AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, APRIL 9, 2018

2:30 P.M. - STATE CAPITOL ROOM 444

(PLEASE NOTE ROOM CHANGE)

ITEMS TO BE HEARD

ITEM	DESCRIPTION	
ISSUE 1	***SPECIAL INFORMATIONAL ISSUE*: "MENTAL HEALTH IN CALIFORNIA" CALIFORNIA HEALTH CARE FOUNDATION**	**8**
4260 4560	**DEPARTMENT OF HEALTH CARE SERVICES MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION**	**9**
ISSUE 2	MENTAL HEALTH SERVICES ACT OVERSIGHT	9
ISSUE 3	SUICIDE PREVENTION OVERSIGHT	21
4560	**MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION**	25
ISSUE 4	COMMISSION OVERVIEW AND BUDGET	25
ISSUE 5	COUNTY MENTAL HEALTH INNOVATION PLANNING BUDGET CHANGE PROPOSAL	28
ISSUE 6	COMMISSION PROPOSAL FOR CHILDREN'S INNOVATION INCUBATOR	32
ISSUE 7	COMMISSION AND STAKEHOLDER PROPOSAL ON MENTAL HEALTH SERVICES FOR IMMIGRANTS AND REFUGEES AND REDUCING CRIMINAL JUSTICE SYSTEM INVOLVEMENT	36
0977 4560	**CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION**	38
ISSUE 8	INVESTMENT IN MENTAL HEALTH WELLNESS ACT OVERSIGHT	38
ISSUE 9	COMMISSION PROPOSAL TO REAPPROPRIATE TRIAGE FUNDS	40
4140	**OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT**	**41**
ISSUE 10	MENTAL HEALTH WORKFORCE EDUCATION AND TRAINING (WET) PROGRAM OVERSIGHT	41
ISSUE 11	MENTAL HEALTH LOAN ASSUMPTION PROGRAM SPRING FINANCE LETTER	44
ISSUE 12	MEMBER/STAKEHOLDER PROPOSAL TO EXTEND WET FUNDING	46
ISSUE 13	STAKEHOLDER PROPOSAL ON PRIMARY CARE MENTAL HEALTH FELLOWSHIP	49
4260	**DEPARTMENT OF HEALTH CARE SERVICES**	**52**
ISSUE 14	MEDI-CAL MENTAL HEALTH SERVICES	52
ISSUE 15	MENTAL HEALTH SERVICES DIVISION POLICY IMPLEMENTATION BUDGET	59

	CHANGE PROPOSAL	
ISSUE 16	DRUG MEDI-CAL AND SPECIALTY MENTAL HEALTH SERVICES: FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CENTERS (SB 323) BUDGET CHANGE PROPOSAL	63
ISSUE 17	FEDERALLY QUALIFIED HEALTH CENTER AUDITS (AB 1863) BUDGET CHANGE PROPOSAL	66
ISSUE 18	STAKEHOLDER PROPOSAL ON COUNTY FUNDING (AB 1299)	69

LIST OF PANELISTS IN ORDER OF PRESENTATION

ISSUE 1: *SPECIAL INFORMATIONAL ISSUE*: "MENTAL HEALTH IN CALIFORNIA"

SPEAKER

- ***Catherine Teare***, Associate Director, High-Value Care, California Health Care Foundation

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

ISSUE 2: MENTAL HEALTH SERVICES ACT OVERSIGHT

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health Services and Substance Use Disorder Services, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Kirsten Barlow**, Executive Director, County Behavioral Health Directors Association of California
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 3: SUICIDE PREVENTION OVERSIGHT

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health Services and Substance Use Disorder Services, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Kirsten Barlow**, Executive Director, County Behavioral Health Directors Association of California
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance

- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 4: COMMISSION OVERVIEW AND BUDGET

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 5: COUNTY MENTAL HEALTH INNOVATION PLANNING BUDGET CHANGE PROPOSAL

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 6: COMMISSION PROPOSAL FOR CHILDREN'S INNOVATION INCUBATOR

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 7: COMMISSION AND STAKEHOLDER PROPOSAL ON MENTAL HEALTH SERVICES FOR IMMIGRANTS AND REFUGEES AND REDUCING CRIMINAL JUSTICE SYSTEM INVOLVEMENT

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Khatera Aslami-Tamplen**, Vice Chair, Mental Health Services Oversight & Accountability Commission
- **Kimberly Chen,** Government Affairs Manager, California Pan-Ethnic Health Network (CPEHN)
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY
4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 8: INVESTMENT IN MENTAL HEALTH WELLNESS ACT OVERSIGHT

PANEL

- **Ronald Washington**, Executive Director, California Health Facilities Financing Authority
- **Carolyn Aboubechara**, Program Manager, California Health Facilities Financing Authority
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 9: COMMISSION REQUEST TO REAPPROPRIATE TRIAGE FUNDS

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Norma Pate,** Deputy Director, Administrative and Legislative Services, Mental Health Services Oversight & Accountability Commission

- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

4140 OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT

ISSUE 10: MENTAL HEALTH WORKFORCE EDUCATION AND TRAINING (WET) PROGRAM OVERSIGHT

PANEL

- **Stacie Walker**, Deputy Director, Healthcare Workforce Development Division, OSHPD
- **Kirsten Barlow**, Executive Director, County Behavioral Health Directors Association of California
- **Noah Johnson,** Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 11: MENTAL HEALTH LOAN ASSUMPTION PROGRAM SPRING FINANCE LETTER

PANELISTS

- **Norlyn Asprec,** Executive Director, Health Professions Education Foundation, OSHPD
- **Noah Johnson,** Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 12: MEMBER/STAKEHOLDER PROPOSAL TO EXTEND WET FUNDING

PANELISTS

- **Assemblymember Kansem Chu**
- **Le Ondra Clark Harvey, Ph.D.,** Director of Policy and Legislative Affairs, California Council of Community Behavioral Health Agencies

Public Comment

ISSUE 13: STAKEHOLDER PROPOSAL ON PRIMARY CARE MENTAL HEALTH FELLOWSHIP

PANELISTS

- **Robert Michael McCarron**, **D.O**.
  - Professor and Vice Chair of Education and Integrated Care, Psychiatry & Human Behavior, UC Irvine
  - Residency Training Director, Psychiatry & Human Behavior School of Medicine
  - Co-Director, Train New Trainers Primary Care Psychiatry Fellowship, Psychiatry & Human Behavior School of Medicine

Public Comment

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 14: MEDI-CAL MENTAL HEALTH SERVICES

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health Services and Substance Use Disorder Services, Department of Health Care Services
- **Kirsten Barlow**, Executive Director, County Behavioral Health Directors Association of California
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 15: MENTAL HEALTH SERVICES DIVISION POLICY IMPLEMENTATION BUDGET CHANGE PROPOSAL

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health Services and Substance Use Disorder Services, Department of Health Care Services
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 16: DRUG MEDI-CAL AND SPECIALTY MENTAL HEALTH SERVICES; FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CENTERS (SB 323) BUDGET CHANGE PROPOSAL

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health Services and Substance Use Disorder Services, Department of Health Care Services
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 17: FEDERALLY QUALIFIED HEALTH CENTER AUDITS (AB 1863) BUDGET CHANGE PROPOSAL

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health Services and Substance Use Disorder Services, Department of Health Care Services
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 18: STAKEHOLDER PROPOSAL ON COUNTY FUNDING (AB 1299)

PANEL

- **Carroll Schroeder**, Executive Director, California Alliance of Child and Family Services
- **Kirsten Barlow**, Executive Director, County Behavioral Health Directors Association of California

Public Comment

ITEMS TO BE HEARD

ISSUE 1: *SPECIAL INFORMATIONAL ISSUE*: "MENTAL HEALTH IN CALIFORNIA"

SPEAKER

- ***Catherine Teare***, Associate Director, High-Value Care, California Health Care Foundation

ISSUE

In March 2018, the California Health Care Foundation (CHCF) released a Health Care Almanac, titled: *Mental Health in California: For Too Many, Care Not There*, which provides important up-to-date data on mental health in California. The Subcommittee asked CHCF to come and present their research. Their key findings include:

- The prevalence of serious mental illness varied by income, with much higher rates of mental illness at lower income levels for both children and adults.

- Compared to the US, California had a lower rate of suicide, although it varied considerably within the state by gender, age, race/ethnicity, and region.

- About two-thirds of adults with a mental illness and two-thirds of adolescents with major depressive episodes did not get treatment.

- Medi-Cal pays for a significant portion of mental health treatment in California. The number of adults receiving specialty mental health services through Medi-Cal has increased by nearly 50% from 2012 to 2015, coinciding with expansion of Medi-Cal eligibility.

- The supply of acute psychiatric beds may have stabilized after a long period of decline. However, emergency department visits resulting in an inpatient psychiatric admission increased by 30% between 2010 and 2015. More robust community services might decrease emergency department use.

- The incidence of mental illnesses in California's jails and prisons is very high. In 2015, 38% of female prison inmates and 23% of the male prison population received mental health treatment while incarcerated.

Staff Recommendation: Subcommittee staff recommends no action as this is an informational issue.

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

ISSUE 2: MENTAL HEALTH SERVICES ACT OVERSIGHT

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health Services and Substance Use Disorder Services, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Kirsten Barlow**, Executive Director, County Behavioral Health Directors Association of California
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE

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

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

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

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

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

- **Innovation.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and promote interagency collaboration. This component is funded with five percent of the Community Services and Supports funds and five percent of the Prevention and Early Intervention funds.

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

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

DHCS Oversight

DHCS has statutory responsibility for fiscal and programmatic oversight activities of MHSA-funded programs. Specifically these statutory responsibilities include:

1) Annual Revenue and Expenditure Report: DHCS develops the MHSA Annual Revenue and Expenditure Report that identifies county MHSA expenditures, determines any additional funds generated as a result of MHSA, identifies unexpended funds and interest earned, and determines reversion amounts. MHSA programs are evaluated based on this expenditure information. DHCS may withhold funds from counties that do not submit the MHSA Annual Revenue and Expenditure Report by the specified due date. (W&I Code § 5899)

2) Performance Contracts with Counties: DHCS implements mental health services for children/adult/older-adult systems of care and prevention and early intervention through contracts with county mental health programs. DHCS conducts program review of county performance contracts to determine compliance. DHCS must review every county at least once every three years. DHCS may request a plan of correction from a county that does not comply with the performance contract. (W&I Code § 5897)

3) Referrals of Critical Performance Issues from the Mental Health Services Oversight and Accountability Commission (MHSOAC): DHCS may receive notifications deemed as critical performance issues related to the performance of county mental health programs from the MHSOAC.

4) Withholding of Funds and Corrective Action Plans if County Found to be Failing to Comply in a Substantial Manner: If the Director determines that there is or has been a failure to comply with a provision of this code or regulations in a substantial manner, the Department may withhold part or all of state mental health funds from the county, require the county to enter into a plan of correction, or bring an action in mandamus or any other action appropriate to compel compliance (W&I Code § 5655).

As described above, DHCS develops the MHSA Annual Revenue and Expenditure Report, to be released in January each year, however this year's report has not yet been released. Hence, the information in the following charts is contained in last year's (2017) report.

Table 1: MHSA Estimated Total Revenue at 2017-18 Governor Budget

(Dollars in Millions)

		FY 2015-16	FY 2016-17	FY 2017-18
Updated Governor's FY 2017-18 Budget[1]				
	Personal Income Tax	$1,806.0	$1,863.0	$1,887.6
	Interest Income Earned During Fiscal Year	1.2	1.2	1.2
	Annual Adjustment Amount	[382.5]	[371.0]	[345.4]
Total Estimated Revenue[2]		**$1,807.2**	**$1,864.2**	**$1,888.8**

Table 2: MHSA Estimated Revenue
By Component[4]
(Dollars in Millions)

	FY 2015-16	FY 2016-17	FY 2017-18
Community Services and Supports (Excluding Innovation)	$1, 304.8	$1,345.9	$1,363.7
Prevention and Early Intervention (Excluding Innovation)	326.2	336.5	340.9
Innovation	85.8	88.6	89.8
State Administration[5]	90.4	93.2	94.4
Total Estimated Revenue	**$1,807.2**	**$1,864.2**	**$1,888.8**

Table 3a: MHSA Expenditures
Local Assistance
January 2017
(Dollars in Thousands)

	Actual	Estimated	Projected
	FY 2015-16	FY 2016-17	FY 2017-18
Local Assistance			
Department of Health Care Services • MHSA Monthly Distributions to Counties[6]	1,418,778	1,340,000	1,340,000
CSS (Excluding Innovation)	[1,078,271]	[1,018,400]	[1,018,400]
PEI (Excluding Innovation)	[269,568]	[254,600]	[254,600]
INN	[70,939]	[67,000]	[67,000]
Office of Statewide Health Planning and Development • WET State Level Projects (Not Including Mental Health Loan Assumption Program (MHLAP) funds)	15,972	30,174	12,650
Total Local Assistance	**1,434,750**	**1,370,174**	**1,352,650**

The following table shows where State Administration funds are expended and the table on the subsequent page describes the various uses of the MHSA State Administration funding as of January 2017:

Table 3b: MHSA Expenditures
State Administration
January 2017
(Dollars in Thousands)

	Actual	Estimated	Projected
	FY 2015-16	FY 2016-17	FY 2017-18
State Administration			
Judicial Branch	1,070	1,077	1,077
California Health Facilities Financing Authority • Mobile Crisis Services Grants	3,999	15,000	4,000
OSHPD – Administration	3,369	3,357*	3,372*
OSHPD – Non-Administrative State Operations (including MHLAP)	12,132	15,951	10,001
Department of Health Care Services	8,415	15,234	9,283
Department of Public Health	5,097	14,230	50,208*
Department of Developmental Services • Contracts with Regional Centers	1,222	1,142	1,142
Mental Health Services Oversight & Accountability Commission • Triage Grants beginning January 2014 ($32.0 M annually)	48,002	56,344	45,146
Department of Education	129	138	138
Board of Governors of the California Community Colleges	85	89	89
Financial Information System for California	188	150	135
Military Department	1,467	1,351	1,351
Department of Veterans Affairs • Provide information on local mental health services to veterans and families	506	505	505
University of California	3,564	9,800	0
Department of Corrections and Rehabilitation	0	233	229
Department of Housing and Community Development	0	6,200	0
Statewide General Administration[7]	0	2,701	2,867
Total Administration	**$89,245**	**$143,502**	**$129,543**
Total of Local Assistance and Administration	**$1,523,995**	**$1,513,676**	**$1,482,193**

*A portion of these funds were re-appropriated from prior year administrative funds and are attributed to the 5% administrative cap for a different fiscal year in which they are expended.

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

The following table details the administration's estimate of MHSA State Administration (5%) Fund. The table shows that the administration estimates that $62.3 million will remain after appropriating this Fund for various purposes already designated in the Governor's proposed budget.

Mental Health Services Fund Administrative Cap - 2018-19 Governor's Budget
(dollars in thousands)

Fiscal Year	Monthly Cash Transfers	Accruals	Interest	Total Revenue	Admin Cap[4]	Expenditures & Appropriations[3]	Available Cap	Comments
				(A+B+C=D)	(D[.035 or .05])		(E - F = G)	
	A	B	C	D	E	F	G	
2012-13[1]	$1,204,444	$479,780	$721	$1,684,945	$58,973	$31,572	$27,401	Item 4265-001-3085 ($15m appropriated w/o regard to FY in 2012 BA, but not spent, reflected in FY 16/17 and beyond) Item 6440-001-3085 ($12.3m appropriated in 2014 BA but not spent).
2013-14	$1,187,411	$94,253	$548	$1,282,212	$64,111	$39,474	$24,637	Item 4265-001-3085 ($15m appropriated w/o regard to FY in 2013 BA, reflected in FY 16/17 and beyond)
2014-15	$1,366,501	$464,136	$844	$1,831,481	$91,574	$78,989	$12,585	**2014-15 Budget Act** Item 4265-001-3085 ($15m approp. w/o regard to FY in 2014 BA, but not spent, reflected in FY 16/17 and beyond) Items 4560-491 and 6440-001-3085 (subject to available funds through June 30, 2017).
2015-16	$1,423,508	$446,046	$1,196	$1,870,750	$93,538	$78,246	$15,292	**2015-16 Budget Act** Item 4265-001-3085 ($15m appropriated w/o regard to FY in 2015 BA, but not spent, reflected in FY 16/17 and beyond). Chapter 6, Statutes of 2016 (AB 847) appropriated $1 million.
2016-17/e[2]	$1,484,054	$311,680	$1,899	$1,797,633	$89,882	$93,470	($3,588)	**2016-17 Budget Act** Of the $60m appropriated for the CA Reducing Disparities Project in the 2012, 2013, 2014, and 2015 BA, $9.94m was spent for the CA Reducing Disparities Project (4265). Of the remaining CA Reducing Disparities Project funds, $9.56m will be spent in FY 17/18, and $40.5 is anticipated to be spent in FY 18/19. $500k for MHSA performance contracts (per AB 1622). Reappropriation $1.043m from Budget Acts of 2013, 2014 and 2015 to continue funding triage personnel grants through June 30, 2018. $1.952m for data contracts (reflected as savings in GB) One-Time Funding DHCD (2240) - $6.2m for No Place Like Home Housing Program CHFFA (0977) - $11m for Children's Crisis Services Grant Program (Subject to availability of funds) Funds released May 8, 2017. MHSOAC (4560) - $3m for Children Crisis Services (Subject to availability of funds) Funds Released May 8, 2017. DHCS (4260) - $4m for Suicide Hotlines (Subject to availability of funds) Funds released May 8, 2017.
2017-18/e[2,5]	$1,606,766	$482,060	$1,899	$2,090,725	$104,536	$114,189	($9,653)	**2017-18 Budget Act** MHSOAC (4560) - Includes $157k (ongoing) for MH advocacy contract admin and $309k (ongoing) for prevention and early intervention plan reviews Reappropriation MHSOAC(4560) - $5.6m for Triage, Advocacy, and Evaluation Grants One-Time Funding CHFFA (0977) - Includes $16.7m for Children's Mental Health Crisis Grants MHSOAC (4560) - Includes $100k for development of a Statewide Strategic Suicide Prevention Plan DHCS (4260) - Includes $4.3m for Suicide Hotlines (Subject to availability of funds).
2018-19/e[2]	$1,685,393	$544,000	$1,899	$2,231,292	$111,565	$115,986	($4,421)	**2018-19 Governor's Budget** MHSOAC (4560) - Includes $2.5m in FY 18/19 and FY 19/20 for County Mental Health Innovation Planning Reappropriation UC (6440) - $1.83 million
TOTALS:					$614,178	$551,926	$62,252	

[1] The admin cap applicable in 11-12 and 12-13 was 3.5%. Display begins with 12-13 as this was the first year that funds were distributed monthly to counties based on unreserved funds. The cap was restored to 5% in 13-14.

[2] e/ = estimate

[3] Source: Expenditures per the 2018-19 Governor's Budget Fund Condition Statement for fund 3085 for FY 16/17, 17/18, 18/19

[4] Welfare and Institutions Code Section 5892(d) and 5892(e)(4)

[5] 2017-18 does not yet include one-time $6.2m carryover from 2016-17 for DHCD (2240) No Place Like Home Housing Program. This will reduce the total amount of administrative cap available.

Departments Funded in 2018-19: Judicial Branch (0250), CA State Treasurer (Health Facilities Financing Authority (0977), Office of Statewide Health Planning & Development (4140), Dept. of Health Care Services (4260), Dept. of Public Health (4265), Dept. of Developmental Services (4300), Mental Health Services Oversight & Accountability Commission (4560), Dept. of Corrections & Rehabilitation (5225), Dept. of Education (6110), University of California (6440), CA Community Colleges (6870), Dept. of the Military (8940), Dept. of Veterans Affairs (8955)

Last updated 12/22/17

Reversion Requirements for Unspent County Funds. MHSA requires the reversion of unspent county funds to the state. According to Welfare and Institutions Code section 5892 (h), "any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years". However, DHCS has not reverted unspent county funds since 2008.

AB 114 (Committee on Budget, Chapter 38, Statutes of 2017)

The Legislature addressed the issue of unspent funds by counties that have not reverted to the state through AB 114, a budget trailer bill. AB 114 clarifies and defines the reversion process for MHSA funds that have been unspent for over three years by counties. Specifically, this bill:

a) Deems all unspent funds subject to reversion as of July 1, 2017, to have been reverted to the Mental Health Services Fund and reallocated to the county of origin for the purposes for which they were originally allocated;

b) Requires the Department of Health Care Services (DHCS), on or before July 1, 2018, in consultation with counties and other stakeholders, to prepare and submit a report to the Legislature identifying the amounts that were subject to reversion prior to July 1, 2017, including to which purposes the unspent funds were allocated;

c) Requires DHCS to provide to counties the amounts it has determined are subject to reversion, and provide a process for counties to appeal this determination;

d) Requires counties with unspent funds subject to reversion, that are deemed reverted and reallocated, to prepare and submit a plan (by July 1, 2018) to expend these funds on or before July 1, 2020;

e) Restarts the three-year clock on expenditure of Innovation funds when a county's Innovation Plan has received approval by the Mental Health Services Oversight and Accountability Commission (Commission);

f) Authorizes small counties, with a population of less than 200,000, to expend MHSA funds for up to five years before unspent funds will be reverted to the state;

g) Requires DHCS, in consultation with the Commission and the County Behavioral Health Directors Association of California, to develop and administer instructions for the Annual MHSA Revenue and Expenditure Report. Requires that the instructions include a requirement that the county certify the accuracy of this report. Requires counties to submit the report electronically to DHCS and to the Commission. Requires DHCS and the Commission to annually post each county's report on its website in a timely manner. Requires the Department, in consultation with the Commission and the County Behavioral Health Directors Association of California, to revise these instructions by July 1, 2017, and as needed thereafter, to improve the timely and accurate submission of county revenue and expenditure data. Specifies the purpose of the Report;

h) Requires DHCS, by October 1, 2018, and by October 1 of each subsequent year, in consultation with counties, to publish on its internet web site a report detailing funds subject to reversion by county and by originally allocated purpose; and

i) Requires that, on or after July 1, 2017, funds subject to reversion be reallocated to other counties for the purposes for which the unspent funds were initially allocated to the original county.

The following chart details the status of counties submitting Annual Revenue and Expenditure Reports to DHCS as required.

Status of County Annual MHSA Revenue and Expenditure Report
Current through 03/23/18

	FY 15-16			FY 16-17		
County	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date
Alameda	9/29/2017		1/3/2018	1/2/2018		1/3/2018
Alpine	11/22/2017		11/27/2017			
Amador	4/7/2017		4/10/2017			
Berkeley City	4/13/2017		4/13/2017	1/25/2018		2/1/2018
Butte	4/17/2017		4/18/2017			
Calaveras	4/18/2017		4/19/2017			
Colusa	5/17/2017		5/17/2017			
Contra Costa	4/17/2017		4/18/2017	12/29/2017	1/5/2018	1/24/2018
Del Norte	4/17/2017		5/19/2017	2/23/2018		2/26/2018
El Dorado	4/17/2017		4/19/2017	12/29/2017	1/5/2018	1/24/2018
Fresno	4/17/2017		4/18/2017	12/29/2017	1/8/2018	
Glenn	7/20/2017		7/20/2017	2/22/2018		2/22/2018
Humboldt	4/13/2017		4/18/2017	12/21/2017	1/3/2018	
Imperial	4/27/2017		4/27/2017	12/28/2017		1/9/2018
Inyo	5/9/2017		5/9/2017			
Kern	5/30/2017	1/16/2018[1]	2/7/2018	1/30/2018		2/7/2018
Kings	5/2/2017		5/24/2017	1/29/2018		1/29/2018
Lake						
Lassen	5/18/2017		5/25/2017			
Los Angeles	1/31/2018		2/1/2018			
Madera	5/12/2017	1/4/2018[1]				
Marin	5/10/2017		5/11/2017	1/31/2018		2/1/2018
Mariposa	5/18/2017		5/19/2017	3/14/2018		3/14/2018
Mendocino	8/31/2017		8/31/2017			
Merced	7/21/2017		7/21/2017	2/1/2018		2/1/2018
Modoc	4/17/2017		4/19/2017			
Mono	4/25/2017		6/20/2017			
Monterey						
Napa	11/9/2017		11/13/2017			
Nevada						
Orange	12/27/2016		4/13/2017	12/29/2017	1/17/2018	1/25/2018
Placer	4/14/2017		4/18/2017	12/22/2017		1/23/2018
Plumas						
Riverside	6/9/2017		6/12/2017	12/29/2017	1/24/2018	1/25/2018
Sacramento	6/19/2017		6/20/2017	12/29/2017	1/24/2018	1/25/2018
San Benito	9/8/2017		9/12/2017			
San Bernardino	5/1/2017		5/1/2017			
San Diego	5/26/2017		5/26/2017			
San Francisco	7/5/2017		9/18/2017	3/21/2018		
San Joaquin	10/3/2017		10/4/2017	12/29/2017	1/24/2018	1/25/2018
San Luis Obispo	5/12/2017		5/16/2017	2/15/2018		2/16/2018
San Mateo	10/10/2017		10/18/2017			
Santa Barbara	5/24/2017		6/20/2017	12/22/2017	1/22/2018	1/25/2018
Santa Clara	12/18/2017		1/4/2018			
Santa Cruz						
Shasta	4/14/2017		4/17/2017			
Sierra	8/16/2017	1/4/17[1]				
Siskiyou	6/30/2017		7/10/2017			
Solano	3/23/2017		4/4/2017	12/28/2017	1/23/2018	1/25/2018
Sonoma	6/26/2017		6/27/2017			
Stanislaus	4/5/2017		4/5/2017			
Sutter-Yuba						
Tehama	5/8/2017		5/16/2017			
Tri-City	4/6/2017		4/6/2017	12/29/2017	1/24/2018	2/15/2018
Trinity	7/14/2017		7/14/2017			
Tulare	4/12/2017		4/12/2017	12/26/2017	1/22/2018	1/25/2018
Tuolumne	4/10/2017		5/18/2017	2/16/2018		3/1/2018
Ventura	4/14/2017		4/27/2017			
Yolo	3/9/2018		3/12/2018	3/22/2018		
Total	**53**		**51**	**27**		**23**

1 DHCS has had ongoing communication with county regarding submission.

Bureau of State Audits (BSA) Audit

The BSA completed and published an audit on the effective use of MHSA funding in February 2018 and concluded that the state could better ensure the effective use of the funding. The audit includes the following Key Findings and Recommendations:

Key Findings

- Health Care Services has not provided effective direction to local mental health agencies on how to spend MHSA funds.
    - It has not developed a process for recovering MHSA funds from local mental health agencies after time-frames for spending the funds have elapsed—agencies maintain excessive MHSA reserves and have accumulated $2.5 billion in unspent funds as of fiscal year 2015–16 of which they should have returned over $230 million to be redistributed to agencies.
    - There is no guidance in how local mental health agencies should treat interest they earn on MHSA funds and thus, agencies accumulated over $80 million in interest on unspent MHSA funds. Also, the three agencies we visited did not have policies on how to spend interest earned.
    - Because it has not required local mental health agencies to adhere to a standard reserve level, agencies hold reserves of MHSA funds—$535 million as of fiscal year 2015–16.
    - Although it knew of a $225 million fund balance in the state Mental Health Services Fund, it had not determined whether the balance was owed to local mental health agencies or was an accounting error.
- Health Care Services inadequately oversees the MHSA funds that local mental health agencies receive.
    - It has not enforced reporting deadlines—only one of the 59 agencies submitted its fiscal year 2015–16 annual report on time.
    - Although it developed a fiscal audit process in 2014, its audits focus on data and processes that are at least seven years old, and has yet to develop regulations to allow agencies to appeal findings.
- Although the Oversight Commission is implementing processes to evaluate the effectiveness of MHSA-funding programs, it still needs to develop guidance on the Innovation program approval process, complete an internal process for reviewing reports to ensure data is reliable and timely, and develop metrics to evaluate the outcome of the triage grants on a statewide level.

Key Recommendations

- Health Care Services should do the following:
    - Ensure that local mental health agencies spend MHSA funds in a timely manner by implementing policies and processes to reallocate any MHSA funds that are unspent within the statutory time-frames, clarify that the interest earned on unspent MHSA funds is subject to reversion requirements, and establish an acceptable MHSA reserve level.

- Regularly analyze fund balances to identify excess fund balances and distribute those funds accordingly.

- Implement fiscal and program oversight of local mental health agencies.

- The Oversight Commission should continue discussions on innovative approaches to meeting requirements of the MHSA, complete internal program review processes, and establish statewide outcome metrics.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS and the Commission to provide an overview of the MHSA and state oversight of the MHSA, and to respond to the following:

- The recent state audit revealed challenges in how DHCS is monitoring the use of MHSA fiscal resources. The Auditor has reported that the Department initiated the process to establish fiscal regulations for MHSA funds in 2016, but delayed that work and now proposes to submit fiscal regulations to the Office of Administration Law in 2019.

- The Auditor also has reported, based on information from the Department, that counties have amassed more than $220 million in unspent MHSA funds from as far back as 2005, funds that would have reverted if the state had enforced the three-year reversion window under the terms of the Mental Health Services Act.

- The Audit reported that the Department of Health Care Services has received between $7.9 million and $8.6 million annually over the past four years to oversee the implementation of the MHSA. Included in those funds is support for the Department's efforts to conduct fiscal oversight of the MHSA. The Department's organizational chart, dated January 2017, indicates the department maintains 15 positions dedicated to MHSA Oversight and Fiscal Reporting.

In her cover letter to the Legislature, the Auditor has written:

> "Finally, Health Care Services' oversight of local mental health agencies is minimal: it does not enforce annual revenue and expenditure reporting nor has it performed fiscal or program audits to ensure local mental health agencies comply with fiscal and program requirements contained in state laws and regulations."

In consideration of these concerns, please respond to the following questions:

1. Recognizing the impact that the lack of clear and consistent fiscal rules has on the ability of counties to spend these funds, please outline the rationale for the multi-year delay the implementation of the Department's fiscal regulations for the MHSA.

2. Please provide an update on the status of county reporting of their Revenue and Expenditure Reports, including:

   a) How many county reports were submitted by the statutory deadline?
   b) Has the Department ever enforced the statutory deadline for county reporting and what steps is the Department taking to enforce the reporting requirements?
   c) What additional authority, if any, does the Department need to ensure county reporting is up to date?
   d) What processes are in place to withhold unspent funds?
   e) How would those funds be used when and if they revert back to the state Mental Health Services Fund?

3. Please outline how the Department conducts fiscal oversight of the MHSA funds, the roles and duties of these 15 positions, the challenges the Department faces in monitoring MHSA revenues, spending and unspent funds and any additional resources or authority it may need to fulfill this responsibility.

4. How and when will reversion begin?

5. The audit states that, although DHCS knew of a $225 million fund balance in the state Mental Health Services Fund, it had not determined whether the balance was owed to local mental health agencies or was an accounting error. Can DHCS explain this at this time?

6. The audit states that DHCS may receive notifications deemed as critical performance issues related to the performance of county mental health programs from the MHSOAC. Has DHCS received any of these notifications?

7. What are the reasons that counties are not spending their MHSA funds?

8. What is the purpose of counties having MHSA reserves? DHCS explains that there is a time lag in auditing of cost reports that determines FFP for various services for which counties use Proposition 63 funds as the non-federal match. Please explain the impact of this on the availability of Prop 63 funds for non-Medi-Cal purposes.

9. What are the reasons that the annual expenditure report is not available prior to April Subcommittee hearings?

10. Please provide an overview of how much MHSA state administration funding there is, and how it is used.

11. How does the administration determine the percentage of MHSA state administration funding that can be appropriated on an on-going basis, rather than one-time?

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 3: SUICIDE PREVENTION OVERSIGHT

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health Services and Substance Use Disorder Services, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Kirsten Barlow**, Executive Director, County Behavioral Health Directors Association of California
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE

Over the past few years, the Subcommittee has been exploring and discussing suicide and suicide prevention in California, for various reasons, including: 1) rising suicide rates; 2) the conclusion of limited-funding for statewide projects operated by CalMHSA; and 3) the Subcommittee receiving various stakeholder proposals related to suicide prevention. In 2017, the Subcommittee included an oversight/informational segment in its April 3, 2017 hearing including a panel of suicide experts who shared data and policy recommendations. Today's issue is for the purpose of continuing this oversight and continuing the conversation on how California can improve its suicide prevention efforts.

BACKGROUND

DHCS Office of Suicide Prevention

In 2013, under the terms of the Governor's Reorganization Proposal 2, the functions of the Department of Mental Health were distributed to a number of state agencies, including DHCS. The 2012 Transition Plan indicates that the Department of Mental Health maintained three positions to fulfill the functions of the Office of Suicide Prevention. Under the terms of the transition plan approved by the Legislature and the Governor, those positions and the related funding, were transferred to DHCS to continue the work. Today's DHCS website indicates that the Office of Suicide Prevention fulfills a range of functions, including:

- Providing suicide prevention technical assistance to counties and local organizations

- Coordinating local, state and national level partners that expand suicide prevention networks in California

- Collecting, analyzing and disseminating suicide data and best practices for suicide prevention

Although the Department's website indicates the Office of Suicide Prevention is currently functioning, prior testimony from the Department suggests the program was eliminated; moreover, the Department's current organizational chart does not indicate the Office as a program within the Department.

Golden Gate Bridge Project
In 2014, the Legislature approved of $7 million (Proposition 63 State Administration funds) to provide the final component of funding needed to build a suicide deterrent system on the Golden Gate Bridge. The Golden Gate Bridge District awarded the construction contract and construction began during the spring of 2017. The project is expected to take four years to complete.

Suicide Hotlines
In 2016 and 2017 the Legislature approved and the final budgets includes $4 and $4.3 million (Proposition 63 State Administration funds), respectively, for suicide hotlines, to replace funding formerly provided by the California Mental Health Services Authority (CalMHSA) with county Proposition 63 dollars. The Department of Finance recently reported to the Legislature that none of the $8.3 million included in the 2016 and 2017 budgets has gone to suicide hotlines due to disagreements with a potential contractor over certain aspects of the contract.

Statewide Suicide Prevention Strategic Plan
In 2017, under the leadership of Assembly Budget Subcommittee #1, the Legislature adopted and the 2017 budget includes $100,000 (MHSA State Administration Fund) and the following Supplemental Reporting Language directing the Commission to develop a Statewide Suicide Prevention Strategic Plan:

> ***"State Suicide Prevention Strategic Plan***. The Mental Health Services Oversight and Accountability Commission (Commission) shall develop and write a State Suicide Prevention Strategic Plan. The Commission shall provide the suicide prevention plan to the Legislature by July 1, 2018. If the Commission cannot meet this deadline, it shall notify the Senate and Assembly Budget Committees by May 31, 2018.
>
> The Commission shall form an advisory group to help the Commission develop the suicide prevention plan. The advisory group shall include suicide experts, interested constituency groups, state and local agencies, and any other individuals deemed appropriate by the Commission.
>
> Development of this plan may include all of the following:
>
> - A competitive or noncompetitive contracting process in order to contract with an entity other than the Commission to develop and write the plan.

- Extensive review and analysis of social science research on causes, methods, and effectiveness of prevention strategies of suicide.

- Establishment of public-private partnerships for purposes of development of innovative prevention strategies and to maximize resources.

- Exploration and development of the role of social media, and establishment of partnerships between social media, community organizations, and state and local governments to develop innovative prevention strategies and to maximize resources.

- Public hearings or meetings in various locations in the state in order to generate interest, discussion, and resources for this project.

The State Suicide Prevention Strategic Plan shall include the following:

- A summary of research and literature on suicide and suicide prevention.

- A summary of California-specific suicide data.

- A summary of best practices and innovative models from other states and countries.

- An assessment of existing suicide prevention resources in California.

- An assessment of unmet needs, missed opportunities, and unique challenges in California.

- Recommendations on prioritizing suicide prevention strategies and interventions in California."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to respond to the following:

Office of Suicide Prevention

1. Please clarify whether the Office of Suicide Prevention is currently operating within the Department.

2. If so, please describe the work conducted by the Office of Suicide Prevention, the resources currently dedicated to the efforts outlined on your website and any challenges the Department faces in promoting effective suicide prevention in California and your efforts to address those challenges.

3. If the Office of Suicide Prevention does not exist, please outline how the Office was dismantled, how the funding and personnel dedicated to that work was transferred and where those resources are currently dedicated.

Suicide Hotlines Funding

4. Please outline the status of the Department's work to distribute funds approved of and appropriated through the 2016 and 2017 Budget Acts to fortify the efficacy of the Suicide Hotlines and discuss the need for additional funding for this purpose moving forward.

5. Please outline any challenges the Department has encountered in accessing and distributing those funds and what steps the Department recommends to improve the effectiveness of these funds.

The Subcommittee requests the Commission to provide updates on the Golden Gate Bridge project and on their development of the Statewide Suicide Prevention Strategic Plan.

Staff Recommendation: Subcommittee staff recommends no action at this time.

NATIONAL SUICIDE PREVENTION LIFELINE 1-800-273-TALK (8255) suicidepreventionlifeline.org

If you or someone you know is in crisis, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255). (Not DHCS)

Si usted o alguien que usted conoce esta en una crisis por favor llame a la Red para la Prevención del Suicidio al 1-888-628-9454. (Not DHCS)

RED NACIONAL de PREVENCIÓN del SUICIDIO 1-888-628-9454 prevenciondelsuicidio.org

4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 4: COMMISSION OVERVIEW AND BUDGET

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Mental Health Services Oversight & Accountability Commission (Commission) proposed 2018-19 budget is $69.9 million, an $8.9 million (11.3%) decrease from current year funding. Nearly all of the funding for the Commission is Proposition 63 (Mental Health Services Act) state administration funding.

Commission Budget

	2016-17 Actual	2017-18 Estimated	2018-19 Proposed	CY to BY Change
Total MHSA Funds	$40,965,000	$78,839,000	$69,896,000	-$8,943,000 (-11.3%)
Positions	27.3	26.6	26.6	0

BACKGROUND

The MHSA created the Mental Health Services Oversight and Accountability Commission to provide broad oversight and leadership in the community mental health system statewide. The Commission's primary roles include: (1) providing statewide advice and policy leadership on the community mental health system, including oversight, review, accountability, and evaluation of projects and programs supported with MHSA funds, (2) ensuring that mental health consumers, family members, and underserved communities are meaningfully involved in every level of the community mental health system, (3) supporting dissemination and adoption of cost-effective best practices in the mental health system, (4) administering the Mental Health Wellness Act of 2013 Triage Personnel Grants, and (5) providing vision and leadership in the exploration of innovative strategies to transform community mental health services, including oversight and approval of over $100 million per year in county innovation projects.

Commissioners

The Mental Health Services Oversight and Accountability Commission (Commission) was established in 2005 and is composed of 16 voting members. These members include:

Elected Officials:

- Attorney General
- Superintendent of Public Instruction
- Senator selected by the President pro Tem
- Assemblymember selected by the Speaker

12 members appointed by the Governor:

- Two persons with a severe mental illness
- A family member of an adult or senior with a severe mental illness
- A family member of a child who has or has had a severe mental illness
- A physician specializing in alcohol and drug treatment
- A mental health professional
- A county sheriff
- A superintendent of a school district
- A representative of a labor organization
- A representative of an employer with less than 500 employees
- A representative of an employer with more than 500 employees
- A representative of a health care services plan or insurer

In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

Among other responsibilities, the role of the MHSOAC is to:

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

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

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

STAFF COMMENTS/QUESTIONS

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

- Please explain the $8.9 million decrease in the Commission's proposed budget from the current year to budget year.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 5: COUNTY MENTAL HEALTH INNOVATION PLANNING BUDGET CHANGE PROPOSAL

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Mental Health Services Oversight and Accountability Commission (MHSOAC) requests $2.5 million in 2018-19 and in 2019-20 from the Mental Health Services Fund (State Administration) to contract with a private consulting entity to: evaluate existing county plans and innovative strategies to address local mental health needs, coordinate with the state and counties to understand the current utilization of various mental health services, and determine how those services could support the development of counties' mental health innovation plans that employ new strategies and approaches to mental health treatment. These efforts would help with planning and also would help counties access community placement funds related to incompetent to stand trial (IST) diversion efforts.

BACKGROUND

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). The MHSA imposes a 1 percent tax surcharge on taxpayers with annual taxable income of more than $1 million for purposes of funding and expanding mental health services. The Act specifies component allocations for county expenditures, but permits each county to develop plans to address their specific needs. Each month, counties receive monthly MHSA distributions; of which, 80 percent is allocated for community services and supports and the remaining 20 percent is allocated for Prevention and Early Intervention (PEI) programs. Of the total funding provided to each county, five percent is required to support innovation projects.

The Act created the Mental Health Services Oversight and Accountability Commission to provide broad oversight and leadership in the community mental health system statewide. The Commission's primary roles include: (1) providing statewide advice and policy leadership on the community mental health system, including oversight, review, accountability, and evaluation of projects and programs supported with MHSA funds, (2) ensuring that mental health consumers, family members, and underserved communities are meaningfully involved in every level of the community mental health system, (3)supporting dissemination and adoption of cost-effective best practices in the mental health system, (4) administering the Mental Health Wellness Act of 2013 Triage Personnel Grants, and (5) providing vision and leadership in the exploration of

innovative strategies to transform community mental health services, including oversight and approval of over $100 million per year in county innovation projects.

In June of 2013, the Governor signed AB 82 (Chapter 23, Statutes of 2013), a budget trailer bill that modified the Mental Health Services Act and directed the Commission to issue regulations for Prevention and Early Intervention Programs and Innovation Programs that were initially authorized under Proposition 63. In 2014-15, the Commission promulgated the required innovation regulations; and effective October 1, 2015, these regulations are in place to:

1) Clarify innovation project requirements;
2) Specify reporting requirements for innovation projects and related revenue and expenditure reports;
3) Define key terms;
4) Outline the framework for required reports; and
5) Specify applicable due dates for these reports.

The Act's Innovation component provides California the opportunity to develop and test new, unproven approaches to service delivery, or to adapt existing strategies with the potential to become tomorrow's best practices to improve mental health services.

The primary purpose of Innovation Projects is to achieve the following:

- Increase access to mental health services to underserved groups, including permanent supportive housing.

- Increase the quality of mental health services, including measurable outcomes.

- Promote interagency and community collaboration related to mental health services or supports or outcomes.

- Increase access to mental health services, including permanent supportive housing.

Innovation projects may address issues faced by children, transition-age youth, adults, older adults, families (self-defined), neighborhoods, tribal and other communities, counties, multiple counties, or regions. The project may initiate, support and expand collaboration and linkages, especially connections between systems, organizations and other practitioners not traditionally defined as a part of mental health care. The project may influence individuals across all life stages and all age groups, including multigenerational practices/approaches.

Innovation funding represents a large amount of the Mental Health Services Act funds that are expected to be subject to reversion pursuant to WIC Section 5892.1. The Commission has found that the innovation component of the MHSA could be enhanced through the support and technical assistance of external innovators and subject matter experts, as well as strategies to encourage cross-county collaboration. This proposal

encourages counties to collaborate, engage in best practices, and think innovatively, enabling the counties to maximize all available resources for mental health services.

Chapter 38, Statutes of 2017 (Assembly Bill (AB) 114) addresses the reversion of specified MHSA funds. Funds subject to reversion as of July 1, 2017 are those distributed to counties from Fiscal Year (FY) 2005-06 through FY 2014-15. Per statute, these funds are deemed to have been reverted and reallocated to the county of origin for the purposes for which they were originally allocated (WIC Section 5892.1 (a)). By July 1, 2018, the Department of Health Care Services is required to prepare a report to the Legislature identifying the amounts of funds subject to reversion by county. By July 1, 2018, counties are required to have a plan to spend those funds by July 1, 2020 (WIC Section 5892.1 (c)

Innovation is a strategic component of the MHSA, which includes specific goals for reducing homelessness, incarceration, suicide, unemployment and mental health related challenges. Counties develop plans for expenditure of Innovation funds, while the Commission reviews and approves funds proposed from those plans. Based on historical county expenditures, a significant amount of Mental Health Service Funds will be subject to reversion if not spent prior to July 1, 2020.

Although counties are responsible for prioritizing uses of innovation funds, how effectively counties use these resources has implications for the state. Currently, there are various approaches to providing intensive wrap-around services for individuals with mental illness who become involved with the criminal justice system. The Commission explains that the Commission's recent focus on entry/reentry of the individuals with mental illness into the criminal justice system and the annual increase in State Hospital IST referrals provide an opportunity for counties to utilize innovation funding, with the assistance of an external contractor, to focus on innovative planning.

Given the recent emphasis on counties to use their innovation funds and the increased focus on appropriate treatment for individuals with mental illness prior to interaction with the criminal justice system, the Commission proposes to contract with a private consulting entity to provide technical assistance to the counties in developing their innovation plans, with a focus on IST diversion. As the goals of the MHSA include the reduction in the incarceration of individuals with mental illness, the MHSA is an allowable and appropriate fund to support California's response to increasing interactions between individuals with mental illness and the criminal justice system, particularly related to ISTs.

Under this proposal, state MHSA funds would be used for technical assistance and support, while counties' monthly MHSA allocation would be used to implement the proposed innovative plans. In the short-term, the planning effort would be targeted to counties facing recent increases in IST referrals, particularly smaller counties that face resource/capacity limitations, and could benefit from regional or other collaborative approaches. Technical assistance would include assisting counties to better understand the data associated with individuals who have been historically designated as an IST, who have had numerous interactions with the criminal justice system, and who are eligible for Medi-Cal but have not accessed treatment consistently.

The consultant service is expected to allow California to bring together experts from health care, technology, communications, and translational science and management sectors to improve California's utilization of Innovation funds. Counties would not be required to use the consultant services, but incentivized to participate given the coordinated approach of the consultant and the Commission (which is responsible for plan approval). After two fiscal years of state funding, counties are encouraged to continue ongoing partnerships with contracted private entity utilizing county funds, should the counties choose to continue the contracted innovation planning assistance.

Due to the increases in IST referrals to the State, the Commission notes that this proposal could alleviate the dependency on the State Hospital system, which is at maximum capacity. The Commission states that increasing access to community mental health services through more county utilization of MHSA innovation funding would keep individuals with mental illness out of the courts, state hospitals, and jails/prisons, by providing them with services rather than incarceration.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Commission to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 6: COMMISSION PROPOSAL FOR CHILDREN'S INNOVATION INCUBATOR

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Commission is requesting $5,000,000 additional one-time funding from the Mental Health Services Fund to create a Children's Innovation Incubator to support program implementation, provide technical assistance and training and ensure that counties are fully leveraging funds to improve outcomes for children within California's mental health system. The Commission explains that the Children's Innovation Incubator will help counties develop their ideas, put them into practice, and share their learning with other counties.

BACKGROUND

California's counties are required to set aside five percent of their annual Mental Health Services Act funding allocation for innovation. These innovation funds are intended to drive quality improvement and transformational change into the community mental health system. Statewide innovation funding is approximately $100 million each year.

To support the effective use of innovation funds, the Commission is working with the counties to develop an innovation incubator to improve how counties use their innovation funds. The incubator will help the counties develop collaborative innovation proposals, provide technical assistance, support enhanced evaluations, and disseminate lessons learned. The Governor's budget includes $5 million in Mental Health Services Act state administrative funds – one time funding across two years – to enable the Commission to launch the innovation incubator. The Governor's proposal requires the initial focus of the incubator to address the number of mental health consumers who are deemed to be Incompetent to Stand Trial (IST). The State is facing a waiting list of persons determined to be IST and the $5 million incubator proposal is part of a larger budget initiative to address this challenge.

The Commission supports the Governor's proposal but is concerned that focusing on adults deemed Incompetent to Stand Trial forgoes efforts support a broader innovation agenda, particularly around the needs of children and youth. In response, the Commission is asking for an augmentation of the initial $5 million investment in the innovation incubator to support innovation planning and technical assistance to transform how California's mental health system responds to the needs of children and

youth. To the extent funding is available, the Commission respectfully requests an additional $5 million in Mental Health Services Act funding, from the State Administrative portion of the funds, for this purpose.

Welfare and Institutions Code (WIC), section 5830, provides for the use of Mental Health Services Act (MHSA) funds for Innovative Programs. County mental health programs are authorized to spend their innovation funds for Innovation programs upon approval by the Mental Health Services Oversight and Accountability Commission.

The Mental Health Services Act's Innovation component provides California the opportunity to develop and test new, unproven mental health models with the potential to become tomorrow's best practices. The primary purpose of Innovation Projects is to achieve one of the following:

- Increase access to mental health services to underserved groups, including permanent supportive housing.

- Increase the quality of mental health services, including measurable outcomes.

- Promote interagency and community collaboration related to mental health services or supports or outcomes.

- Increase access to mental health services, including permanent supportive housing.

Innovation projects may address issues faced by children, transition-age youth, adults, older adults, families (self-defined), and neighborhoods, tribal and other communities, counties, multiple counties, or regions. The project may initiate, support and expand collaboration and linkages, especially connections between systems, organizations and other practitioners not traditionally defined as a part of mental health care. The project may influence individuals across all life stages and all age groups, including multigenerational practices/approaches.

The creation of an Innovation Incubator is consistent with the existing authority in Welfare and Institution Code Section 5846 (c). Under that authority, the Commission may provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the Commission or when local programs could benefit from technical assistance for improvement of their plans.

This one-time funding request for the creation of a Children's Innovation Incubator will assist the Commission and counties in improving the effectiveness of innovative approaches for children's mental health services, and provide California the opportunity to develop and test new, unproven mental health models with the potential to become tomorrow's best practices.

The Commission currently provides consultation on a case-by-case basis in response to requests or as part of the Commission's review of innovation spending proposals. This proposal will allow the Commission to increase the utility of Innovation programs for improving county mental health programs for children in California.

This proposed investment in improving California's use of innovation funding for children's mental health programs will help guide county efforts to achieve those goals which are intended to reduce costs for the counties as well as the state, through both cost avoidance and reduction in unit costs.

The Commission states that establishing a Children's Innovation Incubator will allow California to more effectively marshal innovation funds to improve outcomes for children within California's mental health system. Anticipated direct outcomes include increased collaboration among California's counties for innovative proposals. Rather than investing limited innovation funds in multiple innovations across 59 local mental health agencies, the Incubator is intended to focus innovation investments on core, shared challenges, leading to larger investments in a smaller number of shared innovation programs that have improved potential for scalable impact.

Short-term outcomes are anticipated to include project proposals that are more innovative and have greater potential for success. Short-term outcomes also are anticipated to include the establishment of more creative and diverse partnerships between mental health and other health and human service or related programs, more public-private-academic partnerships and the leveraging of private sector resources to support the innovation agenda of the MHSA.

Long-term outcomes are anticipated to include changes in the core practices of county mental health programs that result in reduced costs, improved quality and clear and concrete outcome improvements. The Children's Innovation Incubator is intended to move California's mental health system toward becoming a learning system characterized by innovation, evaluation, and where successful, wide-spread implementation.

This request is for a one-time investment in the start-up costs and initial operations of the Children's Innovation Incubator. Under its existing authority, the Commission can incentivize county utilization of the Incubator. The Commission can authorize the counties to use a portion of their innovation funding to secure technical assistance. The Commission also can encourage the counties to seek the assistance of the Incubator, including modifying its Innovation program approval process to "fast-track" county plans that have been certified by the Incubator as meeting statutory and regulatory standards for approval. Counties would not be required to use the Incubator, but incentivized to participate through these strategies. As an accountability strategy for the Incubator, funding is sought for a limited term with the expectation that counties would fund the incubator on an ongoing "fee-for-service" basis. This approach creates a "market test" for the Incubator. If it provides ongoing value, the counties will have the resources, incentives and opportunity to fund the Incubator on an ongoing basis. If the Incubator does not deliver value to the counties, it would close because of inadequate funds. We anticipate that the $5,000,000 initial investment will fully subsidize start-up costs, and

partially subsidize operating costs for three years. After that time, the Incubator will be required to generate revenue to cover its operations or it will close.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Commission to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 7: COMMISSION AND STAKEHOLDER PROPOSAL ON MENTAL HEALTH SERVICES FOR IMMIGRANTS AND REFUGEES AND REDUCING CRIMINAL JUSTICE SYSTEM INVOLVEMENT

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Khatera Aslami-Tamplen**, Vice Chair, Mental Health Services Oversight & Accountability Commission
- **Chris Galeano,** California Immigrant Policy Center (CIPC)
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Commission and stakeholders are requesting $1,340,000 (MHSA State Administration Fund) to reduce the involvement of mental health consumers in the criminal justice system and to improve mental health services for immigrants and refugees.

BACKGROUND

The Commission provided the following background information:

Stakeholder Advocacy
The Commission currently has budget authority to make funding available for stakeholder advocacy efforts. These funds are used to support non-profit organizations that do outreach, education and training, and advocacy, at the state and local levels, to improve mental health outcomes. The Commission currently provides $670,000 annually to organizations that work with seven targeted populations or goals, including: mental health consumers, children, transition age youth, family members, veterans, LGBTQ communities and efforts to reduce racial and ethnic disparities. These funds are allocated through a competitive process and are intended to ensure that the voices of consumers are part of the decision-making process, particularly at the county level.

The Commission is requesting funding to expand those efforts to reduce the criminal justice involvement of mental health consumers, and to meet the mental health needs of refugees and immigrants.

Last year the Commission published a report on the opportunities to reduce the number of mental health consumers who become involved in the criminal justice system. For too many Californians, becoming involved with law enforcement remains the primary avenue to accessing mental health care. As part of broader strategy to address this challenge, the Commission is requesting an increase in stakeholder advocacy funds to reduce the number of consumers who become involved in the criminal justice system.

The Commission is seeking an augmentation of $670,000, on-going, from the State Administrative portion of the Mental Health Services Fund for this purpose.

Similarly, the Commission is seeking a comparable augmentation of its budget to expand support for immigrants and refugees who are struggling with unmet mental health needs. The Commission has heard testimony from refugee and immigrant advocates that these communities struggle to access mental health services because of the lack of culturally competent care, stigma within the refugee and immigrant communities, and limited understanding of how to access services. The Commission is seeking an additional augmentation of $670,000, on-going, from the State Administrative portion of the Mental Health Services Fund for this purpose.

These funds would be used to support outreach, education and training, and advocacy on behalf of these two populations.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Commission and CIPC to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY
4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 8: INVESTMENT IN MENTAL HEALTH WELLNESS ACT OVERSIGHT

PANEL

- **Ronald Washington**, Executive Director, California Health Facilities Financing Authority
- **Carolyn Aboubechara**, Program Manager, California Health Facilities Financing Authority
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE

This is an oversight issue on the Investment in Mental Health Wellness Act and Children's Crisis Services Grants.

BACKGROUND

SB 82 (Committee on Budget and Fiscal Review, Chapter 34, Statutes of 2013):

Capacity Expansion - Grant Programs. SB 82 authorizes the California Health Facilities Financing Authority (CHFFA) to administer a competitive selection process for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources. These funds were to be made available to counties or to private nonprofit corporations and public agencies. The 2013-14 Budget provided $142.5 million one-time General Fund, $4 million in ongoing Mental Health Services Act (MHSA) funding, and $2.8 million in federal matching funds (reimbursements) for these purposes. The one-time General Fund grants support capital projects to increase capacity for crisis intervention, crisis stabilization, crisis residential treatment, and rehabilitative mental health services. The MHSA and federal funds grants support personnel costs associated with operation of mobile crisis support teams. The grants support capital improvement, expansion and limited start-up costs.

Triage Personnel. SB 82 implements a process by which the MHSOAC allocates funding based upon requests for application of need and description of deployment of triage personnel to assist individuals in gaining access to needed services, including medical, mental health, substance use disorder assistance and other community services. The 2013-14 budget included $54 million ($32 million MHSA State Administrative Funds and $22 federal funds) for this purpose, ongoing.

Children's Crisis Services

The 2016 Budget Act appropriated a total of $17 million to CHFFA and approved trailer bill language to establish a competitive grant program to provide a continuum of crisis services to children under 21 years of age with the following objectives:

1. Provide for early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.
2. Expand community-based services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness-, resiliency, and recovery-oriented.
3. Add at least 200 mobile crisis support teams.
4. Add at least 120 crisis stabilization and crisis residential treatment beds.
5. Add triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders in community-based service points, such as homeless shelters, schools, and clinics.
6. Expand family respite care.
7. Expand family supportive training.
8. Reduce unnecessary hospitalizations and inpatient days.
9. Reduce recidivism and unnecessary local law enforcement expenditures.
10. Provide local communities with increased financial resources to leverage public and private funding sources to improve networks of care for children and youth with mental health disorders.

These grants were part of a package of local public safety investments included in the 2016 Budget Act to reduce people's involvement in the criminal justice system. The total investment in children's crisis services was $31 million ($17 million General Fund and $14 million MHSA funds). The General Fund was composed of approximately $7 million reappropriated from unspent funds previously allocated to the Investment in Mental Health Wellness Grant Program and $10 million of new General Fund resources.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CHFFA and the Commission to provide an overview of these programs and resources, updated information on the specific dollar amounts expended, and on accomplishments (gains) in mental health services that have resulted.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 9: COMMISSION REQUEST TO REAPPROPRIATE TRIAGE FUNDS

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Norma Pate,** Deputy Director, Administrative and Legislative Services, Mental Health Services Oversight & Accountability Commission
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Commission requests approval to reappropriate triage funds; the amount of unencumbered and unspent funds that the Commission is requesting for reappropriation are $2,549,247 from FY 2013-14, $8,784,586 from FY 2014-15, $992,407 from FY 2015-16, and $17,060,629 from FY 2016-17, for a total of $29,386,871.

BACKGROUND

The Investment in Mental Health Wellness Act of 2013 provides counties with funds for crisis programs through a competitive grant process. The Mental Health Services and Accountability Commission awarded the grants in FY 2013–14 however, counties had challenges in hiring triage personnel resulting in delayed implementation. Additionally, the counties were not able to spend all of the funds they received during the term of their grants, resulting in unspent funds that will be returned to the Commission in 2018.

These reappropriated funds will enable the Commission to award more grants in the upcoming grant cycle for the Triage Personnel program and will further assist thousands of high-need individuals in accessing crisis services by providing local communities with increased financial resources to achieve improved networks of care for individuals experiencing a mental health crisis. The Commission explains that this increased capacity to provide assistance will result in a reduced unnecessary hospitalizations and impatient days, reduced recidivism, and will mitigate unnecessary expenditures of law enforcement.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Commission to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

4140 OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT

ISSUE 10: MENTAL HEALTH WORKFORCE EDUCATION AND TRAINING (WET) PROGRAM OVERSIGHT

PANEL

- **Stacie Walker**, Deputy Director, Healthcare Workforce Development Division, OSHPD
- **Kirsten Barlow**, Executive Director, County Behavioral Health Directors Association of California
- **Noah Johnson,** Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

OVERSIGHT ISSUE

The Mental Health Workforce Education and Training (WET) program, established under the Mental Health Services Act, is reaching the end of its planned funding. Therefore, various stakeholders have raised questions about the future of this work, and concerns about the potential loss of the gains made by this project without establishing future plans and funding for on-going work in the area of mental health workforce. This issue is to provide oversight on this issue.

BACKGROUND

Established with the passage of Proposition 63, the Mental Health Workforce Education and Training (WET) programs were developed to address the growing need for a much more diverse public mental health workforce. Statute required a fund be created where revenues were deposited between Fiscal Years 2004-05 and 2007-08. At the end of the this period, a total of $444.5 million was allocated for the education and training portion of the MHSA.

In 2008 the former Department of Mental Health (DMH), developed the first Five Year Plan which spanned April of 2008 – April of 2013; it was accompanied by a ten-year budget projection for the administration of the $444.5 million that had been collected in the WET fund. The budget set aside $210 million to be distributed to counties for local WET program implementation to be expended by 2018 as well as $234.5 million set aside for the administration of WET programs at the State level.

In 2012, with the elimination of DMH, the MHSA WET programs were transferred to the Office of Statewide Health Planning and Development (OSHPD). OSHPD was tasked with the development of the next Five Year Plan that would be in effect from April 2014 – April 2019.

OSHPD provided the following background information on WET:

The Mental Health Services Act sets aside $444.5 million to help build the public mental health workforce.

- $210 million to support local county mental health workforce education and training (WET) programs

- $234.5 million to support state administered WET programs

The Mental Health Services Oversight and Accountability Commission and the Department of Health Care Services are charged with tracking local county WET programs. The Office of Statewide Health Planning and Development (OSHPD) has no oversight over the county programs.

The Mental Health Services Act requires OSHPD to create a statewide WET plan every five years and provides for ten years of funding to support the first two plans. The 2014-2019 WET plan can be found at: https://www.oshpd.ca.gov/documents/HWDD/WET/WET-Five-Year-Plan-2014-2019.pdf.

The plan articulates the state's public mental health workforce priorities through various program components and specifies the level of funding for each component.
OSHPD is administering the second $115 million 5-year plan between 2014 and 2019. Grant funding ends June 30, 2018, and administrative funding and position authority ends June 30, 2019. The outcomes for the following programs are not complete:

- Recruitment and Career Awareness Program – Encourages individuals to pursue careers as mental health professionals.
  - Exposing more than 26,000 students to mental health careers.
  - Providing 90 students with internships in the public mental health system.

- Loan Assumption – Supported 8,237 mental health professionals by providing up to $10,000 in loan repayment in exchange for working 12 months in the public mental health system.

- Stipends – Provided more than 950 stipends of up to $21,000 to mental health professionals in exchange for working in the public mental health system for 12 months.

- Education Capacity – Increased the number of residency and training slots providing rotations in the public mental health system, training at least an additional 135 Clinical Psychiatrists and 138 Psychiatric Nurse Practitioners.

- Consumer and Family Member – Supported the training and job placement of more than 1,300 individuals with lived experience within the public mental health system.

- Regional Partnerships – supported regional coordination of strategic initiatives designed to increase the capacity of the public mental health system.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD provide an overview of the history, current status, and accomplishments of the WET program, and respond to the following:

1. What has been done to track county based programs?

2. Are there statistics that show how well county based WET programs are doing in diversifying the public mental health system (PMHS) workforce?

3. Is the PMHS workforce progressively diversifying and being retained over longer periods of time?

4. How will the ending of the WET funding impact the gains made in the diversification of the county PMHS workforce?

5. Please describe OSHPD's plans with regard to the next 5-year plan, in light of the absence of future funding.

The Subcommittee requests CBHDA respond to the following:

6. Have counties found the WET program to be valuable?

7. Do any of the counties plan to backfill the WET funding with local MHSA funding?

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 11: MENTAL HEALTH LOAN ASSUMPTION PROGRAM SPRING FINANCE LETTER

PANELISTS

- **Norlyn Asprec,** Executive Director, Health Professions Education Foundation, OSHPD
- **Noah Johnson,** Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Office of Statewide Health Planning & Development (OSHPD) requests $215,000 in limited-term funding equivalent to 2.0 positions in FY 2018-19 and FY 2019-20 to support the administrative activities to manage and close out all MHLAP grants awarded through FY 2017-18 and ensure compliance with program requirements.

BACKGROUND

In November 2004, Proposition 63, the Mental Health Services Act (MHSA) imposed a one-percent tax on personal income in excess of $1 million to support prevention, early intervention, and services in the public mental health system. The MHSA included one-time ten-year funding of $444.5 million for the Workforce Education and Training (WET) Program to address the shortage of mental health providers through various programs.

The ten-year budget set aside $210 million to counties for local WET program implementation, and $234.5 million to state and regional levels for the administration of WET programs. Statute authorizes that five-year plans be developed to determine how the funding will be spent. The first Five-Year Plan for 2008-2013 was developed by the former Department of Mental Health. Following the Department of Mental Health being incorporated into the Department of Health Care Services in 2012, the responsibility for developing the second Five-Year Plan was transitioned to OSHPD. OSHPD developed the second Five-Year Plan for 2014-2019. In January 2014, the California Mental Health Planning Council (CMHPC) approved $114.7 million for the second Five-Year Plan 2014-19.

The MHSA created MHLAP and provided funding to develop a loan forgiveness program in order to retain qualified professionals working within the Public Mental Health System (PMHS). Through the WET component of the Act, $10 million is allocated yearly to loan assumption awards. MHLAP recipients can receive up to $10,000 to repay educational loans in exchange for a 12-month service obligation in hard-to-fill or difficult to retain positions within the PMHS.

This service commitment is designed to improve access to mental health resources across California and is a required component of the current WET Five-Year Plan 2014-2019 approved by CMHPC. Eligible professions include but are not limited to registered or licensed psychologists, registered or licensed psychiatrists, postdoctoral psychological assistants, and registered or licensed clinical social workers.

OSHPD administers the state level programs for the WET Program. Under the current WET Five-Year Plan 2014-2019, local assistance grant funding for MHLAP ends on June 30, 2018. At the end of FY 2017-18, approximately 1,200 MHLAP awards will be issued for a total of approximately $10 million in funding.

These grants require administrative support to monitor the awards throughout the duration of the service agreement. Administrative services include program management, verifying employment that includes job transfers/promotions with county mental health directors, monitoring of program compliance, amending award agreements, and processing payments upon recipients' completion of the required service obligation.

Recipients may also request an extension of the 12-month service obligation. The extension may be granted for up to two years for specific circumstances. Extensions for awards granted in FY 2017-18 will require administrative support through FY 2019-20. Within this period, OSHPD is responsible for providing technical and administrative services to the MHLAP awardees.

Since FY 2017-18 is the last year of funding for MHLAP awards, OSHPD reassessed the administrative workload to manage 1,200 new MHLAP grant agreements and open grants issued in prior years to determine the necessary level of resources in FY 2018-19 and FY 2019-20 to close out all MHLAP processes. The WET program budget does not include any administrative funding for MHLAP beyond FY 2017-18.

OSHPD explains that, without the administrative funding for an additional two years through FY 2019-20, there would be a delay in grant management activities, which could affect the awardees' ability to complete their service obligation and provide critical mental health services in areas of unmet need.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 12: MEMBER/STAKEHOLDER PROPOSAL TO EXTEND WET FUNDING

PANELISTS

- **Assemblymember Kansen Chu**
- **Le Ondra Clark Harvey, Ph.D.,** Director of Policy and Legislative Affairs, California Council of Community Behavioral Health Agencies

Public Comment

PROPOSAL

Assemblymember Kansen Chu (with the support of additional Members) and the California Council of Community Behavioral Health Agencies (CBHA), and with the support of additional organizations, requests $26,436,022 General Fund for the Statewide Workforce Education and Training (WET) Program for Fiscal Year 2018-19 to support a one-year extension of the WET programs through the 2018-19 fiscal year.

BACKGROUND

Assemblymember Chu and CBHA provided the following background:

The WET program, established in the MHSA, addresses the growing shortage of behavioral health professionals in California by focusing on recruiting, training and retaining mental health professionals. There has been an increasing demand for services in both mental health and substance use disorder fields, and needs have been exacerbated by the inclusion of behavioral health services as an Essential Health Benefit in the Affordable Care Act (ACA) and the expansion of Medi-Cal.

As this demand increases, the aging behavioral healthcare workforce is retiring at a faster pace than new health professionals are entering the field. Behavioral health agencies statewide are struggling to fill open positions at all levels - especially within licensed and clinical categories - resulting in lack of access to these services for many Californians.

The looming loss of statewide WET funds provided through the MHSA will compound this problem. So far, the state has worked with stakeholders to develop two five-year plans for the WET program, and will be developing a third for 2020 through 2025. WET programs work to address critical workforce issues including maldistribution of services, lack of diversity, and under-representation of professionals with lived experience and from the diverse racial, ethnic and cultural communities they serve.

WET has resulted in successful initiatives such as the Mental Health Loan Assumption program which assists mental health professionals with loan repayment in exchange for 12 months of service in the public mental health system; and stipend programs for

graduate students planning to work in the field. These programs have been identified by behavioral health providers as critical elements in addressing the workforce shortage.

This one-year extension of funding will continue these vital initiatives, and give the administrating agency, the Office of Statewide Health Planning and Development, as well as stakeholders the time necessary to gather data, review outcomes and best practices, and develop a long-term plan for the future of the WET program.

Workforce development, which includes recruiting, training and retention of trainees and licensed professionals, is a top priority for the California Council of Community Behavioral Health Agencies (CBHA) and other organizations that have endorsed this letter. There has been an increasing demand for services in both the mental health and substance use disorder fields, among others, which has been exacerbated by an increased demand for services created by the inclusion of behavioral health services as an Essential Health Benefit in the Affordable Care Act (ACA). This additional demand strained an aging behavioral healthcare workforce that was diminishing faster than it could be replenished. Health service agencies across the state continually struggle to fill open positions to meet demand, but this is especially difficult in the clinical and licensed categories. The WET funding addressed these issues by providing support for a variety of training initiatives including loan repayment and salary stipend programs – incentives that have shown to help alleviate financial stressors of service providers and encourage them to continue working in rural and urban locations that have traditionally had difficulty attracting service providers.

While the MHSA allocated WET funding at the local and state levels, the current MHSA Five Year Plan is set to run out of funding after only four years in June 2018. There is broad acceptance in the behavioral health community for the development of a new plan that is comprehensive, sustainable and builds in accountability. More work needs to be done to gather data, learn what was done with the funds, review the outcome, and review best practices. Currently, the Office of Statewide Health Planning and Development (OSHPD) is working to gather the data from counties to produce a report that will review what has been accomplished over the last four years. In the meantime, it is our belief that allowing a 1-year gap in funding for the WET programs will add to the shortage of health workers, as those who are receiving stipends and loan forgiveness will lose their funding.

CBHA and the organizations that are supporting this proposal believe that it will be in the best interest of behavioral health providers and consumers to let this plan continue to operate for one year, the original goal of the WET Plan, while data is reviewed and a new long-term plan is developed by OSHPD. The WET Plan has resulted in successful programs, namely various Loan Forgiveness Programs and stipend programs for trainees. These programs, have been identified as a critical element in addressing workforce shortages, especially for clinical providers. If the individual elements of the WET Five Year Plan lapse, it will be much more difficult and expensive to reinstate them.

The current Five Year Plan under the Mental Health Services Act (MHSA) has only been budgeted for four years through the end of June 2018. The total approved budget for FY 2017-18 is $25,436,022 and they are requesting the same amount for FY 2018-19 with an additional $1 million dollar allotment for OSHPD's administrative fees for a total of $26,436,022.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Chu and Le Ondra Clark Harvey to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 13: STAKEHOLDER PROPOSAL ON PRIMARY CARE MENTAL HEALTH FELLOWSHIP

PANELISTS

- **Robert Michael McCarron**, **D.O**.
  - Professor and Vice Chair of Education and Integrated Care, Psychiatry & Human Behavior, UC Irvine
  - Residency Training Director, Psychiatry & Human Behavior School of Medicine
  - Co-Director, Train New Trainers Primary Care Psychiatry Fellowship, Psychiatry & Human Behavior School of Medicine

Public Comment

PROPOSAL

The California Psychiatric Association requests $1 million General Fund dollars on a one-time basis to be appropriated to OSHPD for scholarships for primary care physicians that wish to participate in one-year fellowship programs for training in the essentials of primary care psychiatry offered at UC medical schools.

BACKGROUND

The California Psychiatric Association provided the following background:

Often patients with mental health needs present early in the course of their difficulty to their primary care physicians. They often present with physical ailments that upon closer examination are psychiatric in nature, or physical ailments that are accompanied by psychiatric symptoms. Because of the increase in demand for mental health services in our communities, primary care physicians are also seeing more patients with early signs of mental illness. Primary care physicians are given at best rudimentary training in psychiatry in primary care training programs and lack the assessment and treatment skills needed to confidently address the needs of patients with mild to moderate mental illnesses. Given the shortage of psychiatrists in California, especially in rural and remote areas, many primary care physicians must address these issues without the ability to quickly refer these patients or even consult with a psychiatrist. In addition, the lack of experience with mental health conditions limits these physicians' knowledge of the system of care and relationships with mental health providers. As a result, many patients are not provided necessary assistance, particularly at the early stages of their mental health challenges. Of course, the early onset of these conditions is the most important time for them to be addressed. The longer treatment is delayed, the more severe symptoms are when finally addressed, and the less likely are patients to experience good outcomes when compared to peers receiving early interventions and preventative care.

There are two fellowship programs in the UC system, at UC Davis and UC Irvine, which are providing mentorship and training in the area of primary care psychiatry through one-year fellowship programs. Trainees learn how to complete an efficient and evidence-based psychiatric interview in the primary care or medical setting. They are also trained to diagnose and treat commonly encountered psychiatric conditions such as mood, anxiety and psychotic and substance misuse disorders. In addition, because these two programs use a "train the trainer" model, trainees learn how to teach these principles to their primary care colleagues back in their "home" treatment setting, thus multiplying the effects of their fellowship. These programs are one year in duration so as to allow the primary care physicians' participation without disrupting their practices, and include intensive weekends in residence at one of the UC programs, online content and interaction with their primary care physician peers, and very importantly, each fellow is assigned a UC faculty mentor for the course of the fellowship, who then is also available after graduation. This provides psychiatric liaison and consultation on an ongoing basis in the primary care practice. A last feature of these fellowships which is integral to success in meeting the needs of primary care physicians are faculty that are dual board certified in psychiatry and either internal medicine or family practice, which means that fellows are in fact both taught by their peers, as well as specialists in the practice of psychiatry. Outcome data being developed by these programs is pending publication in a peer reviewed medical journal. This data shows positive outcomes for the fellowship and high appreciation of the value of the program by the primary care physician fellows. Demand for fellowship training slots has on doubled since the inaugural year for the program demonstrating the value perceived by primary care physicians.

While these programs have demonstrated success in preparing primary care physicians to meet the growing demand for basic mental health services, the tuition of the programs, $15,000 for one year, is beyond what many community clinics, rural hospitals and independent practitioners can afford. The program has trained about 80 physicians over the last 2 years, with current enrollment for the third year of the program at 67 individuals. But, most of the physicians serve more affluent areas that do not have the same demographic and cultural challenges as underserved areas. They also work in health systems provided by counties or health services plans which have the resources to pay tuition for the fellowship. Financial assistance is needed to maximize the opportunities to provide this valuable training to primary care physicians in underserved areas who lack the resources to participate in the fellowship.

The Legislature would appropriate $1 million to the Office of Statewide Health Planning and Development to administer the scholarship program. The criteria for eligibility would be similar to the Steve Thompson Loan Repayment Program with regard to practice in underserved areas and with underserved populations. The program would be limited to primary care as defined in the Steve Thompson Loan Repayment Program and emergency physicians. Availability would be on a "first come first serve" basis. The appropriation of $1 million to the programs would enable a doubling of current capacity, with 50% of that capacity (or more) devoted to training physicians serving underserved areas and underserved populations.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Dr. McCarron to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 14: MEDI-CAL MENTAL HEALTH SERVICES

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health Services and Substance Use Disorder Services, Department of Health Care Services
- **Kirsten Barlow**, Executive Director, County Behavioral Health Directors Association of California
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED BUDGET

California has a decentralized public mental health system with most direct services provided through the county mental health system. Counties (i.e., county mental health plans) have the primary funding and programmatic responsibility for the majority of local mental health programs. This funding includes 1991 and 2011 realignment funding, Medi-Cal Specialty Mental Health General Fund and Federal Funds, and Mental Health Services Act (Proposition 63) funding, as shown in the following chart:

Fund Source	2017-18	2018-19
1991 Realignment		
Mental Health Subaccount (base and growth)*	$129,099,000	129,099,000
2011 Realignment		
Mental Health Subaccount (base and growth)*	$1,130,982,000	$1,130,648,000
Behavioral Health Subaccount (base)**	$1,328,618,000	$1,432,930,000
Behavioral Health Growth Account	$104,312,000	$100,966,000
Realignment Total	**$2,693,011,000**	**$2,793,643,000**
Medi-Cal Specialty Mental Health Federal Funds	$2,998,853,000	$2,809,387,000
Medi-Cal Specialty Mental Health General Fund	$181,861,000	$199,565,000
Mental Health Services Act Local Expenditures	**$1,827,038,000**	**$1,827,038,000**
Total Funds	**$7,700,763,000**	**$7,629,633,000**

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

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

BACKGROUND

Medi-Cal Mental Health. California has three systems that provide mental health services to Medi-Cal beneficiaries:

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

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

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

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

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

- Psychiatric consultation

Behavioral Health Realignment Funding

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

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

Specialty Mental Health Waiver

While the SMHS Waiver previously had been approved for only two years at a time, CMS has approved the new SMHS Waiver for five years. This is the first time CMS has granted a five year SMHS Waiver renewal to California. However, CMS approved the Waiver on the condition that DHCS meets newly imposed Special Terms and Conditions (STCs), which involve current functions as well as new functions and increased workload. Failure to comply with these STCs places the SMHS Waiver, and up to $2 billion in federal funds at risk.

On June 24, 2015, CMS issued an approval of the five-year SMHS Waiver and indicated that their concerns continue to be program Integrity monitoring and compliance. This renewal is effective July 1, 2015 through June 30, 2020. The STCs will require a substantial increase in workload, over and above current workload. As in prior years, ongoing non-compliance issues and chart review disallowances by the County MHPs remain. In the renewal, CMS has given specific expectations for DHCS to attain compliance with federal and state regulatory requirements as well as the MHP contract requirements, including a process for levying fines, sanctions, and penalties on MHPs that have continued, significant non-compliance issues. DHCS is in the process of developing a performance dashboard that mirrors the Performance Outcome System for children.

Performance Outcome System and CANS

SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012, required DHCS to convene stakeholders to develop a plan for a POS for EPSDT mental health services provided to Medi-Cal eligible children. The department was required to consider the following objectives: 1) enables provision of high quality and accessible EPSDT services for eligible children and youth; 2) collects information that improves practice at the individual, program, and system levels; 3) minimizes costs by building on existing resources; and 4) generates reliable data that are collected and analyzed in a timely fashion. AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, implemented the following additional requirements for the department:

- Convene a stakeholder advisory committee to develop methods to routinely measure, assess, and communicate program information regarding informing, identifying, screening, assessing, referring, and linking Medi-Cal eligible beneficiaries to mental health services.

- The committee reviews health plan screenings for mental health illness, health plan referrals to Medi-Cal fee-for-service providers, and health plan referrals to county mental health plans. This information is to be included in the POS implemented by the department.

- Propose how to implement the updated POS plan no later than January 10, 2015.

The department's implementation plan for the POS includes the following elements:

1) Establish the POS methodology – The department is required to develop a clear methodology for specifying the purpose of the project, stakeholder and partner involvement, the target population, data availability, data limitations or strengths, reporting elements and timelines, and other relevant details necessary for implementation and development of the POS. The department has focused the methodology first on its reporting requirements from existing DHCS databases, with further development of data collection protocols expected in the future.

2) Report performance outcomes from existing DHCS databases – The department is required to utilize existing DHCS data systems to evaluate performance outcomes on a preliminary basis. The systems used are as follows:

    a) Short Doyle/Medi-Cal (SD/MC) Claiming System – Provides information from county mental health plans about who is receiving services, how often the services are received, and the amount claimed for federal reimbursement of services to Medi-Cal beneficiaries.
    b) Client and Services Information System -- Collects data pertaining to mental health clients and the services they receive at the county level including information about non-Medi-Cal mental health services, Medi-Cal SMHS, client demographics, diagnoses, living arrangement, service strategy, race/ethnicity, employment, and education level.

c) Web-Based Data Collection Reporting System - Consumer Perception Surveys – Provides information about the client or family member's perception of satisfaction with regards to services including general satisfaction, access, quality or appropriateness of care, social connectedness, client functioning, criminal justice, and quality of life. Other data include perceived impacts to quality of life including general life satisfaction, living situation, daily activities and functioning, family and social relations, finances, legal and safety, and health.
d) Data Collection and Reporting System – Collects data pertaining to any client enrolled in an MHSA funded Full Service Partnership program. Data includes residential status, education, criminal justice, legal designations, co-occurring disorders, source of financial support, and emergency intervention.
e) Management Information System/Decision Support System – Provides data pertaining to claims and encounter data (mental health Medi-Cal, Drug Medi-Cal, managed care, pharmacy, fee-for-service Medi-Cal), Medi-Cal eligibility data, provider data, and other reference data such as National External Norms and Benchmarks.

Using existing data between 2011-12 and 2014-15, the department has produced several data reports including a statewide aggregate report and county-specific reports (for small, medium, large and rural counties). A county-level aggregate report is still in development. The reports include the following data elements: 1) unique counts of children and youth receiving SMHS; 2) penetration rates of services compared to eligible population; 3) utilization; 4) arrivals, continuance, and exiting of services; and 5) time to step down. Many of these elements are organized in the aggregate, as well as by race, age group, and gender.

3) Comprehensive Data Collection and Reporting – The department, in partnership with stakeholders and academic researchers, is developing a functional assessment tool to assess client clinical and functional status over time. This tool will be deployed at the county level to collect the data needed to assess outcomes in the POS. According to DHCS, the tool is expected to be approved within the next few weeks and provided to county stakeholders in Spring 2017. The department expects additional costs for purchasing the new tool and training 14,614 county clinical staff in its use.

4) Continuous Quality Improvement Using POS Reports – The department plans to utilize existing processes to develop a quality assurance and improvement process. This process is intended to ensure consistent, high-quality, and fiscally effective services are delivered to children and their families to improve school performance, the home environment, child safety, and involvement with the juvenile justice system.

5) Tracking Continuum of Care Screenings and Referrals – The department has required managed care plans to report data on mental health screenings and referrals to specialty mental health services since May 2014. According to DHCS, however, this data is not adequate to evaluate the linkages between managed

care and the SMHS system, as required by statute. The department is attempting to evaluate the data needed to appropriately track these linkages.

Child and Adolescent Needs and Strengths

Stakeholders have reached out to the Subcommittee expressing concerns regarding DHCS's decision to mandate the use of the Child and Adolescent Needs and Strengths (CANS) tool to measure outcomes for EPSDT-funded Children's mental health programs in California. Stakeholders shared the following concerns:

1. UCLA, DCHS' experts hired to evaluate the CANS ability to measure improvement in children's mental health functioning, found that the CANS was not "considered to be a good candidate for measuring outcomes statewide," and determined that the CANS met only 4 of the 9 minimum criteria for selection of a tool to measure this improvement, with its modified Delphi Panel determining that the CANS fell within the lowest range of the final 11 candidate tools.

2. The CANS ranked 7th of the 11 tools on Effectiveness of Care (the extent to which improvement in the outcome, as assessed by the tool is an indicator of effective care); 9th of the 11 tools on Scientific Acceptability; and 9th of the 11 tools on Feasibility.

3. The deficiencies of the CANS for use as an aggregate outcome measurement tool highlighted in our attached document, which were specifically concurred in by the California Behavioral Health Directors' Association (CBHDA) in their March 6, 2018 letter to CHHS, included: 1) its inability to appropriately reflect change at an aggregate program level versus an individual child level; 2) concerns related to the variability of the CANS tool, particularly in relation to proving its reliability/validity as an outcome measurement tool; and 3) the impact of excessive clinician burden.

4. With regard to cost, Los Angeles and Orange Counties alone have projected that the State's mandating the use of the CANS would result in over $100 million in added training and claiming loss costs alone (which does not include extensive IT modification costs that would be required), far in excess of the projected $15 million figure which DHCS provided to the Legislature during the 2017 May Revise budget hearings. These county costs are subject to Proposition 30 and would be imposed on the state, as indicated by CBHDA and DHCS in its last year's May Revise analysis.

5. While Brenda Grealish cited as DHCS' justification for mandating the CANS as a second, clinician administered tool the fact that it was used by 33 California counties, it must be noted that the UCLA Study's County and Provider Survey Results found that two-thirds of those counties had indicated experiencing at least one problem with the CANS, and 36% of those counties "reported experiencing problems with the reliability of the scores/results from the tool."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of Medi-Cal mental health programs, an update on the budget for these programs and services, and respond to the following:

1. Please summarize the findings of the performance outcome system.

2. Please respond to the concerns of stakeholders regarding the use of CANS.

3. What are the reasons that California continues to be one of only three states to carve mental health services out of managed care? How does this benefit Californians?

4. Are there discussions at the federal or state level around the need to make mental health funds, especially for children, more flexible and less dependent on mental illness diagnoses?

4. An OIG audit released in December 2017 looked at services reimbursed in 2014 and resulted in a 20 percent disallowance rate. Hence, counties owe the federal government $230 million. DHCS states that it is working with counties on how to repay the federal government. Please explain the reasons for this high disallowance rate and how the state plans to improve its oversight of counties.

5. DHCS conducts program review of county performance contracts to determine compliance. DHCS must review every county at least once every three years. DHCS may request a plan of correction from a county that does not comply with the performance contract. How often has this happened? Please provide some high-level examples.

6. The Subcommittee requests County Behavioral Health Directors Association to provide their perspective on the quality of, and access to, mental health services.

7. The Subcommittee requests DHCS and CBHDA to discuss how well the state is addressing adverse childhood experiences and toxic stress in kids. What should the state and counties be doing that they are not doing now?

8. Is the unprecedented and constantly growing waiting list of Incompetent to Stand Trial referrals from the courts to the Department of State Hospitals a reflection of failing or inadequate community mental health services?

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 15: MENTAL HEALTH SERVICES DIVISION POLICY IMPLEMENTATION BUDGET CHANGE PROPOSAL

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health Services and Substance Use Disorder Services, Department of Health Care Services
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Department of Health Care Services (DHCS) requests 10.0 permanent positions and expenditure authority to strengthen processes within existing state programs, as well as to develop and implement policies and processes for new state requirements related to recently chaptered legislation.

Total funding request:

Fiscal Year	Total Funds	General Fund	Federal Fund
2018-19	**$1,329,000**	**$665,000**	**$664,000**
Staffing:	$886,000	$443,000	$443,000
External Contracts:	$443,000	$222,000	$221,000
2019-20 and on-going	**$1,275,000**	**$638,000**	**$637,000**
Staffing:	$832,000	$416,000	$416,000
External Contracts:	$443,000	$222,000	$221,000

DHCS requests these resources, specifically to:

- Strengthen program monitoring and oversight of the Mental Health Services Act (MHSA);

- Meet the requirements of Assembly Bill (AB) 501 (Ridley-Thomas), Chapter 704, Statutes of 2017; and

- Augment the mental health External Quality Review Qrganization (EQRQ) contract to implement requirements of Senate Bill (SB) 1291 (Beall), Chapter 844, Statutes of 2016 .

BACKGROUND

DHCS is responsible for administering California's community mental health system, which is operated through California's 58 county mental health departments. California's community mental health system consists of three primary programs: the Bronzan-

McCorquodale Act, the Mental Health Services Act (MHSA), and the Medi-Cal Specialty Mental Health Services (SMHS) program. DHCS enters into two types of contracts related to mental health:

1) A performance contract with the 57 county mental health departments for the Bronzan-McCorquodale Act and the MHSA; and

2) A contract with 56 county Mental Health Plans (MHPs) to administer the SMHS program.

DHCS is responsible for implementing policies, regulations and new legislation related to these mental health programs.

Currently, DHCS is implementing new federal requirements including the Medicaid Managed Care (MMC) Final Rule and the Mental Health Parity and Addiction Equity Act (MHPAEA) Rule. DHCS is also collaborating and coordinating with the Department of Social Services to implement the Continuum of Care Reform program. In addition, recently chaptered legislation (noted above) creates additional implementation workload to MHSD's current efforts. DHCS provided the following background on the workload areas affected by these new requirements.

MHSA Program Monitoring, Oversight, and Program Policies

DHCS has statutory responsibility for fiscal and programmatic oversight activities of MHSA-funded programs. Specifically these statutory responsibilities include:

1. Annual Revenue and Expenditure Report: DHCS develops the MHSA Annual Revenue and Expenditure Report that identifies county MHSA expenditures, determines any additional funds generated as a result of MHSA, identifies unexpended funds and interest earned, and determines reversion amounts. MHSA programs are evaluated based on this expenditure information. DHCS may withhold funds from counties that do not submit the MHSA Annual Revenue and Expenditure Report by the specified due date. (W&I Code § 5899)

2. Performance Contracts with Counties: DHCS implements mental health services for children/adult/older-adult systems of care and prevention and early intervention through contracts with county mental health programs. DHCS conducts program review of county performance contracts to determine compliance. DHCS must review every county at least once every three years. DHCS may request a plan of correction from a county that does not comply with the performance contract (W&I Code § 5897).

3. Referrals of Critical Performance Issues from the Mental Health Services Oversight and Accountability Commission (MHSOAC): DHCS may receive notifications deemed as critical performance issues related to the performance of county mental health programs from the MHSOAC.

4. Withholding of Funds and Corrective Action Plans if County Found to be Failing to Comply in a Substantial Manner: If the Director determines that there is or has been

a failure to comply with a provision of this code or regulations in a substantial manner, the Department may withhold part or all of state mental health funds from the county, require the county to enter into a plan of correction, or bring an action in mandamus or any other action appropriate to compel compliance (W&I Code § 5655).

Mental Health Fiscal Policy Development

DHCS is also responsible for implementing policies related to several state and federal mental health programs. MHSD's Mental Health Management and Performance Outcomes Branch (MHMPOB) develops, implements, and administers fiscal policies related to existing and new state and federal programs and requirements. MHMPOB is currently developing and implementing fiscal policy related to the federal MMC Final Rule, MHPAEA, and the state Continuum of Care Reform program. MHMPOB must respond to federal and state program changes by designing and implementing the necessary fiscal-related changes in a timely manner.

Legislative Changes:

Mental Health Plans External Review (SB 1291)

As required by Title 42 Code of Federal Regulations (CFR) Section 438 Subpart E, DHCS contracts with an EQRO to validate federally required quality improvement activities. The EQRO analyzes information related to quality, timeliness, and access to SMHS provided by MHPs and/or their subcontractors to Medi-Cal beneficiaries. The EQRO publishes individual MHP reports, an annual statewide summary report of county-specific reviews, and quarterly reports on performance improvement projects (PIPs) that MHPs are required to conduct. In addition, the EQRO provides technical assistance and training to county MHPs regarding required reviews, reporting, PIPs, and other topics.

SB 1291 requires annual monitoring and review of each MHP by an EQRO beginning July 1, 2018. SB 1291 requires the EQRO to perform similar functions as those required under 42 CFR 438, Subpart E, but expands the purview of the review to include minor and non-minor dependents in foster care, which requires monitoring specific data on mental health services and SMHS provided to minor and non-minor dependents. Among its requirements, SB 1291 requires MHPs to submit corrective action plans to DHCS, based on EQRO identified deficiencies. All MHP corrective action plans will be required to be posted on the DHCS Internet Website. DHCS will be required to annually share with county boards of supervisors specified disaggregated data on Medi-Cal eligible minor and non-minor dependents in foster care.

Children's Crisis Residential Programs (CCRPs) (AB 501)

Over the last several years, the Legislature has proposed legislation to address the need for greater crisis residential treatment service options for children. In 2016, the Governor directed CDSS and DHCS to work in collaboration with county behavioral health directors and children's advocates to develop a more viable solution to address

the acute shortage of residential programs that provide crisis mental health treatment for children and youth. The outcome of that collaboration is AB 501.

Short Term Residential Therapeutic Programs (STRTPs) are a new type of residential facility operated by a public agency or private organization licensed by California Department of Social Services (CDSS) that provide specialized intensive care and supervision services and supports, treatment, and short-term, 24-hour care and supervision to children.

AB 501 authorizes CDSS to license a STRTP to operate as a Children's Crisis Residential Program (CCRP). A CCRP serves children experiencing mental health crisis as an alternative to psychiatric hospitalization. The primary function of a CCRP is to provide short-term crisis stabilization, therapeutic intervention, and specialized programing in an unlocked, staff secured setting with a high degree of supervision and structure with the goal of supporting the rapid and successful transition of the child back to the community. CCRP level of care is part of the full continuum of care considered medically necessary for many children with serious emotional disturbances. These facilities are limited to fewer than 16 beds, with at least 50 percent of those beds in single-occupancy rooms.

The bill establishes CCRPs and requires DHCS or MHPs to approve mental health programs for this new licensure category. This new licensure category requires CCRPs to obtain and maintain mental health program approval that includes a Medi-Cal mental health certification, issued by DHCS or a county mental health plan to which DHCS has delegated authority.

To issue licensure for CCRP, DHCS must perform comprehensive mental health program approval activities for the STRTP, which consist of continuous, comprehensive on-site review of operations, development of clinical practice standards, policies and procedures, and treatment modalities to ensure these programs are in good standing on an ongoing basis. In addition to the increased mental health program approval activities, DHCS is required to develop CCRP standards and procedures to ensure that children, who are experiencing mental health crises, receive appropriate, intensive mental health treatment services when placed in a STRTP. Up until now, children in mental health crisis primarily turned to emergency rooms and psychiatric hospitalization. CCRPs are expected to provide a more therapeutic, cost effective alternative treatment for children.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal, and respond to the following questions:

- For what reason is MHSA State Admin funding not proposed for part of this, and not sufficient to fund these resources?

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 16: DRUG MEDI-CAL AND SPECIALTY MENTAL HEALTH SERVICES; FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CENTERS (SB 323) BUDGET CHANGE PROPOSAL

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health Services and Substance Use Disorder Services, Department of Health Care Services
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS requests 5.0 permanent, full-time positions, as well as two-year limited-term (LT) resources and expenditure authority equivalent to 21.0 positions to perform the new workload as a result of SB 323 (Mitchell, Chapter 540, Statutes of 2017).

Total funding request:

Fiscal Year (FY)	Total Funds	General Fund (GF)	Federal Fund (FF)
2018-19	$891,000	$446,000	$445,000
2019-20	$3,018,000	$1,509,000	$1,509,000
2020-21	$3,233,000	$1,617,000	$1,616,000
2021-22	$1,161,000	$581,000	$580,000
2022-23 and on-going	$595,000	$298,000	$297,000

The resources will support fiscal oversight and programmatic monitoring requirements of SB 323, which allows federally qualified health centers (FQHCs) and rural health clinics (RHCs) to be reimbursed directly from a county or from DHCS, for providing Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) services to Medi-Cal beneficiaries.

The requirement to expand DMC services and SMHS, and include additional beneficiaries, will lead to an increase in new providers for those services as well as allowing existing providers to expand their available services. Due to the new provisions, DHCS states that it needs additional permanent staff resources to address the associated workload. DHCS's new workload results from the legislative requirement that DMC and SMSH costs be adjusted out of the FQHCs or RHCs per-visit Prospective Payment System (PPS) rate via a Change-in-Scope-of-Service Request (CSOSR) audit.

BACKGROUND

FQHCs and RHCs provide primary care services for all age groups and must provide preventive health services onsite, or by arrangement with another provider. Other

services that may be provided directly by an FQHC or RHC, or by arrangement with another provider, include: dental services; mental health and substance abuse services; transportation services necessary for adequate patient care; hospital services; and specialty care. There are approximately 1,200 FQHCs and RHCs in California that serve vulnerable populations and medically underserved communities.

Under existing federal law, FQHCs and RHCs are reimbursed through their clinic specific PPS rate, set by DHCS, for services provided to Medi-Cal beneficiaries. FQHCs and RHCs may provide any service that is bundled, which establishes their PPS rate, including mental health and alcohol and other drug (AOD) related services. If a Medi-Cal beneficiary receives mental health and/or AOD services at an FQHC or RHC, the clinic may only bill one daily PPS rate per beneficiary. FQHCs and RHCs can elect to add or subtract services, which will adjust the FQHC's or RHC's clinic base rate accordingly by DHCS through a CSQSR.

SB 323 allows FQHCs and RHCs to be reimbursed directly from DHCS, or a county, for providing SMHS or DMC services to Medi-Cal beneficiaries, while preventing the occurrence of duplicative reimbursement. The bill provides DHCS the authority to establish a process in which FQHCs and RHCs can become providers under these carved-out delivery systems.

DMC and SMH Services

The DMC and SMH S programs are a "carve-out" of the broader Medi-Cal program.

Currently, substance abuse services are provided at an undetermined number of FQHCs and RHCs, which are bundled as a part of the clinics' PPS rate and do not qualify as billable DMC services. As such, they are not monitored by DHCS under the DMC standards of Title 22, California Code of Regulations (CCR) Section 51341.1. Under the California Medicaid State Plan, DMC services are provided on a FFS basis that include: perinatal residential drug treatment, Outpatient Drug Free treatment services. Intensive Outpatient Treatment, and narcotic (opioid) replacement therapy. In order for a FQHC or RHC to provide and bill for DMC services, a provider must go through the process set forth by the DHCS Provider Enrollment Division (PED) and become a DMC certified provider. All current provisions of DMC services are applicable for approved DMC certified providers, including a counties' choice not to enter into a contract with a DMC certified provider. To further clarify, to the extent that a county decides not to enter into or terminates its Drug Medi-Cal Treatment Program contract with the department, the department shall contract for Drug Medi-Cal Treatment services in the county as necessary to ensure beneficiary access to these services as stated in Welfare and Institutions Code Section 14124.21.

The SMHS program operates under the authority of a Section 1915(b) waiver. The county mental health plans (MHPs) are required to provide or arrange for the provision of SMHS to beneficiaries in their counties that meet SMHS medical necessity criteria, consistent with a beneficiary's mental health treatment needs and goals as documented in the beneficiary's client plans. CCR Title 9 Section 1810.247 defines SMHS. Under the 1915(b) waiver, the MHPs are the designated county entity authorized to submit claims

to the DHCS for federal financial participation (FFP) reimbursement of medically necessary SMHS provided to Medi-Cal beneficiaries.

Currently, FQHCs and RHCs receive reimbursement for mild-to-moderate mental health services through Medi-Cal managed care health plan (MCP) wrap payments. Under Title 9, CCR Section 1810.355(g)(5), MHPs are not responsible for providing, or arranging to pay for, Medi-Cal services provided by FQHCs and RHCs. As the difference between mild-to-moderate mental health services and SMHS is determined by a beneficiary's requirement to meet medical necessity criteria, rather than by specific services provided, issues may arise when the FQHC submits a claim for mental health services through MCP wrap billing during the reconciliation process. A Medi-Cal MCP may disallow reimbursement if the beneficiary actually met SMHS medical necessity criteria. Since the clinical staff and some of the services within an FQHC or RHC could be the same for mild-to-moderate mental health services and SMHS, it is difficult to differentiate between the two for billing purposes.

SB 323

SB 323 outlined the process for FQHCs and RHCs to become billable providers for DMC services as well as the mechanism for adjusting a FQHC's or RHC's PPS rate, pursuant to the bill. SB 323 requires that rate changes based on a CSQSR are to be evaluated in accordance with Medicare reasonable cost principles. Within 90 days of receipt of the CSQSR, DHCS shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by DHCS. For purposes of recalculating the PPS rate, the FQHC or RHC would be required, upon DHCS' request, to provide verifiable documentation as to which employees spent time, and the actual time spent, providing FQHC or RHC services and DMC services.

Similar to DMC, SB 323 clarified the process for FQHCs and RHCs to become billable providers for SMHS, when an FQHC or RHC enters into a contract with a MHP to provide SMHS. SB 323 requires that rate changes based on a CSQSR are to be evaluated in accordance with Medicare reasonable cost principles. Within 90 days of receipt of the CSQSR, DHCS would be required to issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC s or RHC s projected allowable cost, as determined by DHCS. For purposes of recalculating the PPS rate, the FQHC or RHC will be required, upon DHCS request, to provide verifiable documentation as to which employees spent time, and the actual time spent, providing FQHC or RHC services and SMHS.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 17: FEDERALLY QUALIFIED HEALTH CENTER AUDITS (AB 1863) BUDGET CHANGE PROPOSAL

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health Services and Substance Use Disorder Services, Department of Health Care Services
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Audits and Investigations (A&I), requests limited-term resources and expenditure authority to perform the new audit workload as a result of AB 1863 (Wood, Chapter 610, Statutes of 2016). Specifically, the new audit workload stems from the addition of marriage and family therapists (MFTs) to the list of heath care professionals whose services are reimbursed through Medi-Cal on a per-visit basis to federally qualified health centers (FQHCs) or rural health clinics (RHCs).

To address the anticipated workload, A&I requests staffing over two fiscal years (FY). Total limited-term funding requested: $1,621,000 ($811,000 General Fund/$810,000 Federal Fund).

- Year 1 (FY 2018-19): $282,000 ($141,000 General Fund/$141,000 Federal Fund)
- Year 2 (FY 2019-20): $1,339,000 ($670,000 General Fund/$669,000 Federal Fund)

BACKGROUND

On January 1, 2001, the Benefits Improvement and Protection Act of 2000 instituted a Prospective Payment System (PPS) rate methodology for FQHCs and RHCs. The PPS methodology is an all-inclusive clinic specific per visits reimbursement rate, which is structured to be equivalent to 100 percent of the total costs per visit.

New FQHCs and RHCs have the option of having their initial PPS rate set by using actual and allowable costs, determined by an audit, or the average PPS rate of three comparable FQHCs or RHCs with a similar caseload located in the same or adjacent geographical area or a reasonable similar geographic area. Once the initial PPS rate is set, it can only be adjusted at the clinic's option by submitting a Change in Scope of Service Request (CSOSR).

Prior to AB 1863, MFT services could not be billed to the Medi-Cal program as a FQHC or RHC visit. Now that MFTs have been added to the list of services that can be reimbursed on a per-visit basis, FQHCs or RHCs that currently include MFT services in the costs used to calculate their PPS rate, or elect to now add MFT costs, must seek a recalculation of the rate by submitting a CSOSR if they choose to bill these services as separate visits.

In January 2017, DHCS informed the FQHCs and RHCs that the addition of MFT as a billable provider was not going to be implemented until July 1, 2018. Additionally, Welfare and Institutions Code 14132.100(g)(3) was amended (SB 97, Ch. 52, Budget Act of 2017):

> Notwithstanding any other provision of this section, no later than July 1, 2018, a visit shall include a marriage and family therapist. To date, no FQHC or RHC has submitted a CSOSR. DHCS is currently working on a State Plan Amendment (SPA) to include MFTs as a billable provider. It is anticipated the SPA process will be completed within calendar year 2018. Once SPA approval is obtained and the FQHCs or RHCs have a full fiscal year of MFT costs and visits, the CSOSRs will be eligible for submittal.

It is estimated that 384 clinics currently provide MFT services in their PPS rate. Prior to being allowed to bill MFT visits, FQHCs and RHCs must file a CSOSR to have their PPS rate recalculated. Under current statute, these audits must be finalized within 90 days from the date they are submitted to DHCS. A conservative assumption is that 50 percent of clinics will choose to bill MFT services. With that assumption, DHCS projects there will be a need to perform 192 CSOSR audits. Each CSOSR audit takes approximately 160 hours to perform. Consequently, it will take 30,720 (192 x 160) productive hours, or approximately 17 full-time equivalent (FTEs), assuming 1,800 productive hours for each FTE.

After evaluating the timeline for SPA approval and the submittal of eligible CSOSRs, DHCS projects audit workload from 25% of the 192 clinics in FY 2018-19 and the remaining 75% in FY 2019-20. Given the anticipated workload timeline, for FY 2018-19, DHCS projects staff resource needs effective January 1, 2019 (approximately 48 CSOSRs or 7,680 hours of work for four Auditor I). For FY 2019-20, staffing would need to be increased to a total of resources equivalent to 13.0 Auditor I positions (continuation of the resources equivalent to 4.0 from FY 2018-19) to address the approximately 144 remaining reports. The workload is anticipated to be limited-term and is dependent upon when initial MFT/CSOSRs are submitted.

Ninety-nine percent of all FQHCs or RHCs have fiscal year ends on June 30 or December 31. Due to the delay in implementation of MFTs as a billable provider, and the requirement that a CSOSR include a full fiscal year of MFT costs and visits, DHCS anticipates that the FQHCs or RHCs with a fiscal year end of December 31, 2018, may submit a CSOSR up to May 30, 2019, or earlier. The CSOSR audits would have to be completed 90 days after they are received by DHCS, or no later than September 1, 2019. The FQHCs or RHCs with a fiscal year end of June 30, 2019, are anticipated to

submit a CSOSR by November 30, 2019. The audits would have to be completed no later than March 1, 2020.

Currently, there are approximately 1,300 FQHCs and RHCs in California that bill approximately 10 million visits annually, or on average 7,692 (10,000,000 /1,300) visits per clinic. On average, the 192 clinics that may file a CSOSR bill approximately 1,476,864 (7,692 X 192) visits. DHCS states that if it does not obtain staff resources to perform the CSOSR audits, the CSOSRs would likely be accepted as filed.

The Governor's January 2017 proposed budget included a proposal to delay implementation of AB 1863 to "no sooner than July 1, 2018," however the final 2017 budget extended implementation to "no later than July 1, 2018."

LAO Assessment.
The LAO recommends approving the limited-term resources and expenditure authority for 2018-19, but recommends rejection of the resources and expenditure authority in 2019-20 at this time. The LAO explains that DHCS is currently in the process of submitting a State Plan Amendment (SPA) to include MFTs as a billable provider in 2018, and FQHCs and RHCs will have up to 150 days after their fiscal year ends to submit CSOSRs to the department. Therefore, to date, no FQHC or RHC has submitted a CSOSR. The proposal also would not establish and start recruitment for the limited-term resources in 2019-20 until July 1, 2019. By waiting to consider the 2019-20 limited-term resources and expenditure authority until the 2019-20 budget process, the Legislature would know whether or not the SPA was approved, how many FQHCs and RHCs submitted CSOSRs in 2018-19, and whether the 2018-19 workload suggests a higher or lower workload in 2019-20 than what was assumed in the proposal.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 18: STAKEHOLDER PROPOSAL ON COUNTY FUNDING (AB 1299)

PANEL

- **Carroll Schroeder**, Executive Director, California Alliance of Child and Family Services
- **Kirsten Barlow**, Executive Director, County Behavioral Health Directors Association of California

Public Comment

PROPOSAL

The California Alliance of Child and Family Services requests a budget allocation of $75 million to offset up-front costs related to implementation of AB 1299 (Ridley-Thomas, Chapter 603, Statutes of 2016) which provided for changes in state policy to remove barriers to mental health services for foster youth placed in foster care in counties other than their counties of original jurisdiction. According to July 2017 data shared by the California Child Welfare Indicators Project (CCWIP) at UC Berkeley, almost one in five foster children live in out-of-county placements totaling over 13,000 youth statewide.

BACKGROUND

The California Alliance of Child and Family Services provided the following background:

Young people placed out-of-county often experience lengthy delays or denials in accessing mental health services, despite research indicating that children and youth in foster care are three to six times more likely to experience emotional, behavioral and developmental problems than their peers who are not in care. Indeed, experts estimate that up to 85 percent of children in foster care have mental health disorders.

A 2011 Data Mining Report issued by the California Child Welfare Council however, showed that children placed in out-of-county foster care were 10-15% less likely to receive any mental health service than their in-county peers and that, among those that did receive services, foster children placed out-of-county received fewer services and less intensive treatment compared to children placed in-county. When foster youths' mental health needs are not met, the result is often placement instability, school failure, costly institutionalization, delinquency, and even death.

The out-of-county mental health problem stems from California's county-based system of mental health delivery. Medi-Cal Specialty Mental Health Services are provided using a system of county-administered managed care agencies or Mental Health Plans (MHPs) under contract with the Department of Health Care Services. Each MHP, in turn, contracts with local private mental health service providers (or uses county mental health staff) to deliver services.

This system works efficiently for many children and youth who have the Medi-Cal EPSDT entitlement; however, the county-based MHPs face substantial administrative barriers when services must be provided to children placed out-of-county, that is, outside the service area for its network of providers. These problems include difficulty:

- Finding providers and services in the child's county of residence;
- Contracting for care;
- Getting treatment authorizations;
- Coordinating and monitoring care; and
- Securing adequate reimbursements from responsible governmental parties including federal, state, and local agencies.

AB 1299 (Ridley-Thomas, Chapter 603, Statutes of 2016)

AB 1299 shifted the default responsibility for providing or arranging for Medi-Cal Specialty Mental Health Services from the county where the foster youth entered care to the county where the youth resides, thereby removing the administrative barriers to care. The bill also defined and permitted certain exceptions, focusing on the best interest of the youth. When responsibility for a foster youth's mental health care is presumptively transferred as required in AB 1299, the Medi-Cal funding follows the youth so that any net change in costs to the county of residence is reimbursed through the regular process by which the Department of Finance allocates 2011 Realignment funds.

The problem is that it takes several years before county outlays for services are reflected in their 2011 Realignment allocations. Funding levels will be adjusted over time but in the interim, some counties are already experiencing significant upfront costs, especially those counties that are home to multiple Short Term Residential Treatment Programs (STRTPs) or those where a disproportionately high number of relatives' homes and foster homes are located. These counties become the counties of residence for large numbers of foster youth from other counties, many of whom have needs for intensive mental health services. The sudden increase in demand for Medi-Cal funded mental health services poses a front-end cash flow challenge that can overwhelm county finances.

Stakeholders believe the State has the duty to support these impacted counties through a budget allocation to front load revenue to cover the costs of implementation. The California Alliance is requesting the development of a short-term cost pool to be administered by the Department of Finance for a minimum of 3 years. Based upon calculations from out-of-county placement data and Department of Health Care Services Performance Outcome Systems data, the Alliance estimates that approximately $50 million a year will be needed to cover the up-front costs of providing mental health services for youth placed out-of-county for the first three years of the implementation. Since EPSDT Medi-Cal includes a 50% federal cost share, the State's contribution would be $25 million per year, or $75 million for all three years.

The Department of Finance and stakeholders should develop a claiming process to cover costs directly related to providing mental health services for children and youth placed in foster care out-of-county. This short-term funding source will make it possible for county MHPs to cover their increased costs for services to children and youth placed by other counties until the 2011 Realignment allocation system adjusts each county's allocation to reflect the new levels of care. The Department and stakeholders should also develop a true-up mechanism to ensure the State is repaid over time for the front-loaded funding.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the California Alliance and CBHDA present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.