AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MARCH 7, 2022

2:30 PM, STATE CAPITOL, ROOM 127

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

The public may attend this hearing in person, and it is strongly recommended that masks be used while inside the building. The hearing may also be viewed via live stream on the Assembly's website at http://assembly.ca.gov/todayevents.

A moderated telephone line will be available to assist with public participation. After all witnesses on all panels and issues have concluded, and after the conclusion of member questions, the public may provide public comment by calling the toll-free number: ***877-692-8957 / Access Code: 131 51 27***

ITEMS TO BE HEARD

NON-PRESENTATION ITEMS

LIST OF PANELISTS IN ORDER OF PRESENTATION

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

ISSUE 1: CRISIS RESPONSE AND 988 IMPLEMENTATION

PANEL 1 - PRESENTERS

- **Stephanie Welch**, Deputy Secretary for Behavioral Health, California Health and Human Services Agency
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Kelly Pfeifer**, **MD**, Deputy Director of Behavioral Health, Department of Health Care Services
- **Irina Haack,** Peer Support Specialist, U.C. Davis
- **John Franklin Sierra**, Senior Staff Analyst, Los Angeles County Chief Executive Office
- **Le Ondra Clark Harvey, Ph.D**., Chief Executive Officer, California Council of Community Behavioral Health Agencies
- **Veronica Kelley, Ph.D.**, Chief, Mental Health and Recovery Services, Orange County Health Care Agency
- **Toby Ewing**, Executive Director, Mental Health Services Oversight and Accountability Commission
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Kim Pederson**, Senior Attorney, Mental Health Practice Group, Disability Rights California
- **Peter Murphy**, Outreach Manager, on behalf of Mark Salazar, Chief Executive Officer, Mental Health Association of San Francisco

PANEL 1 – Q&A ONLY

- **Marlies Perez**, Chief of Community Services Division, Department of Health Care Services
- **Jim Kooler, DrPH**, Special Consultant, Behavioral Health, Department of Health Care Services
- **Norma Pate**, Deputy Director, Mental Health Services Oversight and Accountability Commission
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Madison Sheffield**, Staff Finance Budget Analyst, Department of Finance
- **Nina Hoang**, Finance Budget Analyst, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

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

ISSUE 2: SERVING HIGH-NEEDS INDIVIDUALS

PANEL 2 – PRESENTERS

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Kelly Pfeifer**, **MD**, Deputy Director of Behavioral Health, Department of Health Care Services
- **Stephanie Clendenin**, Director, Department of State Hospitals
- **Chris Edens**, Chief Deputy Director of Program Services, Department of State Hospitals
- **Veronica Kelley, Ph.D.**, Chief, Mental Health and Recovery Services, Orange County Health Care Agency
- **Toby Ewing**, Executive Director, Mental Health Services Oversight and Accountability Commission
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Kim Pederson**, Senior Attorney, Mental Health Practice Group, Disability Rights California
- **Stephanie Regular,** Assistant Public Defender, Contra Costa County
- **Michael Risher,** Of Counsel, ACLU Foundation of Northern California
- **Sandra Siedenburg,** Family Member of IST Patient
- **Enrique Enguidanos, MD, FACEP, MBA**, CEO, Community Based Coordination Solutions
- **Tyler Rinde**, Executive Director, California Association of Alcohol and Drug Program Executives, Inc.
- **Jeannette Zanipatin**, California State Director, Drug Policy Alliance

PANEL 2 – Q&A ONLY

- **Marlies Perez**, Chief of Community Services Division, Department of Health Care Services
- **Kate Warburton**, **MD**, Medical Director, Department of State Hospitals
- **Christine Ciccotti**, Chief Legal Counsel/Deputy Director, Department of State Hospitals
- **Norma Pate**, Deputy Director, Mental Health Services Oversight and Accountability Commission
- **Guadalupe Manriquez**, Assistant Budget Program Manager, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Madison Sheffield**, Staff Finance Budget Analyst, Department of Finance
- **Nina Hoang**, Finance Budget Analyst, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 3: BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE PROGRAM

PANEL 3 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Kelly Pfeifer**, **MD**, Deputy Director of Behavioral Health, Department of Health Care Services
- **Veronica Kelley, Ph.D.**, Chief, Mental Health and Recovery Services, Orange County Health Care Agency
- **Kim Pederson**, Senior Attorney, Mental Health Practice Group, Disability Rights California
- **Le Ondra Clark Harvey, Ph.D**., Chief Executive Officer, California Council of Community Behavioral Health Agencies
- **Tyler Rinde**, Executive Director, California Association of Alcohol and Drug Program Executives, Inc.

PANEL 3 – Q&A ONLY

- **Marlies Perez**, Chief of Community Services Division, Department of Health Care Services
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

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

ISSUE 4: EMERGENCY DEPARTMENT CARE FOR PSYCHIATRIC PATIENTS

PANEL 4 – PRESENTERS

- **Seth Thomas, MD**, FACEP, Emergency Physician, Director of Quality and Performance, Vituity
- **Aimee Moulin, MD**, Emergency Department Behavioral Health Director, U.C. Davis
- **Irina Haack,** Peer Support Specialist, U.C. Davis
- **Toby Ewing**, Executive Director, Mental Health Services Oversight and Accountability Commission
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Kelly Pfeifer**, **MD**, Deputy Director of Behavioral Health, Department of Health Care Services
- **Michelle Cabrera**, Executive Director, County Behavioral Health Directors Association
- **Kim Pederson**, Senior Attorney, Mental Health Practice Group, Disability Rights California

PANEL 4 – Q&A ONLY

- **Mary Watanabe**, Director, Department of Managed Health Care
- **Dan Southard**, Chief Deputy Director, Department of Managed Health Care
- **Norma Pate**, Deputy Director, Mental Health Services Oversight and Accountability Commission
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Madison Sheffield**, Staff Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

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

ISSUE 5: ACCESS TO BEHAVIORAL HEALTH SERVICES

PANEL 5 – PRESENTERS

- **Mary Watanabe**, Director, Department of Managed Health Care
- **Dan Southard**, Chief Deputy Director, Department of Managed Health Care
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Kelly Pfeifer**, **MD**, Deputy Director of Behavioral Health, Department of Health Care Services
- **Veronica Kelley, Ph.D.**, Chief, Mental Health and Recovery Services, Orange County Health Care Agency
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Le Ondra Clark Harvey, Ph.D**., Chief Executive Officer, California Council of Community Behavioral Health Agencies
- **Tyler Rinde**, Executive Director, California Association of Alcohol and Drug Program Executives, Inc.
- **Jeannette Zanipatin**, California State Director, Drug Policy Alliance

PANEL 5 – Q&A ONLY

- **Marlies Perez**, Chief of Community Services Division, Department of Health Care Services
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Madison Sheffield**, Staff Finance Budget Analyst, Department of Finance
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

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

ISSUE 6: STATE OVERSIGHT OVER CALIFORNIA'S BEHAVIORAL HEALTH SERVICES

PANEL 6 – PRESENTERS

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Kelly Pfeifer**, **MD**, Deputy Director of Behavioral Health, Department of Health Care Services
- **Ellen Bachman**, Deputy Director Statewide Quality Improvement Division, Department of State Hospitals
- **Toby Ewing**, Executive Director, Mental Health Services Oversight and Accountability Commission
- **Veronica Kelley, Ph.D.**, Chief, Mental Health and Recovery Services, Orange County Health Care Agency

PANEL 6 – Q&A ONLY

- **Stephanie Clendenin**, Director, Department of State Hospitals
- **Janelle Ito-Orille**, Chief of Licensing and Certification, Department of Health Care Services
- **Norma Pate**, Deputy Director, Mental Health Services Oversight and Accountability Commission
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Madison Sheffield**, Staff Finance Budget Analyst, Department of Finance
- **Nina Hoang**, Finance Budget Analyst, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 7: BEHAVIORAL HEALTH STATE OPERATIONS NEEDS

PANEL 7 – PRESENTERS

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Kelly Pfeifer**, **MD**, Deputy Director of Behavioral Health, Department of Health Care Services
- **Brent Houser**, Chief Deputy Director of Operations, Department of State Hospitals
- **Jaci Thompson**, Deputy Director Hospital Strategic Planning and Implementation, Department of State Hospitals
- **Toby Ewing**, Executive Director, Mental Health Services Oversight and Accountability Commission

PANEL 7 – Q&A ONLY

- **Sean Hammer**, Acting Deputy Director Administrative Services, Department of State Hospitals
- **Dr. Kate Warburton**, Medical Director, Department of State Hospitals
- **Janna Lowder**, Assistant Deputy Director (Acting), Hospital Strategic Planning and Implementation, Department of State Hospitals
- **Norma Pate**, Deputy Director, Mental Health Services Oversight and Accountability Commission
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Madison Sheffield**, Staff Finance Budget Analyst, Department of Finance
- **Nina Hoang**, Finance Budget Analyst, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

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

ISSUE 1: CRISIS RESPONSE AND 988 IMPLEMENTATION

OVERVIEW

This issue covers:

- Medi-Cal Qualifying Community-Based Mobile Crisis Intervention Services Benefit Trailer Bill
- Mobile Crisis Infrastructure 2021 Investments – Oversight
- CalHOPE and Warm Line – Oversight
- 988 Implementation – Oversight
- Proposed Reforms to the Mental Health Wellness Act (SB 82)

PANEL 1 - PRESENTERS

- **Stephanie Welch**, Deputy Secretary for Behavioral Health, California Health and Human Services Agency
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Kelly Pfeifer**, **MD**, Deputy Director of Behavioral Health, Department of Health Care Services
- **Irina Haack,** Peer Support Specialist, U.C. Davis
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- **Peter Murphy**, Outreach Manager, on behalf of Mark Salazar, Chief Executive Officer, Mental Health Association of San Francisco

PANEL 1 – Q&A ONLY

- **Marlies Perez**, Chief of Community Services Division, Department of Health Care Services
- **Jim Kooler, DrPH**, Special Consultant, Behavioral Health, Department of Health Care Services

- **Norma Pate**, Deputy Director, Mental Health Services Oversight and Accountability Commission
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- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSALS AND OVERSIGHT ISSUES

Medi-Cal Qualifying Community-Based Mobile Crisis Intervention Services Benefit Trailer Bill

DHCS requests expenditure authority of $108.5 million ($16.3 million General Fund and $92.2 million federal funds) in 2022-23 to provide qualifying community-based mobile crisis intervention services to Medi-Cal beneficiaries in need of behavioral health services. DHCS also proposes trailer bill language to implement this new benefit.

Section 9813 of the federal American Rescue Plan Act of 2021 authorizes state Medicaid programs to provide qualifying community-based mobile crisis intervention services for a period of up to five years, beginning April 1, 2022, and ending March 31, 2027. States that implement the mobile crisis intervention benefit receive an 85 percent federal match for reimbursement of these services for the first three years of the five year period. DHCS proposes to implement this benefit beginning January 1, 2023.

Mobile crisis intervention services are intended to provide rapid response, individual assessment, and crisis resolution by trained mental health and substance use treatment professionals and paraprofessionals in situations that involve individuals with behavioral health conditions. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) describes three core components of a robust crisis system: 1) a 24 hour clinically staffed call center that can serve as the hub of an integrated mental health crisis system, 2) mobile crisis response teams that can respond rather than law enforcement, and 3) crisis receiving and stabilization facilities that provide short-term services and can be accessed readily rather than relying on emergency departments or hospital environments.

Implementation of 988 for Suicide Prevention and Behavioral Health Crises. As discussed in more detail below, in July 2020, the Federal Communications Commission adopted rules to establish 988 as a new, nationwide, three-digit phone number for people in crisis to connect with suicide prevention and mental health crisis counselors. By July 16, 2022, all phone service providers will be required to direct all 988 calls to the existing National Suicide Prevention Lifeline. The new rules apply to all telecommunications carriers as well as all interconnected one-way Voice over Internet Protocol (VoIP) service providers.

Qualifying Community-Based Mobile Crisis Services. DHCS proposes to add qualifying community-based mobile crisis intervention services, as soon as January 1, 2023, for a five-year period as a mandatory Medi-Cal benefit available to eligible Medi-Cal beneficiaries 24 hours a day, seven days a week. The benefit would be implemented through the county behavioral health delivery systems by multidisciplinary mobile crisis teams in the community. The services would cover both mental health and substance use disorder crises, using the specialty mental health benefit and adding crisis intervention as an outpatient service eligible under the Drug Medi-Cal benefit. According to DHCS, the benefit would be provided outside a hospital or other facility setting and include screening and assessment, stabilization and de-escalation, and coordination with, and referrals to, health, social, and other services and supports.

Mobile Crisis Infrastructure 2021 Investments – Oversight

As discussed under issue #3 of this agenda, the 2021 Budget Act included expenditure authority of $755.7 million ($445.7 million General Fund and $310 million Coronavirus Fiscal Recovery Fund or CFRF) in 2021-22, $1.4 billion ($1.2 billion General Fund and $220 million CFRF) in 2022-23 and $2.1 billion General Fund in 2023-24 for competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. Of this amount, $150 million was made available to support mobile crisis infrastructure, along with $55 million in federal grant funds from SAMHSA, for a total investment of $205 million.

The infrastructure investment in mobile crisis units will allow counties and other entities to deploy behavioral health treatment resources for individuals experiencing a behavioral health crisis, or other acute behavioral health needs, in the community. This infrastructure may also be used to implement the new Medi-Cal mobile crisis intervention services benefit, authorized by the federal American Rescue Plan Act.

During the fall of 2021, DHCS requested funding applications for Round 1 of the Behavioral Health Continuum Infrastructure Program (BHCIP) from county, city, or tribal behavioral health authorities to support planning or implementation of the development and expansion of Crisis Care Mobile Units (CCMUs) in California. During Round 1, DHCS awarded more than $140 million to 45 grantees, which will create or enhance 219 mobile crisis response teams in the state.

LAO Comment. The LAO provided this comment on the mobile crisis services proposal: "Although we find that this proposed new benefit appropriately targets treatment gaps, we recommend the Legislature gather additional information before acting on this proposal and consider ways to ensure local capacity to provide this new benefit."

CalHOPE– Oversight

CalHOPE delivers crisis support for communities impacted by a national disaster. This is a crisis counseling assistance and training program funded by the Federal Emergency Management Agency (FEMA) and implemented by DHCS.

According to the CalHOPE website, CalHOPE builds community resiliency and helps people recover from disasters through free outreach, crisis counseling, and support services, including:

- Individual and Group Crisis Counseling and Support
- Individual and Public Education
- Community Networking and Support
- Connection to Resources
- Media and Public Service Announcements

CalHOPE services include:

CalHOPE Warm Line: (833) 317-HOPE (4673)

The CalHOPE warm line connects callers to peer counselors who have experienced similar struggles with stress, anxiety, depression—emotions triggered by the COVID-19 pandemic and other crises. The peer counselors listen, provide non-judgmental support, and offer additional resources for support.

CalHOPE Connect

CalHOPE Connect offers safe, secure, and culturally sensitive emotional support for all Californian's who may need support relating to COVID-19. CalHOPE partnered with California Mental Health Services Association (CalMHSA) which has a statewide, experienced workforce comprised of peers, community mental health workers, and other non-licensed personnel. Individuals in need of emotional and/or crisis support can receive "visits" by phone, videoconference, smart device, or computer chat. Depending upon needs and situation, family and/or group support sessions are also available. Individuals also may be connected to county-based services. CalHOPE connect offers culturally sensitive emotional support for:

- All Californians
- African Americans/Blacks
- Asian and Pacific Islanders
- Latino/Latinx
- LGBTQ+ Community
- Parents/Caregivers
- Veterans
- Young Adults

CalHOPE Red Line

The CalHOPE Red Line, a peer support program run by the California Consortium for Urban Indian Health (CCUIH), is a phone, chat, and video chat service providing national, state, and county resources, referrals, and trauma-informed support for urban Indian and Tribal populations. These include resources related to COVID-19, social services, and financial resources.

Web-based Coping and Stress Management Skills (English and Spanish)

The CalHOPE Together for Wellness website has easy-to-navigate wellness tools, including ones that educate and provide stress-management and coping skills. The University of California, Los Angeles partnered with CalMHSA to create these online resources to support Californians negatively impacted by the stressors brought on by the COVID-19 pandemic. The Spanish version of the CalHOPE Together for Wellness website, Juntos por Nuestro Bienestar, is available through an additional CalMHSA partnership with University of California, Davis. Juntos por Nuestro Bienestar provides culturally appropriate content aimed at teaching coping skills and stress management techniques to the Hispanic population.

CalHOPE Student Support

CalHOPE partnered with the Sacramento County Office of Education (SCOE) to implement and administer the CalHOPE Student Support program. The CalHOPE Student Support program provides training to teachers and school staff through existing educational Communities of Practice to provide crisis counseling through social-emotional learning environments. Additionally, the training for the teachers and school staff includes core components of crisis counseling utilizing learning modules developed through the UC Berkeley Greater Good Science Center. The trainings assist teachers and school staff in identifying children whose behavior reveals mental health distress, providing basic supportive interventions such as validating feelings, helping youth articulate their feelings and needs, and providing emotional support and connection to appropriate mental health resources.

Angst: Building Resilience Program

California's Angst: Building Resilience Program is an element of the CalHOPE Student Support program, which provides mental health support to youth. Angst: Building Resilience aims to help California's youth understand what anxiety is and what it feels like, through the reflections of other young people who have experienced it. It is in collaboration with CalHOPE, the California Department of Education (CDE), the iNDIEFLIX Foundation, and Blue Shield of California. Through this initiative the program will:

- Directly address anxiety, its causes, and solutions
- Help develop long-term resilience, strength, and emotional well-being

- Provide strategies and techniques to help deal with the mental health impacts of COVID-19

For the current academic year (10/11/21 - 06/30/22), schools in California have access to a plug-and-play film-based mental health support program. This program includes access to the Angst documentary, a discussion guide, tip sheet, classroom exercises, and support links and materials. The program is available to all California public and publicly funded charter schools for free as long as they sign up to bring the program to their schools, and it can be delivered to both virtual and hybrid classrooms in English or Spanish.

California's A Trusted Space, A Statewide 2022 Initiative

A Trusted Space: Redirecting Grief to Growth is a 45-minute docu-training film featuring leading experts and research-based curriculum that is designed to help teachers and other youth-serving-adults work together with students to create trusted atmospheres where healing and learning happen naturally. Available free to all K-12 California school staff and school districts, A Trusted Space™ is designed to help all those in the education eco-system mitigate the effects of the grief, trauma, anxiety, and other emotional stressors that so many students, families, and even they themselves, are feeling as they walk – or video conference – into school each day.

California Peer Run Warm Line -- Oversight

The California Peer Run Warm Line, operated by the Mental Health Association of San Francisco (MHASF), is a phone and instant messaging-based service that provides information, referrals, and emotional support to callers. They offer accessible and nonjudgmental peer support to anyone in the state of California who calls them. Specifically, the MHASF states that the Warm Line:

- Provides preventative services thus saving money from emergency room visits, police, EMT and other crisis services;
- Is staffed by peer counselors with lived experience of mental health challenges;
- Provides employment and professional development opportunities for peers; and
- Supports voluntary intervention and is non-intrusive.

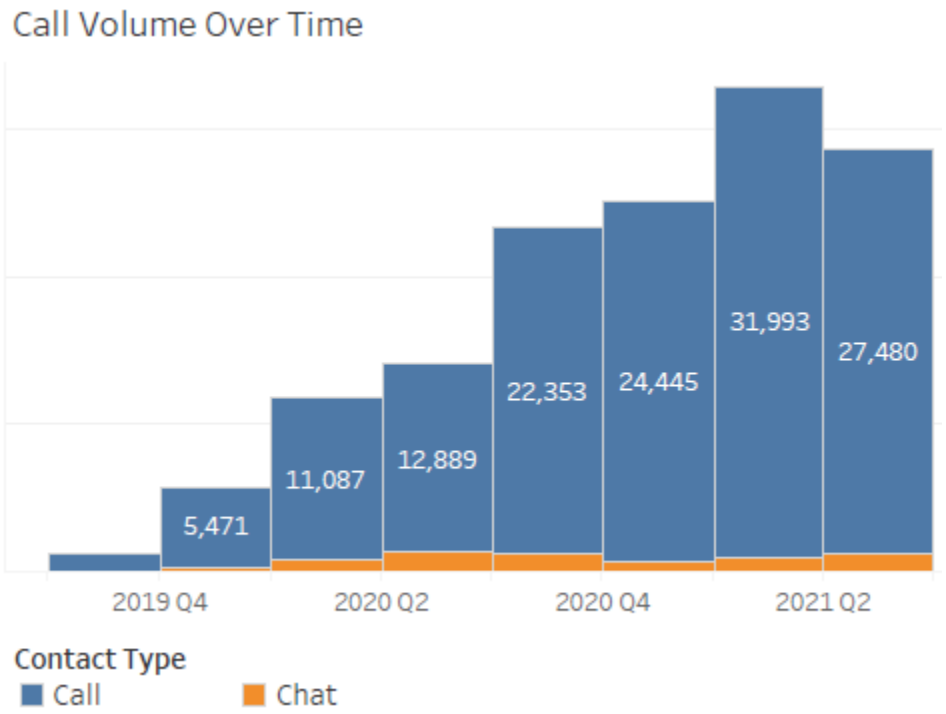
The current state funding for the Warm Line is a total of $10.6 million for 2019 - 2022, averaging $3.6m per year. The following Warm Line data was provided by the MHASF:

CALLS AND CHATS RECEIVED
From August 2014 – June 2021

Year	Phone Calls	Online Web Chat	
Year 1 - 2015	9,727	23	OSHPD Funding
Year 2 - 2016	24,707	354	
Year 3 - 2017	24,000	768	
Year 4 - 2018	24,462	1,200	
Year 5 – 2019	3,048	158	SFDPH Funding
Year 6 – 2020	30, 150	2,261	State Funding
Year 7 – 2021	85,745	3,754	

CALLS FROM MAJOR COUNTIES
From July 2019 – June 2021

Highest Call Frequency			
Los Angeles County	33,071	Contra Costa County	6,083
San Diego County	13,961	San Mateo County	5,505
San Francisco County	12,401	Sacramento County	5,690
Alameda County	10,463	Santa Clara County	5,343



MHASF would like to expand their capacity to support smaller Warm Lines by creating the California Warm Line Coalition that will partner with local county warm lines, population specific warm lines, and county mental health lines. As a 24/7 service available 365 days per year, the Warm Line would support smaller warm lines with less capacity by taking overflow calls, chats and text messages. Additionally, they would partner with counties to become an additional support for information and referral services. The

MHASF states that, as more warm lines join, it would create the largest preventative safety net in the country. To ensure that callers from other warm lines are receiving the same quality of peer support and counseling, the Coalition would develop and release a technical assistance toolkit for small, rural, and vulnerable community mental health organizations which are building their own warm lines, and also would offer grants to further support their development.

The technical assistance toolkit would include resources such as peer training curriculum, management structure, messaging templates, a how-to on call systems/voice over internet protocols (VOIP), database suggestions and best practices, and more. In addition to the toolkit, they would offer technical assistance in the form of group trainings and one-on-one support. The trainings would support program development through the review of policies and procedures to ensure best practices, quality control, HIPAA compliance, operational efficiency and effectiveness, and the development of action plans that strengthen overall operations and delivery of Warm Line Services. Grant opportunities for other budding warm lines could include peer workforce grants, training and development grants, technology grants, and more.

988 Implementation – Oversight

The National Suicide Hotline Designation Act of 2020 established 988 as a new three-digit telephone number to function as a national suicide prevention and mental health crisis hotline system that will connect people in crisis with lifesaving resources. With this easy-to-remember number, Congress hopes to increase public access to mental health and suicide prevention crisis resources, encourage help-seeking for individuals in need, and provide a crucial entry point to a continuum of crisis care.

In July 2020, the Federal Communications Commission adopted rules to establish 988 as a new, nationwide, three-digit phone number for people in crisis to connect with suicide prevention and mental health crisis counselors. By July 16, 2022, all phone service providers will be required to direct all 988 calls to the existing National Suicide Prevention Lifeline. The new rules apply to all telecommunications carriers as well as all interconnected one-way Voice over Internet Protocol (VoIP) service providers.

California has a network of 13 organizations that operate the National Suicide Prevention Lifeline, which will be receiving and responding to 988 calls. This network includes the following organizations:

1. Buckelew Suicide Prevention Program
2. Central Valley Suicide Prevention Hotline – Kings View
3. Contra Costa Crisis Center
4. Crisis Support Services of Alameda County
5. Kern Behavioral Health and Recovery Services Hotline
6. Optum
7. San Francisco Suicide Prevention Felton Institute

8. Santa Clara County Suicide and Crisis Services
9. StarVista
10. Didi Hirsch Mental Health Services
11. Suicide Prevention of Yolo County
12. Suicide Prevention Service of the Central Coast
13. WellSpace Health

Current State/Federal Funding for the Call Centers	
FUNDING SOURCE	**PROPOSED USE OF FUNDS**
Annual $4.3 million state appropriation through DHCS	• Ongoing operations
2021 one-time $20 million 988 capacity building grant through DHCS	• IT infrastructure capacity building • Increased staffing costs through 12/31/2022
$14.4 million one-time federal (SAMHSA) grant through DHCS	• Sustain increased staffing levels through 3/31/2024

The call centers provided the following estimated future funding requirements for successfully implementing 988:

	FISCAL YEAR		
	2022-23	2023-24	2024-25
TOTAL ANNUAL OPERATING COSTS	**$32,172,369**	**$44,919,261**	**$55,994,865**
Funded from existing statewide appropriation	$4,300,000	$4,300,000	$4,300,000
Funded from state $20 million grant	$11,768,333		
Funded from SAMHSA Grant	$8,068,335	$6,419,800	
SUBTOTAL FUNDED	**$24,136,668**	**$10,906,306**	**$4,300,000**
BALANCE TO BE FUNDED	**$8,035,700**	**$34,012,955**	**$51,694,865**

Proposed Reforms to the Mental Health Wellness Act (SB 82)

The Mental Health Services Oversight and Accountability Commission (Commission) receives $20 million each year to support the Mental Health Wellness Act, also known as the Triage Program, established through 2013 budget trailer bill. This funding is made available to county behavioral health departments through a competitive procurement process to support their crisis continuum of care. SB 82 prohibits the Commission from

requiring local matching funds for this purpose. SB 82 requires funding to be used to hire staff, although the funds also can be directed to community providers by the county.

In prior years the Commission has bundled these funds into multi-year allocations of $60-$80 million (committing funding from multiple fiscal years) and has directed that a portion of the funds be set aside for specific goals, such as 50 percent for children, or a specific set-aside to support collaboration between county behavioral health programs and schools. The Commission is currently monitoring $107.6 million in Triage grants that it has made available to support 30 separate programs. The Commission has contracts with multiple university partners to support evaluation and reporting requirements.

During its February 24th meeting, the Commission discussed opportunities to modify the Mental Health Wellness Act to address five concerns:

1. “These funds must be allocated through a competitive procurement process, creating barriers for small counties that may not have the capacity to respond to grant applications.
2. Funding is only available to county behavioral health programs. California’s community mental health system is led by county mental health departments, but includes a range of partners, including hospitals, First Five Commissions, health care districts, schools, community based organizations, child welfare programs, cities, and others.
3. Funding must be used to hire additional personnel. County mental health programs are struggling to hire additional staff and the most effective investments in systems change may include training, program development, community outreach, service delivery, or other strategies beyond additional staff hiring.
4. SB 82 grants are focused on crisis. The Commission, in partnership with counties and others, has made great progress identifying prevention and early intervention strategies to reduce the need for crisis services and to take pressure off already overburdened programs.
5. The Commission is prohibited from requiring match funding in allocating these funds, which restricts the impact this investment can have in supporting transformational change and improving mental health and wellness outcomes.”

The Commission is developing proposed trailer bill language to address these concerns.

STAFF COMMENTS/QUESTIONS

- The Subcommittee requests the California Health and Human Services Agency provide an overview of the administration's plans, analysis, and timing of 988 implementation. Please describe the Governor's new "Care Court" initiative.

- The Subcommittee requests DHCS present the DHCS proposals contained in this issue of the agenda, provide overviews of the implementation of mobile crisis infrastructure investments and CalHOPE, and describe how the state's many different crisis-response initiatives and programs will be coordinated and integrated together.

- The Subcommittee requests the Commission discuss its work and thinking on SB 82 reforms, as well as provide general comments and recommendations regarding the state's crisis response services.

- The Subcommittee requests the stakeholders on this panel share their experiences, expertise, and recommendations on the state's crisis response services and the implementation of 988.

Staff Recommendation: Hold open to allow for additional discussion and exploration of these issues and proposals, however the Subcommittee may want to urge the administration to accelerate their 988 implementation planning given the possibility of significant public confusion and misinformation when 988 goes live in July of this year.

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

ISSUE 2: SERVING HIGH-NEEDS INDIVIDUALS

OVERVIEW

This issue covers:

- DHCS Bridge Housing Proposal
- DSH Incompetent to Stand Trial Proposals
- MHSOAC Evaluation of Full-Service Partnership Model Outcomes (SB 465) BCP
- MHSOAC Innovation Incubator
- Community Based Coordination Solutions

PANEL 2 – PRESENTERS

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Kelly Pfeifer**, **MD**, Deputy Director of Behavioral Health, Department of Health Care Services
- **Stephanie Clendenin**, Director, Department of State Hospitals
- **Chris Edens**, Chief Deputy Director of Program Services, Department of State Hospitals
- **Veronica Kelley, Ph.D.**, Chief, Mental Health and Recovery Services, Orange County Health Care Agency
- **Toby Ewing**, Executive Director, Mental Health Services Oversight and Accountability Commission
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Kim Pederson**, Senior Attorney, Mental Health Practice Group, Disability Rights California
- **Stephanie Regular,** Assistant Public Defender, Contra Costa County
- **Michael Risher,** Of Counsel, ACLU Foundation of Northern California
- **Sandra Siedenburg,** Family Member of IST Patient
- **Enrique Enguidanos, MD, FACEP, MBA**, CEO, Community Based Coordination Solutions
- **Tyler Rinde**, Executive Director, California Association of Alcohol and Drug Program Executives, Inc.
- **Jeannette Zanipatin**, California State Director, Drug Policy Alliance

PANEL 2 – Q&A ONLY

- **Marlies Perez**, Chief of Community Services Division, Department of Health Care Services
- **Dr. Kate Warburton**, Medical Director, Department of State Hospitals
- **Christine Ciccotti**, Chief Legal Counsel/Deputy Director, Department of State Hospitals
- **Norma Pate**, Deputy Director, Mental Health Services Oversight and Accountability Commission

- **Guadalupe Manriquez**, Assistant Budget Program Manager, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Madison Sheffield**, Staff Finance Budget Analyst, Department of Finance
- **Nina Hoang**, Finance Budget Analyst, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSALS AND OVERSIGHT ISSUES

Bridge Housing Proposal

DHCS requests General Fund expenditure authority of $1 billion in 2022-23 to support bridge housing projects to address the immediate housing and treatment needs of people experiencing unsheltered homelessness with serious behavioral health conditions. Funding would be administered through the Behavioral Health Continuum Infrastructure Program process and would be used to purchase and install tiny homes with time-limited operational supports, as well as other bridge housing settings, such as assisted living. DHCS expects county behavioral health departments and Medi-Cal managed care plans to improve coordination to serve people with acute behavioral health challenges and those needing housing, treatment, and services, including medication, peer and family supports.

LAO Comment. The LAO provided this comment on the bridge housing proposal: "Although we find that this proposal appropriately targets an area of need, we raise several issues and provide recommendations—such as the adoption of trailer bill language to ensure legislative input into the design of the program—for legislative consideration."

Incompetent to Stand Trial (IST) Treatment – Proposals and Oversight

The State Hospitals system admits individuals determined to be incompetent to stand trial (IST) under Section 1370 of the Penal Code, typically for felony offenses, and provides clinical and medical services to restore these individuals to competency. Because of capacity constraints within the state hospital system, as of December 2021, 1,706 individuals in the IST population are housed in county jails awaiting placement into a state hospital bed or jail-based competency program. This backlog, which has grown significantly in the last two years due to the COVID-19 pandemic, places operational and fiscal stress on county jails and, according to recent court rulings, violates the due process rights of individuals in custody for longer than a reasonable time to evaluate their potential for restoration to competency.

Under California law "[a] person cannot be tried or adjudged to punishment or have his or her probation, mandatory supervision, post-release community supervision, or parole revoked while that person is mentally incompetent." IST patients are referred to DSH under Section 1370 of the Penal Code if a court has determined they are unable to understand the nature of criminal proceedings or assist counsel in their defense. IST

patients receive competency-based treatment and are returned to court once able to participate in court proceedings. If a defendant's attorney raises concerns about his or her competency to stand trial, the judge in the case may order a mental health evaluation by a psychiatrist or clinical psychologist. If the evaluation finds substantial evidence the defendant is incompetent, a competency hearing is scheduled with additional expert testimony and an opportunity for the defendant to respond to or refute the findings of the evaluation. If the court finds a defendant incompetent to stand trial, the local community health director determines whether the defendant is best treated in a local facility, an outpatient facility, or at a state hospital. Misdemeanants are typically treated in an outpatient setting or released, while felonies are typically referred for treatment at a state hospital. If a bed is not available in a state hospital, the defendant remains in the custody of the county until a bed becomes available. Capacity constraints in the state hospital system have resulted in ongoing backlogs of defendants deemed IST in county jails for extended periods awaiting treatment.

IST Backlog. Since the 2007-08 fiscal year, the backlog of IST referrals awaiting treatment in state hospitals has grown from between 200 and 300 to 1,706 as of December 2021. In 1972, the United States Supreme Court found in *Jackson v. Indiana* that a person committed on account of his or her incapacity to proceed to trial cannot be held for longer than the reasonable period of time necessary to determine whether the individual is likely to attain capacity. California law requires state hospital or outpatient facility staff to report to the court within 90 days on the status of the defendant's restoration to competency. Based on this 90 day requirement, several court rulings have recommended that a "reasonable" time to transfer IST patients for treatment is no more than 30 to 35 days. Many IST patients remain in county custody for longer, which may violate these patients' due process rights. In addition, the housing of IST patients in county jails while they await availability of treatment beds in state hospitals places stress on county jail systems.

Stiavetti v. Clendenin Requires Commencement of Treatment for IST Patients Within 28 Days. In 2015, five family members of IST patients committed to DSH and the Department of Developmental Services (DDS) filed suit against the state challenging statewide delays in transfer of IST patients from county jails to DSH or DDS to begin substantive treatment services as a violation of the patients' due process rights. On April 19, 2019, the Alameda County Superior Court concluded that IST patients have a constitutional right to substantive services within a reasonable period of time and that DSH and DDS had violated the due process rights of IST patients referred to a state hospital or to DDS. The court found that constitutional due process requires that DSH and DDS must commence substantive services to restore an IST patient to competency within 28 days of the transfer of responsibility for an IST patient to DSH. On August 25, 2021, the California Supreme Court denied final review of the court's decision and, upon remand, the Alameda County Superior Court issued the following amended compliance timelines for DSH and DDS:

- No later than August 27, 2022: DSH and DDS must commence substantive services for all IST patients within 60 days from the transfer of responsibility date.
- No later than February 27, 2023: DSH and DDS must commence substantive services for all IST patients within 45 days from the transfer of responsibility date.
- No later than August 27, 2023: DSH and DDS must commence substantive services for all IST patients within 33 days from the transfer of responsibility date.
- No later than February 27, 2024: DSH and DDS must commence substantive services for IST patients within 28 days from the transfer of responsibility date.

Administration Proposals to Increase IST Capacity in State Hospitals. Over recent years, the Administration has proposed a series of projects to expand capacity in State Hospitals for the treatment of IST patients. These proposals were in response to the growing backlog of IST patients in county jails over the last ten years and the potential for court mandates resulting from the *Stiavetti* case. These proposals include: 1) expansion of secured bed capacity at Metropolitan State Hospital to treat IST patients; 2) expansion of existing jail-based competency treatment programs and implementation of new programs; and 3) activation of OMD bed capacity at Coalinga State Hospital to allow transfer from other secured units to provide treatment space for IST patients in other hospitals.

2018 Budget Act - IST Community-Based Diversion Program. The 2018 Budget Act included General Fund expenditure authority of $100 million to establish an IST Diversion Program, which contracts with counties to serve individuals with serious mental illnesses with potential to be determined to be incompetent to stand trial (IST) on felony charges. The program prioritized $91 million of funding for these programs in the 15 counties with the highest referrals of ISTs to DSH in 2016-17, including Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Santa Barbara, Santa Clara, Solano, Sonoma, and Stanislaus. These counties were not required to submit a competitive application. In May 2020, Stanislaus County chose not to participate due to COVID-19 related economic issues and lack of other county resources to establish the program.

Of the remaining funding, $8.5 million was made available to other counties under a competitive funding process. In June 2019, DSH awarded funding to the following counties: Del Norte, Marin, Placer, San Francisco, San Luis Obispo, Santa Cruz, and Yolo. In November 2019, DSH awarded a second round of funding to Humboldt, San Mateo, Siskiyou, and Ventura counties.

IST Workgroup Established to Recommend Solutions to Reduce Backlog. In response to the court's ruling in *Stiavetti*, the 2021 Budget Act included trailer bill language to require DSH to convene an IST Solutions Workgroup to identify short-term, medium-term, and long-term solutions for alternatives to placement of defendants determined to be IST in a state hospital. The IST Solutions Workgroup met five times between August 2021 and

November 2021 to develop solutions to the backlog of IST patients awaiting admission to state hospitals. The workgroup focused on three primary areas: 1) early access to treatment and stabilization for individuals determined to be IST on felony charges; 2) diversion and community-based restoration for individuals determined to be IST on felony charges; and 3) improving the quality of initial county competency evaluations. The workgroup released its findings in a report in November 2021 that included short-, medium-, and long-term recommendations.

IMD and Sub-Acute Bed Capacity Funding Program. In addition to establishment of the IST Workgroup, the 2021 Budget Act included 22 positions and General Fund expenditure authority of $267.1 million to authorize DSH to contract for subacute bed capacity to address the increasing number of IST patient referrals to state hospitals. DSH reports it began engagement with multiple private providers in summer 2021 and continues to work with those providers to develop bed capacity throughout the state. DSH is attempting to partner with providers that can provide a blend of acute and sub-acute bed capacity, which DSH believes will allow more individuals to transition from jail to community settings and promote a broader continuum of care. DSH is engaging counties that currently lack capacity to stabilize IST patients to provide funding to expand the reach of diversion programs. In addition, DSH is engaging with counties that have not been able to fully participate in diversion and community-based restoration programs due to lack of availability of sub-acute beds in their communities. DSH is also attempting to align funding for this program with the proposals contained within its IST Solutions Package.

Governor's January Budget Proposes Package of IST Solutions. DSH requests General Fund expenditure authority of $93 million in 2021-22 and $571 million annually thereafter to support implementation of solutions to provide timely treatment for patients determined incompetent to stand trial (IST) on felony charges and to support ongoing efforts to decriminalize mental illness in California. Included in this request is General Fund expenditure authority of $75 million in 2021-22 and $175 million annually thereafter for IST solutions, and $18 million in 2021-22 and $46 million annually thereafter for IST diversion and community-based restoration (CBR), approved in the 2021 Budget Act. The total additional ongoing funding requested in the Governor's January budget is $350 million beginning in 2022-23.

The Administration proposes the following solutions:

Stabilization and Early Access to Treatment. $24.9 million in 2021-22 and $66.8 million in 2022-23 and annually thereafter would provide access to treatment services for individuals on the IST waitlist. Treatment would be facilitated in partnership with county jail mental health providers and would include administration of medications such as long-acting injectable (LAI) medications, increased clinical engagement, and competency education. DSH indicates it would leverage its existing jail-based competency treatment infrastructure to provide these services.

Care Coordination and Waitlist Management. $1.7 million in 2021-22 and $4.9 million in 2022-23 and annually thereafter would support teams to screen all IST patients to determine eligibility for community-based programs, provide enhanced monitoring of the waitlist, and provide commitment to admission case management to coordinate appropriate placements and maximize bed usage.

Housing Augmentation for Current Diversion Contracts. $60 million in 2021-22 would support one-time interim housing investments for IST patients participating in a DSH diversion program. $75,000 per patient would support the cost of appropriate housing to facilitate increased diversion placements of patients determined IST on felony charges. Counties would use this funding to provide housing to diversion clients in the most appropriate level-of-care such as IMDs, mental health rehabilitation centers, residential housing with clinically enhanced services, board and care homes, and other appropriate residential facilities.

Housing Infrastructure - CBR or Diversion Beds. $6.4 million in 2021-22 and $233 million in 2022-23 and annually thereafter would support development of residential housing settings for IST patients participating in CBR or diversion programs. $350,000 in start-up funds would be provided for approximately 700 housing units to cover down payment, retrofitting, and furnishings to provide approximately 5,000 beds.

Community Program Funding for CBR or Diversion Clients. $266.5 million in 2022-23 and annually thereafter would support creation or expansion of permanent community-based treatment programs for IST patients. These resources would support a robust per-patient rate, non-treatment costs of managing community-based programs, transitional housing support for IST patients released from custody, and technical assistance resources for participating counties.

Increased Conditional Release Program (CONREP) Placements. $433,000 in 2022-23 and annually thereafter would support a pilot for a new independent placement determination panel to increase the number of individuals served in the community through the Conditional Release Program (CONREP). The panel would revise the role of the Community Program Director and improve the assessment process for individuals committed to DSH as Not Guilty by Reason of Insanity (NGI) and Offenders with a Mental Health Disorder (OMD). Increasing utilization of CONREP would increase bed capacity in the state hospitals available for inpatient treatment of IST patients.

In addition to these investments, DSH requests trailer bill language to cap the total number of felony IST referrals by each county based on the current fiscal year (2021-22) and require counties to assume a share of the cost of care for IST patients referred above the cap. According to DSH, the county's share of the cost of care would be based on the treatment location, including inpatient or community-based programs.

LAO Comment. The LAO provided this comment on the IST proposals: "Although we find the priorities reflected in this proposal reasonable, we raise several issues—such as the feasibility of imposing a county cap on felony IST referrals—and provide recommendations—such as monitoring the status of other promising ideas from the workgroup—for legislative consideration."

MHSOAC Innovation Incubator

In 2017, the Commission received $5 million to expand criminal justice diversion strategies that would reduce the numbers deemed IST with a felony charge. The Commission invested this $5 million in a range of projects, including:

Data Driven Recovery Project. Ten counties working through two cohorts linked criminal justice and behavioral health data to better understand the mental health needs of people in the criminal justice system. The first cohort comprises Sacramento, San Bernardino, Nevada, Plumas, and Yolo counties. The second cohort includes Calaveras, El Dorado, Lassen, Marin, and Modoc counties. The goal of the project is to improve the ability of counties to offer mental health services and avoid reliance on law enforcement resources.

Full-Service Partnerships. Eight counties are evaluating and refining their Full-Service Partnerships (FSP) to improve the results from this "whatever it takes" approach. More than $1 billion is spent annually on FSPs statewide. Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, Stanislaus, Lake and Ventura counties are working together to assess their programs and develop metrics for improvement efforts.

Psychiatric Advanced Directives (PADs). Five county teams – Fresno, Orange, Shasta, Mariposa and Monterey counties – are exploring options to deploy advanced directives to improve the response from county officials, behavioral health as well as law enforcement, when working with individuals who are in a behavioral health crisis.

Crisis Now. Eleven counties – Nevada, Plumas, Butte, Shasta, City of Berkley, Yolo, Placer, Solano, Mono, Inyo and Sacramento County – are developing comprehensive and financially sustainable crisis response systems designed to meet people's needs better and reduce incarcerations and hospitalizations, based on the nationally recognized, evidence-based model, Crisis Now. Crisis Now plans are designed to support the coming roll out of the 988 crisis system.

Fiscal Sustainability. Three counties – Sacramento, San Luis Obispo, and Santa Barbara – are assessing the effectiveness of interventions to reduce the criminal justice involvement of people with unmet mental health needs and develop strategies for improving performance and financial sustainability. All three counties received significant one-time funds from the Department of State Hospitals.

Fiscal Mapping. This project is identifying, assessing, and developing existing revenue streams that counties can tap into and developing policy options that would lead to more manageable and sustainable funding streams to support cost-effective strategies and services for preventing and reducing criminal justice involvement among those with mental health needs.

Outreach and Engagement. The Commission has partnered with the Forensic Mental Health Association of California and the Council of State Governments Justice Center to spread knowledge through webinars and workshops on these projects.

Evaluation of Full-Service Partnership Model Outcomes (SB 465) OAC BCP
The Commission requests 1.0 permanent position and $400,000 Mental Health Services Fund in 2022-23 and annually thereafter to annually report the outcomes for those receiving community mental health services under a full service partnership (FSP), to issue a progress report when a report is otherwise not due, to report any barriers to receiving the data relevant to completing this report, and include recommendations to strengthen full service partnerships to reduce incarceration, hospitalization, and homelessness, as required by SB 465 (Eggman, Chapter 544, Statutes of 2021).

SB 465 requires the Commission, by November 15, 2022 and biennially thereafter, to analyze and report on persons eligible for FSPs, whether served or not, including community mental health services delivered (whether as part of an FSP or not) and key outcomes, including FSP client outcomes for a period of not less than 12 months after disenrollment.

Under the Mental Health Services Act (MHSA) each county Mental Health Plan is required to spend at least half of its MHSA Community Services and Supports (CSS) funds (38 percent of its total annual MHSA funding) to its Full Service Partnership Service Category (California Code of Regulations Title 9, Section 3620(c)). Counties additionally bill Medi-Cal where appropriate for FSP services. Historically, counties have roughly matched their MHSA expenditures with non-MHSA expenditures across FSP programs and services. In 2018-19, counties reported serving approximately 63,000 individuals in FSPs.

FSP is a required service category under MHSA in which the county and a client (and/or the client's family) negotiate an Individual Services and Supports Plan (ISSP) to provide a previously unserved or underserved client with a full spectrum of community services necessary to achieve the client goals specified in the ISSP, which may include a broad array of mental health services and supports as well as non-mental health services and supports, including but not limited to assistance with food, clothing, housing, employment, respite care and medical care, and, for children, wrap-around services.

Counties are obligated to serve all age groups (Children, Transition-Age Youth, Adults, and Older Adults) of persons with serious mental illnesses through FSPs (CCR Title 9, Section 3620(j)). Additionally, eligibility for an FSP is restricted to persons underserved or unserved (as defined in CCR Title 9, Sections 3200.300 and 3200.310, respectively) and meets additional requirements, such as being homeless or at risk of homelessness, involved or at risk of involvement with the criminal justice system, at risk of institutionalization or involuntary hospitalization, a frequent user of hospital or emergency room mental health services, or any one of several other statuses. In practice, these requirements very often imply that the individual is income-eligible for Medi-Cal.

SB 465, among other requirements, directs the Commission to report on the number of persons eligible for FSPs by whether they are enrolled or not enrolled, and the community mental health services received and outcomes obtained for each group. As the Commission is required to report on persons eligible but not enrolled as well as those enrolled, the Commission will require access to appropriate data sources to identify those persons and to link those persons to appropriate outcomes data, such as arrests, hospital and emergency room admissions, and housing status.

STAFF COMMENTS/QUESTIONS

- The Subcommittee requests DHCS present the bridge housing proposal and comment on how the Governor's new initiative integrates with the many other behavioral health proposals in the budget designed to address the needs of the highest-needs individuals.

- The Subcommittee requests DSH provide an overview and updates on the IST issue and present the proposals included in the 2022 proposed budget to address this issue.

- The Subcommittee requests the Commission provide an overview of the Commission's relevant work, including the Innovation Incubator.

- The Subcommittee requests other stakeholders on the panel share their experiences, expertise and recommendations on how the state can best serve the needs of the population with the most significant behavioral health needs.

Staff Recommendation: Hold open to allow for additional discussion and exploration of these issues and proposals, particularly in light of the Governor's new Care Court Initiative.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 3: BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE PROGRAM

OVERVIEW

This issue covers:

- Overview of Behavioral Health Assessment
- Infrastructure Investments in 2021 Budget – Oversight
- Infrastructure Proposals n 2022 Budget

PANEL 3 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Kelly Pfeifer**, **MD**, Deputy Director of Behavioral Health, Department of Health Care Services
- **Veronica Kelley, Ph.D.**, Chief, Mental Health and Recovery Services, Orange County Health Care Agency
- **Kim Pederson**, Senior Attorney, Mental Health Practice Group, Disability Rights California
- **Le Ondra Clark Harvey, Ph.D**., Chief Executive Officer, California Council of Community Behavioral Health Agencies
- **Tyler Rinde**, Executive Director, California Association of Alcohol and Drug Program Executives, Inc.

PANEL 3 – Q&A ONLY

- **Marlies Perez**, Chief of Community Services Division, Department of Health Care Services
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSALS AND OVERSIGHT ISSUES

Overview of Behavioral Health Assessment

On January 10th, 2022, DHCS released its report, "Assessing the Continuum of Care for Behavioral Health Services in California, Data, Stakeholder Perspectives, and Implications." This assessment was prepared between July and November 2021 using data from existing California reports and surveys as well as California-specific information from national databases and a review of Medi-Cal administrative claims. The assessment also draws from a survey of counties' behavioral health directors conducted in partnership with the County Behavioral Health Directors Association of California (CBHDA) as well as

stakeholder interviews and focus groups. The assessment provides some data and information on the broader behavioral health system in California, but focuses most heavily on the services available to Medi-Cal enrollees living with serious mental illness and substance use disorders.

The report identifies the following "key issues and opportunities:"

- "It is critical to have a comprehensive approach to crisis services that emphasizes community-based treatment and prevention, and connects people to ongoing services.

- Community-based living options are essential for people living with serious mental illness and/or a substance use disorder.

- More treatment options are vital for children and youth living with significant mental health and substance use disorders.

- Prevention and early intervention are critical for children and youth, especially those who are at high risk.

- Behavioral health services should be designed and delivered in a way that advances equity and addresses disparities in access to care based on race, ethnicity, and other factors.

- More can be done to encourage evidence-based and community-defined practices are used consistently and with fidelity throughout California's behavioral health system.

- More effectively addressing the behavioral health issues—and related housing, economic and physical health issues—of individuals who are justice-involved is critical."

The full Assessment can be accessed here:
https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf

Infrastructure Investments in 2021 Budget – Oversight

The 2021 Budget Act included expenditure authority of $755.7 million ($445.7 million General Fund and $310 million Coronavirus Fiscal Recovery Fund or CFRF) in 2021-22, $1.4 billion ($1.2 billion General Fund and $220 million CFRF) in 2022-23 and $2.1 billion General Fund in 2023-24 for competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. Of this amount, $150 million was made available to support

mobile crisis infrastructure, along with $55 million in federal grant funds from the Substance Abuse and Mental Health Services Administration (SAMHSA), for a total investment of $205 million. DHCS announced the BHCIP funding would be released in six rounds, as follows:

- Round 1: Mobile Crisis - $205 million
- Round 2: County and Tribal Planning Grants - $16 million
- Round 3: Launch Ready - $518.5 million
- Round 4: Children and Youth - $480.5 million
- Round 5: Behavioral Health Needs Assessment Phase One - $480 million
- Round 6: Behavioral Health Needs Assessment Phase Two - $480 million

The following facility types may be considered for project funding through BHCIP:

- Community wellness centers
- Hospital-based outpatient treatment (e.g. outpatient detox or withdrawal management)
- Intensive outpatient treatment Narcotic Treatment Programs (NTPs)
- NTP medication units
- Office-based outpatient treatment
- Sobering centers
- Acute inpatient hospitals – medical detox or withdrawal management
- Acute psychiatric inpatient facilities
- Adolescent residential treatment facilities for substance use disorders (SUD)
- Adult residential treatment facilities for SUD • Chemical dependency recovery hospitals
- Children's crisis residential programs (CCRPs)
- Community treatment facilities (CTFs)
- Crisis stabilization units (CSUs)
- General acute care hospitals (GACHs) and acute care hospitals (ACHs)
- Mental health rehabilitation centers (MHRCs)
- Psychiatric health facilities (PHFs)
- Short-term residential therapeutic programs (STRTPs)
- Skilled nursing facilities with special treatment programs (SNFs/STPs)
- Social rehabilitation facilities (SRF)
- Peer respite
- Recovery residence/sober living homes

Funding may also be used for mobile crisis infrastructure, which is discussed in more detail under issue #1.

Subsequent Rounds of Funding – Launch Ready, Children and Youth, and Filling Gaps. Round 3 of BHCIP will focus on projects that are considered "launch ready" (as defined) and will award up to $518.5 million to qualified applicants. The application process for Round 3 opened on February 15, 2022, and will consist of two parts, one closing March 31, 2022, and one closing May 31, 2022.

Round 4 will focus on children and youth-focused behavioral health infrastructure projects and will award up to $480.5 million to qualified entities. The department is currently engaging in stakeholder meetings to inform policies around this application process.

Rounds 5 and 6 are expected to be available in October 2022, and December 2022, respectively, and will award up to $480 million each to qualified entities. These funding rounds are expected to address gaps identified in the department's Behavioral Health Needs Assessment, released in January 2022.

Infrastructure Proposals in 2022 Budget

DHCS requests expenditure authority of $466 million ($166 million General Fund and $300 million Coronavirus Fiscal Recovery Fund or CFRF) in 2021-22 and $1.7 billion ($1.4 billion General Fund and $218.5 million CFRF) in 2022-23. If approved, these resources would support continuing grant funding rounds for the Behavioral Health Continuum Infrastructure Program (BHCIP).

STAFF COMMENTS/QUESTIONS

- The Subcommittee requests DHCS provide overviews of the Behavioral Health Needs Assessment and BHCIP, and comment on how this program fits within the new Care Court Initiative.

- The Subcommittee requests the various stakeholders on the panel share their knowledge, experience, and recommendations regarding behavioral health infrastructure in California.

Staff Recommendation: Hold open to allow for additional discussion and exploration of these issues and proposals, particularly in light of the Governor's new Care Court Initiative.

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

ISSUE 4: EMERGENCY DEPARTMENT CARE FOR PSYCHIATRIC PATIENTS

PANEL 4 – PRESENTERS

- **Seth Thomas, MD**, FACEP, Emergency Physician, Director of Quality and Performance, Vituity
- **Aimee Moulin, MD**, Emergency Department Behavioral Health Director, U.C. Davis
- **Irina Haack,** Peer Support Specialist, U.C. Davis
- **Toby Ewing**, Executive Director, Mental Health Services Oversight and Accountability Commission
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Kelly Pfeifer**, **MD**, Deputy Director of Behavioral Health, Department of Health Care Services
- **Michelle Cabrera**, Executive Director, County Behavioral Health Directors Association
- **Kim Pederson**, Senior Attorney, Mental Health Practice Group, Disability Rights California

PANEL 4 – Q&A ONLY

- **Mary Watanabe**, Director, Department of Managed Health Care
- **Dan Southard**, Chief Deputy Director, Department of Managed Health Care
- **Norma Pate**, Deputy Director, Mental Health Services Oversight and Accountability Commission
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Madison Sheffield**, Staff Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

OVERSIGHT ISSUE

A common refrain in the public dialogue is that emergency departments (EDs) are inappropriate, ineffective, and generally terrible settings for treating patients experiencing psychiatric emergencies. Much work has been done to identify and create alternative care settings for these patients, to divert them from hospital EDs to other locations, arguably to ensure better care for these patients while simultaneously focusing ED resources and energy on patients experiencing physical medical emergencies.

However, a growing body of research supports the opposite approach. On Wednesday, December 15, 2021, the Assembly Health and Judiciary Committees held an informational hearing on the Lanterman-Petris Short Act, which included a presentation

by Dr. Scott Zeller on a psychiatric emergency model of care for EDs, called "EmPATH." EmPATH seeks to transform EDs into appropriate, effective, and compassionate treatment settings for psychiatric patients. This approach challenges conventional wisdom that says that since EDs do not typically provide good care for psychiatric patients, these patients should be treated elsewhere. Instead, EmPATH asserts that EDs can and should commit to and develop the ability to provide high quality care to all patients experiencing medical emergencies, including psychiatric emergencies. Dr. Zeller pointed out that federal law defines psychiatric emergencies as medical emergencies, and therefore must be treated by hospital EDs. The key components to EmPATH include:

- Designated destination for all medically-cleared patients in crisis prior to determination of disposition or IP admission; not viewed as an alternative destination but THE destination;

- Designed and staffed to treat all emergency psychiatric patients – philosophy of "no exclusion;"

- Immediate patient evaluation and treatment by a psychiatrist, constant observation and re-evaluation;

- Provides a calming, healing, comfortable setting completely distinct from the Medical ED; and

- Wellness and recovery-oriented approach.

EmPATH includes a multidisciplinary team approach, including:

- Psychiatrists/Psychiatric Providers
- RNs
- Social Workers
- Psychiatric Assistants
- LVNs/ LPTs
- Peer Support Specialists

Evaluation research published in the Academic Emergency Medicine Journal in August 2021 found that an EmPATH unit decreases hospital admission, and the following:

- Reduced ED boarding from an average of 16.2 hours to just 4.9 hours (70% reduction);

- Reduced inpatient psychiatric admissions by 53% (from 57% of patients to just 27% of patients);

- Improved the outpatient follow-up of patients from 39.4% to 63.2% (60% improvement); and
- Reduced 30-day psych patient return to ED (recidivism) by 25%.

According to Dr. Zeller: "For every $8,000 a County Mental Health Medi-Cal plan pays for EmPATH care, they avoid $36,000 in inpatient payments."

Crisis Stabilization Units (CSU)
EmPATH is an academic term, not copyrighted or licensed, and each unit differs. Crisis stabilization units (CSUs) are a very similar model in California, and in some cases are considered to be EmPATH programs when located on a hospital campus close to an ED.

STAFF COMMENTS/QUESTIONS

- The Subcommittee requests the various stakeholders on the panel share their knowledge, experience, and recommendations regarding model ED psychiatric care.

- The Subcommittee requests DHCS clarify what types of ED mental health care and services are reimbursable by Medi-Cal, and how (i.e., by County Mental Health Plans or by Medi-Cal managed care plans).

- The Subcommittee requests that CBHDA provide information on the prevalence of hospital-based CSUs and any other similar ED models of care. Please also explain the financing opportunities for these models of care.

Staff Recommendation: Hold open to allow for additional discussion and exploration of possible ways for the state to encourage and expand model ED psychiatric care.

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

ISSUE 5: ACCESS TO BEHAVIORAL HEALTH SERVICES

OVERVIEW

This issue covers:

- DMHC Follow-Up Appointments for Mental Health and Substance Use Disorder Timely Access Standards (SB 221) BCP
- DHCS Behavioral Health Timely Access to Care Oversight (SB 221) BCP
- DHCS Medication Assisted Treatment Expansion Program BCP, TBL

PANEL 5 – PRESENTERS

- **Mary Watanabe**, Director, Department of Managed Health Care
- **Dan Southard**, Chief Deputy Director, Department of Managed Health Care
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Kelly Pfeifer**, **MD**, Deputy Director of Behavioral Health, Department of Health Care Services
- **Veronica Kelley, Ph.D.**, Chief, Mental Health and Recovery Services, Orange County Health Care Agency
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Le Ondra Clark Harvey, Ph.D**., Chief Executive Officer, California Council of Community Behavioral Health Agencies
- **Tyler Rinde**, Executive Director, California Association of Alcohol and Drug Program Executives, Inc.
- **Jeannette Zanipatin**, California State Director, Drug Policy Alliance

PANEL 5 – Q&A ONLY

- **Marlies Perez**, Chief of Community Services Division, Department of Health Care Services
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Madison Sheffield**, Staff Finance Budget Analyst, Department of Finance
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSALS

Follow-Up Appointments for Mental Health and Substance Use Disorder Timely Access Standards (SB 221) BCP

DMHC requests 16.0 positions and expenditure authority (equivalent to 0.5 position) and $3,882,000 from the Manage Care Fund in 2022-23, 19.0 positions and expenditure authority (equivalent to 0.5 position)and $4,479,000 in 2023-24, 19.0 positions and expenditure authority (equivalent to 0.5 position)and $4,267,000 in 2024-25, 19.0 positions and expenditure authority (equivalent to 0.5 position)and $4,357,000 in 2025-26, 19.0 positions and $4,151,000 in 2026-27, 19.0 positions and $4,241,000 in 2027-28 and annually thereafter to address timeliness standard for follow-up appointments for certain mental health and substance use disorder providers as specified pursuant to SB 221 (Wiener, Chapter 724, Statutes of 2021).

This request includes consulting funding in the amount of $611,000 in 2022-23, $855,000 in 2023-24, $667,000 in 2024-25, $757,000 in 2025-26, $667,000 in 2026-27, $757,000 in 2027-28 and annually thereafter for statistical consultants to assist in developing a regulation, a clinical consultant to assist with the ongoing review of health plans policies and procedures, analyze utilization management processes and expert witness consultants to assist with trials. Additionally, this request also includes $11,000 in 2022-23, $12,000 in 2023-24 and annually thereafter for software licensing costs for access to the Necessary Infrastructure Modernization for Business Unified Services (NIMBUS) platform.

SB 221 made several changes to the Knox-Keene Act effective January 1, 2022. In general, the bill deletes several portions of HSC Section 1367.03 that originally directed the DMHC to develop timely access regulations and replaces those provisions with many of the standards for timely access for non-emergency services contained in the Rule 1300.67.2.2. SB 221 changes some of those standards, as they exist in law today. SB 221 codified the timely access standards adopted in regulation by the DMHC into the HSC. This bill also specified a timeliness standard for follow-up appointments for certain mental health and substance use disorder providers, and it adds references to mental health and substance use disorder providers to other timely access provisions.

SB 221 requires health plans, as of July 1, 2022, to ensure that its contracted provider network can offer non-urgent follow-up appointments with a non-physician mental health care or substance use disorder provider (MH/SUD) within 10 business days of the prior appointment, or longer if such a wait does not have a detrimental impact on the health of the enrollee. Previous law required the provision of health care services, including follow-up care, consistent with good professional practice, as a general matter. This follow-up appointment standard is a minimum standard and it does not prohibit a plan from offering follow-up appointments for MH/SUD providers sooner or more frequently.

In addition, SB 221 made the following changes to the timely access standards found in the DMHC's current timely access rule ("Rule 1300.67.2.2"):

- Requires interpreter services with scheduled appointments for health care services, without delaying the scheduling of the appointment.
- Requires a health plan that uses a tiered network to demonstrate compliance with the timely access standards at the lowest cost-sharing tier.
- Requires a health plan to arrange coverage outside of the plan's contracted network if medically necessary treatment of mental health or substance use disorder is not available timely in network.
- Addresses mental health and substance use disorders by including providers of those services in provisions related to advanced scheduling, telephone triage requirements and requirements for plans to arrange coverage outside of its contracted network, when that treatment is not available in network, as specified.
- Requires the DMHC's methodology for health plan reporting to include a new metric: demonstration of the average waiting time for each class of appointment.

SB 221 requires the DMHC to do the following:

- Promulgate timely access regulation to clarify SB 221 requirements and standards for follow-up appointments for non-physician mental health care providers and substance use disorder providers.
- Promulgate regulation, with stakeholder input, to develop standards to make specific network requirements for health plans to comply with timely access standards.
- Set forth parameters and standards for adequate capacity, availability and sufficiency of the provider types subject to timely access standards.
- Revise the DMHC's methodology for health plan reporting to include a new metric: demonstration of the average waiting time for each class of appointment.
- Develop standardized methodologies for health plan reporting that shall be used by health plans to demonstrate compliance with SB 221.
- Issue guidance on follow-up appointments by July 1, 2022 and promulgate regulations by January 1, 2025. SB 221 includes an Administrative Procedures Act (APA) exemption until July 1, 2025, for the DMHC.
- Annually review health plans documents for compliance with the timely access standard requirements pursuant to HSC Section 1367.03.
- Investigate and take enforcement action or assess administrative penalties against health plans regarding noncompliance with SB 221.

Behavioral Health Timely Access to Care Oversight (SB 221) BCP

DHCS, Managed Care Quality and Monitoring Division (MCQMD), and Medi-Cal Behavioral Health Division (MCBHD), request 8.0 permanent positions and expenditure authority of $1,320,000 ($660,000 General Fund (GF); $660,000 Federal Fund (FF)) in fiscal year (FY) 2022-23 and $1,248,000 ($624,000 GF; $624,000 FF) in FY 2023-24 and ongoing to perform compliance oversight of Medi-Cal managed care plan timely access

to care requirements for follow-up behavioral health services, as required by SB 221 (Wiener, Chapter 724, Statutes of 2021).

These resources are needed to implement and maintain the new workload resulting from the bill's additional timely access requirements for substance use disorder (SUD) providers; non-urgent follow-up appointments with mental health/SUD providers; and specialty referrals, as well as to provide technical assistance to Medi-Cal managed care health plans (MCPs), county Mental Health Plans (MHPs), and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties; develop the necessary monitoring tools; and conduct ongoing monitoring activities.

Pursuant to Welfare and Institutions Code Section 14197, all MCPs, county MHPs, and DMCODS counties are required to comply with the appointment time standards specified in Health and Safety Code Section 1367.03 and the Department of Managed Health Care's (DMHC) Timely Access Regulations (Title 28, California Code of Regulations (CCR), Section 1300.67.2.2). Specifically, MCPs, county MHPs, and DMC-ODS counties are required to provide, or arrange for the provision of, covered health care services in a timely manner appropriate for a beneficiary's condition consistent with good professional practice. The regulations establish metrics for measuring and monitoring the ability of a given MCP, county MHP, or DMC-ODS provider network to provide beneficiaries with access to health care services. MCPs, county MHPs, and DMC-ODS counties are required to maintain provider networks that have adequate capacity and include a sufficient number of available licensed health care providers to offer appointments that meet the specified timeframes.

Federal law (Title 42 Code of Federal Regulations (CFR), Section 438.206(c)) requires that MCP, MHP, and DMC-ODS contracts require them and their network providers to meet state standards for timely access to care and services. DHCS complies with this federal law by requiring all MCPs, MHPs, and DMC-ODS counties to follow DMHC's timely access regulations.

DHCS verifies MCP compliance with the timely access requirements through the use of its External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), that conducts a timely access Survey of all MCPs measuring provider compliance with appointment wait time standards. The Timely Access Survey includes a statistically valid random sample of network providers to confirm the first three available times for urgent and non-urgent appointments for pediatric and adult members; the availability of interpreter services; and the languages spoken by the network providers and provider site locations.

To verify that MHPs provide timely access to services, DHCS requires each MHP to have a system in place for tracking and measuring timeliness of care, which includes the timeliness to receive a first appointment of first Specialty Mental Health Services (SMHS). For this purpose, DHCS developed a uniform data collection tool to enable the analysis

of non-urgent and non-psychiatric appointments. DHCS also verifies MHP and DMC-ODS county compliance with timeliness standards for urgent appointments and follow up care through the use of its EQRO for Medi-Cal SMHS and DMC-ODS, Behavioral Health Concepts (BHC). BHC surveys MHPs and DMC-ODS counties to determine adherence with timeliness standards for urgent appointments and follow-up care. Additionally, for MHPs and DMC-ODS counties, DHCS reviews the policies and procedures relevant to timely access.

The differences between the existing timely access requirements that MCPs, MHPs, and DMCODS counties are currently held to and those pursuant to SB 221, are as follows:

- SB 221 more specifically notes an appointment time standard of 10 business days from the date of a request for a non-urgent SUD appointment. Currently, DMHC uses the non-physician mental health appointment standard of 10 business days to capture SUD appointments.
- SB 221, commencing July 1, 2022, adds an appointment time standard for non-urgent follow-up appointments with a non-physician mental health care or SUD provider, with a follow-up appointment required within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or SUD condition. Currently, there are no timely access requirements for follow-up appointments for any provider type.
- SB 221 requires referrals to a specialist by a primary care provider or another specialist to be subject to the relevant time-elapsed standards established in the bill, unless specified requirements are met. Currently, there are no timely access requirements related to referrals.
- SB 221 requires interpreter services to be coordinated with scheduled appointments for health care services in a manner that facilitates the provision of interpreter services at the time of the appointment without imposing delay on the scheduling of the appointment. Currently, the delay of scheduling an appointment in this circumstance is not prohibited.
- SB 221 requires out-of-network coverage if medically necessary treatment of a mental health disorder or SUD is not available in network within the geographic and timely access standards.

Medication Assisted Treatment Expansion Program BCP, TBL

DHCS, Community Services Division (CSD), requests 5.0 permanent positions and expenditure authority of $101,000,000 ($96,000,000 General Fund (GF) and $5,000,000 Opioid Settlement Fund [OSF]) in fiscal year (FY) 2022-23, $61,000,000 GF in FY 2023-24 and ongoing to support the Medication Assisted Treatment (MAT) Expansion Project in further reducing overdose and death related to opioid misuse by expanding the Naloxone Distribution Project, supporting 100 new MAT access points statewide, expanding MAT in county jails, and increasing MAT services within state-licensed facilities.

The request includes ongoing contract authority of $3,000,000 General Fund per year beginning in FY 2022-23 and thereafter for DHCS to contract with the administrative entity who will assist with grantee contracting, invoicing, and technical assistance and training. The requested resources will be utilized to oversee the continuation of the MAT Expansion Project through general project administration, contract and grantee monitoring, data collection, reporting, stakeholder engagement, and training and technical assistance.

The United States Centers for Disease Control and Prevention reported in December 8, 2021, that more than 100,000 people died of drug overdoses in the United States during the 12 month period ending April 2021. This is a 28.5 percent increase from the same period one year ago in addition to doubling over the past five years. Opioids, primarily fentanyl, are the predominant cause of overdose deaths. Fentanyl caused 64 percent of all drug overdose deaths during this 12-month period, which was an increase of 49 percent from the year before.

In California, overdose deaths have reached a historic high, totaling 9,617 deaths from August 2020 through July 2021. All opioid-related deaths, including by prescription, heroin, and fentanyl, made up 65 percent of the lives lost, and fentanyl was a factor in more than 50 percent of all drug-related overdose deaths. Since 2018, fentanyl-related overdose deaths have increased by more than 500 percent. Fentanyl has also severely affected homeless populations. Los Angeles County's report on homeless mortality found that drug overdoses were responsible for approximately 30 percent of homeless deaths in 2020, which accounted for a greater percentage than those directly attributed to COVID-19. Heroin, methamphetamines, and cocaine are often laced with fentanyl, which appeared in 41 percent of homeless overdose death cases in Los Angeles in 2020 – double 2019 figures.

The impacts of COVID-19 and increased use of fentanyl are drivers behind the substantial increases in opioid overdoses. Fentanyl use across California has increased dramatically. Low costs for street fentanyl, contamination of fentanyl within other drugs of choice, and widespread availability are some of the causes of increased use. Additionally, addiction experts note the impact COVID-19 has played on this crisis due to the havoc isolation causes with individuals with a substance use disorder (SUD) in treatment or long-term recovery, decreased access to SUD services, employment changes, financial losses and the stress of the pandemic.

While California has made progress with a continued increase in SUD system access, substantial redesigns of the SUD Medi-Cal benefit, increased availability of prevention activities with naloxone, and other California-created innovative efforts duplicated across the nation, the demand for evidence-based SUD services outstrips the availability of services.

Several years ago, the federal government began providing time-limited federal funding for states to utilize for prevention, treatment, harm reduction, and recovery services in response to the opioid epidemic. California has received federal funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) through the State Opioid Response (SOR) grants.

SOR, SOR Supplement, and SOR 2 are state discretionary, non-competitive grants that have 24-month periods of performance, beginning on September 30, 2018. The SOR Award totals $139.6 million, SOR Supplement Award totals $36.4 million, and SOR 2 Award totals $211.7 million. SOR 2, the latest iteration, expires on September 29, 2022. With this total SOR funding, DHCS created the MAT Expansion Project which addresses opioid use disorder (OUD) by increasing the available prevention, treatment, harm reduction, and recovery services in the state. The project has a special focus on populations with limited access to MAT; the evidence-based gold standard for treatment of OUD.

The goals of the MAT Expansion Project are to increase access to MAT, reduce unmet treatment need, and reduce opioid related overdose deaths through prevention, treatment, harm reduction, and recovery activities. The project has a special focus on populations with limited MAT access, including youth, people in rural areas, and American Indian & Alaska Native tribal communities. DHCS supports projects wherever individuals with a SUD seek help, including health care settings, justice systems, and treatment programs. The project also includes media campaigns, engagement of opioid safety coalitions, naloxone distribution, supportive housing, and other efforts.

Some of the outcomes of the 27 projects in the MAT Expansion Project include: 88,770 patients treated for OUD, 6,848 patients treated for stimulant use disorder, 32,895 stakeholders trained on MAT and the science of addiction, 650 new access point locations and over 50,000 overdose reversals through the Naloxone Distribution Project (NDP).

Medication Assisted Treatment Trailer Bill:
DHCS proposes to expand the continuation of the MAT Expansion Project by requiring SUD residential facilities and certified programs to provide access to MAT services. DHCS also proposes to conform state law to federal regulations to allow NTPs to provide mobile methadone/MAT services.

MAT Services within State-Licensed Facilities and Certified Programs
DHCS is proposing to require all SUD licensed facilities and certified programs to either provide MAT services onsite or make effective referrals to MAT providers. Specifically, all SUD licensed facilities and certified programs would be required to implement and maintain a MAT policy, approved by DHCS, which would include the following:

- How a client receives information about the benefits and risks of MAT;

- The availability of MAT at the program, if applicable, and/or the referral process for MAT;
- Identify an evidence-based assessment for determining a client's MAT needs;
- Address administration, storage and disposal of MAT, if applicable; and
- Outline training for staff about its MAT policy as well as the benefits and risks of MAT

NTP Mobile MAT Services

On June 28, 2021, the Drug Enforcement Administration (DEA) published a final rule that allows DEA-registered Opioid Treatment Programs (NTPs in California) to establish and operate components to dispense narcotic drugs in schedules I-V—such as mobile methadone vans—without obtaining a separate DEA registration for each mobile component. While federal guidance now allows mobile methadone, DHCS proposes to make statutory changes to state law to conform to federal regulations.

STAFF COMMENTS/QUESTIONS

- The Subcommittee requests DMHC and DHCS present these BCPs and proposed trailer bill, and provide an overview of the current state of access to behavioral health services in California.

- The Subcommittee requests the various stakeholders on the panel share their knowledge, experience, and recommendations regarding access to behavioral health care in California.

Staff Recommendation: Hold open to allow for additional discussion and exploration of these issues and proposals, particularly in light of the Governor's new Care Court Initiative.

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

ISSUE 6: STATE OVERSIGHT OVER CALIFORNIA'S BEHAVIORAL HEALTH SERVICES

OVERVIEW

This issue covers:

- DHCS Compliance Oversight of Insurance Policies for Licensed Alcohol and Drug Abuse Recovery or Treatment Facilities (Ab 1158) BCP
- DSH Quality Improvement and Internal Auditing, Monitoring, Risk Management, and Hospital Support BCP
- OAC Oversight

PANEL 6 – PRESENTERS

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Kelly Pfeifer**, **MD**, Deputy Director of Behavioral Health, Department of Health Care Services
- **Ellen Bachman**, Deputy Director Statewide Quality Improvement Division, Department of State Hospitals
- **Toby Ewing**, Executive Director, Mental Health Services Oversight and Accountability Commission
- **Veronica Kelley, Ph.D.**, Chief, Mental Health and Recovery Services, Orange County Health Care Agency

PANEL 6 – Q&A ONLY

- **Stephanie Clendenin**, Director, Department of State Hospitals
- **Janelle Ito-Orille**, Chief of Licensing and Certification, Department of Health Care Services
- **Norma Pate**, Deputy Director, Mental Health Services Oversight and Accountability Commission
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Madison Sheffield**, Staff Finance Budget Analyst, Department of Finance
- **Nina Hoang**, Finance Budget Analyst, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSALS

Compliance Oversight of Insurance Policies for Licensed Alcohol and Drug Abuse Recovery or Treatment Facilities (AB 1158) BCP

DHCS, Licensing and Certification Division (LCD), requests 4.0 permanent positions and expenditure authority of $626,000 in Residential Outpatient Licensing Fund (ROPLF) upon approval of a proposed fee increase, in fiscal year (FY) 2022-23, $590,000 ROPLF in FY 2023-24 and ongoing to implement the requirements as outlined in AB 1158 (Petrie-Norris, Chapter 443, Statutes of 2021). These resources will allow DHCS to monitor the compliance of insurance policies for licensed alcohol and other drug (AOD) recovery or treatment facilities and the promulgation of regulations to enable the enforcement of AB 1158 specifications. As part of this request, DHCS requests a ROPLF licensure and certification fee increase for residential and outpatient recovery and/or treatment programs effective July 1, 2022.

DHCS has the sole authority to license, certify, and monitor AOD recovery or treatment facilities to support the health and safety of program clients. The statutory and regulatory requirements focus on the health and safety of individuals served in these facilities. 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.

Licensed AOD recovery or treatment facilities provide residential non-medical services to individuals who are recovering from problems related to AOD misuse or abuse. Licensure is required when one or more of the following treatments services is provided: incidental medical services, detoxification, individual sessions, group sessions, educational sessions, or alcoholism or drug abuse treatment or recovery planning. These services can be provided by a variety of providers such as alcohol and drug counselors, mental health therapists, social workers, psychologists, nurses, and physicians.

Recovery residences, sometimes referred to as sober living environments/transitional housing, are homes for people in recovery from a substance use disorder. It may serve as support for individuals undergoing treatment, but it does not provide treatment services or care. Current laws and licensing requirements that govern treatment and care facilities do not currently include recovery residences. Therefore, DHCS does not keep a list of registered recovery residences, conduct inspections of recovery residences, or perform any of the other activities associated with licensing facilities. A recovery residence may be completely self-governed or have formal on-site management, but in the latter case, the managers' duties relate to the administration of the house rather than the tenants or their recovery (as in "case management"). The tenants of a recovery residence pay rent and abide by house rules, which always include maintenance of sobriety and

participation in a self-help program. Additionally, the Department has the statutory authority to adjust licensure and certification fees for residential and outpatient recovery and/or treatment programs.

The chaptered bill amends Section 11834.10 of the Health and Safety Code, and adds Section 11853.5, relating to the insurance coverage required by alcoholism or drug abuse recovery or treatment facilities. The bill requires a licensee operating an alcoholism or drug abuse recovery or treatment facility and serving more than six residents to maintain specified insurance coverages, including, among others, commercial general liability insurance and employer's liability insurance. The bill requires a licensee that serves six or fewer residents to maintain general liability insurance coverage.

Furthermore, the bill requires any government entity that contracts with a privately owned recovery residence or an alcoholism or drug abuse recovery or treatment facility to provide, respectively, recovery services or treatment services for more than six residents, to require the contractor to maintain those specified insurance coverages. If a residence or facility provides services for six or fewer residents, this bill requires the government entity to require the contractor to maintain general liability insurance coverages, as specified. The bill makes these provisions applicable to contracts entered into, renewed, or amended on or after January 1, 2022.

Currently, DHCS regulations do not require licensed AOD recovery or treatment facility providers to obtain or maintain insurance coverage. However, comprehensive (general) liability insurance is typically obtained by providers because it protects their business against general liability claims. Insurance is often identified on the provider's line item budget which they must provide to the department as a requirement for licensure.

AB 1158 requires a more in-depth level of review and analysis for all licensed AOD recovery or treatment facilities. This new requirement increases the overall volume of workload for DHCS to monitor licensed AOD recovery or treatment facilities for compliance. This responsibility includes ensuring licensed AOD recovery or treatment facilities' compliance by obtaining and maintaining the required minimum insurance policies set forth in this bill.

AB 1158 requires DHCS staff to monitor AOD recovery or treatment facilities' insurance coverage, which includes additional analysis during initial application review, expansions, renewals and population changes as well as monitoring of existing providers. DHCS states that if it were to absorb the new workload required by the bill within its current staff, it could result in increased backlogs and delays in the oversight functions for DHCS' licensed and certified AOD recovery or treatment facilities, which could lead to compromised client safety due to the inability of DHCS staff to respond to its licensed and certified facilities in a timely manner.

Under the new requirements of AB 1158, DHCS will be responsible for promulgating regulations and DHCS staff will incur additional travel expenses, such as weekly airfare, per diem, taxi fares, and hotel rentals associated with compliance monitoring and investigations of insurance complaints against AOD recovery or treatment facilities. This bill will also add time to licensing activities, inspections, and renewals. For the implementation of this bill, DHCS states that it needs to hire and train 4.0 staff members, and that these positions need to be permanent to support the additional ongoing workload addressed in by AB 1158.

Although DHCS is still working on the final proposed fee increase, DHCS estimates the increase to all residential licensure and certification fees will be approximately 45 percent. For reference, the initial combined residential licensure and certification application fee would increase from $4,068 to $5,899. This increase is needed because license and certification fees for residential and outpatient programs have not been adjusted since the enactment of SB 857 (Committee on Budget and Fiscal Review, Chapter 31, Statutes of 2014), which authorized DHCS to set forth a new fee structure. The proposed increase would be effective July 1, 2022 and help address the ongoing deficiency in the fund that has been exacerbated by impacts of the current public health emergency.

Quality Improvement and Internal Auditing, Monitoring, Risk Management, and Hospital Support BCP

DSH requests 11 positions and General Fund expenditure authority of $1.6 million annually. If approved, these positions and resources would allow DSH to support standards compliance and quality improvement operations, and provide resources to conduct independent financial, operational, compliance, and performance audits.

The DSH Statewide Quality Improvement Division (SQID) guides and monitors policy formulation and implementation of an integrated quality improvement program at the five state hospitals. The SQID includes four units: the Statewide Quality Improvement Program (SQIP), the Standards Compliance/Quality Improvement (SC/QI) unit, the Office of Audits (OOA), and Enterprise Health and Safety (EHS). These four units are responsible for the following:

- *Statewide Quality Improvement Program (SQIP) Unit*. The Statewide Quality Improvement Program (SQIP) Unit provides overall guidance and direction for the SQID, and provides technical support for the DSH Governing Body, including facilitating statewide communication of meetings, reports, and decisions. The DSH Governing Body is the entity that is legally responsible for the conduct of the hospital, pursuant to federal and state regulations.

- *Standards Compliance/Quality Improvement (SC/QI) Unit*. The Standards Compliance and Quality Improvement (SC/QI) Unit is responsible for centralized coordination of monitoring, oversight, and compliance with federal and state laws,

regulations, policies, and procedures. These include compliance with Department of Public Health (DPH) licensing regulations, Joint Commission hospital accreditation standards, and federal Centers for Medicare and Medicaid Services (CMS) regulations. The SC/QI Unit also develops and maintains oversight of the statewide quality improvement program, which includes the following focus areas:

1. Performance Improvement – a data driven methodology approach to continuous study and improvement of processes, systems, and structures within a healthcare facility that directly impact the safety and quality of care, treatment, and services provided to patients and others.
2. Quality Assurance – a systemic process that monitors and evaluates various aspects of patient care to ensure that established standards of quality are maintained and met.
3. Incident Management – activities within a system that identify and analyze hazards to patient safety, security, and treatment and hospital operation and property to correct them and prevent recurrence.
4. Clinical Risk Management – an approach to improving the quality and safety of healthcare services by identifying the circumstances and chances that put patients at risk of harm and then acting to prevent or manage those risks.
5. Clinical Outcomes – endpoints chosen that reflect the efficacy of interventions on patient care at a particular point in time.
6. Regulatory Compliance – a process for compliance with relevant laws, standards, policies, regulations, and guidelines.

In addition, DSH reports the SC/QI unit assumed additional roles and responsibilities to support, assess, implement, and evaluate the department's COVID-19 pandemic response.

- *Office of Audits (OOA)*. The Office of Audits (OOA) mitigates risks and enhances the effectiveness of DSH operations by conducting independent and objective audits of the department's program, administrative, and accounting controls.

- *Enterprise Health and Safety (EHS) Unit*. The Enterprise Health and Safety (EHS) Unit is responsible for statewide systems coordination and oversight of occupational employee safety and health programs including serving as liaison with Cal/OSHA, emergency planning and preparedness coordination for the state hospital system, conducting ergonomic equipment assessments for employees, and providing specialized project management services.

According to DSH, due to lack of centralized oversight and monitoring with sufficient clinical and analyst staff, DSH has been unable to develop standardized clinical compliance auditing tools, conduct analysis of statewide quality assurance audit data, or establish an integrated systems approach to reviewing survey and investigation findings

and implementing corrective measures. The current SQID resources enable development of the infrastructure for an integrated QI program, but do not enable DSH to use the data for statewide QI initiatives, planning purposes, or adequately monitor and identify deviations in practice or compliance measures. In addition, an external peer review of OOA recommended it conduct more performance, operational, and compliance audits to determine if controls are in place and working as intended to help ensure DSH meets its goals and objectives.

Mental Health Services Oversight and Accountability Commission (Commission) Oversight

The Commission, on its website, has published fiscal data on county MHSA revenues, expenditures, and unspent funds. Prior to posting this information, state and local policymakers were unaware of the large levels of unspent funds held by counties. Counties assert they are making prudent fiscal decision and explain that while they may hold large levels of unspent funds, the law requires them to spend those funds within three years of receipt (five years in some instances) and they generally comply with that requirement. Furthermore, counties argue that it is irresponsible for the Commission to post fiscal data that is misleading to the public because it lacks explanatory contextual information to help the public understand the MHSA statutory requirements and community MHSA processes.

The Commission has not received fiscal data from the counties to update the Fiscal Transparency Tool for the 2020-21 fiscal year. Based on revenue reports, counties received increased levels of funding in 2020-21 relative to the prior year. Some reports suggest county MHSA spending declined during the fiscal year, as the pandemic resulted in few people seeking services and limited the capacity to deliver care. If those anecdotal reports are accurate, counties may have expanded the level of unspent funds because revenues increased while expenditures decreased.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS, DSH, and the Commission to explain their oversight roles with regards to behavioral health services in California, present the proposals described above, and make recommendations on how the state can provide better oversight of these services.

Staff Recommendation: Hold open to allow for additional discussion and analysis.

ISSUE 7: BEHAVIORAL HEALTH STATE OPERATIONS NEEDS

OVERVIEW

This issue covers:

- DHCS Behavioral Health Workload BCP
- DSH Administrative Services Workload BCP
- DSH Increasing Regulations Resources to Improve Operations And Mitigate Departmental Risk BCP
- MHSOAC Staffing Proposals

PANEL 7 – PRESENTERS

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Kelly Pfeifer**, **MD**, Deputy Director of Behavioral Health, Department of Health Care Services
- **Brent Houser**, Chief Deputy Director of Operations, Department of State Hospitals
- **Jaci Thompson**, Deputy Director Hospital Strategic Planning and Implementation, Department of State Hospitals
- **Toby Ewing**, Executive Director, Mental Health Services Oversight and Accountability Commission

PANEL 7 – Q&A ONLY

- **Sean Hammer**, Acting Deputy Director Administrative Services, Department of State Hospitals
- **Dr. Kate Warburton**, Medical Director, Department of State Hospitals
- **Janna Lowder**, Assistant Deputy Director (Acting), Hospital Strategic Planning and Implementation, Department of State Hospitals
- **Norma Pate**, Deputy Director, Mental Health Services Oversight and Accountability Commission
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Madison Sheffield**, Staff Finance Budget Analyst, Department of Finance
- **Nina Hoang**, Finance Budget Analyst, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSALS

Behavioral Health Workload BCP

DHCS requests 33.0 permanent positions, the conversion of 1.0 limited-term (LT) resource to permanent position, three-year LT resources equivalent to 5.0 positions, and expenditure authority of $21,239,000 ($9,755,000 General Fund (GF); $10,601,000 Federal Fund (FF); $883,000 reimbursement authority) in fiscal year (FY) 2022-23, $20,942,000 ($9,629,000 GF; $10,430,000 FF; $883,000 reimbursement authority) in FY 2023-24 through FY 2024-25, $5,230,000 ($1,773,000 GF; $2,574,000 FF, $883,000 reimbursement authority) in FY 202526, $4,347,000 ($1,773,000 GF; $2,574,000 FF) in FY 2026-27, and $3,643,000 ($1,421,000 GF; $2,222,000 FF) in FY 2027-28 and ongoing to address increased behavioral health workload. The request includes three-year, LT contract authority of $15,000,000 ($7,500,000 GF; $7,500,000 FF) per year for technical assistance/training.

The ongoing workload is related to network adequacy oversight, data and operational quality improvement, administration of recurring federal grants, oversight of new behavioral health investments, and licensing legal work. The limited-term workload is related to the five-year administration of a Medi-Cal mobile crisis intervention services benefit, technical assistance to counties for compliance with implementation of the 90-day justice in-reach program and federally-required interoperability standards, five-year administration of the Children's Crisis Continuum pilot, and three-year support of the Family First Prevention Services Act.

Unprecedented federal and state attention is on behavioral health, and there is critical work ahead to make sure behavioral health services are accessible, timely, high-quality, equitable, culturally appropriate, and integrated. County behavioral health departments are on a journey from serving as provider organizations to assuming responsibilities required due to implementation of the federal managed care final rule. DHCS is tasked with setting a high standard for county performance, aligning expectations across the Department for all delivery systems, and ensuring that Mental Health Plans (MHPs), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) meet these high standards. DHCS seeks resources to build our capacity to hold counties accountable for these new standards, expectations, and services.

The impact of COVID-19 has also played a significant role in the need for behavioral health services and at the same time the state and federal focus on behavioral health issues has increased substantially. Overdose deaths continue to rise, suicide ideation and attempts are rising, and the frequency and acuity of mental health crises are increasing due to the isolation, financial instability, and growing human loss due to COVID-19. Significant increases in federal funding offer new opportunities to improve California behavioral health to increase access, quality, and capacity.

According to DHCS, in order to meet state and federal requirements and the rising expectations for the performance of the behavioral health delivery system, MCBHD needs resources to meet federal network adequacy standards, implement new county oversight efforts related to improving access and operations, monitor county implementation of quality improvement efforts led by the Office of Quality Improvement and Population Health, and provide executive leadership with resources to meet new ambitious goals related to expanding the crisis continuum of care to expand treatment capacity for children, youth and adults.

Network Adequacy Oversight. DHCS seeks to add new requirements to network adequacy standards and to hold counties accountable for delivering the full continuum of care per Medicaid and Children's Health Insurance Program Managed Care Final Rule, which revised 42 Code of Federal Regulations and required DHCS to monitor Plans' compliance with the network adequacy requirements set forth in section 14197 and 42 C.F.R. parts 438.68, 438.206, and 438.207. Staff resources will be needed to develop new requirements, review county submissions, evaluate requests for alternative access standards, and administer corrective action plans.

Data and Operational Quality Improvement. DHCS seeks resources to sufficiently monitor county MHPs and DMC-ODS plans compliance with quality assurance requirements related to operations, access and service, and to oversee counties' implementation of activities related to deficiencies and opportunities for improvement identified by the External Quality Review Organization and in county quality improvement plans. Staff are needed to allow ongoing and frequent meetings with counties to address deficiencies and improvement opportunities, monitor progress, assess improvement, and provide technical assistance to support counties in meeting DHCS expectations. While clinical quality initiatives will be led by the Chief Quality Officer, MCBHD will continue to be responsible for county oversight, monitoring, and compliance related to quality assurance, operational quality, and oversight of county quality improvement plans and quality improvement projects.

Behavioral Health Quality Improvement Program (BH-QIP): Time-Limited Technical Assistance to Counties to Implement the Medi-Cal Mobile Crisis Intervention Benefit and 90-Day Justice In-Reach Program. DHCS proposes to build out the BH-QIP as a vehicle to support counties in successful implementation of new initiatives prioritized by the Administration and/or mandated by the Centers for Medicare &Medicaid Services (CMS). Specifically, DHCS proposes to augment the BH-QIP to support county implementation of the Medi-Cal mobile crisis intervention services benefit and the DHCS 90-day justice in-reach program.

BH-QIP was originally developed to support the behavioral health CalAIM proposals. Later, it was expanded to support Mental Health Plans (MHP) if the Department, in consultation with the Department of Finance, determines that a Short-Term Residential Therapeutic Program (STRTP) contracted with an applicable county mental health plan

is no longer eligible for federal financial participation under the Medicaid program due to determination that the STRTP is deemed an institution for mental disease.

This BCP proposes to add staff resources to expand BH-QIP for new initiatives, as a mechanism for DHCS to set goals, milestones and metrics, and incentivize counties to reach these goals, in support of new state and federal programs and priorities. The structure of BH-QIP allows DHCS to offer start-up payments for counties to start operational improvements and then incentive payments as the counties meet goals and milestones. The BH-QIP incentive component is paired with technical assistance for counties to support building this new capacity. Staff resources will be needed to build out new capacity for BH-QIP, including setting measures, reviewing county data and submissions, providing feedback and technical assistance, issuing payments, and overseeing technical assistance contractors.

Technical Assistance to Counties for Compliance with Federally-Required Interoperability Standards. DHCS proposes staff resources to support technical assistance to counties in complying with federally-required interoperability standards. Specifically, on May 1, 2020, the Centers for Medicare and Medicaid Services (CMS) published the "CMS Interoperability and Patient Access final rule" to further advance interoperability for Medicaid and Children's Health Insurance Program (CHIP) providers and improve beneficiaries' access to their data. The final rule requirements include county support of payer to payer data exchange as requested by patients and patient access to their health information.

Five-Year Administration of a Medi-Cal Mobile Crisis Intervention Services Benefit. DHCS proposes to add mobile crisis intervention services, as soon as January 1, 2023, as a new Medi-Cal benefit, taking advantage of the 85 percent enhanced federal match for 12 quarters of a 5-year period available through ARPA for states implementing qualifying community-based mobile crisis intervention services. At the same time, the national deployment of the 988 suicide prevention and mental health crisis line requires California to develop a mechanism to bring trained professionals to people in behavioral health crisis, in-person in lieu of transfer to an emergency department or law enforcement response. DHCS requires staff resources to implement the new mobile crisis benefit and engage with other departments to assist in brainstorming the interplay between the mobile crisis services and the 988 hotline. Work includes engaging with stakeholders on implementation plans, submitting a state plan amendment, developing and issuing guidance, amending regulations, and providing oversight to make sure services are billed appropriately. The proposed Assistant Deputy Director (ADD) CEA position would serve as a second DHCS' lead on statewide crisis services, in addition to the other key department priorities described above.

Three-Year Support of the Family First Prevention Services Act

Sixth, in collaboration with the California Department of Social Services (CDSS), MCBHD is actively engaged in the implementation of FFPSA, which is generating significant new workload that cannot be absorbed by existing behavioral health staff. The FFPSA amends the Title IV-E foster care program and makes other revisions to the Title IV-B, subparts 1 and 2 programs, both of which have significant impact on specialty mental health services. Part IV implementation is currently underway, while Part I activities are still in the early planning stages. Much of the effort under Part IV has been focused on the implementation of the Qualified Individual (QI) role and providing technical assistance to the MHPs. Part IV includes additional activities that are in the early stages of implementation such as establishing certification and re-certification standards for the QIs, providing initial and ongoing trainings for the QIs, developing the process for soliciting and approving QI waiver applications, and reviewing and approving county wraparound aftercare services plans, which will require initial start-up efforts and ongoing resources for monitoring. As such, additional resources are needed to implement Part IV FFPSA and to support Part I implementation between FYs 2022-23 and 2024-25.

Five-Year Administration of the Children's Crisis Continuum Pilot

In collaboration with CDSS, MCBHD will provide technical assistance to implement the Children's Crisis Continuum Pilot program. The 2021 Budget provides one-time resources for CDSS to implement the Children's Crisis Continuum Pilot program between FY 2021-22 and FY 2024-25. DHCS will execute an interagency agreement with CDSS to receive reimbursement authority to support DHCS workload.

Assistant Deputy Director Oversight of New Behavioral Health Investments

DHCS states that the ambitious behavioral health policy agenda of this Administration requires additional executive leadership to execute. There is unprecedented attention on DHCS from the Legislature, stakeholders, and advocates demanding improvement on multiple fronts at once: better access to the continuum of care for children and youth; increased accountability of county behavioral health plans to deliver on access and network adequacy standards; ensuring timely, transparent and comprehensive behavioral health data in easy-to-use dashboards; launching new behavioral health programs, mobile crisis services, peer support services, , etc. Additional executive leadership at the Assistant Deputy Director level is required to guide the initiatives and staff to make sure the ambitious timelines are met, and would specifically focus on the crisis continuum of care; children and youth issues in behavioral health; emergency response initiatives such as CalHOPE and other crisis counseling programs; collaborative efforts between the DSS and DHCS to improve the foster care system; and data transparency, working closely with the Enterprise Data and Information Management program and the Chief Quality Officer to develop transparent dashboards on behavioral health equity, access, utilization, quality and spending.

Licensing Legal Workload
Additionally, DHCS proposes ongoing resources in the Office of Legal Services to assist and advise programs on investigations of substance use disorder treatment providers, drafting accusations suspending or revoking licenses, and representing DHCS before the Office of Administrative Hearings in settlement conference and evidentiary hearings.

Administration of Recurring Federal Grants
DHCS proposes resources to administer recurring federal grants. On March 11, 2021, CSD Federal Grants Section (FGS) received CRRSAA-funded supplemental awards totaling $238.4 million for Substance Abuse Prevention and Treatment Block Grant (SABG) and $108.2 million for Mental Health Services Block Grant (MHBG) with a performance period of March 15, 2021 through March 14, 2023. On May 18, 2021, CSD FGS received ARPA-funded supplemental awards totaling $205.9 million for SABG and $186.9 million for MHBG with a performance period of September 1, 2021 through September 30, 2025.

CSD FGS currently consists of 29 total positions. Prior to receipt of these new awards, CSD FGS has been responsible for administering approximately $1.125 billion in on-going federal grants, including: annual prime SABG, annual prime MHBG, annual prime PATH, SOR I, SOR I Supplement, SOR II, Emergency COVID-19, and Emergency COVID-19 Supplement. The addition of the new CRRSAA and ARPA grants brings the total grant funding FGS is responsible for administering to $1.865 billion, representing a 66 percent augmentation and translating to a substantial increase in workload.

Prime SABG
SAMHSA issues the Prime SABG award to DHCS annually, and it has a 24-month performance period, beginning October 1 of each Federal Fiscal Year (FFY) and continuing through September 30 of each FFY. As a result, DHCS administers two SABG awards each FY. SABG is a noncompetitive, formula grant and is intended to:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance.
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services.

The FFY 2021-22 SABG Award totals $254.4 million.

Prime MHBG

SAMHSA issues the Prime MHBG award to DHCS annually, and it has a 24-month performance period, beginning October 1 of each FFY and continuing through September 30 of each FFY. As a result, DHCS administers two MHBG awards each FY. MHBG is a noncompetitive, formula grant and is intended to:

- Provide access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental services, and health services, as well as mental health services and supports.
- Promote participation by consumer/survivors and their families in planning and implementing services and programs, as well as in evaluating state mental health systems.
- Provide access for underserved populations, including people who are homeless, residents of rural areas, and older adults.
- Promote recovery and community integration for adults with SMI and children with SED.
- Increase accountability through uniform reporting on access, quality, and outcomes of services.

The FFY 2021-22 MHBG Award totals $94.1million.

Prime PATH

SAMHSA issues the Prime PATH award to DHCS annually, and it has a 24-month performance period, beginning October 1 of each FFY and continuing through September 30 of each FFY. As a result, DHCS administers two PATH awards each FY. PATH is a noncompetitive, formula grant and is intended to support service delivery to individuals with a SMI or co-occurring Substance Use Disorder (SUD) who are homeless or are at imminent risk of becoming homeless. The primary goal is to connect individuals to mental health and supportive services as a method of working towards the elimination of homelessness. PATH funding is allocated to participating counties to provide street outreach, case management, and other services that are not supported by mainstream mental health programs. The FFY 2021-22 PATH Award totals $8.8 million.

SABG, MHBG, and PATH Annual County Applications

The existing and ongoing SABG, MHBG, and PATH programs are primarily administered through California's counties. DHCS releases annual applications to counties for each of these federal grants, which require DHCS to update all relevant sections to reflect new programmatic and administrative initiatives and requirements prior to release each year.

Counties are then required to submit their annual programmatic and budgetary proposals, and CSD FGS must review each of the 57 MHBG applications, 58 SABG applications, and 39 PATH applications in detail and provide approval prior to the start of each FY. Counties administer several programs funded under each grant, amounting to

approximately 500 total county programs across all three block grants. Counties provide detailed budgets and comprehensive budget narratives for each program, and CSD FGS analysts must review every line item of every budget for accuracy, completeness, compliance, and data, and to verify that it comports exactly with the respective budget narrative.

SABG, MHBG, and PATH County Performance Contract (CPC)
The CPC is required per state law, and sets forth conditions and requirements that counties must meet in order to receive funding for the block grants. CSD FGS administers the CPC contract for 58 counties, along with the Tri-City Mental Health Authority and the City of Berkeley, every three years.

SOR I, SOR I Supplement, and SOR II
SOR I, SOR I Supplement, and SOR II are discretionary, non-competitive grants that have 24month periods of performance, beginning on September 30, 2018. SOR II, the latest iteration, expires on September 29, 2022 with a likely no-cost extension (NCE) available through September 29, 2023. California's SOR program addresses opioid use disorder (OUD) and stimulant use disorder by increasing the available prevention, treatment, harm reduction, and recovery services in the state. The project has a special focus on populations with limited access to medication assisted treatment and contingency management, which are evidence-based approaches and the gold standards for treatment of OUD and stimulant use disorder, respectively.

SOR I, SOR I Supplement, and SOR II consist of 60 statewide contracts with State departments, counties, and private organizations. Each of these contracts required specific design and development by CSD FGS, and management of these contracts is extremely time-consuming as each contract has its own unique set of terms, conditions, and requirements that necessitate significant attention. Contract analysts receive a multitude of inquiries from sub recipients/contractors regarding interpretation, application, and enforcement of contract provisions. Because every contract and program is unique, these inquiries often result in additional discussion and conference with various vested parties or subject matter experts, including DHCS Office of Legal Services, Financial Management Division, and Licensing and Certification Division.

The SOR I Award totals $139.6 million, SOR I Supplement Award totals $36.4 million, and SOR II Award totals $211.7 million.

Emergency COVID-19 and Emergency COVID-19 Supplement
The Emergency COVID-19 and Emergency COVID-19 Supplement awards are discretionary, non-competitive grants that have 28-month and 24-month performance periods, respectively, which began on April 20, 2020. The Emergency COVID-19 Supplement grant, the latest iteration, expires on May 31, 2022, with a likely 12-month extension available through May 31, 2023. These grants are intended to deliver treatment to individuals impacted by COVID-19 with SUD and/or mental health disorders, youth and

patients with SED, as well as to health care professionals and others with mental health disorders less severe than SMI.

The Emergency COVID-19 and Emergency COVID-19 Supplement grants are administered through a single contractor, and require that a contract analyst regularly meet and engage with the sub recipient/contractor regarding grantee inquiries relating to contract and budget provisions. Should any funding changes occur to the grant program, the contract analyst would be responsible for reviewing and processing a contract amendment request, which may take approximately three to six months to complete.

The Emergency COVID-19 Award totals $2 million, and the Emergency COVID-19 Supplement Award totals $2.8 million.

All Federal Grant Indirect Cost Rate Certification (ICR)
CSD FGS is additionally responsible for maintaining the ICR certification process for all its federally-funded sub recipients/contractors. Each sub recipient/contractor that does not have a federally approved ICR is required to submit certification to CSD FGS verifying their appropriate ICR if they intend to claim indirect costs.

CRRSAA and ARPA Statewide and County Projects Statewide Projects
CSD FGS will launch a series of innovative statewide demonstration projects, comprised of a multitude of programs within each project, resulting in new workload. These efforts include historic expansion of telehealth infrastructure and behavioral health workforce, establishment of a statewide mobile crisis and non-crisis system, criminal justice intervention services, naloxone distribution, development of a statewide SUD prevention plan, conducting a statewide mental health assessment, and implementation of an advanced statewide treatment locator. These initiatives have short timelines, requiring immediate implementation to maximize the full use of grant funds and comply with federal grant terms and conditions.

CSD FGS will be required to immediately develop, release, and score requests for applications (RFA) and enter into individual contracts with several consultant organizations that will assist with administration of these statewide efforts. Once administrative consultant contracts have been executed by CSD FGS, DHCS, in partnership with its consultants, will be required to design and release a new set of RFA for eligible local government, provider, and community organization grantees to deliver direct prevention, early intervention, harm reduction, treatment, and/or recovery services.

Supplemental County Applications
In addition to statewide programs, CSD FGS intends to also fund counties with newly awarded CRRSAA and ARPA funding through supplemental agreements to SABG and MHBG Annual County Applications. CSD FGS policy staff will be responsible for the design and development of these entirely new agreements, which carry their own set of federal, state, and programmatic laws, regulations, and requirements.

Federal Application and Reporting Requirements

Every federal grant requires CSD FGS to submit extensive applications and annual reports to SAMHSA. The current CSD FGS Program Policy Unit is responsible for developing the entirety of every federal grant application, which include spending proposal summaries and implementation timelines, detailed budgets, program narratives, proposed performance measures, goals and targeted outcomes, priority populations, and needs assessments. Applications may take several weeks to research, draft, revise, and submit for management review, in addition to several weeks of revisions based on management feedback. In some cases, public comment through associations and other stakeholders is required, which adds additional workload. SABG, MHBG, and PATH require annual applications, and discretionary grants require initial applications and annual continuation applications.

Along with federal applications, each grant contains various reporting requirements. SABG, MHBG, PATH, SOR I, SOR I Supplement, SOR II, Emergency COVID-19, and Emergency COVID-19 Supplement require annual reports, in addition to grant-specific data reporting. Multiple DHCS Branches are responsible for various reporting metrics and categories, and CSD FGS must consult with these groups over several months to collect, review, and validate the information prior to submission.

The addition of the new CRRSAA and ARPA grants adds significant federal application workload, including development of proposal summaries and implementation timelines, detailed budgets, program narratives, proposed performance measures, goals and targeted outcomes, priority populations, and needs assessments. Reporting workload associated with CRRSAA and ARPA will also increase significantly, resulting in new annual reports and grant-specific data reporting.

Administrative Services Workload BCP

DSH requests 12 positions and General Fund expenditure authority of $1.7 million annually. If approved, these positions and resources would allow DSH to address additional administrative workload resulting from increases in staff in recent years and to address complex policy issues.

Over the past several fiscal years, the Legislature has approved DSH proposals that have significantly increased the number of staff positions throughout the state hospital system. The DSH Mission-Based Review proposals, covering the areas of protective services, treatment teams, direct care nursing, workforce development, and court evaluations and reports, will add a total of 829.5 positions to DSH once fully implemented. In addition, expansions of capacity at Metropolitan and Coalinga State Hospitals will add 475.7 positions and 81.2 positions, respectively, when fully implemented. Several other proposals, including implementation of an electronic health records system and development of tele-psychiatry resources, have also increased staff positions at DSH.

DSH reports its administrative services workload has increased significantly along with the increase in staff. DSH human resources staff are experiencing increases in personnel workload such as recruitment and hiring, onboarding and training, grievances and employee discipline, increased management consultation and special projects, and monthly payroll and benefits transaction processing. DSH's Office of Human Rights, which is responsible for implementing non-discrimination policies and the Equal Employment Opportunity (EEO) program, has also experienced an increase in workload related to additional staff. DSH budget staff are also experiencing increased workload related to fiscal oversight, accountability, and analysis.

In addition to administrative services workload related to increased staff, DSH research, evaluation, and data staff have experienced increased workload related to the need for evaluation of data related to implementation of new programs and initiatives.

Increasing Regulations Resources to Improve Operations and Mitigate Departmental Risk BCP

DSH requests three positions and General Fund expenditure authority of $510,000 annually. If approved, these positions and resources would allow DSH to meet demand for DSH to promulgate regulations, resulting in standardization of practices, transparency, and accountability across the DSH integrated behavioral health system.

According to DSH, the Regulations and Policy Unit (RPU) was initially staffed to coordinate a minimal number of regulations. However, as DSH has moved towards operating as an integrated behavioral health system, the need for promulgation of new regulations to support operation of new programs has increased. The RPU currently has four positions, one manager and three analyst positions, responsible for reviewing all hospital administrative directives and policies for regulatory language.

DSH reports that, as a result of insufficient staffing to promulgate regulations, it received 16 underground regulation challenges in 2018-19 and an additional four challenges in 2020-21. In addition, insufficient staffing has led to delays in regulations, such as those for the enhanced treatment program to treat patients at high risk of dangerous behavior.

OAC Staffing Proposals

Support Performance and Outcomes Based Governance Fellowship for Behavioral Health

The Mental Health Services Act calls for strategies to ensure that persons with lived experience have a central role in decision-making related to mental health services. To strengthen the Commission's attention to the views and expertise of peers and providers, the Commission sought and received statutory authority to appoint a Peer Mental Health Fellowship and a Mental Health Practitioner Fellowship. Through a public vote the Commission named the Peer Fellowship after Sally Zinman and the Practitioner Fellowship after Rusty Selix, a foundational author of Proposition 63 and the MHSA. The Fellowships are designed to allow the Commission to "hire" peer leaders and practitioners

to support the Commission's work. The Commission formed the Fellowship Advisory Committee to inform the design of the Fellowships and to support their launch and implementation.

Establish a role for peers within DHCS, the Commission and other state agencies
While the Commission is establishing a Fellowship to ensure the voices of mental health peers inform our work, some members of the Commission are concerned that the State has not included peers in its mental health related departments. The federal government has an infrastructure to support peers, as do county mental health departments. During its February 24th meeting, the Commission discussed developing a proposal to hire peers within DHCS and related departments that work on mental health.

Expand Executive Leadership at the Commission
Recent budget acts have substantially increased the resources, authority, and responsibilities of the Commission. This has included a nominal increase in state operations funding and positions authority, however arguably not sufficiently. Therefore, the Commission is seeking funding for two CEA positions: 1) a legislative liaison; and 2) a Chief Deputy Director.

STAFF COMMENTS/QUESTIONS

- The Subcommittee requests DHCS, DSH, and the Commission present these proposals and provide general comments on the departments' state operations capacity and needs.

Staff Recommendation: Hold open to allow for more discussion and analysis of these proposals.

NON-PRESENTATION ITEMS

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 8: ATASCADERO – SEWER AND WASTEWATER TREATMENT PLANT BCP

PROPOSAL

DSH requests General Fund expenditure authority of $4.1 million in 2022-23 to support preliminary plans for Atascadero State Hospital to provide upgrades to the sewer collection system, installation of a screening system, and connection to the City of Atascadero's wastewater treatment system.

BACKGROUND

According to DSH, Atascadero State Hospital has not made significant improvements to its sewer collection and wastewater treatment plant since it was commissioned in the early 1950s. An assessment by the Central Coast Regional Water Quality Control Board determined the plant's treatment processes will not comply with requirements of a new general order for Waste Discharge Requirements (WDR). The assessment also identified a variety of other deficiencies including improper flow rates complicated by inadequate treatment capabilities and various corroded components. To avoid potential shut down of the plant by the State Water Resources Control Board, DSH proposes to upgrade the sewer collection system and connect to the wastewater treatment plant operated by the City of Atascadero, rather than upgrade the existing plant, due to the significant number of deficiencies identified in the assessment.

Capital Outlay Request – Preliminary Plans. DSH requests General Fund expenditure authority of $4.1 million in 2022-23 to support preliminary plans for Atascadero State Hospital to provide upgrades to the sewer collection system, installation of a screening system, and connection to the City of Atascadero's wastewater treatment system. The upgrades to the sewer collection system would include spot repairs, replacement of sections of pipes, and installation of new manholes to provide maintenance access. The screening system would be used to remove certain solids from the sanitary sewer collection system prior to conveying to the city wastewater treatment plant. Connection to the city's plant results in DSH becoming a new city sewer customer, with screened wastewater flowing by gravity to the plant. This connection would result in a one-time Sewer Connection Fee and monthly Sewer Service Charges that would be subject to negotiation and agreement between DSH and the City of Atascadero. These charges would be a function of the average daily wastewater discharge volume and wastewater strength composition.

According to DSH, total project costs are estimated to be $14.2 million, including:

- Preliminary Plans - $4.1 million
- Working Drawings - $1 million
- Construction - $9.1 million

The construction phase costs would include $7.1 million for the construction contract, $495,000 for contingency, $772,000 for architectural and engineering services, and $729,000 for other project costs. According to DSH, the preliminary plans phase would begin in July 2022 and be completed in July 2023.

Staff Recommendation: Hold open.

ISSUE 9: ATASCADERO – POTABLE WATER BOOSTER SYSTEM BCP

PROPOSAL

DSH requests General Fund expenditure authority of $1.9 million in 2022-23 for the construction phase of the continuing project to install a potable water booster pump system to improve the performance of the main water system at Atascadero State Hospital.

BACKGROUND

Atascadero State Hospital's water supply is generated from five underground wells located on the northeast part of the campus. Each well station has a pump that sends water from the wells to an adjacent underground reservoir, from which it is pumped to a one million gallon storage tank on top of a hill. The storage tank then supplies water to the hospital by gravity feed. This gravity line supports the hospital's fire sprinkler system, as well as patient showers, kitchens, and bathrooms.

DSH reports that when multiple users draw water, the hospital's main water pressure drops considerably. Water pressure during normal operations averages between 40 and 50 pounds per square inch (psi), which is below the necessary 60 psi required for normal facility operations. According to DSH, the reduced pressure could compromise the hospital's fire sprinkler system in the event of a fire.

Capital Outlay Request – Construction. DSH requests General Fund expenditure authority of $1.9 million in 2022-23 for the construction phase of the continuing project to install a potable water booster pump system to improve the performance of the main water system at Atascadero State Hospital. The project would include installation of a booster pump station parallel to the existing main line. The pump station would consist of five pumps that would turn on when the inlet pressure drops. When the pressure rises to an acceptable level, the booster pump station would shut off and the existing gravity system would provide the required pressure to the buildings. A second in-line booster pump would also be installed parallel to the distribution line at the central plant feeding the water system to handle peak demand.

According to DSH, total project costs are estimated to be $2.3 million, including:

- Preliminary Plans - $133,000
- Working Drawings - $229,000
- Construction - $1.9 million

The construction phase costs would include $1.5 million for the construction contract, $103,000 for contingency, $180,000 for architectural and engineering services, and $156,000 for other project costs.

Staff Recommendation: Hold open.

ISSUE 10: METROPOLITAN – CENTRAL UTILITY PLANT REPLACEMENT BCP

PROPOSAL

DSH requests General Fund expenditure authority of $1.8 million in 2022-23 to support preliminary plans for Metropolitan State Hospital to replace its existing Central Utility Plant, which supplies steam for hot water and central heating and chilled water for air conditioning to 32 patient housing and administrative buildings.

BACKGROUND

The Central Utility Plant at Metropolitan State Hospital was completed in 1988 and provided a net electrical output of 27,800 kilowatts. Originally built and operated by Wheelabrator Norwalk Energy Corporation, Metropolitan assumed control of plant operations after termination of the contract with Wheelabrator. The plant operates the central steam boiler system and chiller plants, underground mechanical, electrical, and steam distribution infrastructure, energy management systems, and provides connection to the site's natural gas, water, and sanitary sewer lines. DSH reports that the old, inefficient design of the plant and the age of the equipment, along with the lack of modern environmental controls, makes future repair and maintenance difficult and extremely costly. In addition, DSH reports the original steam and underground piping distribution system was installed in 1915 and up to 20 percent of steam is lost through leaks. Major repairs to the infrastructure and full replacement of the older heating and cooling systems are necessary to achieve current operating standards for reliability, efficiency, and cost-effectiveness.

Capital Outlay Request – Preliminary Plans. DSH requests General Fund expenditure authority of $1.8 million in 2022-23 to support preliminary plans for Metropolitan State Hospital to replace its existing Central Utility Plant, which supplies steam for hot water and central heating and chilled water for air conditioning to 32 patient housing and administrative buildings. DSH expects the project to: 1) replace the chillers, boilers, and pumps and replace all steam and condensate piping with hot water piping; 2) remove the steam and condensate piping campus-wide; 3) install hot water lines in the tunnels, crawl spaces, and open trenches with removable steel open grating locations; 4) install temporary steam boilers at several locations; and 5) install new boiler plant in the existing gas compressor room, consisting of three hot water boilers and pumps with room for a fourth boiler and pump if needed in the future. According to DSH, the new boilers would be comprised of commercial duty, low emissions equipment certified by the Southern California Air Quality Management District. The hot water pumps would also utilize variable speed operation to maximize plant efficiency.

According to DSH, total project costs are estimated to be $38.7 million, including:

- Preliminary Plans - $1.8 million
- Working Drawings - $1.7 million
- Construction - $35.2 million

The construction phase costs would include $28.5 million for the construction contract, $2 million for contingency, $2.5 million for architectural and engineering services, and $2.2 million for other project costs. The preliminary plans phase would begin in July 2022 and be completed in November 2022.

Staff Recommendation: Hold open.

ISSUE 11: METROPOLITAN – FIRE WATER LINE CONNECTION TO WATER SUPPLY BCP

PROPOSAL

DSH requests General Fund expenditure authority of $548,000 in 2022-23 to support preliminary plans for Metropolitan State Hospital to provide the capacity of water required for its fire sprinkler system to comply with current fire code requirements.

BACKGROUND

According to DSH, marginal pressure and fire flows serving the new fire sprinkler system in the Central Kitchen at Metropolitan State Hospital resulted in a new fire water line project in 2011. The project included laying approximately 2,760 feet of dedicated fire main pipe from the existing storage tank site to the Central Kitchen. In addition, a 16-inch water line was designed to connect from the outlets of both existing 750,000 gallon steel water tanks. However, before completion of the project the State Fire Marshall inspector discovered the outlets on both water tanks did not possess an anti-vortex plate. As a result, the project was not completed and there is no dedicated fire suppression line throughout the hospital as required by the National Fire Protection Association (NFPA).

Capital Outlay Request – Preliminary Plans. DSH requests General Fund expenditure authority of $548,000 in 2022-23 to support preliminary plans for Metropolitan State Hospital to provide the capacity of water required for its fire sprinkler system to comply with current fire code requirements. DSH proposes to demolish one of the existing 750,000 gallon steel tanks and replace it with a new 1 million gallon dedicated fire water storage tank that would be able to meet current and future NFPA fire water flow requirements. The project would provide adequate fire flows and pressures to the fire suppression sprinkler systems for the hospital's Central Kitchen, skilled nursing facility, and Administration building. In addition, the project would allow for future expansion of the system to cover the entire hospital campus, including sizing the pump house for a future additional set of fire water pumps.

Total project costs are estimated to be $8.8 million, including:

- Preliminary Plans - $548,000
- Working Drawings - $486,000
- Construction - $7.8 million

The construction phase costs would include $6.5 million for the construction contract, $454,000 for contingency, $603,000 for architectural and engineering services, and $245,000 for other project costs. The preliminary plans phase would begin in July 2022 and be completed in November 2022.

Staff Recommendation: Hold open.

ISSUE 12: PATTON – FIRE ALARM SYSTEM UPGRADE – RE-APPROPRIATION BCP

PROPOSAL

DSH requests re-appropriation of General Fund expenditure authority of $9.4 million originally approved in the 2018 Budget Act to support the construction phase of a project to remove and replace fire alarm systems in four secured patient housing buildings and treatment areas at Patton State Hospital.

BACKGROUND

According to DSH, the existing alarm systems at Patton State Hospital are not serviceable and have reached the end of their usable life. In addition, the Department of General Services reports that the systems are not in compliance with regulatory requirements and industry standards including occupancy requirements (I-2 and I-3) set by the State Fire Marshal, National Fire Protection Association (NFPA) codes, and Underwriters Laboratory (UL) standards. The project would remove and replace alarm systems in four buildings at Patton that house the majority of patients and contain satellite kitchens, dining rooms, medical clinics, and dental clinics. The 2015 Budget Act authorized General Fund expenditure authority of $731,000 for preliminary plans and the 2016 Budget Act authorized General Fund expenditure authority of $554,000 for working drawings. The 2018 Budget Act included General Fund expenditure authority of $9.4 million in 2018-19 to continue to the construction phase of the fire alarm replacement project at Patton. At the time of approval, DSH expected the project to proceed to bid in October 2018, the contract to be awarded in January 2019, and the project to be completed in December 2020. However, due to delays in the regulatory review process and impacts of the COVID-19 pandemic, DSH requests re-appropriation of this funding to complete the construction phase of the project.

Capital Outlay Request – Construction. DSH requests re-appropriation of General Fund expenditure authority of $9.4 million originally approved in the 2018 Budget Act to support the construction phase of a project to remove and replace fire alarm systems in four secured patient housing buildings and treatment areas at Patton State Hospital.

The total project costs are estimated to be $10.7 million, including:

- Preliminary Plans - $731,000
- Working Drawings - $554,000
- Construction - $9.4 million

The construction phase costs would include $6.6 million for the construction contract, $463,000 for contingency, $843,000 for architectural and engineering services, and $1.5 million for other project costs. Construction would begin in March 2022 and be completed in August 2024.

Staff Recommendation: Hold open.

ISSUE 13: DATA GOVERNANCE AND DE-IDENTIFICATION COMPLIANCE BCP

PROPOSAL

DSH requests General Fund expenditure authority of $1.5 million in 2022-23 and 2023-24 to allow DSH to establish the leadership for its Research, Evaluation, and Data Insights (REDI) Program, which would implement a comprehensive data strategy, stablish a data governance structure, and comply with state data de-identification guidelines.

BACKGROUND

According to DSH, the state hospital system and related programs manage a significant amount of health information data including patient pre-admission and discharge data, clinical data, law enforcement data, and administrative and operational data for its programs. In addition, DSH collects health information data in the categories of psychiatric treatment planning and delivery, medical treatment delivery, forensic evaluation and court reporting, pharmacy, law enforcement and criminal offense data, billing and utilization, licensing, health and safety, administration, and community re-entry.

DSH reports much of its current data analytics work requires manual data collection, merging, reconciliations, adjustments, and data cleanup. DSH provides several regular reports on a daily, weekly, and monthly basis for internal and external stakeholders. According to DSH, automation and standardization of these efforts would allow for more rapid analytics. DSH plans to establish a Research, Evaluation, and Data Insights (REDI) program to implement a comprehensive data strategy, and establish a data governance structure. The REDI data team would guide business teams to standardize best practice governance and quality processes that reduce the time to get to analysis and insights while balancing the operational needs of the business teams to reduce burdens.

Data De-identification Guidelines. Federal and state privacy laws require data de-identification when disclosing personally protected health information or personally identifiable information without the authorization of the individual. The California Health and Human Services Agency (CalHHS) is developing a data de-identification guidelines (DDG) policy directive to provide guidance to departments to implement DDG and ensure compliance with federal and state privacy laws. DSH reports it needs additional resources to fully adhere to the CalHHS policy direction, including in the expert determination process and governance.

Staff Recommendation: Hold open.

ISSUE 14: NAPA CAMILLE CREEK IMPLEMENTATION, MONITORING, AND ADAPTIVE MANAGEMENT PLAN STAFFING BCP

PROPOSAL

DSH requests six positions and General Fund expenditure authority of $1.1 million in 2022-23 and $1 million annually thereafter for DSH to implement and maintain operations of water storage facilities at Napa State Hospital in compliance with the California Fish and Game Code.

BACKGROUND

Napa State Hospital manages five water storage facilities that historically had been used to meet domestic and agricultural water needs of the hospital. These facilities continue to operate as water impoundments but are no longer used for domestic or agricultural water consumption. The operation of these facilities affect the timing and flow of water passing through the structures and may impact downstream fish populations in Camille Creek. State fish and wildlife laws require sufficient water to pass through a dam to keep any fish below the dam in good condition.

In 2018, Water Audit California filed a lawsuit alleging violations of state fish and game laws governing water impoundment at the Lake Marie and Lake Camille dams operated by DSH at Napa. Under a proposed settlement to address the claims in the lawsuit, DSH would need to complete ongoing stream assessments and modify the operations of the Lake Marie dam. DSH would also have to coordinate with, and receive approval from, the California Department of Fish and Wildlife. DSH reports it retained a consultant to develop an Implementation, Monitoring, and Adaptive Management Plan (IMAMP) for compliance with the relevant fish and wildlife laws. The IMAMP document would summarize existing baseline conditions (e.g. hydrology, fish habitat, fish species distribution), identify the facilities that can be used to augment flow, and describe the proposed flow release regime. The IMAMP would include the following components:

- Implementation procedures including: 1) valve testing and calibration of flows to ensure flow release amounts; 2) development of a flow release schedule including timing, metrics, triggering flow releases, and duration; 3) procedures for initiating and curtailing flow releases, including determining flow release amounts; 4) identification of DSH personnel authorized to make flow releases; 5) communication protocol for flow releases; and 6) safety procedures to be followed during all aspects of the flow release program.

- Monitoring procedures including: 1) flow monitoring below the Lake Marie outlet with installation of a stream gauging station, discharge measurements during flow releases, and development of a state discharge rating curve; 2) reservoir elevation

monitoring with installation of a water level recorder and barometric pressure transducer near low lake elevation valve; 3) water temperature monitoring with installation of a longitudinal array of temperature recorders; and 4) wet-dry habitat mapping.

- Biological monitoring procedures including: 1) fish surveys in areas wetted by flow releases; 2) annual fish surveys in the inlet tributary; and 3) qualitative invertebrate sampling within areas wetted by flow releases.

Staffing and Resource Request. DSH requests six positions and General Fund expenditure authority of $1.1 million in 2022-23 and $1 million annually thereafter to implement and maintain operations of water storage facilities at Napa State Hospital in compliance with the California Fish and Game Code.

In addition to these positions, DSH requests General Fund expenditure authority of $300,000 in 2022-23 and $175,000 annually thereafter to support contracted subject matter experts to assist in implementing the recommended flow release program by installing flow measurement and recording devices, calibrating the gate valve to establish the flow release, initiating the data collection protocol, assessing the program impact on fish habitat and populations, and training DSH staff until knowledge and expertise is gained to conduct these activities on an ongoing basis.

Staff Recommendation: Hold open.

ISSUE 15: ELECTRONIC HEALTH RECORDS PHASE 3 – WIRELESS NETWORK UPGRADES BCP

PROPOSAL

DSH requests six positions and General Fund expenditure authority of $2.4 million in 2022-23, two additional positions and General Fund expenditure authority of $19.8 million in 2023-24, two additional positions and General Fund expenditure authority of $20.8 million in 2024-25, and $8.2 million annually thereafter. If approved, these positions and resources would allow DSH to prepare for and support operation of the Enterprise Continuum Electronic Health Records (EHR) Project.

BACKGROUND

In 2017, DSH began a project to implement an integrated electronic health record (EHR) for state hospital patients, submitting a Stage 1 Business Analysis and Stage 2 Alternatives Analysis to the California Department of Technology (CDT) as part of its Project Approval Lifecycle (PAL) process. The 2018 Budget Act included four positions and General Fund expenditure authority of $1.3 million in 2018-19 and $713,000 in 2019-20 for DSH to complete Stages 3 and 4 of the PAL process for implementation of the EHR system. Due to the COVID-19 pandemic, DSH received approval in the 2020 Budget Act to extend the timeline of the project for two years, with a go-live date of 2026.

DSH reports that when the EHR system is implemented, it will employ its current wireless network to support wireless medical devices, such as tablets, blood pressure cuffs, and glucometers. According to reports from other healthcare providers, EHR implementation has the potential to increase wireless traffic by as much as three-fold. DSH is planning to enhance its networks and implement a technology that would allow its wireless access points to automatically re-calibrate to maintain network accuracy and integrity. The EHR solution would support patient triage, care management functions, administrative functions, document management, email, web browsing, real-time image transfer, bi-directional data exchange, telemedicine, remote system monitoring, and administration.

Staff Recommendation: Hold open.

ISSUE 16: STATEWIDE PLANT OPERATIONS WORKLOAD BCP

PROPOSAL

DSH requests 26 positions and General Fund expenditure authority of $2.6 million annually for DSH to expand plant operations capacity at the five state hospitals to address deferred maintenance backlogs, regulatory compliance projects, and preventative maintenance programs. This request would allow DSH to develop and maintain a proper maintenance program with continuous inspections, data collection, and an analysis of operations.

BACKGROUND

According to DSH, its five state hospitals are comprised of 474 buildings, more than 6.6 million square feet of space on 2,600 acres of land. The oldest state hospital campus is 145 years old. DSH reports that several factors have hindered its ability to sustain the environmental and physical requirements of its hospital campuses and mitigate system-wide infrastructure deficiencies. Some of these factors include: older buildings originally designed for civilly committed patients, increased referrals to DSH, aging interior building infrastructure (plumbing, mechanical, electrical, elevators), aging campus infrastructure (roads, parking lots, utilities, water, fire water lines, sewage/wastewater, storm drainage), seismically deficient buildings, and regulatory compliance (e.g. Americans with Disabilities Act, historical buildings, building codes). In addition, surveys and inspections by the State Fire Marshall, the Joint Commission, and the Department of Public Health have identified the need for plumbing repairs, replacement of rusty vents, additional signage, equipment testing improvements, extension of smoke barriers, repair of negative pressure in isolation rooms, repair of chipped or peeling paint, and replacement of broken patient beds.

The 2020 Budget Act included General Fund expenditure authority of $15 million and the 2021 Budget Act included General Fund expenditure authority of $100 million to address the most essential deferred maintenance and repair projects including roof replacement, replacing chillers and water tanks, and emergency access road repairs.

Staff Recommendation: Hold open.

ISSUE 17: WORKPLACE VIOLENCE PREVENTION IN HEALTHCARE REPORTING COMPLIANCE BCP

PROPOSAL

DSH requests six positions and General Fund expenditure authority of $1.6 million in 2022-23 and $1.1 million annually thereafter to support DSH compliance with reporting requirements for prevention of workplace violence in the five state hospitals. DSH also requests one-time consultant services for improving data collection and reporting capabilities through its Wellness and Recovery Model Support System (WaRMSS).

BACKGROUND

SB 1299 (Padilla, Chapter 842, Statutes of 2014), requires specified healthcare settings to develop and implement a Workplace Violence Prevention Plan and other reforms to improve employee safety. SB 1299 contained language that exempted certain state departments from these requirements, including DSH, the Department of Developmental Services (DDS), and the California Department of Corrections and Rehabilitation (CDCR). However, SB 1299 also authorized the Occupational Safety and Health Standards Board (OSHSB) to require any of these exempt departments to adopt Workplace Violence Prevention Plans.

In October 2016, OSHSB adopted new regulations that continued to exempt CDCR and DDS, but did not exempt DSH. These regulations included the following requirements for DSH:

- Development and implementation of a Workplace Violence Prevention Plan at each hospital
- Utilization of a new statewide violent incident reporting system with data elements defined by Cal/OSHA
- 80 specific procedures for oversight, monitoring, and improvements, where necessary
- Development, implementation, and maintenance of a Violent Incident Log and Violent Incident Report
- Development and delivery of comprehensive violence prevention training to all staff, with refresher training annually for patient contact staff
- Establishment of a system to review and evaluate the effectiveness of the Plan with criteria for staffing, security systems, job design, high risk areas, and conducted with employees and their representatives.

Due to lack of sufficient staff resources, DSH applied for and received from the Department of Industrial Relations (DIR) a temporary experimental variance for the reporting requirements. The variance required that DSH produce and transmit the Violent Incident Report to Cal/OSHA each quarter and include specific data elements including assaults requiring medical attention or hospitalization, weapons, and sexual assaults. The variance also relieved DSH from reporting within 24 hours the use of physical force with a high likelihood of resulting in injury, psychological trauma or stress, and other less severe or potentially violent incidents within 72 hours. DSH received two variance extension approvals in June 2018 and November 2018. DSH applied to OSHSB for a permanent variance in January 2019, but the variance expired while the application was pending review. OSHSB ultimately denied DSH's application for permanent variance, but DIR approved an extension of the experimental variance until October 1, 2022, to allow DSH sufficient time to secure the necessary resources to address the additional workload associated with the expanded reporting requirements expected when the variance expires.

According to DSH, compliance with SB 1299 requirements will require the following current and new activities:

- Redesign of the Workplace Violence Prevention Plans at each state hospital to reflect the expedited timelines and reporting requirements.
- Redesign training curriculum and retrain all employees on the expedited timelines and reporting requirements.
- Improve data collection and reporting capability to meet the expanded violent incident reporting timelines.

Staff Recommendation: Hold open.

ISSUE 18: STATE HOSPITALS COST OF CARE AND TREATMENT/FINANCIAL ASSISTANCE POLICY TBL

PROPOSAL

DSH proposes trailer bill language to update or remove outdated statutory language and provide patient financial relief for billing the cost of care and treatment in a state hospital that does not jeopardize the ability to seek reimbursement from the federal Medicare Program.

BACKGROUND

DSH is required by state law to seek and collect payments for the cost of care from liable patients and their legal representatives. The 2014 Budget Act authorized the creation of the DSH Patient Cost Recovery Section (PCRS) to develop and implement a standardized and streamlined third-party billing program. In particular, PCRS is tasked with maximizing reimbursement of patient treatment costs from the federal Medicare program.

The issue of DSH billing and other financial practices first came to the subcommittee's attention during discussion of a 2019 Budget Act proposal to increase the patient minimum wage for vocational services and sheltered workshop programs. The wages earned by patients in these programs are deposited into the patient's personal deposit fund. Previously, DSH would retain any patient earnings above $500 in the patient's account to support the cost of care and treatment in a state hospital. The Legislature adopted trailer bill language as part of the 2019 Budget Act to prohibit that practice, but the subcommittee identified several other areas of state law that permit DSH to confiscate other funds received by patients, as well as collect for the cost of care and treatment from a patient's or former patient's estate or from family members or other responsible parties.

During evaluation of the 2021 Budget Act, advocacy organizations reported clients that received bills for more than $1 million for care and treatment of family members that had been discharged from the state hospital system. According to DSH, as a condition of participation in the federal Medicare program, patients must be required to repay the cost of medical services they receive while in a state hospital program, and the state must enforce this requirement in the same way it enforces the collection of all other debts. However, Medicare does not require billing of family members for these services and the Legislature adopted trailer bill language in the 2021 Budget Act prohibiting that practice, as well. The Legislature also adopted supplemental reporting language to require DSH to prepare a report assessing existing law and guidance pertaining to patient and family member financial liability for the care and treatment at a state hospital facility, necessity of those laws in obtaining Medicare reimbursement, and recommendations regarding patient relief from the financial impact of these requirements.

DSH receives reimbursement for the treatment and care of its patients from the following sources (includes Lanterman-Petris-Short reimbursements from counties):

Source	2017-18	2018-19	2019-20	2020-21
Medicare Parts A/B	$838,397	$516,104	$471,776	$510,144
Medicare Part D	$1,091,620	$1,130,527	$1,045,330	$989,063
Private Pay	$2,574,851	$2,538,219	$1,741,601	$2,044,477
Other	$109,204	$117,971	$47,609	$125,167
Lanterman-Petris-Short	$156,030,990	$160,656,436	$168,617,208	$166,076,215
Uninsured COVID-19 Reimb	N/A	N/A	N/A	$8,989,126
CARES Act	N/A	N/A	$491,882	$458,201
TOTAL	**$160,645,082**	**$164,959,257**	**$172,415,406**	**$179,192,393**

DSH proposes trailer bill language to update or remove outdated statutory language and provide patient financial relief for billing the cost of care and treatment in a state hospital that does not jeopardize the ability to seek reimbursement from the federal Medicare Program. Specifically, DSH is proposing the following changes to statute:

- *Financial Assistance Program* (WIC Section 7276) – DSH is proposing to amend WIC Section 7276 to require development and implementation of a financial assistance program to reduce or cancel the amount a patient owes for the cost of care and treatment. Criteria for eligibility for the program would include the following factors: 1) income level, 2) essential living expenses and financial liabilities, 3) and public benefit program participation (e.g. Medi-Cal and Social Security). The program would also allow DSH to develop reasonable payment plans suited to the patient's ability to pay.

- *Repeal Authority Requiring Sales of Estate Property* (WIC Section 7279) – DSH is proposing to repeal statutory authority to order a guardian or conservator over a patient's estate to sell the estate's property to pay for the cost of care and treatment. DSH indicates this practice is not a necessary collection effort and is not in alignment with its mission or goals.

- *Repeal Removal of Funds from Patient Personal Deposit Fund* (WIC Section 7281) – DSH is proposing to repeal its authority to remove funds in excess of $500 from a patient's personal deposit fund. DSH indicates allowing patients to accumulate income in excess of $500 would ease their transition into the community upon discharge.

- *Repeal Ability of DSH to Apply to be Patient Guardian or Conservator* (WIC Sections 7284 and 7287) – DSH proposes to repeal its authority to apply to the court to be appointed as guardian or conservator of a person's estate. DSH believes engaging in this practice would be a conflict of interest.

- *Repeal Ability of DSH to Invest Estate Funds* (WIC Sections 7285, 7286, and 7290) – DSH proposes to repeal its authority to invest funds held as executor, administrator, guardian, or conservator of estates. DSH believes engaging in these practices would be a conflict of interest.

- *Repeal Obsolete Provisions for County Payments for Patients* (WIC Sections 7291 and 7292) – DSH proposes to repeal requirements that counties pay for the cost of care and treatment for individuals referred to state hospitals under obsolete commitment categories.

Staff Recommendation: Hold open.