WDR is not a viable alternative, i.e., the existing WWTP cannot be effectively retrofitted.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 38: DEPARTMENT OF GENERAL SERVICES STATEWIDE SURCHARGE ADJUSTMENTS BUDGET CHANGE PROPOSAL

PROPOSAL

DSH requests $1.9 million in General Fund in Fiscal Year (FY) 2023-24 and ongoing to address ongoing increased costs due to the Department of General Services (DGS) Statewide Surcharge.

BACKGROUND

The Administration provided the following background information:

DGS functions as business manager for the State of California. They provide a variety of services to State departments, such as facilitation of procurement, management of state owned and leased real estate, management of the state's vehicle fleet and development of building standards. DGS funds its operations through fees charged to client departments.

The DGS Statewide Surcharge was introduced, per Budget Letter (BL) 04-14 for FY 2005-06 as a more equitable method of recovering costs associated with central services delivered by DGS. Examples of some of these services include State Capitol security, and maintenance of Capitol grounds, Legislative office buildings, Governor's office space, and Legislators' office space, and coordinating legislative and Governor's office work orders. The DGS Statewide Surcharge methodology was revised per BL 06-26 to better align charges and to exempt federal funding as a means to pay the surcharge costs.

The DSH appropriation for the DGS Statewide Surcharge has not changed since implementation however, the fees have increased year over year. The resource table below reflects the actual cost increases for the last four prior years and the projected costs for 2022-23 based on these trends. This request will provide the difference between the 2013-14 and 2023-24 fiscal years.

Currently, any increase in surcharges and fees must be absorbed by the Department. Every time a fee in increased, the Department must reduce its other activities and services to cover the charge. Since DSH is one of the larger California state departments, the current methodology of allocating fees based on authorized positions translates to DSH having a larger surcharge and fee amount. While other State departments experience similar fee increases, the magnitude of the impact on DSH is greater. In FY 2013-14, DSH's portion of DGS' Statewide Surcharge was roughly $1.7 million, to which it has grown to roughly $3.1 million in FY 2021-22.

Over the past 10 years, DSH has increased by over 3,000 positions and this surcharge is based on position count. DSH has not received a budget adjustment for the statewide surcharge since FY 2005-06. This proposal provides sufficient funding for the increase that has occurred between FY 2013-14 and the projected cost in FY 2023-24.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 39: ELECTRONIC HEALTH RECORDS PLANNING BUDGET CHANGE PROPOSAL

PROPOSAL

DSH requests $21.5 million General Fund and 40.2 positions in Fiscal Year (FY) 2023-24, and $22.3 million General Fund and 58.0 positions ongoing to complete remaining planning activities, complete the System Integrator procurement and initiate the activities needed for the transition into implementation of the Continuum Electronic Health Record (EHR) System.

BACKGROUND

The Administration provided the following background information:

EHR systems have become a healthcare industry standard supporting the successful foundation to operate a hospital organization. These systems maximize the availability of patient information to all health care providers at any time needed, eliminating the delay or loss of valuable medical information which avoids interference in providing quality care and increases the efficiency of managing complex patient treatment pathways.

Resource History from Prior Budget Acts

- In the 2018 Budget Act, the DSH EHR BCP1 was authorized for $1.3 million and 4.0 limited-term positions in FY 2018-19 and $713,000 in FY 2019-20 to continue Stages 3 and 4 of the Project Approval Lifecycle.
- In the 2020 Budget Act, DSH EHR BCP2 was authorized for $2.4 million and 4.0 positions in FY 2020-21, $3.2 million and 8.0 positions in FY 2021- 22, $6.1 million and 18.0 positions in FY 2023-24 and $3.5 million and 18.0 positions in FY 2024-25 and ongoing to continue planning and procurement of the EHR. This funding supports the activities required by the State's Project Approval Lifecycle (PAL) Stage Gates 3 and 4, which includes procurement of the solution.
- In the 2022 Budget Act, DSH EHR BCP3 is authorized for $2.4 million General Fund and 6.0 positions in FY 2022-2023, $19.8 million and 8.0 positions in FY 2023-24, $20.8 million and 10.0 positions in FY 2024-25, and $8.2 million and 10.0 positions ongoing beginning in FY 2025-26 to prepare for and support the operation of the enterprise Continuum Electronic Health Record (EHR) Project, primarily to upgrade the Wireless Local Area Networks at all five hospitals.
- Also in the 2022 Budget Act, DSH received a reappropriation of funding from FY 2021-22 and an extension of the encumbrance/expenditure period until June 30, 2024, to continue the implementation phase of the Pharmacy Modernization project. In addition, DSH will receive $3.2 million in FY 2023-24, $3 million in FY 2024-25, $2.9 million in FY 2025-26 and $1.2 million in FY 2026-27 to complete the implementation phase at all hospitals and to cover initial maintenance and operations costs. The Pharmacy Modernization project addresses the need to

replace the current, manual processes used for inventory control, medication dispensing and security of controlled drugs. This will be accomplished with the implementation of automated, integrated systems, re-architecture of the pharmacy application environment, and equipment with standardized practices across the DSH system. The re-architecture of the Pharmacy application environment consolidates the five hospital systems and will provide a single connector for future use by the Department's proposed Electronic Health Record system.

Project Approval Lifecycle History

In 2017, DSH initiated the EHR project with submittal of its Project Approval Lifecycle (PAL) Stage One Business Analysis (S1BA) to CDT. The S1BA package was approved by CDT in November of 2017. Subsequently, DSH submitted its Stage 2 Alternatives Analysis (S2AA) package which was approved by CDT in April of 2021.

Currently, DSH has completed Stage 3 Solution Development (S3SD) documentation and anticipates CDT approval early in 2023 which would enable the EHR procurement to begin prior to the end of FY 2022-23, paving the way for vendor selection and contract award early in FY 2024-25. In concert with PAL activities, DSH has focused on readiness initiatives designed to support the project and mitigate risks that potentially threaten project objectives and success. These activities focus on:

Upgrading WLANs in all five hospitals

DSH has retained a contractor to assess the WLAN infrastructure at each of the five hospitals. The contractor will make recommendations for improvements that allow for increased EHR network traffic while preserving the capacity to meet existing demands. Once the assessment is complete at each of the five hospitals sequentially, DSH will contract for WLAN upgrade services. DSH is currently in progress of the procurement for DSH-Coalinga for such services and expects to begin implementation of the WLAN access points in March of 2023, with the remaining hospitals to follow consistent with the rollout of the sequencing of the EHR system.

Data Architecture and Integration

The core of DSH data is currently housed in an outdated and cumbersome mainframe systems developed in the 1980's. These systems are completely dependent on architectures and technology foundations developed well over 30 years ago. Primary among these systems is the mainframe Admission Discharge Transfers (ADT) application. ADT ensures patients are admitted, moved, and discharged and serves as the primary data store of the patient record for DSH.

DSH has several other legacy systems running like ADT, each with their own direct connections that populate patient data to and from each other. Each of these connections are then running via slightly different legacy codebases and technologies which are much older, less secure communication mechanisms than what is available today. Each

connection is difficult to maintain and will require considerable work to enable communication via standard modern data exchange formats.

The data within these legacy systems is buried inside aged and unsupported software, locked into original and poorly structured formats not designed for the needs of a modern hospital system. Being locked into this legacy format impedes modern data analytics, makes integration difficult and conformance to healthcare interoperability standards requires expensive workarounds to achieve.

In FY 2021-22, DSH contracted with a data consulting firm to analyze the state of DSH legacy data and make recommendations on how best to utilize the data in the new HER system. The assessment was completed in July 2022, allowing DSH to partner with CDT in the development of the data architecture and integration contract. DSH will contract with another provider utilizing the results of the analysis and recommendations in the spring of FY 2022-23. The focus of these roles will provide recommendations, guidance, and support with respect to data activities; profiling, standardization, cleansing, conversion, migration, integration, cloud integration, and data governance required for the Continuum-HER project.

The EHR Project Team is composed of a mixture of state staffing and consultant resources. This mix is needed to meet all on-going project implementation, planning, administrative, contracts, project management, technical, architecture, program, business, organizational change management, communication, training (enterprise and local), and coordination activities. This proposal requests funding to align state staff to be reflective of current and expected project needs. Obtaining state staff with the appropriate knowledge, experience and skills is critical to meet the technical complexities required for this project and ensure overall success. Embedding requested state staff in the project will also ensure retention of project knowledge, as well as increase project efficiencies because internal resources have deep familiarity with hospital, department, and state business practices. Assigning state staff to the project will increase the likelihood of long-term sustainment of organizational change brought by implementation of the EHR system.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 40: INCREASED COURT APPEARANCES AND PUBLIC RECORDS ACT REQUESTS - CONTINUATION OF FUNDING BUDGET CHANGE PROPOSAL

PROPOSAL

DSH requests $847,000 General Fund (GF) to support 5.5 positions, ongoing, that were included in the 2021 Budget Act with limited-term funding which expires in June 2023. This funding is to support the permanent positions needed to address the sustained increase in workload of court hearings at which DSH attorneys are required to appear throughout the state and the sustained increase in workload of Public Records Act (PRA) requests to which DSH must respond.

BACKGROUND

The Administration provided the following background information:

In recognition of prior substantial growth in workload, including the number of hearings, court appearances, and responses related to the IST population and associated litigation, the 2019 Budget Act included limited term resources for the Legal Division (LD). Workload continued to increase, and the 2021 Budget Act renewed the funding temporarily and converted the positions from limited term to ongoing.

Court Appearances

Over the last decade, the State of California has seen significant growth in the number of individuals found Incompetent to Stand Trial (IST) on felony charges. The year-over-year growth in this commitment type to the DSH has outpaced the Department's ability to create additional capacity in its system despite recent efforts including increased inpatient bed capacity, decreased average length of stay, and implementation of county-based treatment programs, leading to a large waitlist and long wait times for IST defendants pending DSH placement. Furthermore, the impacts of the COVID-19 pandemic and infection control measures required at DSH facilities such as creating Isolation units and admission observation units, caused slower admissions and reduced capacity for the treatment of felony ISTs at DSH's hospitals.

DSH statutorily must provide reports to the committing criminal court within 90 days of a patient's commitment order, advising the court whether it is likely or not that a patient will regain competency, so they can be returned to court and stand trial, or if the court should order continued competency treatment. As the IST waitlist grew, the timelines for admission to DSH increased, with many patients not being admitted for competency treatment until shortly before the statutorily-required 90-day report, or later. While the waitlist and admission timelines have trended down in recent months from their high point early in 2022, for some patients they can still exceed 90 days. Consequently, the superior courts have questioned the amount of time ISTs wait in county jail before they are

admitted to DSH to receive competency restoration treatment and returned to trial. As a result of the ongoing waitlist of IST patients, DSH has experienced a significant amount of court appearances and litigation.

DSH attorneys must respond, object, appear, or serve as staff counsel to represent DSH in each of these types of motions, status conferences, OSCs, standing-order requests, writs, and civil-rights litigation. The courts oftentimes provide DSH less than one-week notice that they must appear to defend DSH against an OSC, and it is not uncommon for DSH to be provided only 24 or 48-hour notice of a contempt hearing.

YEAR	# OF MATTERS APPEARED IN
2014	1,730
2015	1,871
2016	3,117
2017	3,614
2018	3,972
2019	2,112
2020	1,943
2021	2,797
2022*	2,951

*Projected End of Year Appearance based on data through October 2022.

In calendar year 2021, there was a 43 percent increase in the number of court appearances over calendar year 2020 signifying the sustained increase in workload. These appearances require additional attorney time and manager guidance and oversight of attorneys, especially considering recent cases addressing the admission of IST patients.

The California Public Records Act

The California Public Records Act (Government Code 6250 et seq) (PRA) provides a fundamental right of access to government information. Under the PRA, all government records shall be disclosed to the public, upon request, unless there is a legal basis not to do so. The PRA defines public records as “any writing containing information relating to the conduct of the public’s business prepared, owned, used, or retained by any state or local agency regardless of physical form or characteristics.” Every person has a right to inspect any public record and requests can be made in writing, orally, in person or by phone. Records must be produced promptly to requestors and an agency must respond no later than 10 calendar days from the receipt of the request to notify the requester whether records will be disclosed. An agency may extend the 10-day response period for up to 14 additional calendar days to search for and collect the request records from field offices, to search for, collect and examine a voluminous amount of separate and distinct records requested in a single request; to consult with another agency having a substantial

interest in the request; or to compile data, write programming language, or construct a computer report to extract data for electronic records.

If the Superior Court finds that an Agency has withheld requested records, it must award the plaintiff attorneys' fees and costs. If an agency loses a public records case, it has no right to appeal to the Court of Appeal (although the requester may appeal a court decision upholding denial). Instead, it may petition the Court of Appeal for a writ of mandate, a form of appellate review that allows the appellate court discretion whether or not to hear the matter. Section 6259(c). The California Supreme Court upheld this seeming unfairness as an expression of the Legislature's preference for public access to government information. (Filarsky v. Superior Court, 28 Cal.4th 419 (2002)).

There has been an increase in the number of PRAs and subpoenas from 2020 to 2021. In 2020, DSH received over 733 PRAs and subpoenas, and in 2021, DSH received over 834 PRAs and subpoenas.

While this proposal only requests a continuation of funding that has been approved to sustain increased workload for increased court appearances and PRAs, it is anticipated workload will continue to increase related to IST litigation as the Department addresses workload associated related to the Stiavetti v. Clendenin case brought against DSH by the American Civil Liberties Union in 2015 alleging the amount of time IST defendants were waiting for admission into a DSH treatment program violated individuals' constitutional right to due process.

The 2021 Budget Act provided permanent position authority for 5.5 positions and reflected another two-years of funding from the 2019 Budget Act where the resources were originally approved. However, the workload is permanent and over a year later, data through 2022 demonstrates that these high workload levels are not only sustained but increasing, justifying the need to permanently fund the original positions.

As the number of IST referrals outpaced DSH's bed capacity and the waitlist was exacerbated during COVID-19, DSH's legal appearances also increased via the number of OSCs set by the courts to determine status of admissions and/or set an evidentiary hearing to determine whether sanctions should be issued. DSH attorneys have worked on dozens of OSC evidentiary hearings with the Attorney General's Office related to IST admissions or the on-going complex litigation previously mentioned, in addition to appearing in the other OSC appearances identified. The legal landscape of IST-related litigation is fast-paced, complex, and spans almost every county superior court, several district courts of appeal, and federal court, under a variety of different causes of action and legal theories.

In addition to receiving hundreds of PRAs sustained over the past five years, the PRAs that DSH receives have increased significantly in complexity and require more staff time to respond to. Complexity can be driven by a combination of factors including volume (reviewing pages numbering in the hundreds or thousands), time horizon for which data is requested, legal analysis required, privacy issues, etc. The number of hours of workload for the Legal Division related to PRAs has increased significantly due to this increased complexity. Many PRA requests seek complex series of documents such as e-mails, costing and budgeting data, trainings, meeting minutes, facility memos, plans, studies, protocols, data and trends analysis, audits, grants, logbooks, programs, and catalogs.

The nature of PRA requestors is also increasingly changing to plaintiffs' attorneys who may be seeking to utilize publicly available information to bring litigation against DSH, which necessitates attorney involvement in the response. PRA responses now involve more complex legal issues such as those requiring the assertion of the deliberative process or official information exemptions to protect the agency's internal decision-making, peer-review records wherein doctors evaluate whether fellow physicians met the required standard of patient care, and private patient records. PRA requests such as these require far more involvement by LD attorneys and increase the workload. Even with the additional resources provided in the 2021 Budget Act, DSH is challenged in meeting PRA deadlines and frequently must request extensions or provide rolling responses.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 41: METROPOLITAN: CENTRAL UTILITY PLANT REPLACEMENT BUDGET CHANGE PROPOSAL

PROPOSAL

DSH requests $1,863,000 General Fund for the working drawings phase of the Metropolitan: Central Utility Plant (CUP) replacement. The project includes the replacement of the existing CUP located at DSH-Metropolitan that presently supplies steam for hot water and central heating, as well as chilled water for air conditioning, to 32 patient housing and administrative buildings. Total project costs are estimated at $43,931,000, including preliminary plans ($1,835,000), working drawings ($1,863,000), and construction ($40,233,000). The construction amount includes $32,842,000 for the construction contract, $2,299,000 for contingency, $2,865,000 for architectural and engineering services, and $2,227,000 for other project costs. The current project schedule estimates preliminary plans will be completed by December 2023. Working drawings are estimated to begin in January 2024 and be completed in June 2025. Construction is scheduled to begin in June 2025 and be completed in December 2026.

BACKGROUND

The Administration provided the following background information:

DSH – Metropolitan resides in Norwalk, California. The facility was opened in 1916 to provide care and treatment to California's increasing population of individuals with substance use disorders and serious mental illness. The campus is comprised of approximately 162 acres with 109 on-site structures including patient housing and treatment units, administrative buildings, and warehouses. Approximately 1,530 employees work at DSH-Metropolitan providing around-the-clock care, including psychologists, psychiatrists, social workers, rehabilitation therapists, registered nurses, psychiatric technicians, and other clinical and administrative staff.

Construction of DSH-Metropolitan's existing Central Utility Plant (CUP) was completed in 1988 and provided a net electrical output of 27,800 Kilowatts. The DSH-Metropolitan's CUP was built and operated by Wheelabrator Norwalk Energy Corporation (WNEC) which was contingent upon a long-term Power Purchase Agreement (PPA) between WNEC and Southern California Edison Company (SCE). SCE sent a notice of contract termination to WNEC effective February 2018. Additionally, the plant's space was leased from the state through a Department of General Services (DGS) PPA with WNEC which also expired February 2018 at which time the state then acquired the plant. DSH-Metropolitan's CUP, which is now greater than 30-years old, currently operates the central steam boiler system and chiller plants, underground mechanical, electrical and steam distribution infrastructure, energy management systems, and provides connection to the site's natural gas, water, and sanitary sewer lines. The old, inefficient design of the CUP and age of

the equipment, along with the lack of modern environmental controls, makes future repair and maintenance difficult and extremely costly to maintain the 24/7 operations required of the facility.

Inadequate and deteriorating insulation and extensive leaks in the underground steam piping, limit DSH's ability to operate the CUP in an energy-efficient manner. The original steam and underground piping distribution system was installed in 1915 and up to 20 percent of the steam is lost through leaks and will be replaced with new hot water piping.

DSH is required by the California Code of Regulations to provide comfortable ambient air and water temperatures for patient and staff use. The Joint Commission and California Department of Public Health perform life/safety and licensing compliance reviews on behalf of the Centers for Medicare and Medicaid Services (CMS). Federal reimbursement from CMS is contingent upon DSH compliance with all licensing requirements. Heating Ventilation and Air Conditioning (HVAC) systems that fail to maintain the required interior building temperature range subjects patients to possible elevated body temperatures and, as a result, possible heat related illness. The vast majority of DSH patients are on psychotropic medications, which may impair the body's ability to regulate its own temperature. During hot and humid weather, individuals taking antipsychotic medications are at risk of developing excessive body temperature, or hyperthermia. Individuals with chronic medical conditions (i.e., heart and pulmonary disease, diabetes, alcoholism, etc.) are especially vulnerable.

The demolition and replacement of the CUP will allow the new boilers to meet the commercial duty, low emissions, Southern California Air Quality Management District (SCAQMD) authority to construct and operate the certified equipment. The CUP will provide a centralized solution for system upgrades to increase energy efficiency and improve the resiliency and sustainability of the utility services. The steam and condensate piping will be removed and replaced with heating hot water supply and return piping and the underground tunnels will be used to distribute new hot water around the campus in combination with building chases and new concrete open trenches with removable steel grating bolted down with security bolts.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 42: METROPOLITAN: FIRE WATER LINE CONNECTION TO WATER SUPPLY BUDGET CHANGE PROPOSAL

PROPOSAL

DSH requests $536,000 General Fund for the working drawings phase of the DSH-Metropolitan Fire Water Line Connection project. This project will provide the capacity of water required for the fire sprinkler system to comply with current fire code requirements related to fire flow. During the construction of the Central Kitchen (c. 2010) the State Fire Marshal found that the old existing water storage tanks did not meet the NFPA requirements, specifically neither tank had an NFPA 22 compliant outlet with Anti-vortex plate. The replacement of the existing northerly 750,000-gallon steel tank with a new 1,000,000-gallon dedicated fire water storage tank and connection to fire water line supply will allow the hospital to meet current and future NFPA 22 fire flow requirements. Total project costs are estimated at $10,014,000, including preliminary plans ($548,000), working drawings ($536,000), and construction ($8,930,000). The construction amount includes $7,468,000 for the construction contract, $523,000 for contingency, $694,000 for architectural and engineering services, and $245,000 for other project costs. The current project schedule estimates preliminary plans will be completed in August 2023. Working drawings are scheduled to begin in September 2023 and will be completed in October 2024. Construction is scheduled to begin in November 2024 and will be completed in June 2026.

BACKGROUND

The Administration provided the following background information:

Due to marginal pressure and fire flows serving the new fire sprinkler system at the Central Kitchen, a new fire water line project was started in 2011. The project included laying approximately 2,760 lineal feet of 12-inch diameter dedicated fire main pipe from the existing storage tank site to the Central Kitchen. The new main was connected to the existing 12-inch fire main at the intersection of Balsam and Eighth Streets which serves the existing Skilled Nursing Facility (SNF). A 6-inch connection was provided to the fire main serving the Administration Building.

A 16-inch water line was designed but not constructed from the outlets of both existing 750,000-gallon steel water tanks located northeast of the intersection of Balsam and Ninth Streets. The 16-inch line was routed to a new pumphouse that includes one new 1,500-gallon per minute (GPM) diesel fire pump, one new 1,500 GPM electric fire pump, one new 15 GPM jockey pump, and associated piping and appurtenances. A fire alarm, fire sprinkler, and electrical system was included and constructed in the pumphouse. Provision was also included for a future 2,500 GPM diesel pump and a 2,500 GPM electrical fire pump, all of which are rated for a nominal outlet pressure of 100 PSI.

Close to completion of construction of this project, the State Fire Marshall (SFM) Inspector discovered issues with the existing water storage tanks citing that the equipment did not comply with the fire code. Specifically, the outlets on both tanks did not comply with the requirement of NFPA 22 regarding the provision of an anti-vortex plate on the tank outlet. The project could not be completed, and a dedicated fire water line was not connected from the water tanks to the newly constructed pumphouse resulting in the lack of dedicated fire suppression line throughout the hospital as required by NFPA.

The connection of the fire water line supply to the 1,000,000-gallon water storage tank provides a dedicated fire water storage tank sized to meet current and future campus fire flow requirements thus meeting all fire code and NFPA requirements. This option does not require any interruption or modification to the existing domestic water storage tank or distribution system and will utilize the pumphouse, pumps, etc. already constructed and will meet the design intent of the original project.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 43: SEXUALLY VIOLENT PREDATORS (SB 1034) BUDGET CHANGE PROPOSAL

PROPOSAL

DSH requests $598,000 to support 2.0 permanent, full-time positions and contracted resources in fiscal year (FY) 2023-24, and ongoing, to support new workload for DSH and its contracted CONREP-SVP provider resulting from the passage of Senate Bill (SB) 1034 (Atkins), Chapter 880, Statutes of 2022: Sexually Violent Predators. Effective January 1, 2023, SB 1034 requires DSH to convene for each SVP patient approved for conditional release, a committee of specified county representatives to obtain relevant assistance and consultation regarding securing suitable housing. Additionally, for the court to make a finding of extraordinary circumstances, the bill requires the committed person's county of domicile to petition the court only after specific tasks are completed and specified criteria has been met. These new requirements will result in an increased number of court hearings, task and criteria tracking, reporting requirements, and inter-agency coordination.

BACKGROUND

The Administration provided the following background information:

The Forensic Conditional Release Program (CONREP) is DSH's statewide system of community-based services for specified court-ordered forensic individuals. Sexually Violent Predators (SVP) were added to the CONREP population (Welfare and Institutions Code (WIC) Section 6604) on January 1, 1996. DSH contracts with a provider to provide CONREP services including housing, treatment, and supervision for SVPs. Existing law requires when an SVP patient is conditionally released into the community by court order that they be conditionally released to their county of domicile and sufficient funding be available to provide treatment and supervision services.

The process for SVP conditional release is outlined in detail in WIC Sections 6607-6609. In summary, the process in law is as follows:

In order to enter CONREP, an SVP patient must petition the court in the county which initially committed the individual to DSH for inpatient treatment. An SVP patient may make the petition with or without concurrence from the DSH Director. In the conditional release hearing, the court must determine whether the patient committed would be a danger to the health and safety of others meaning that it is likely that they will engage in sexually violent criminal behavior due to their diagnosed mental disorder if under supervision and treatment in the community. If the court determines that the SVP patient would not be a danger to others due to their diagnosed mental disorder while under supervision and treatment in the community, the court shall order they be placed into CONREP-SVP and the terms and conditions for the patient's participation are set. Apart from the threshold

court finding that the SVP patient will not pose a danger to others if treated in the community, CONREP-SVP involves an intensive regimen of treatment and supervision, including weekly individual contact, group and individual therapy, GPS tracking, surveillance, unscheduled home visits, and regular drug screening. Based on an SVP's individual characteristics, the release conditions can also include polygraph examinations, and anti-androgen medical treatment.

Similar to the general non-SVP program, CONREP-SVP offers patients direct access to an array of mental health services with a forensic focus. Additionally, required services for SVP patients in CONREP include regularly scheduled sex offender risk assessments, polygraph testing, and the review of Global Position System (GPS) data and surveillance. In recent years, DSH experienced significant challenges that impacted the operating cost of CONREP-SVP. The most notable issues include locating appropriate housing and public resistance to the placement of SVP patients within their communities. Once the court orders an SVP patient be released from a state hospital into the community via CONREP, it takes an average of 12 months to secure court-approved housing. To ensure both patient and public safety, at times 24/7 security and monitoring may need to be provided. These have been drivers of cost increases for the program.

There are two types of placements for SVP patients ordered to CONREP: either in a fixed residence or transient. A transient placement typically includes the use of a recreational vehicle or a series of motels that require the individual move between locations periodically. Transient releases are the least optimal placement; they present a variety of challenges, such as an increased risk of non-compliance, decreased ability to implement the treatment plan, increased supervision costs, and the continuous pattern of relocation typically disrupts the patient's stability. SVP patients placed in fixed residences have resulted in better clinical outcomes and overall success in the CONREPSVP program than those SVP patients placed in the community as transient. In fixed residences the environment is stable which allows for optimal external monitoring, lower levels of unpredictable environmental risks, and more time to meaningfully engage in treatment, employment opportunities, and opportunities for safe and effective community reintegration. As the courts approve additional petitions for release, the lack of housing options may result in some SVPs being released into their communities as transient, further increasing program costs.

After the court finds the individual is fit for conditional release, the court orders CONREPSVP to locate a residence for the patient in their county of domicile, which is legally determined by the court. The county of domicile is typically the same county that handles the patient's SVP commitment proceeding. Placements to other counties only occur in extraordinary circumstances when court ordered. The court identifies the county or counties in which CONREP is ordered to search for placement and CONREP does not search in counties outside of the court's ordered locations. Pursuant to WIC 6608.5, "extraordinary circumstances" is defined as circumstances that inordinately hinder the department's ability to effect conditional release of a committed person in their county of domicile in accordance with WIC Section 6608, or any other provision of the article. Prior

to SB 1034, no clear guidelines existed for ordering extraordinary circumstances and it was at the court's discretion when an order of extraordinary circumstances was deemed appropriate.

SB 1034 establishes additional new activities required to occur as part of the processes outlined in WIC Sections 6608 and 6608.5.

Prior to SB 1034, when a suitable placement was not located in the county of domicile, a court could order extraordinary circumstances allowing DSH or its designee to search for housing in a county outside the committed person's county of domicile. After SB 1034 is enacted, it will allow the committed person's county of domicile to petition the court for consideration of extraordinary circumstances only after the following criteria have been met:

1. the county of domicile has demonstrated engagement in an exhaustive housing search within its county, with robust participation from the committee members specified above;
2. the county of domicile has provided a minimum of one alternative placement for consideration and has noticed the district attorney(s) of the alternative placement county or counties and DSH regarding their intention to file a petition for extraordinary circumstances, which is to include the committed person's connection to the proposed alternative county, if applicable;
3. the county of domicile has provided the required information to DSH and the district attorney(s) of the alternative placement county for criteria (1) and (2) above; and
4. DSH and the district attorney(s) of the proposed placement of the alternative county had the opportunity to be heard at a hearing, receiving no fewer than 30-day notice before the date of the hearing.

SB 1034 states that the court shall not order out of county housing searches until the petition for extraordinary circumstances has been granted and that harrowing housing costs is not grounds for a finding of extraordinary circumstances. During the last three FYs, approximately 18 percent1 of SVP patients who have been conditionally released have resulted in placement outside of the patient's county of domicile.

SB 1034 requires DSH to convene, for each SVP patient approved for conditional release, a committee of specified county representatives to obtain relevant assistance and consultation regarding securing suitable housing for the patient. The committee will consist of the counsel for the SVP patient (committed person), the sheriff or the chief of police of the locality for placement, and the county counsel and the district attorney of the county of domicile, or their designees. This results in increased workload and additional staff to convene the committee and to review the criteria for consideration of extraordinary circumstances.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 44: TELESERVICES - VISITATION AND COURT HEARINGS BUDGET CHANGE PROPOSAL

PROPOSAL

DSH requests $2.1 million General Fund (GF) and 15.0 positions in fiscal year (FY) 2023-24 and ongoing to establish permanent resources for managing teleservices for patient visitation and court hearings.

BACKGROUND

The Administration provided the following background information:

During the COVID-19 pandemic, DSH increased reliance on videoconferencing for virtual court appearances and use of video equipment for patient visitations with family, friends, and attorneys. DSH initially implemented and operationalized virtual teleservices (court and visitation) at the beginning of the pandemic when in-person individual or group therapy and interviews were significantly limited which allowed available space and personnel to be repurposed or redirected for these vital teleservices.

Prior to COVID-19, televisitation services did not exist and telecourt appearances were only offered by a small number of courts. The below tables display the monthly pre-COVID-19 levels of telecourt appearances and televisits as well as the level during COVID-19:

Telecourt Appearances

HOSPITAL	PRE-COVID	FY 20-21 monthly avg	FY 21-22 monthly avg
Atascadero	None	208	283
Coalinga	98	225	292
Metropolitan	None	68	36
Napa	18	85	107
Patton	None	83	119

Televisits

HOSPITAL	Pre-COVID	FY 20-21 monthly avg	FY 21-22 monthly avg
Atascadero[1]	None	280	215
Coalinga	None	115	123
Metropolitan	None	143	41
Napa	None	181	77
Patton	None	86	53
[1] Pending updates from Atascadero State Hospital			

As in-person services incrementally continue to resume towards pre-pandemic operational levels, a new demand to provide both in-person and teleservices simultaneously has emerged and is expected to continue into the future. In order to manage the consistent need for teleservices, additional personnel resources are needed. Staff support is needed to fulfill tasks such as coordination of patient scheduling, providing technology support to the patients, visitors, and courts, intervention in a medical/psychiatric emergency during a teleservice appointment, and ensuring the safety of all participants and observers. The number of staff and specific classifications may vary between locations and is attributed to different population types and the unique geographic layouts of each facility. Analytical staff are being requested to perform scheduling for telecourt and visitation, to monitor equipment during both process and to coordinate with the transportation staff. Hospital Police Officers and Psychiatric Technicians are requested to provide patient transportation services and to be present during televisitation and court should any incidents occur

DSH has experienced a significant increase in the use of telecourt across all locations. Telecourt is anticipated to remain a significant model for court appearances because it is effective for the court system, DSH and the patient. For example, telecourt services provide the ability for an entire treatment team to attend a patient's court hearing without significantly impacting treatment delivery. Furthermore, tele court services allows the patient to remain in DSH's hospital, receive continued treatment, and maintain their daily routines while attending a video hearing rather than be transferred back to a jail setting to be housed and risk disruptions to treatment while attending an in-person hearing. Additionally, attending the court hearings from DSH hospitals reduces the chance of transmitting COVID-19 between jails, DSH hospitals, and the courts.

Providing virtual visits for DSH patients allows DSH to continue to provide access to visitors, which is a patient's right, during periods of quarantine and isolation and aligns with departmental goals of holistic and person-centered care. Historically, many patients have endured extended periods of time without, and in some cases, never had a visit from a family member. With televisiting services, family members are able to visit virtually whereas in-person visits may have been geographically, medically, and financially unfeasible. Televisits afford all family and friends the opportunity and means to connect more frequently with patients, and this contact is a valuable therapeutic component for the patient's recovery and rehabilitation. Family involvement and participation in the patient's treatment and discharge planning are important and encouraged.

To quickly implement telecourt and teleservices during COVID-19, staff were temporarily redirected from other off unit areas/services that may have been suspended or have reduced access due to COVID-19 risks or worked overtime to support the workload associated with implementing virtual services. Teleservices workload entails patient escorting, monitoring, scheduling, troubleshooting various virtual court platforms, and de-escalation should the outcome of the hearings yield a difficult decision for a patient or news from family or friends be upsetting to the patient. As DSH continues to adjust to the changing nature of the pandemic and resume the full extent of pre-COVID services such as off-unit group therapy, off-unit patient activities, and other COVID-19 reopening plans, staff will be required to cover their original assignments leaving a significant staffing void for DSH to fill and add further strain on existing staff with the use of overtime. It is important to note that hospital staff responsible for outside transport to courts or outside medical cannot simply be redirected because those services are still required and utilized.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 45: EXTEND FUNDING FOR HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT COMPLIANCE AND ACCOUNTING WORKLOAD, SPRING FINANCE LETTER ISSUE 60

PROPOSAL

DSH requests $615,000 General Fund (GF) in Fiscal Year (FY) 2023-24 to support 5.0 positions that were included in the 2021 Budget Act with limited-term funding which expires in June 2023. This funding is needed to continue processing invoices and payments from external medical providers containing Protected Health Information (PHI) in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

BACKGROUND

The Administration provided the following background information:

In FY 2021-22, DSH processed over 51,000 outside medical invoices and more than 80 percent of these (45,000) contained PHI. DSH patients have unique and acute medical and clinical needs that often times require visits to specific external providers (i.e., specialists, emergency services, etc.). These medical providers' invoices in turn contain a combination of patient information (i.e., patient's name, patient identification number, diagnosis, medical service received, date of service, etc.) to document services rendered to DSH patients. Invoices that contain PHI are governed by mandated HIPAA requirements. Each state hospital receives direct invoices from outside medical providers for services rendered to its patients. Every invoice is adjudicated by designated DSH accounting and program staff.

New electronic systems introduce the need to develop protection measures to prevent exposure of PHI, including auditing and incident response to safeguard internal controls. As noted previously, a significant portion of DSH's invoices contain confidential and sensitive information, including patient data that falls under mandated HIPAA compliance. Security experts estimate data breach costs ranging from $150 to $350 per record. These costs include required fines that the state would pay and services for the individuals impacted that include phone service to answer questions, advertising to publicize the breach, and credit monitoring services if social security numbers (SSN) are involved. A data breach would be detrimental to those whose data is compromised and costly to the State.

In July 2018, the statewide accounting system Financial Information System for California (FI$Cal) was implemented. FI$Cal was not configured to accept PHI and given DSH's approximate annual volume of 45,000 PHI invoices, the risk of information security breaches is high. DSH developed the Medical Claims Processing (MedCP) data base system that allows for HIPAA compliancy while still using FI$Cal to create voucher payments.

Additionally, DSH developed a HIPAA compliant process for procurement, claim adjudication, and claim payments of invoices to external providers. MedCP de-identifies PHI so payments can still occur timely, but will not include any PHI, consequently reducing DSH's risk of an information security breach. DSH includes the minimum information necessary for vendors to reconcile their invoice to the voucher and reduce the number of vendor inquiries regarding vouchers. The 2021 Budget Act including resources for DSH to develop and implement a Statewide Integrated Health Care Provider Network (HCPN), which also includes Third Party Administrator (TPA) services to serve as a centralized function to process all outside medical claims with DSH's outside medical providers. DSH recently selected a vendor to award the HCPN/TPA contract to. Implementation is expected to begin in this fiscal year and upon full implementation of the HCPN/TPA services, DSH anticipates no longer requiring the utilization of MedCP to process outside medical claims.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 46: SHIFT FUNDING FOR PATIENT EDUCATION FROM REIMBURSEMENTS TO FEDERAL FUNDS, SPRING FINANCE LETTER ISSUE 62

PROPOSAL

DSH requests $100,000 Federal Fund (FF) authority in fiscal year (FY) 2023-24 and ongoing to support special education and vocational education programs at DSH that had previously been collected as reimbursement from the Department of Development Services. DSH requests a corresponding $100,000 decrease in Reimbursement Authority in FY 2023-24 and ongoing.

BACKGROUND

The Administration provided the following background information:

Federal law, the Individuals with Disabilities Education Act (IDEA) and Workforce Investment and Opportunity Act (WIOA) and related state law, requires that certain education programs are provided to eligible individuals. Education Code 56850(e) requires that cooperative agreements to provide educational services for state hospitals seek to maximize federal financial participation in funding these services. IDEA funds are federal funds received from the Department of Education and are based on the number of expected eligible students (those under age 22, which is a very small percentage of DSH's population). Federal WIOA grants provide supplemental funds for programs based on adult learner progress. Learners who advance levels on the tests and/or attain a High School Equivalency Certificate earn payment points that will generate funds to supplement the state program. In addition to the supplemental funding that reimburses agencies for the items they purchase pursuant to grant requirements, the grant provides all testing materials, software required for reporting, training, and online testing (optional), technical assistance, curriculum development online, and professional development for staff who work with adult learners.

DSH facilities, provide treatment for individuals with serious mental health issues. The state hospitals serve individuals with a civil or forensic commitment and diagnosis of major mental, emotional, physical, psychological limitations or illness. Patients in state hospitals present widely varied skills and functional cognitive abilities. Patients have varying educational backgrounds, including many who have not completed high school. To help patients overcome these limitations, DSH provides educational services at their hospitals which includes the administration of Special Education, Adult Basic Education (ABE), Vocational Education (Voc Ed), and High School Equivalency (HSE) programs and courses.

The Individuals with Disabilities Education Improvement Act (IDEA) requires all patients admitted to a state hospital under age 22 to have a free appropriate public education offered to them if they have previously received special education services. Additionally,

Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) covers all education programs regardless of the age of the participant. To remain compliant with this requirement, all newly admitted patients 22 years of age or younger are interviewed by the DSH education departments at each hospital upon admission. If students self-report that they received past special education services or it is determined by some other means (i.e., transcript confirmation) that they have received special education, DSH enrolls students in education services. Education services for patients 22 years and older are provided in the ABE and Vocational Services programs. ABE includes educational services that teach basic literacy or to work towards their HSE. ABE also includes academic skill building and developing life skills. They also offer Vocational Services in a pre-vocational class or Industrial Therapy assignment. Other services offered within these programs include computer skills, occupational skills, treatment program courses, and substance recovery programs, to name a few.

DSH offers the full complement of the adult education, vocational programs, High School Equivalency (HiSET), and diploma programs to patients. Specific requirements for many of these programs are set forth in the following legislation: 1) the Federal Individuals with Disabilities Education Act (IDEA, Part B, 2) Workforce Innovation and Opportunity Act (WIOA), 3) Proposition 98 General Fund allocations per California Education Code, and 4) Code of Federal Regulation, Title 34, Section 300.32.

DSH applied for the 2023-27 Workforce Innovation and Opportunity Act (WIOA), Title II: Adult Education and Family Literacy Act (AEFLA) to provide adult Basic Education (ABE), Vocational Adult Basic Education (learning job skills), ESL, Vocational ESL, and HiSET. This grant provides supplemental funding to participating schools. It provides funding for educational supplies, equipment and some training. It also provides the data collection software and testing materials and training through the California Adult Student Assessment System (CASAS), some professional development and technical assistance for curriculum development. Individual state hospital funding is based on payments points that are generated by progress made by students on the CASAS testing. Points are earned when students move up a level in testing and when they attain a high school equivalency certificate. Funding per payment point varies from year to year as it is dependent on the amount of funding Congress allocates for adult education. Generally funding per payment point is around $250- $300 for each level attained and $500 for earning a high school equivalency certificate.

Historically, DSH has received federal IDEA Part B and WIOA funds via a pass through from the Department of Developmental Services (DDS), which also provides education administration services to DSH via an interagency agreement. DDS will no longer provide these services after June 2024. The next federal grant cycle for the combined educational services grant, administered by the federal WIOA program, runs from federal fiscal year 2023-27.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 47: COALINGA: HYDRONIC LOOP REPLACEMENT RE-APPROPRIATION, SPRING FINANCE LETTER CAPITAL OUTLAY

PROPOSAL

DSH requests a re-appropriation of $26,176,000 General Fund for the construction phase of the DSH-Coalinga Hydronic Loop Replacement. This project replaces the severely corroded and deteriorated existing below-grade hydronic loop piping system with a completely new hydronic loop. The re-appropriation is necessary to ensure project continuity should regulatory reviews not be completed in the current fiscal year. This reappropriation will allow DSH to proceed to construction in Fiscal Year 2023-24.

Total project costs are estimated at $27,459,000, including preliminary plans ($539,000), working drawings ($744,000), and construction ($26,176,000). The construction amount includes $22,133,000 for the construction contract, $1,549,000 for contingency, $1,554,000 for architectural and engineering services, and $940,000 for other project costs. The current project schedule estimates that working drawings will be completed by October 2023. Construction is scheduled to begin in October 2023 and be completed in April 2025.

BACKGROUND

The Administration provided the following background information:

Results from a 2021 budget package/study recommended the replacement of the heating hot water (HHW) piping loop to address the failure of DSH-Coalinga's current system. The piping system will include direct buried, prefabricated/pre-insulated, polypropylene pressure piping with heat fused connections for HHW distribution piping looped around the hospital. The piping alignment will follow a pre-determined path that was developed during subgrade exploration of the facility infrastructure. The new HHW piping system will have multiple points of connection to the campus buildings. This project will include the installation of new, precast concrete vaults with access manholes on both the new heating hot water hydronic valves and the existing chilled water hydronic valves to provide better access for maintenance as well as extend the operating life expectancy of the valves. A detailed phasing plan will be developed and implemented to ensure that minimal disruption to the hospital operation occurs.

DSH and DGS decided that using direct buried, prefabricated/pre-insulated Aquatherm Blue Pipe for HHW distribution piping was the optimal choice as it drastically reduced the construction costs in both labor and material costs and provides the Department with an efficient piping system. Additionally, this method to replace the hydronic loop addresses all the issues identified in the geotechnical investigation report, and condition assessment of apparent corrosion in the pipelines, dated September 15, 2016, by GEOCON

Consultants, Inc. The Aquatherm Blue Pipe is not subject to corrosion and will provide DSH with a long-term solution to the corrosive soil. This proposed method will meet patient care standards and operational needs for the hospital.

4440-491—Reappropriation, State Department of State Hospitals. The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for in those appropriations and shall be available for encumbrance or expenditure until June 30, 2026:

0001—General Fund
(1) Item 4440-301-0001, Budget Act of 2021
(2) 0008343-Coalinga Hydronic Loop Replacement
(c) Construction

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 48: INFORMATION TECHNOLOGY AND SECURITY UNIT BUDGET CHANGE PROPOSAL

PROPOSAL

MHSOAC requests 2.0 permanent positions and $435,000 Mental Health Services Fund (MHSF) in 2023-24 and annually thereafter, to create an Information Technology (IT) and Security unit to address increased IT and security workload.

BACKGROUND

The Commission provided the following background information:

Cybersecurity Audits and Assessments

Pursuant to Government Code section 11549.3, CDT completes information security audits for each state entity every other year to verify compliance with state security and privacy policies. In addition to CDT audits, the California Military Department's Cyber Network Defense team conducts recurring independent security assessments of every state entity's network and selected web applications, to identify security vulnerabilities and provide concrete, implementable actions to reduce the possibility of damaging security breaches. While these audits and assessments can provide crucial findings to improve the Commission's security posture, many ongoing and new tasks resulting from these mandatory engagements require resources to implement security policies, monitor processes, and perform ongoing operational security upgrade. The Commission has had increasingly complex security remediation items identified in the cybersecurity assessments administered by the California Military Department.

Remote Work

In 2020 Governor Newsom declared a lockdown in response to the global Covid-19 pandemic and rising deaths in California. The Commission's IT staff transferred roughly 60 users to remote work. IT staff had significantly increased workload requiring technology procurement, help desk support, and determining and implementing the most secure platforms and applications for remote work and communication. Since 2020, the state of California has adopted a statewide telework policy that encourages the use of teleworking as a management work option. Given this policy, the Commission's increased IT workload is expected to be ongoing in nature.

Commission Relocation

In April 2022, the Commission moved to a new location which has significantly impacted IT workload. Previously the Commission rented space in a state building that was managed by an external management company. The external company provided internet/wi-fi network and managed the physical security of the building. With the relocation, the Commission's IT staff is now responsible for providing these services, which includes building new network infrastructure, setting up contracts with internet providers, physical aspects such as cabling the whole building, setting up the Main Distribution Frame and Independent Distribution Frame and maintain the Minimum Point of Entry. It also required developing and implementing a system for Commission meetings that now meet concurrently in person, over Zoom, and livestreamed. IT staff also supports the building security cameras and badge access.

New Self-Managed Systems Workload due to Termination of CDT Services

Currently the Commission outsources multiple services to the CDT. Several of these services will soon be transitioned to the Commission's IT staff. CDT has ended their support of Office 365 which moves the responsibility to each department, creating additional workload for the IT staff to monitor, backup, manage permissions, and provide account administration. Additionally, CDT has been moving towards Off Premises Cloud Service providers. The move to a new building has provided an opportunity for the Commission to remove the middleman and contract with cloud service providers directly which cuts costs and provides more control and security for the Commission. However, it does require more staff time to set up and maintain. Lastly The Commission has decided to not renew their contract with CDT for their Shared File services. The performance and support were not adequate to meet Commission's business needs. Numerous help desk tickets regarding the system created significant amount of work and the move to a different provider will create efficiencies for the Commission. However, it will also put more responsibility and require more staff time to transition and maintain these services. These three services that will now be self-managed will greatly improve the user experience for the commission staff but will require an additional 2.0 ongoing IT staff to address the increased workload to effectively maintain the systems.

Staff Recommendation: Subcommittee staff is unaware of any concerns with this proposal and therefore recommends approval at a future hearing.

PUBLIC COMMENT

(PUBLIC COMMENT WILL BE TAKEN ON ALL ITEMS ON THE AGENDA)

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