AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER TONY THURMOND, CHAIR

MONDAY, MARCH 28, 2016

2:30 P.M. - STATE CAPITOL, ROOM 127

ITEMS TO BE HEARD

ITEMS TO BE HEARD

4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 1: OVERVIEW & BUDGET

PANELISTS

- **Toby Ewing,** Executive Director, Mental Health Services Oversight & Accountability Commission
- **Lawana Welch**, Finance Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

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

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

Most of the act's funding is to be expended by county mental health departments for mental health services consistent with their 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 its stakeholder process, a listing of programs for which these funds would be used. Of total annual revenues, 80 percent is allocated to this component.

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

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

increase the quality of services, improve outcomes, and promote interagency collaboration. This is funded 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, 10 percent of total revenues were allocated to this component, for a total of $460.8 million. Counties have 10 years to spend these funds.

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

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

MHSOAC Budget

The table below shows the MHSOAC funding (MHSA State Administration funds) over three years. The MHSOAC proposed 2016-17 budget is $42.9 million, a $6.7 million (13%) decrease from current year funding. All of the funding for the MHSOAC is Proposition 63 (Mental Health Services Act) state administration funding. The substantial (13%) decrease in funding from the current year to the proposed budget does not reflect any policy changes, but rather has resulted from the phasing in of the triage grants program, which resulted in the need to re-appropriate funding from prior years into the 2015-16 budget, but not the 2016-17 budget.

MHSOAC BUDGET			
	2014-15 Actual	**2015-16 Estimated**	**2016-17 Proposed**
Total MHSA Funds	$52,599,000	$49,575,000	$42,922,000
Positions	25.5	23.2	26.2

Overview of MHSOAC Evaluation Efforts. On March 28, 2013 the MHSOAC approved an Evaluation Master Plan which prioritizes possibilities for evaluation investments and activities over a five year course of action. The MHSOAC five-year Evaluation Master Plan (July 2013 – June 2018) describes seven activities related to performance monitoring, ten evaluation projects, and eight exploratory/developmental work efforts. The 2013 budget provided resources for six positions to implement the Evaluation Master Plan. There are also many other entities engaged in MHSA evaluation projects, including by counties.

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

Triage Grants. SB 82 (Committee of Budget and Fiscal Review), Chapter 34, Statutes of 2013, enacted the Investment in Mental Health Wellness Act of 2013 which appropriated $54.4 million ($32 million Mental Health Services Act [MHSA] State Administration and $22 million federal) in ongoing funding to the MHSOAC to add 600 mental health triage personnel in select rural, urban, and suburban regions.

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

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

Grants cover four fiscal years, with grant funds allocated annually for 2013-14 (for five months), 2014-15, 2015-16, and 2016-17. Delays in hiring have led to delays in expenditure of these funds, and therefore the MHSOAC is seeking to reappropriate the funds which is discussed in more detail under issue 2 of this agenda.

A total of 47 grant applications were submitted to the MHSOAC. Twenty-four counties were awarded grant funding. The MHSOAC approved 24 triage grants and allocated funds for 491 triage positions. Counties have hired the triage staff and continue to expand the number of mental health personnel available to provide crisis support services that include crisis triage, targeted case management and linkage to services for individuals with mental health illness who require a crisis intervention. These personnel will be located in hospitals, emergency rooms, jails, shelters, high schools, crisis stabilization and wellness centers, and other community locations where they can engage with persons needing crisis services.

STAFF COMMENTS/QUESTIONS

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

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

2. Please provide an update on the status of MHSOAC's evaluation efforts and activities.

Staff Recommendation: No action is recommended at this time.

ISSUE 2: TRIAGE PERSONNEL GRANTS BUDGET CHANGE PROPOSAL

PANELISTS

- **Toby Ewing,** Executive Director, Mental Health Services Oversight & Accountability Commission
- **Lawana Welch**, Finance Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The MHSOAC requests reappropriation of funds from Fiscal Years 2013-14, 2014-15, and 2015-16, to support Triage Personnel Grants until Fiscal Year 2017-18, allowing counties to spend the Triage Grant funding until the end of the current grant cycle.

BACKGROUND

The Mental Health Wellness Act of 2013 provides counties with funds for crisis programs through a competitive grant process. The MHSOAC awarded the grants in FY 2013-14, however, counties had challenges in hiring triage personnel which resulted in delayed implementation. The Commission is requesting reappropriation of funds to allow counties that received grants to continue their triage programs through fiscal year 2017-18.

SB 82 mandated the Commission to establish and administer a new competitive grant program that supports local mental health departments in the hiring of 600 new mental health triage personnel statewide. SB 82 also tasked the Commission with ongoing administration and monitoring of this new triage program.

Through a competitive grant process the Commission awarded 22 triage personnel grants to counties for a term beginning 2013-14 through 2016-17. Given the delayed implementation of the initial awards, the Budget Act of 2014 reappropriated fiscal year 2013-14 unexpended triage personnel grant funds through 2016-17. With the reappropriated funds, the Commission funded 2 additional county triage grant requests. The Commission is requesting to reappropriate funds to extend the term of the grants to fiscal year 2017-18 to allow counties to spend the funds awarded in the grant process for the intended four-year grant cycle.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the MHSOAC to present this proposal and provide an overview and update on the implementation of the triage grants. How many triage personnel have been hired to date?

Staff Recommendation: No action is recommended at this time.

ISSUE 3: INNOVATION PLAN REVIEWS BUDGET CHANGE PROPOSAL

PANELISTS

- **Toby Ewing,** Executive Director, Mental Health Services Oversight & Accountability Commission
- **Lawana Welch**, Finance Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The MHSOAC is requesting $396,000 (Mental Health Services Fund) and 3 positions to support administration of regulatory authority under AB 82 (Committee on Budget, Chapter 23, Statutes of 2013), and to provide technical assistance to counties for program improvement. AB 82 mandated the Commission to promulgate and implement regulations for Prevention and Early Intervention Programs and Innovation Programs.

BACKGROUND

In June of 2013, the Governor signed AB 82, a budget trailer bill that modified the Mental Health Services Act and directed the MHSOAC to issue regulations for prevention and early intervention programs and innovation programs that were initially authorized under Proposition 63.

In the summer of 2015, the MHSOAC adopted regulations governing county implementation of prevention and early intervention programs and innovation programs. For this first phase of regulatory work, the MHSOAC redirected administrative, program and legal staff for the development, review and adoption of regulations. The MHSOAC absorbed this workload by delaying other work, reducing its short-term commitments in some areas, such as plan review, contract monitoring and recruitment.

For the second phase of its obligations under AB 82, the MHSOAC is directed to monitor implementation of the regulations and to provide technical assistance to counties under both prevention and early intervention programs and innovation programs. The MHSOAC is proposing to deploy two existing positions for this work - a Consulting Psychologist and a Staff Mental Health Specialist - and is requesting three additional positions - two Health Program Specialist I/II positions, and one Research Program Specialist I/II position. The MHSOAC also will dedicate, on a temporary basis, a second Staff Mental Health Specialist to support initial implementation of PEI regulations.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the MHSOAC to present this proposal and provide an update on this project.

Staff Recommendation: No action is recommended at this time.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 4: COMMUNITY MENTAL HEALTH SERVICES

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor**, Deputy Director, Mental Health and Substances Use Disorder Services, Department of Health Care Services
- **Lawana Welch**, Finance Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **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. Medi-Cal Specialty Mental Health services are budgeted at $139.8 million General Fund, $2.3 billion federal funds for 2016-17, a modest decrease from current year costs of $151.2 million General Fund and $2.3 billion federal funds.

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 Government Code Section 30025(f).

A substantial balance of $128 million has accumulated in the 2011 Behavioral Health Growth Special Account. DHCS indicates that they are in discussions with counties on how these funds will be distributed.

Mental Health Services Act (Proposition 63, Statutes of 2004)

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

The following table shows where State Administration funds are expended:

MHSA State Administration Expenditures (*Dollars in Thousands*)	**2014-15 Actual**	**2015-16 Estimated**	**2016-17 Projected**
Judicial Branch	$1,058	$1,070	$1,078
Califoria Health Facilities Financing Authority	$3,999	$4,000	$4,000
OSHPD -- Administration	$4,052	$3,337*	$4,414*
OSHPD -- Non-Administration State Operations	$8,388	$13,200	$15,075
Department of Health Care Services	$9,052	$9,213	$9,120
Department of Public Health	$3,557	$50,074*	$18,066*
Department of Developmental Services	$1,180	$1,222	$1,178
Mental Health Services Oversight & Accountability Commission	$52,599	$49,575*	$42,922*
Department of Education	$127	$149	$137
Community Colleges Board of Governors	$85	$104	$94
Financial Information System for California	$70	$188	$150
Military Department	$1,313	$1,600	$1,610
Department of Veterans Affairs	$498	$510	$517
University of California	$1,636	$13,364*	$0
TOTAL STATE ADMINISTRATION	**$87,614**	**$147,606**	**$128,339**
TOTAL PROPOSITION 63 REVENUE	**$1,831,897**	**$1,508,671**	**$1,463,442**

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

The following table on the next page describes the various uses of the MHSA State Administration funding:

Judicial Branch Positions for workload relating to mental healht prevention and early intervention for juveniles in the juvenile court system. Positions to address workload relating to menal illness in adults in the criminal justice system.
Califoria 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 assitance 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 commnity-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 buid 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 healht 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 iimprove mental healht 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.

MHSA State Administration

Based upon estimated MHSA revenues, the five percent administration cap for 2015-16 is $101.4 million and administrative expenditures are estimated at $134.4 million. The amount exceeding the administative cap in 2015-16 has been re-appropriated and attributed to prior year available funds. For 2016-17, the projected five percent administrative cap is $102.6 million and the total projected expenditures are $83.3 million. As shown in the table below, a portion of this total has been approrpriated from available administrative funds in prior years.

MHSA State Admin Cap
(Dollars in Thousands)

FY	Admin Cap	Expenditures	Available In Cap
2012-13	$58,965	$31,572	$27,393
2013-14	$64,077	$39,474	$24,603
2014-15	$92,592	$78,989	$13,603
2015-16	$101,442	$134,406	($32,964)
2016-17	$102,592	$83,286	$19,306
Cumulative Total	**$419,669**	**$367,727**	**$51,942**

STAFF COMMENTS/QUESTIONS

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

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

2. Please describe and provide an update on the Performance Outcome System.

3. Please describe DHCS's process with regard to developing a distribution plan for the 2011 Behavioral Health Growth Special Acccount. Which stakeholders are involved in these discussions?

Staff Recommendation: No action is recommended at this time.

ISSUE 5: SPECIALTY MENTAL HEALTH OVERSIGHT BUDGET CHANGE PROPOSAL

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor**, Deputy Director, Mental Health and Substances Use Disorder Services, Department of Health Care Services
- **Lawana Welch**, Finance Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS, Mental Health Services Division (MHSD), requests 13.0 full-time, permanent positions and expenditure authority of $1,925,000 ($866,000 General Fund/$1,059,000 Federal Fund) for FY 2016-17 and $2,128,000 ($972,000 General Fund/$1,156,000 Federal Fund) on-going. The permanent resources requested include $400,000 for contracted clinicians, who will work to meet the Special Terms and Conditions (STCs) required by the Centers for Medicare and Medicaid Services (CMS). CMS placed this as a condition of the renewal of DHCS Medi-Cal Specialty Mental Health Services (SMHS) Waiver authorized under Section 1915(b) of the Social Security Act.

BACKGROUND

While the SMHS Waiver has previously been approved for only two years at a time, CMS has approved the 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 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 federal funds at risk. DHCS explains that in order to develop and implement the infrastructure to implement new functions and maintain additional workload, 13.0 new positions are needed within the Program Oversight and Compliance Branch (POCB; 6.0 positions) and the Program Policy and Quality Assurance Branch (PPQAB; 7.0 positions). The resources will address the increased workload related to oversight and monitoring of the 56 County Mental Health Plans (MHPs) throughout California.

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; these issues have recently triggered an audit by the Office of the Inspector General (OIG), which is currently underway. 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 states that, while meeting the STCs involves current functions and workload for which resources are needed, it also involves completely new functions and a substantial increase in workload that requires additional resources.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Subcommittee staff recommends holding this item open at this time.

ISSUE 6: SHORT-TERM RESIDENTIAL TREATMENT CENTER LICENSING (AB 403) BUDGET CHANGE PROPOSAL

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor**, Deputy Director, Mental Health and Substances Use Disorder Services, Department of Health Care Services
- **Lawana Welch**, Finance Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS, Mental Health Services Division, requests the following resources to implement AB 403, Chapter 773, Statutes of 2015:

- Permanent position and expenditure authority of $118,000 for 1.0 Associate Governmental Program Analyst (AGPA).

- Three-year funding (phased-in) of $251,000 for staffing resources equivalent to 1.0 Staff Services Manager I and 1.0 AGPA

- Total Funding Requested: Year 1 $350,000 ($175,000 General Fund/$175,000 Federal Fund), Year 2 $369,000 ($185,000 General Fund/$184,000 Federal Fund).

AB 403 decreases the usage of group homes and establishes Short-Term Residential Treatment Centers (STRTCs) as a new type of a community care facility licensed and regulated by the California Department of Social Services (CDSS). The services provided through STRTCs include mental health treatment for children assessed as seriously emotionally disturbed (SED) or that meet the medical necessity criteria for Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

BACKGROUND

AB 403 requires DHCS or its Mental Health Plans (MHPs) to certify mental health programs for STRTCs. This process includes an on-site review of operations, clinical practice standards, policies and procedures, and treatment modalities. Currently, DHCS is responsible for the certification of Rate Classification Level (RCL) 13 and 14 group homes under the county MHPs. Under AB 403, the STRTCs will replace the RCL scheme and it is anticipated that a portion of the currently identified 679 RCL group homes will transition to STRTCs. Prior to AB 403, DHCS and MHPs were responsible for certification of 54 RCL 13/14 group homes. Therefore, AB 403 is projected to result

in an initial increase in the volume of mental health service centers that must be certified as STRTCs.

In addition to the increased certifications, AB 403 requires DHCS to develop program standards so that intensive mental health treatment services are provided to children housed in STRTCs. Therefore, DHCS will need to promulgate regulations, provide legal consultation and opinion, and develop policies and procedures to implement these requirements.

The intensive treatment services that foster children and youth would have access to in STRTCs include, but are not limited to, clinical treatment such as psychiatric and psychological services, which could include specialty mental health services; learning disability assessment and educational services; pre-vocational and vocational counseling; development of independent living, self-help and social skills; and community outreach to develop linkages with other local support and service systems.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Subcommittee staff recommends holding this item open at this time.

ISSUE 7: FOSTER CARE TRAINING REQUIREMENTS ON PSYCHOTROPIC MEDICATIONS (SB 238) BUDGET CHANGE PROPOSAL

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor**, Deputy Director, Mental Health and Substances Use Disorder Services, Department of Health Care Services
- **Laura Ayala**, Finance Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS requests one full-time permanent Research Program Specialist II (RPS II) and $134,000 ($67,000 General Fund (GF)/ $67,000 Federal Fund (FF)) in Fiscal Year (FY) 2016-17 and $125,000 ($63,000 GF/$62,000 FF) ongoing, to implement the requirements of SB 238 (Chapter 534, Statutes of 2015) which requires data sharing agreements between DHCS and the Department of Social Services (CDSS) as well as between DHCS, CDSS and county placing agencies. It also requires CDSS, in consultation with DHCS and stakeholders, to develop and distribute a monthly report to each county placing agency, and would require this report to include specified information regarding foster youth taking psychotropic medications that have been paid for under Medi-Cal.

BACKGROUND

SB 238 outlines criteria for the use of psychotropic medication for children and youth in foster care. The categories of psychotropic medication are fairly broad, and include drugs that work on the central nervous system that alter behavior, mood, perception, or emotion, and include such drug classes as anti-psychotics, anti-neuroleptics, anti-depressants, psychostimulants, hypnotics and anti-anxiety medications. Psychotropic medications are prescribed to treat symptoms of conditions ranging from Attention Deficit Hyperactivity Disorder (ADHD) to childhood schizophrenia.

The federal Child and Family Services Improvement and Innovation Act of 2011 requires states to develop protocols regarding the appropriate use and monitoring of psychotropic medications and how the state will address emotional trauma associated with being a child that is maltreated and removed from their home through placement in foster care.

In October 2012, DHCS and CDSS undertook a quality improvement project titled "Improving Psychotropic Medication Use in Children and Youth in Foster Care" in order to explore, identify, and support effective strategies in overseeing and monitoring the use of psychotropic medications of children and youth in the foster care system. This

topic and project has received significant interest from, and heightened the awareness of stakeholders, the media, government oversight entities like the Child Welfare Council, as well as the Legislature.

DHCS currently has an interagency agreement (IA) with CDSS, effective April 2015, to share information regarding the oversight and monitoring of psychotropic medication prescribing within the child foster care population. Additionally, DHCS has encouraged and signed data use agreements (DUAs) with individual counties who want to monitor psychotropic medication use in their specific foster care population. In an effort to address foster youth psychotropic medication prescribing from the provider perspective, the Medical Board of California (MBC) also entered into a DUA with DHCS in April 2015. The work necessary to pull the data required by these agreements is currently being completed by existing, temporarily redirected DHCS Pharmacy Benefits Division (PBD) resources. This redirection has resulted in other PBD work either not getting completed or being delayed. DHCS states that the additional and expanded DUA mandates and reporting requirements established by SB 238 cannot be absorbed by existing staff.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Subcommittee staff recommends holding this item open at this time.

ISSUE 8: STAKEHOLDER PROPOSAL: SUICIDE HOTLINE FUNDING PROPOSAL

PANELISTS

- **Rusty Selix**, Executive Director, California Council of Community Mental Health Agencies
- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor**, Deputy Director, Mental Health and Substances Use Disorder Services, Department of Health Care Services
- **Lawana Welch**, Finance Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

Community mental health advocates request that the Legislature identify a long-term, stable funding source for suicide hotlines.

BACKGROUND

The eleven crisis centers that answer calls through the National Suicide Prevention Lifeline network have no stable funding. Yet, the Lifeline is advertised by health insurers, federal/state/county health and mental health agencies, schools and universities, and private practitioners.

Although the federal Substance Abuse and Mental Health Services Administration (SAMSHA) funded the launch of Lifeline, and funds the agency coordinating Lifeline operations— such as linking technology, data collection and best practices--it provides no other long-term financial support to the local agnecies that operate it, other than annual stipends of $1,000 to $3,000.

Five years ago, California's counties agreed to pool some Mental Health Services Act (MHSA/Proposition 63) funds for three initiatives: school mental health, stigma reduction and suicide prevention. In 2012, this funding helped establish new crisis lines; develop common crisis line metrics and best practices; add services in Korean and Vietnamese; and support agencies that had been answering Lifeline calls without reimbursement. This funding for suicide prevention, however, ended on July 1, 2015 when many counties declined to renew, or reduced, the percentage of MHSA funds they would contribute. Advocates state that the loss of MHSA funding has resulted in:

- withdrawal of crisis lines from the Common Metrics project;
- some counties no longer receiving services;
- the ending of a best practices initiative; and
- only one center provides full-time services in Spanish made possible by its own county doubling its financial support.

2015 BUDGET ACTION

Advocates raised this same issue last year, and in response, Budget Subcommittees in both houses required Supplemental Reporting Language (SRL) from DHCS to explore potential long-term, stable funding sources for suicide hotlines and make recommendations to this effect. DHCS has yet to provide this SRL to the Legislature, however states that it is near completion, and that productive discussions with the counties and advocates are underway.

STAFF COMMENTS/QUESTIONS

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

1. Please clarify the allegation that both federal and state agencies promote the national suicide hotline number, yet neither provides funding for local agencies to staff it.

2. Please explain the history of Proposition 63 funding that has been lost.

3. Please explain what aspects of the hotline services have been, or will be, lost due to the recent reduction in funding.

Staff Recommendation: No action is recommended at this time.

ISSUE 9: SUBSTANCE USE DISORDER SERVICES

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor**, Deputy Director, Mental Health and Substances Use Disorder Services, Department of Health Care Services
- **Lawana Welch**, Finance Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSED BUDGET

The Drug Medi-Cal (DMC) program provides medically necessary substance use disorder treatment services for eligible Medi-Cal beneficiaries. The proposed budget includes $396.5 million for DMC in 2016-17. See the following table for DMC funding summary.

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

	2015-16				2016-17			
Service Description	**General Fund**	**County Funds**	**Federal Funds**	**Total Funds**	**General Fund**	**County Funds**	**Federal Funds**	**Total Funds**
Narcotic Treatment Program		$76,438	$93,397	$169,835	$421	$78,896	$96,208	$175,525
Residential Substance Use Services*	$5,096	$5,088	$14,627	$24,811	$32,494	$5,650	$64,143	$102,287
Outpatient Drug Free Treatment Services		$13,228	$14,495	$27,723	$121	$10,648	$14,496	$25,265
Intensive Outpatient Services**	$12,293	$1,708	$20,339	$34,340	$12,644	$2,094	$16,550	$31,288
Drug medi-Cal Program Cost Settlement		$393	$3,036	$3,429		$393	$3,036	$3,429
Annual Rate Adjustment					$369	$94	$766	$1,229
County Administration	$1,287	$9,339	$14,564	$25,190	$1,864	$10,376	$16,710	$28,950
County Utilization Review & Quality Assurance						$9,980	$18,537	$28,517
TOTAL	**$18,676**	**$106,194**	**$160,458**	**$285,328**	**$47,913**	**$118,131**	**$230,446**	**$396,490**

*Previously named “Perinatal Residential Substance Abuse Services

**Previously named “Day Care Rehabilitative Services”

BACKGROUND

In 2011, funding for the DMC program was transferred from the Department of Alcohol and Drug Programs (DADP) to DHCS as part of the Public Safety Realignment initiated by AB 109 (Committee on Budget), Chapter 15, Statutes of 2011. Prior to the realignment of the DMC program, DMC was funded with General Fund and federal funds. Enactment of the 2011 Public Safety Realignment marked a significant shift in the state's role in administering programs and functions related to substance use 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. As of November 2013, DHCS contracts with 44 counties for DMC services. Another county has direct provider contracts thus resulting in DMC services being offered in 45 total counties. DHCS also has 15 direct provider contracts for DMC services in five counties (Imperial, Orange, San Diego, Solano, and Yuba-Sutter).

Health Care Reform Expansion of SUD Benefits

The federal Affordable Care Act (ACA) requires states electing to enact the 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 will have access to the same set of services.

For SUD-related services, SB 1 X1:

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

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

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

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

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.

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

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

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

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

Drug Medi-Cal Waiver

DHCS has received CMS approval for a DMC Organized Delivery System Waiver. DHCS states that this waiver will give state and county officials more authority to select quality providers to meet drug treatment needs. DHCS indicates the waiver will support coordination and integration across systems, increase monitoring of provider delivery of services, and strengthen county oversight of network adequacy, service access, and standardize practices in provider selection.

Key elements of the new waiver include:

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

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

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

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

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

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

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

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

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

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

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

This waiver will only be operational in counties that elect to opt into this organized delivery system, which currently includes 54 counties. DHCS states that the early phases are considered demonstration projects but the goal is for the model to eventually be implemented statewide. Counties that opt into this waiver will be required to meet specified requirements, including implementing selective provider contracting (selecting which providers participate in the program), providing all DMC benefits, monitoring providers based on performance criteria, ensuring beneficiary access to services and an adequate provider network, using a single-point of access for beneficiary assessment and service referrals, and data collection and reporting. In a county that does not opt-in, there will be no change in services from the current delivery system.

Drug Medi-Cal Program Integrity

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

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the Drug Medi-Cal program and budget and respond to the following questions:

1. Please provide an overview and the implementation timeline of the new Drug Medi-Cal waiver.

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

3. Are Drug Medi-Cal services a covered benefit for minors (younger than 21)? If not, please describe the circumstances for this.

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

ISSUE 10: RESIDENTIAL TREATMENT FACILITIES (AB 848) BUDGET CHANGE PROPOSAL

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor**, Deputy Director, Mental Health and Substances Use Disorder Services, Department of Health Care Services
- **Lawana Welch**, Finance Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS, Substance Use Disorders/Compliance Division, requests 4.0 permanent positons and expenditure authority of $478,000, from the Residential and Outpatient Program Licensing Fund (ROLF), to implement AB 848, Chapter 744, Statutes of 2015. One Nurse Consultant 11 position will be phased-in effective January 1, 2017, while the rest will be effective July 1, 2016.

AB 848 permits medical care in a residential treatment facility, and requires specific oversight activities. AB 848 is a direct result of concerns raised, in the September 12, 2012 report by the California Senate Office of Oversight and Outcomes, regarding state oversight of drug and alcohol homes and the potential benefits of limited onsite medical care.

BACKGROUND

AB 848 requires DHCS to develop, adopt and implement regulations on or before July 1, 2018 to include the requirements for a standard certification to be signed by a health care practitioner, further definition of the identified "incidental medical services," the minimum requirements that a facility shall meet in order to be approved to permit the provision of incidental medical services, and the content and manner of providing a required admission agreement. In addition, staff will establish in-house policies and procedures related to the enforcement of regulations and will provide oversight of Residential Treatment Facilities (RTFs) that provide incidental medical services. DHCS is also required to review applications from facilities requesting to amend their licenses to include incidental medical services, and establish and collect an additional fee from participating facilities, in an amount sufficient to cover the department's reasonable costs of regulating the provision of those services.

Under Health and Safety Code (HSC) Section 11834.01, DHCS has sole authority in state government to license adult alcoholism or drug abuse recovery or treatment facilities. Prior to the enactment of AB 848, HSC Section 11834.02 defined residential Alcohol and Other Drug facilities as any premises, place or building that provides 24-

hour residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, that includes at least one of the following: recovery services, treatment services or detoxification services, but prohibited incidental medical services from being provided onsite.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 11: SUBSTANCE USE DISORDERS HEALTH CARE REFORM IMPLEMENTATION BUDGET CHANGE PROPOSAL

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor**, Deputy Director, Mental Health and Substances Use Disorder Services, Department of Health Care Services
- **Lawana Welch**, Finance Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS, Enterprise, Innovation, and Technology Services (EITS), the Substance Use Disorders (SUD) Prevention, Treatment, and Recovery Services Division (PTRSD), and the Office of Legal Services (OLS), requests $1,456,000 ($729,000 General Fund/$727,000 Federal Fund) to convert 10.0 limited-term positions to permanent full-time positions and 1.0 new permanent legal position. The 10.0 two-year limited-term positions are set to expire on June 30, 2016. DHCS proposes the conversion of the positions to permanent full-time positions in order to continue to support the requirements set forth in the Affordable Care Act (ACA) and enacted in SBX1 1 as part of the 2013-14 Budget Act for enhanced Medi-Cal substance use disorder services. The additional position for OLS will address litigation workload associated with both SBX1 1 and AB 848, Chapter 744, Statutes of 2015. The OLS position will be phased-in effective January 1, 2017.

BACKGROUND

The ACA required states electing to participate within 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, in accord with the federal requirements. The ACA regulations delineated mental health and substance use disorder services as part of the EHB standard and required all alternative benefit plans under Section 1937 of Title XIX of the Social Security Act to cover such services.

To comply with ACA, substance use disorder services under the Drug Medi-Cal (DMC) program were expanded and made available to additional beneficiaries. Treatment planning was added as a component to narcotic treatment, naltrexone treatment, and outpatient drug free treatment services. Intensive outpatient treatment services (previously available only to those who are pregnant, postpartum, or youth eligible for Early and Periodic Screening, Diagnosis and Treatment) was made available to all beneficiaries who meet the requirement for medical necessity. Counseling time limits in narcotic treatment settings were eliminated.

To implement expanded benefits as a result of the ACA and SBX1 1, PTRSD and EITS established 10.0 limited-term positions (2.0 AGPA in Performance Management Branch (PMB), 3.0 AGPA in Fiscal Management Accountability Branch (FMAB), and 5.0 in Enterprise Information Technology Solutions (EITS)) in 2014-15. Due to the numerous program integrity issues related to potential fraud and information technology system Issues, this staff was reassigned to assist in other areas to deal with unforeseen events and program inconsistencies between the two departments at transition. Therefore, DHCS explains that the workload associated with SBX 1 1 is not complete and these positions are still needed to carry out the ongoing functions associated with the ACA and related duties.

The requirement to expand substance use disorder services and include additional beneficiaries has led to an increase in new providers as well as existing providers expanding their available services. This in turn has increased the baseline workload in SUD PTRSD, necessitating additional permanent positions to meet the ongoing demands of updating and maintaining certified provider information databases, processing claims and payments, conducting onsite provider post-service, post-payment reviews, developing and monitoring county and direct provider contracts, and analyzing and settling county and provider cost reports.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 12: STAKEHOLDER PROPOSAL: NALOXONE GRANT PROGRAM

PANELISTS

- **Peter J. Davidson,** PhD, Assistant Professor, U.C. San Diego School of Medicine, Division of Global Health
- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor**, Deputy Director, Mental Health and Substances Use Disorder Services, Department of Health Care Services
- **Lawana Welch**, Finance Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Drug Policy Alliance proposes $3 million General Fund for DHCS to implement a community grant program for the distribution of naloxone kits to first responders, patients, families and at-risk drug users.

BACKGROUND

Naloxone is a safe, easy-to-administer, lifesaving overdose reversal medication. Advocates cite data that shows that an average of nine Californians die of drug overdose every day. Annually, over 2,700 Californians die from opioid overdoses. Nationally, the rates of fatal drug overdoses doubled over the last ten years, making it a leading cause of preventable death. Prescription opioids are the most common drug used in these deaths.

Based on evidence from programs in various parts of California and the U.S., advocates estimate that a $3 million investment in a naloxone kit distribution grant program could be expected to save an estimated 1,200 lives. Moreover, the use of Naloxone has been found to reduce emergency room costs. According to the federal Centers for Disease Control and Prevention in 2012, there were at least 188 overdose education and response programs in the U.S. that provided naloxone to community members, and that between 1996 and 2010, these programs in 15 states and the District of Columbia trained and provided naloxone to 53,032 people, resulitng in 10,171 drug overdose reversals using naloxone. Advocates also cite a San Francisco program as a model. The Drug Overdose Prevention Education project of San Francisco trained 5,508 drug users and their friends, family or service providers, resulting in 1,580 reported reversals. The annual number of heroin deaths dropped from a peak of 130 per year to fewer than 10, and emergency room visits for heroin overdose were cut in half during this same time period.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Dr. Peter Davidson to present this proposal.

Staff Recommendation: No action is recommended at this time.