AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER ELOISE GÓMEZ REYES, ACTING CHAIR

MONDAY, MARCH 25, 2019

UPON ADJOURNMENT OF BUDGET SUBCOMMITTEES 1 AND 2
JOINT INFORMATIONAL HEARING
STATE CAPITOL, ROOM 444

ITEMS TO BE HEARD

ITEM	DESCRIPTION	
4265	**DEPARTMENT OF PUBLIC HEALTH**	
ISSUE 1	PUBLIC HEALTH STRATEGIES ADDRESSING SUBSTANCE ABUSE AND ADDICTION • SUBSTANCE ABUSE AND ADDICTION MORBIDITY AND MORTALITY STATISTICS • TOBACCO PREVENTION/CONTROL • CANNABIS EDUCATION • MANUFACTURED CANNABIS SAFETY • GAMBLING CONTROL • OPIOID OVERDOSE RESPONSE	2
4260	**DEPARTMENT OF HEALTH CARE SERVICES**	
ISSUE 2	SUBSTANCE USE DISORDER SERVICES • OPIOID OVERDOSE RESPONSE • DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM • PROPOSITION 64 REVENUE	11

NON-DISCUSSION ITEMS

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4260	**DEPARTMENT OF HEALTH CARE SERVICES**	
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ISSUE 4	SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT COMPLIANCE AND AUDIT ENHANCEMENT BUDGET CHANGE PROPOSAL	25

LIST OF PANELISTS IN ORDER OF PRESENTATION

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: PUBLIC HEALTH STRATEGIES ADDRESSING SUBSTANCE ABUSE AND ADDICTION

PANELISTS

- **Karen Smith, MD, MPH,** State Health Officer, Director, Department of Public Health
- **Miren Klein,** Assistant Deputy Director, Center for Environmental Health, Department of Public Health
- **Monica Morales,** Deputy Director, Center for Healthy Communities, Department of Public Health
- **Terri Sue Canale,** Assistant Deputy Director, Center for Healthy Communities, Department of Public Health
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 2: SUBSTANCE USE DISORDER SERVICES

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- **Dr. Alice Gleghorn**, Director, Santa Barbara County Department of Behavioral Wellness, Member, County Behavioral Health Directors Association Executive Board
- **Anam Khan**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ryan Millendez,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

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4265 DEPARTMENT OF PUBLIC HEALTH

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Public Comment

OVERSIGHT ISSUE

The purpose of this issue is to provide information about the prevalence of substance abuse and addiction, the leading causes of substance abuse fatalities and other individual and societal costs of addiction, and the state's public health strategies to address this epidemic.

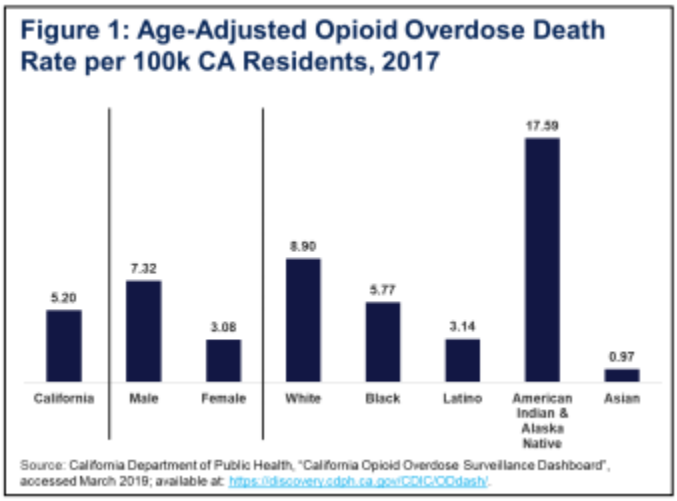
Substance Abuse Data

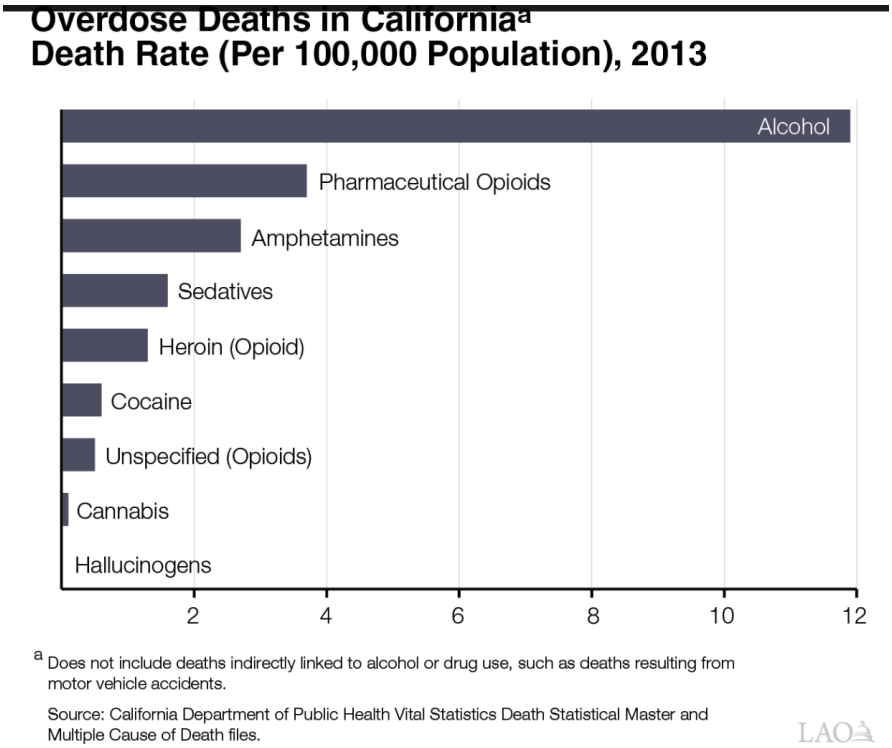
The data that follows describes the prevalence of substance abuse and addiction in California. 2013 is the most recent data available on the Department of Public Health's (DPH) website which does not reflect the significant increase in heroin and opioid use and fatalities that has occurred since 2013. According to testimony last year by Dr. Karen Smith, (DPH Director), heroin overdose deaths increased 57% between 2012 and 2015 and heroin-related emergency rooms visits increased by 140% between 2010 and 2015.

According to the U.S. Centers for Disease Control and Prevention (CDC), over 4,600 Californians died due to prescription drug overdose or illegal heroin use in 2016, an increase of 50% since 2002. The Drug Policy Alliance reports that accidental drug overdose is the leading cause of death for Americans under 50 and the leading cause of accidental death in California.

From the DPH Opioid Overdose Dashboard: In 2017, there were more than 2,000 opioid overdose deaths in California or 5.2 deaths per 100,000 residents, a 9 percent increase since 2015.

These rates vary by county with particularly high rates in counties in the northern part of the state including Modoc (23.6), Humboldt (21.0), Mendocino (19.3), Lake (17.0), Shasta (14.1), Lassen (13.9), Yuba (13.2), and Del Norte (12.6). Opioid overdose death rates also vary by sex, with males having higher rates than females, and by ethnicity, with much higher rates among American Indian & Alaska Native populations (see Figure 1).





Overdose Deaths in California[a]

2013

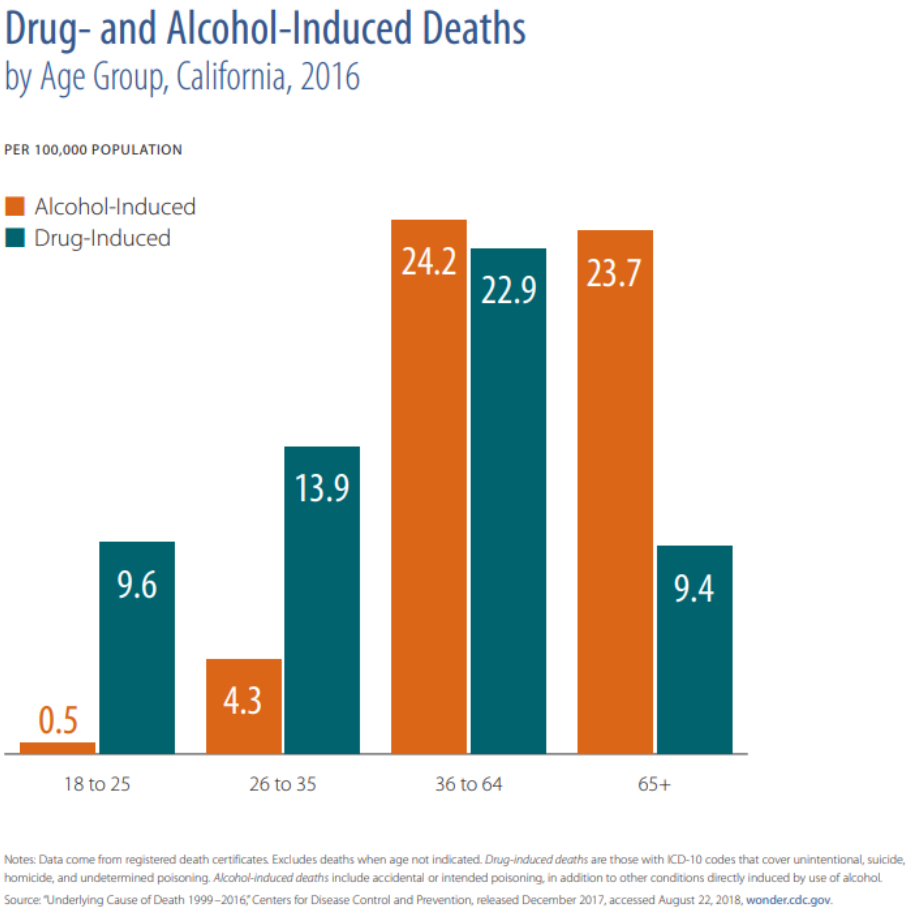
Substance	Number of Deaths	Death Rate (Per 100,000 Population)
Alcohol	4,554	11.9
Pharmaceutical Opioids	1,412	3.7
Amphetamines	1,036	2.7
Sedatives	599	1.6
Heroin (Opioid)	483	1.3
Cocaine	233	0.6
Unspecified (Opioids)	207	0.5
Cannabis	51	0.1
Hallucinogens	1	—[b]

[a] Does not include deaths indirectly linked to alcohol or drug use, such as deaths resulting from motor vehicle accidents.

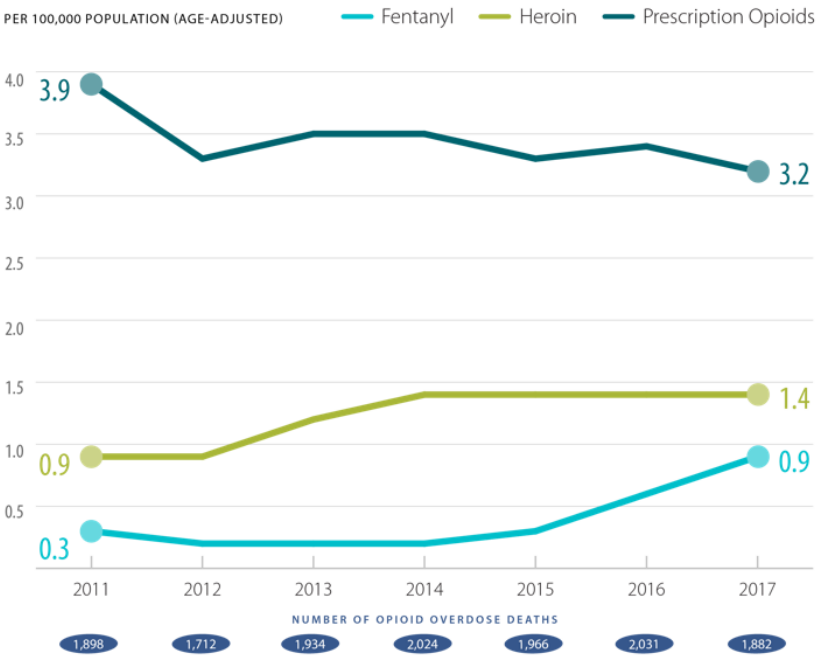
[b] Rates are not displayed if they are based on fewer than 20 cases because they are not reliable.

Source: CDPH Vital Statistics Death Statistical Master and Multiple Cause of Death files

The following data was included in a report published last year by the California Health Care Foundation, "*Substance Use in California: A Look at Addiction and Treatment*."



Opioid Overdose Deaths
California, 2011 to 2017

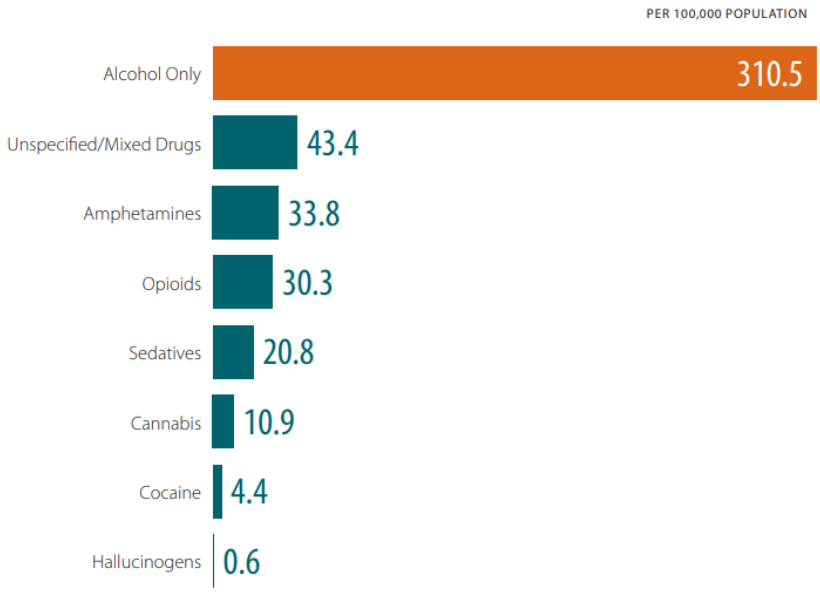


Notes: *Fentanyl* is a strong synthetic opioid that may be prescribed or obtained illegally. *Prescription opioid deaths* are based on an underlying cause of death being ICD-10 codes X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), or Y10–Y14 (undetermined intent) plus at least one of these multiple cause-of-death codes: T40.2, T40.3, or T40.4.

Source: "California Opioid Overdose Surveillance Dashboard," California Department of Public Health, accessed August 2, 2018, discovery.cdph.ca.gov.

CALIFORNIA HEALTH CARE FOUNDATION

Nonfatal ED Visits for Alcohol or Other Drug Diagnoses
California, Annual Average, 2012 to 2014



Notes: *Nonfatal ED visits* refers to patients treated in emergency departments but not admitted to that hospital. Substance determined from principal diagnosis at discharge. *Opioids* includes heroin, methadone, prescription opioids, other opioids, other illegal narcotics, and other pharmaceutical drugs.

Source: Author-generated report, California Department of Public Health, epicenter.cdph.ca.gov.

The death rates shown above related to alcohol reflect only alcohol poisoning, excluding alcohol-related traffic fatalities. The following data on injuries and fatalities attributed to motor vehicle crashes comes from the California Highway Patrol:

Alcohol-Related Vehicle Fatalities and Injuries		
Year	**# of Fatalities**	**# of Injuries**
2011	1,017	16,568
2012	1,066	16,615
2013	1,075	16,060
2014	1,053	16,821
2015	1,023	17,604

According to DPH:

- There are approximately 40,000 tobacco-caused deaths annually in California;
- 4 million adults in California smoke; and
- Youth smoking has nearly doubled since the introduction of e-cigarettes.

The major public health programs and activities related to substance abuse and addiction at DPH are described below:

Tobacco Control Program (TCP)

The mission of the TCP is to improve the health of all Californians by reducing illness and premature death attributable to the use of tobacco products. The goal of the TCP is to change the social norms surrounding tobacco use by "indirectly influencing current and potential future tobacco users by creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible." To change tobacco-related social norms, the TCP funds a statewide media campaign and state and community interventions which focus on policy, system, and environmental change in four priority areas:

1. *Limit Tobacco Promoting Influences*. Efforts in this area seek to curb advertising and marketing tactics used to promote tobacco products and their use, counter the glamorization of tobacco use through entertainment and social media venues, expose tobacco industry practices, and hold tobacco companies accountable for the impact of their products on people and the environment.

2. *Reduce Exposure to Secondhand Smoke, Tobacco Smoke Residue, Tobacco Waste, and Other Tobacco Products*. Efforts in this area address the impact of tobacco use on people, other living organisms, and the physical environment resulting from exposure to: secondhand smoke, tobacco smoke residue, tobacco waste, and other non-combustible tobacco products.

3. *Reduce the Availability of Tobacco*. Efforts in this area address the sale, distribution, sampling, or furnishing of tobacco products and other nicotine containing products that are not specifically approved by the Food and Drug Administration (FDA) as a treatment for nicotine or tobacco dependence.

4. *Promote Tobacco Cessation*. Efforts in this area include the provision of free cessation assistance in six languages and for the hearing impaired through the California Smokers' Helpline and efforts to improve awareness, access, and availability of cessation support offered by the health care system, health care plans, and employers.

Tobacco Control Program Funding

The DPH Tobacco Control Branch (TCB) was established as a result of Proposition 99 (1988), which added a 25-cent excise tax per 20-cigarette pack and an equivalent tax increase on other tobacco products. In addition to Proposition 99 revenue, the Proposition 56 (the tobacco tax passed in 2016) statute requires that Proposition 56 revenue be used to backfill any loss in Proposition 99 revenue resulting from the increase in the tobacco tax due to Proposition 56.

Proposition 99 Adjustments in the January 2019 proposed budget:

Proposition 99 (Tobacco Tax) Revenues
2019-20
(Dollars in Thousands)

	Health Education Account 20%	Hospital Services Account 35%	Physicians' Services Account 10%	Research Account 5%	Public Resources Account 5%	Unallocated Account 25%	TOTALS
Beginning Balance	$14,895	$48,438	$17,526	$4,601	$2,685	$26,977	**$115,122**
Total Revenues	$59,215	$84,622	$24,210	$14,859	$6,947	$54,319	**$244,172**
Totals Available	**$74,110**	**$133,061**	**$41,735**	**$19,460**	**$9,632**	**$81,296**	**$359,294**

The following chart shows just the information for the Health Education Account, the primary funding for DPH TCB, across three fiscal years:

Proposition 99
Health Education Account
(*Dollars in Thousands*)

	2017-18 Actuals	2018-19 Estimate	2019-20 Proposed	CY to BY $ Change	CY to BY % Change
Beginning Balance	$8,130	$9,543	$14,895	$5,352	56.1%
Total Revenues	$59,028	$59,772	$59,215	-$557	-0.9%
Totals Available	**$67,158**	**$69,315**	**$74,110**	**$4,795**	**6.9%**

Cannabis Education

Proposition 64 (the California Marijuana Legalization Initiative of 2016) provided $5 million one-time to DPH which funded an educational campaign called "Let's Talk Cannabis," targeting youth and pregnant and breastfeeding women.

Manufactured Cannabis Safety

The Manufactured Cannabis Safety Branch (MCSB) was created by the enactment of the Medical Cannabis Regulation and Safety Act of 2015. MCSB is currently developing statewide standards, regulations, and licensing procedures, and is addressing policy issues in support of cannabis manufacturers. MCSB is responsible for issuing licenses to manufacturers of cannabis products.

Office of Problem Gambling (OPG)

The OPG is charged with developing and providing quality statewide prevention and treatment programs and services, to address problem and pathological gambling issues, to the people of California. OPG is responsible for developing prevention and treatment programs to address gambling disorders. In designing and developing prevention and treatment programs OPG has accomplished the following:

- Developed a statewide plan to address gambling disorders
- Developed a prevention program
- Developed a treatment services program
- Developed priorities for funding criteria for distributing program funds
- Monitored the expenditures of State funds by organizations receiving funding
- Evaluated the effectiveness of services provided through programs

Opioid Overdose Response

Naloxone Funding Update. The 2016 Budget Act included $3 million one-time General Fund for DPH to purchase and distribute Naloxone, a life-saving opioid overdose reversal medication, to counties and community-based organizations in order to prevent opioid overdose deaths. DPH reports that 69,830 nasal spray doses were distributed and that DPH will issue a final report, with detailed information on which entities received the naloxone and estimates of lives saved, in June 2019. Finally, Dr. Karen Smith (DPH Director) issued statewide standing orders for naloxone in order to increase access to the drug.

Federal Grants Funding. DPH also has received federal grant funding to respond to the opioid crisis, and uses these funds for:

- Convening a state inter-agency collaborative, including 40 different entities/stakeholders (primarily state agencies and departments). This state collaborative developed an agenda of strategies for the state. DPH also funds community collaboratives that mirror the state collaborative.

- DPH has created a California Opioid Overdose Dashboard to collect data on opioid overdoses. The data sources include: 1) vital statistics data; 2) hospital admissions data collected by the Office of Statewide Health Planning and Development; and 3) prescription data collected by the Department of Justice. DPH states that they

also will be collecting contextual information in order to learn about overdose risk factors.

Alcohol Abuse Prevention and Control

As shown in the data above, compared to other types of drugs (except tobacco), alcohol is the leading cause of morbidity, mortality and emergency room visits. The following are the state's public health investments and efforts in alcohol abuse prevention:

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to provide an overview of substance abuse/addiction statistics and the department's programs and public health strategies in response.

Staff Recommendation: Subcommittee staff recommends no action at this time as this is an oversight issue.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 2: SUBSTANCE USE DISORDER SERVICES

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Public Comment

ISSUE

The purpose of this issue is to provide information about the state's Drug Medi-Cal program and its budgetary impacts, as well as the opioid response activities being undertaken by DHCS.

Opioid Overdose Response

DHCS has received at least two significant federal grants for the purpose of responding to the opioid overdose crisis: 1) $90 million 2-year grant; and 2) $140 million 2-year grant. These funds are supporting the following activities:

Medication Assisted Treatment (MAT) Expansion Project (Hub and Spoke System). The 21st Century Cures Act created funding for the Substance Abuse and Mental Health Services Administration (SAMHSA) – State Targeted Response (STR) Opioid Grant Program. California is receiving $90 million over two years and is using it to expand MAT for opioid misuse and dependence. The California "hub and spoke" system (H&SS) includes access to methadone or buprenorphine, as well as ensuring that individuals are enrolled in health insurance and connected to primary medical care. California is prioritizing rural areas, tribal communities, and other areas with limited access to MAT. DHCS reports that currently the state has 18 hubs.

The MAT Expansion Project consists of six main objectives:

- Develop additional MAT locations with a focus on rural locations;
- Provide MAT access to specialized and underserved communities;
- Transform entry points for individuals with opioid use disorders (OUDs) and create effective referrals into treatment;
- Develop coordinated referral processes to manage high-risk transitions;

- Engage current and potential MAT prescribers; and
- Enact overdose prevention activities to prevent opioid misuse and overdose deaths.

DHCS is implementing a variety of projects that span a range of settings where individuals with opioid OUD may seek help, including:

- Clinical settings such as emergency departments, hospitals, tribal health centers, and primary care clinics;
- County and state criminal justice systems, including jails, prisons, and juvenile justice;
- Communities, through media campaigns, opioid safety coalitions, naloxone distribution, drug takeback, and supportive housing; and
- Substance use disorder (SUD) treatment programs, including community outpatient programs, narcotic treatment programs, and residential facilities.

The California Bridge Program—MAT in Emergency Departments and Hospitals
SUD patients routinely present to emergency departments in need of treatment. This program provides training and technical assistance to support and enhance evidence-based treatment for SUD within acute care settings throughout California. This program develops hospitals and emergency rooms into primary access points for the treatment of acute symptoms of SUD by way of motivation, resources, and encouragement for patients to enter and remain in treatment. Participating sites address SUD as a treatable chronic illness by beginning MAT with buprenorphine immediately, as well as using harm reduction techniques, such as naloxone distribution, to minimize the risks associated with SUD. To date, 31 health care facilities are participating in this program, spanning 27 counties throughout the state.

Emergency Department Peer Navigators. Using federal grant funds, DHCS is supporting the hiring of substance abuse peer navigators to work in hospital emergency departments. DHCS indicates that initial funding supported peer navigators in 30 rural hospitals, and that subsequent funding will eventually support peer navigators in 80 hospitals.

Expanding MAT in County Criminal Justice Settings
Historically, individuals with SUDs have not been able to access MAT during periods of incarceration, despite an estimated 65 percent of individuals in the criminal justice system meeting the criteria for an SUD. Individuals leaving California Department of Corrections and Rehabilitation are 40 times more likely to die of an overdose in the first two weeks compared to CA's general population. This is due to decreased tolerance and lack of treatment during incarceration. Through the MAT expansion project, DHCS is funding a technical assistance program for counties interested in developing or expanding MAT to individuals in county jails and drug courts. The first cohort, selected in August 2018, consists of 22 counties throughout the state. The second cohort will begin in April 2019. Over the course of 18-months, each cohort will participate in learning collaboratives, receive monthly coaching calls, and technical assistance to develop or expand county-specific MAT programs in jails and drug courts.

Naloxone Distribution. Using federal grant funds, DHCS has purchased 146,000 naloxone nasal spray kits and has distributed them to law enforcement (23%), schools, universities, libraries, correctional institutions, and community harm reduction organizations.

Drug Medi-Cal

As shown in the tables below, the January budget includes $593.4 million ($59.7 million General Fund, $403.2 million federal funds, and $130.5 million county funds) in 2018-19 and $687.1 million ($70.3 million General Fund, $489.9 million federal funds, and $126.9 million county funds) in 2019-20 for Drug Medi-Cal. Caseload remains relatively stable at approximately 12,865.

2019-20 Drug Medi-Cal Program Funding Summary
(Dollars in Thousands)

Service Description	**2018-19**				
	Total Funds	General Fund	Federal Funds	County Funds	Case-load
Narcotic Treatment Program	$174,676	$5,364	$123,246	$46,066	9,144
Outpatient Drug Free Treatment Services	$19,165	$731	$14,633	$3,801	3,266
Intensive Outpatient Treatment Services	$7,377	$2,089	$4,872	$416	427
Residential Treatment Services	$1,467	$20	$831	$616	28
Drug Medi-Cal Organized Delivery System Waiver	$425,215	$60,840	$314,022	$50,353	-
Drug Medi-Cal Program Cost Settlement	$0	$0	$0	$0	-
Drug Medi-Cal Annual Rate Adjustment	$7,229	$431	$4,932	$1,866	-
Drug Medi-Cal County Admin	$44,908	$858	$22,454	$21,596	-
Drug Medi-Cal County Utilization Review and Quality Assurance	$7,104	$0	$4884	$2,220	-
DRUG MEDI-CAL TOTAL	**$687,141**	**$70,333**	**$489,874**	**$126,934**	**12,865**

2018-19 Drug Medi-Cal Program Funding Summary (Dollars in Thousands)					
Service Description	**2018-19**				
	Total Funds	General Fund	Federal Funds	County Funds	Case-load
Narcotic Treatment Program	$174,360	$5,334	$122,889	$46,137	9,164
Outpatient Drug Free Treatment Services	$18,712	$711	$14,309	$3,692	3,164
Intensive Outpatient Treatment Services	$7,176	$1,961	$4,814	$401	412
Residential Treatment Services	$2,882	$35	$1,638	$1,209	26
Drug Medi-Cal Organized Delivery System Waiver	$308,297	$50,627	$216,330	$41,340	-
Drug Medi-Cal Program Cost Settlement	($818)	($105)	($713)	$0	-
Drug Medi-Cal Annual Rate Adjustment	$5,781	$166	$4,009	$1,606	-
Drug Medi-Cal County Admin	$69,592	$992	$34,796	$33,804	-
Drug Medi-Cal County Utilization Review and Quality Assurance	$7,417	$0	$5,099	$2,318	-
DRUG MEDI-CAL TOTAL	**$593,399**	**$59,721**	**$403,171**	**$130,507**	**12,788**

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

Current regulations create requirements for oversight of DMC providers at both the state and county levels. DHCS is tasked with administrative and fiscal oversight, monitoring, auditing and utilization review. Counties can contract for DMC services directly, or contract with DHCS, which then directly contracts with DMC providers to deliver DMC services. Counties that elect to contract with DHCS to provide DMC services are required to maintain a system of fiscal disbursement and controls, monitor to ensure that billing is within established rates, and process claims for reimbursement.

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

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

For SUD-related services, SB 1 X1:

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

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

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

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

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

Drug Medi-Cal program services include:

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

- **Residential Treatment Services** – These services provide rehabilitation services to persons with substance use disorder diagnosis in a non-institutional, non-medical residential setting. (Room and board is not reimbursed through the Medi-Cal program.) Prior to SB 1 X1, this benefit was only available to pregnant and postpartum women.

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

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

Drug Medi-Cal Organized Delivery System

DHCS received CMS approval for a DMC Organized Delivery System (ODS) Waiver. DHCS states that the ODS waiver supports coordination and integration across systems, increases monitoring of provider delivery of services, and strengthens county oversight of network adequacy, service access, and standardizes practices in provider selection.

Key elements of the ODS waiver include:

- **Continuum of Care:** Participating counties are required to provide a continuum of care of services available to address substance use, including: early intervention, physician consultation, outpatient treatment, case management, medication assisted treatment, recovery services, recovery residence, withdrawal management, and residential treatment.

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

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

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

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

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

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

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

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

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

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

This waiver is operational only in counties that elect to opt into this organized delivery system and currently 40 counties have submitted implementation plans. DHCS states that the goal is for the waiver to be implemented statewide. In counties that do not opt-in, there is no change in services from the current (past) delivery system.

Proposition 64

Proposition 64 legalizes non-medical uses of Cannabis and taxes it. According to the Legislative Analyst's Office (LAO), the estimated revenue is subject to significant uncertainty. The LAO provided the following overview of how the proposition specifies the distribution and mandates uses of the revenue:

- The figure below summarizes the specific allocations made after regulatory and administrative cost are addressed.

Proposition 64 Makes Specific Allocations for Various Purposes

Primary Administrator	Purpose	Annual Funding	Duration
Governor's Office of Business and Economic Development	Implement a community reinvestment grant program that would fund certain services (such as job placement assistance and substance use disorder treatment) in communities most affected by past drug policies.	$10 million to $50 million[a]	2018-19 and ongoing
Public University or Universities in California	Evaluate the effects of the measure.	$10 million	2018-19 through 2028-29
California Highway Patrol	Create and adopt methods to determine whether someone is driving while impaired, including by cannabis.	$3 million	2018-19 through 2022-23
University of California San Diego Center for Medical Cannabis Research	Study the risks and benefits of medical cannabis.	$2 million	2017-18 and ongoing

[a] $10 million in 2018-19, increasing by $10 million annually until 2022-23, and $50 million each year thereafter.

Allocation of Remaining Revenues

☑ **60 Percent—Youth Education, Prevention, Early Intervention and Treatment Account**

- Funds would be allocated to the Department of Health Care Services to support youth programs including substance use disorder education, prevention, and treatment program.

☑ **20 Percent—Environmental Restoration and Protection Account**

- Funds would be allocated to the Department of Fish and Wildlife and the Department of Parks and Recreation to clean up and prevent environmental damage resulting from the illegal growing of cannabis.

☑ **20 Percent—State and Local Government Law Enforcement Account**

- Funds would be allocated to the California Highway Patrol to support programs designed to reduce driving while impaired, including by cannabis.
- Funds would also be allocated to the Board of State and Community Corrections to support programs designed to reduce any potential negative impacts on public health or safety resulting from the measure.

DHCS and Department of Finance have indicated that updated revenue projections will be included in the 2019 May Revise, and that DHCS will engage with stakeholders on the planned expenditures for those funds once a more certain revenue estimate is established.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS provide an overview of substance use disorder services and the budget for those services and respond to the following:

1. Is there sufficient access to all Drug Medi-Cal services for all eligible populations?

2. Please describe evidence of the quality of SUD services and of the overall Drug Medi-Cal program. Please summarize the evaluations of the ODS.

The Subcommittee requests the County Behavioral Health Directors Association to describe the quality of, and access to, substance use disorder services as delivered by counties.

Staff Recommendation: Subcommittee staff recommends no action at this time as this is an oversight issue.

NON-DISCUSSION ITEMS

The Subcommittee does not plan to have a presentation of the items in this section of the agenda, unless a Member of the subcommittee requests that an item be heard. Nevertheless, the Subcommittee will ask for ***public comment*** on these items.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 3: DRUG MEDI-CAL CHAPTERED LEGISLATION (SB 823, SB 1228, AB 2861) BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS requests 16.0 permanent positions and expenditure authority to address the new workload resulting from the passage of the following chaptered legislation:

- Senate Bill (SB) 823 (Hill, Chapter 781, Statutes of 2018) - Alcohol and Drug Treatment Abuse Recovery and Treatment Facilities.

- Senate Bill (SB) 1228 (Lara, Chapter 792, Statutes of 2018) - Alcoholism or Drug Abuse Recovery and Treatment Services.

- Assembly Bill (AB) 2861 (Salas, Chapter 500, Statutes of 2018) - Medi-Cal: Telehealth: Alcohol and Drug Use Treatment.

Total Funding Request:

Fiscal Year	Total Funds	General Fund	Federal Fund
2019-20	**$1,858,000**	**$1,723,000**	**$135,000**
SB 823	$981,000	$981,000	
SB 1228	$606,000	$606,000	
AB 2861	$271,000	$136,000	$135,000
2020-21 and ongoing	**$2,176,000**	**$2,041,000**	**$135,000**
SB 823	$918,000	$918,000	
SB 1228	$987,000	$987,000	
AB 2861	$271,000	$136,000	$135,000

The following chart identifies the positions requested with the corresponding activity (and bill).

Division	Request	Tenure/Effective Date	Activity
Substance Use Disorder – Program Policy and Fiscal Division	1.0 Permanent Positions • 1.0 Associate Governmental Program Analyst (AGPA)	Permanent Effective 7/1/19	• AB 2861
Substance Use Disorder – Compliance Division	3.0 Permanent Positions • 1.0 Staff Services Manager I (SSM I) • 2.0 AGPAs	Permanent Effective 7/1/19	• SB 1228
	3.0 Permanent Positions • 3.0 AGPAs	Permanent Effective 7/1/20	• SB 1228
	7.0 Permanent Positions • 1.0 SSM I • 6.0 AGPAs	Permanent Effective 7/1/19	• SB 823
Office of Legal Services	1.0 Permanent Position • 1.0 Attorney	Permanent Effective 7/1/19	• AB 2861
	1.0 Permanent Position • 1.0 Attorney	Permanent Effective 7/1/19	• SB 1228

BACKGROUND

SB 823

DHCS has the sole authority to license, certify, and monitor licensed alcohol and other drug (AOD) residential treatment programs to ensure the health and safety of program clients. DHCS is responsible for all activities associated with facility licensure and/or certification, compliance with statutory and regulatory requirements, and client-related health and safety issues. These activities include, but are not limited to initial facility application and on-site reviews; renewal processes; on-site monitoring compliance reviews; and complaint investigations of facilities and counselors.

The current licensing requirements do not mandate clinical assessment for treatment planning. However, with the implementation of SB 823 treatment in residential facilities will be raised to a higher level with a greater focus on clinical processes. The guiding principles of the American Society of Addiction Medicine (ASAM) criteria will transform how residential treatment is delivered to the individual, involving a major shift from program-driven to clinically, outcomes-driven treatment, from fixed length of service to variable length of service and from a limited number of inconsistent levels of care to a broad and flexible continuum of care.

The ASAM criteria, formerly known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results-based care in the treatment of addiction. To date, the ASAM criteria is the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

SB 1228

The nationwide rise in the opioid epidemic has fueled a surge in patient brokering and patient trafficking. Prior to the enactment of SB 1228 there were instances of patient brokering occurring in California's SUD facilities and among the SUD workforce; however, DHCS did not have the authority to take action against the facility and/or the workforce. This practice has resulted in insurance fraud and overbilling for inappropriate treatment services. Within the last three years, DHCS has started to receive complaints with allegations specific to issues of the illegal practice of patient brokering and trafficking.

Complaints include:

- Individuals with or without a SUD being paid to enter certain SUD facilities;
- Counselors or staff receiving kick-backs via money, gifts or services for making referrals to particular facilities;
- Counselors or staff telling individuals they will enter one facility and placing them at a different facility in order to make money; and
- Facilities purchasing individual referrals from a referral service, and providing illicit drugs to individuals in order to refer them or retain them in the facility.

DHCS explains that all of these activities are extremely damaging to the individual seeking treatment services as individuals with a SUD are very vulnerable during the engagement and retention phases of their recovery. Traumatic experiences such as patient brokering can result in the individual relapsing which can likely end in continued drug use and or death for the individual.

Since the rise of these concerns, DHCS has generally been the first point of contact for the public regarding questions and complaints with patient brokering, but DHCS had not been able to investigate complaints into this practice due to the lack of authority. SB 1228 provides DHCS the authority to take an action against a licensee and counselor for their participation in patient brokering.

AB 2861

Existing law provides that in-person contact between a health care provider and a patient is not required under the Medi-Cal program for services appropriately provided through telehealth. Existing law, for purposes of payment for covered treatment or services provided through telehealth, prohibits DHCS from limiting the type of setting where services are provided for the patient or by the health care provider.

AB 2861 requires that a Drug Medi-Cal (DMC) certified provider receive reimbursement for individual counseling services provided through telehealth. The statute calls for the services to be rendered by a Licensed Practitioner of the Healing Arts (LPHA), a registered or certified alcohol counselor, or other drug counselors. Telehealth state substance use disorder services must be medically necessary and in accordance with the Medicaid state plan, and on condition that federal financial participation is available and the necessary federal approvals have been obtained.

At present, there are 18 counties that are part of State Plan DMC (not in the Organized Delivery System) which constitute some of the most rural demographics in the state. Consequently, the adoption of SUD telehealth services, as a result of this recent legislation, presents an opportunity to reach critically-underserved populations and improve health outcomes for DMC beneficiaries.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 4: SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT COMPLIANCE AND AUDIT ENHANCEMENT BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS requests 14.0 permanent positions and expenditure authority of $1,916,000 federal fund (FF) in fiscal year (FY) 2019-20 and $2,078,000 FF in FY 2020-21 and ongoing to comply with the corrective action plan (CAP) requirements arising from deficiencies identified in the federal core technical review and single state audit findings related to California's administration of the annual Substance Abuse Prevention and Treatment Block Grant (SABG) award (approximately $254 million).

BACKGROUND

The SABG is a noncompetitive, formula grant awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to support state and county services, technical assistance, planning, implementation activities, and evaluation activities that prevent and treat substance abuse and supplement Medicaid, Medicare, and private insurance services. California applies annually for the SABG and DHCS acts as the single state agency (SSA) allocating the funding to the counties and monitoring fiscal and programmatic use of the award.

DHCS' inability to provide appropriate SABG oversight resulted in repeated audit findings in State fiscal years (SFY) 2015-16 and 2016-17, from the California State Auditor (CSA) and SAMHSA, which resulted in returning unobligated SABG funds to SAMHSA. Going forward, as a special condition of receiving the annual SABG award, SAMHSA requires DHCS to develop and implement a CAP to address audit findings and recommendations. DHCS requests positions and expenditure authority to develop, implement and sustain the CAP to satisfy the following recommendations:

1. Develop policies and procedures (P&P) that satisfy DHCS' obligation to comply with SABG statutory and regulatory requirements (office of legal services).

2. Confer with SAMHSA to design and establish appropriate SABG reporting timeframes and processes, taking into account the inherent constraints of California's subaward cost settlement process.

3. Develop sufficient fiscal controls and accounting procedures to make certain expenditures are reported to SAMHSA within the agreed-upon timeframe.

4. Revise P&Ps for cash management, manage drawdowns from the federal Payment Management System, under U.S. Department of Health and Human Services (HHS), awards are timely, made according to actual immediate program cash requirements and limited to the minimum expenditure amounts needed within thirty days (quarterly invoicing process).

5. Develop sufficient internal controls for monitoring sub-recipients and make certain counties adequately carry out their pass-through entity responsibilities.

DHCS states that the additional resources are necessary to enhance fiscal oversight, programmatic processes, and monitoring/auditing of county sub-recipients and substance use disorder (SUD) facilities providing SABG funded SUD prevention, treatment, and recovery support services to beneficiaries. Non-compliance with audit recommendations could potentially result in the reduction and/or disruption of receipt of annual SABG awards.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

This agenda and other publications are available on the Assembly Budget Committee's website at: https://abgt.assembly.ca.gov/sub1hearingagendas. You may contact the Committee at (916) 319-2099. This agenda was prepared by Andrea Margolis.