AGENDA PART I
ASSEMBLY BUDGET SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES

Assemblymember Mervyn Dymally, Chair

WEDNESDAY, APRIL 21, 2004
STATE CAPITOL, ROOM 444
1:30 P.M.

VOTE ONLY CALENDAR

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ITEM #4200 DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

VOTE ONLY 1: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) STAFFING REDUCTION

BACKGROUND:

The DADP proposes a permanent staffing reduction of one Staff Services Manager I position, commencing in FY 2004-05. This reduction would result in State Operations cost reductions of $77,000 to the Department of Alcohol and Drug Programs HIPAA Program baseline budget. The position proposed for reduction is funded with $38,000 from the State General Fund (SGF) and $39,000 from Federal Reimbursement.

The Department received five positions on July 1, 2001 as part of its HIPAA implementation effort. One position was eliminated as part of the workforce reduction plan on July 1, 2003.

The DADP recognizes the need for additional staffing reductions due to the current budget crisis and recommends the proposed reduction. The elimination of the position results in SGF savings and a reduction in ADP's workforce.

The staff in the position conducted and reviewed analytical studies, formulated policies, and developed program alternatives for ADP's HIPAA compliance project. The position also was intended to provide and coordinate advice and counsel to executive-level management on implementation issues, strategies, and resolution alternatives. The Department has determined, however, the roles and responsibilities of this position can be accommodated without this position.

ACTION:

Adopt the budget proposal to reduce staffing.

ITEM 4440 DEPARTMENT OF MENTAL HEALTH

VOTE ONLY 1: HEALTHY FAMILIES PROGRAM CASELOAD ADJUSTMENTS

BACKGROUND:

The budget proposes to increase by $2,965,000 (federal fund reimbursements from DHS) to reflect caseload adjustments for supplemental mental health treatment services provided by the counties under the Healthy Families Program for children with intensive mental health needs. According to the DMH, this budget estimate is based on past actual claims data and anticipated caseload for 2004-05. The proposal also requests a reduction of $44,000 in local assistance reimbursements in the current year.

The Healthy Families Program provides health care coverage and dental and vision services to children between the ages of birth to 19 years with family incomes at or below 250 percent of poverty (with income deductions) who are not eligible for no-cost Medi-Cal. Monthly premiums, based on family income and size, must be paid to continue enrollment in the program. California receives an annual federal allotment of federal Title XXI funds (Social Security Act) for the program for which the state must provide a 34 percent General Fund match, except for supplement mental health services in which County realignment funds are used as the match. With respect to legal immigrant children, the state provides 100 percent General Fund financing.

The enabling Healthy Families Program statute linked the insurance plan benefits with a supplemental program to refer children who have been diagnosed as being seriously emotionally disturbed (SED). The supplemental services provided to Healthy Families children who are SED can be billed by County Mental Health Departments to the state for a federal Title XXI match. Counties pay the non-federal share from their County Realignment funds (Mental Health Sub-account) to the extent resources are available.

Under this arrangement, the Healthy Families Program health plans are required to sign Memoranda of Understanding (MOU) with each applicable county. These MOUs outline the procedures for referral. It should be noted that the health plans are compelled, as part of the required Healthy Families benefit package and capitation rate, to provide certain specified mental health treatment benefits prior to referral to the counties.

ACTION:

Adopt the Governor's Budget proposal for caseload changes.

VOTE ONLY 2: PREADMISSION SCREENING AND RESIDENT REVIEW FOR MENTAL ILLNESS LEVEL II REVISION

BACKGROUND:

Federal law (OBRA of 1987) established each state's responsibility for evaluating persons seeking admission to or residing in nursing facilities for level of care and service needs. The DMH is responsible for administering a contract with an agency that is independent of the state and nursing home industry for the purpose of clinically evaluating each person admitted to or residing in a nursing facility if that person has mental illness. Litigation regarding the design and implementation of the evaluation instrument for this purpose has subsequently occurred.

The budget proposes an increase of $1.9 million ($470,000 General Fund) to fund expenditures associated with a pending Settlement Agreement (Charles Davis vs CA Health and Human Services Agency) regarding PASRR/MI. Of this amount, about $1.5 million would be used for a contractor and the remaining amount is for information-related technology costs. According to the DMH, this funding will support substantial revisions to the evaluation instrument, the training manual and related items.

ACTION:

Adopt the Governor's Budget proposal.

VOTE ONLY 3: FUNDING ADJUSTMENT FOR SAN MATEO PHARMACY AND LABORATORY SERVICES

BACKGROUND:

The San Mateo County Mental Health Department has been operating as the mental health plan under a federal Waiver agreement and state statute as a "field test" since 1995. The field test is intended to test managed care concepts which may be used as the state progresses toward consolidation of specialty mental health services and eventually, a capitated or other full-risk model. As the model has matured and evolved, additional components have been added and adjusted.

The budget proposes an increase of $3.3 million (Reimbursements from the DHS) to reflect an adjustment to the funding levels for this project. This adjustment is needed to reflect (1) the trend factor for pharmacy (nine percent increase), (2) the adjustment in the federal fund cost sharing ratio (from 53.3 percent to 50 percent) for the state's Medicaid (Medi-Cal Program), and (3) the adjustment needed to account for the shift from accrual to cash in last year's budget.

The budget proposes adjustments which reflect the existing agreement (i.e., Waiver for this Field Test model) the state has with San Mateo.

ACTION:

Adopt the Governor's Budget proposal.

VOTE ONLY 4: REPEAL OF RESIDENTIAL CARE MANDATES

BACKGROUND:

SB 155, Statutes of 1985, was enacted to address issues regarding the rates paid to private residential care facilities. According to the DMH, supplemental payments were provided for this purpose in 1989-90 and 1990-91. Then, beginning in 1991-01 (the first year of Realignment), the entire mandate was suspended pursuant to Section 17851 of the Government Code. The DMH states that the funding that had supported the supplemental payment was included in Realignment and the counties now had the option as to how to spend these dollars. The mandate has remained suspended since this time. No other funding has been provided for this purpose.

The Governor's budget proposes trailer bill language to eliminate the language that remains in the Welfare and Institutions Code.

At this point in time it is unclear from the Administration as to whether the elimination of the Welfare and Institutions Code section regarding this issue is even needed since the provision was subsumed under Realignment.

Trailer bill language is permanent statutory change that is needed to implement the Budget Bill. The Administration's proposal is not needed to implement the Budget Bill. No General Fund savings are identified for the action and it appears that the necessity for the language is as yet, unclear. In either case whether the language is desired for "clean-up" purposes or not, the proposal is not budget-related.

ACTION:

Delete this request from the budget and direct the Administration to introduce a policy bill on the matter.

ITEM #4200 DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

ISSUE 1: SCREENING, BRIEF INTERVENTION, REFERRAL, AND TREATMENT GRANT

BACKGROUND:

California was awarded the Screening, Brief Intervention, Referral, and Treatment (SBIRT) Grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). This is a five-year, $3,486,000 per year grant ($43,000 State Support and $3,443,000 for Local Assistance). The Department of Alcohol and Drug Programs requests an increased federal expenditure authority for an amount equal to the grant award.

The California SBIRT program proposes to reduce substance use by screening and providing appropriate brief interventions, referrals, and treatment to adult patients in medical settings across four counties over five years. Services will be concentrated in hospital emergency and trauma settings where patient volume and substance abuse rates are higher. Over the five years, it will provide $17.5 million in federal funds for new services and provide the example, policies, and foundation to expand it to other counties.

San Diego County pioneered the screening, brief intervention, and referral (SBIR) services. Under this grant, the existing SBIR services will be expanded to now include brief treatment. The Healthcare Association of San Diego and Imperial Counties will be the lead agency with the responsibility for replicating the service in three additional counties to test the efficacy of this modality and SBIRT policies.

California had over 564,000 residents age 12 or older in 2000 who needed treatment but did not receive it (Office of National Drug Control Policy, 2003). This is the largest "treatment gap" of any state. Moreover, the annual National Household Survey of Drug Abuse reports on "past 30-day use." The estimate for California is about six percent of the state's population. It is this large crucial population that the SBIRT program will triage for appropriate services at "teachable moments" and it is this population that is most in need of screening, brief intervention, and brief treatment services, the DADP argues. The Administration believes that performing these services in medical settings offers privacy, trust, and professional credibility, which could increase the probability of introducing behavioral change.

The DADP states that non-dependent users suffer individual consequences and account for most of the social problems and costs associated with substance abuse. The key to identifying and engaging non-dependent users in appropriate brief intervention is to routinely screen a very large number of patients and immediately deliver appropriate brief interventions and treatments during their medical visit.

The DADP estimates that the expected outcomes of the five-year program include a 25 percent reduction in drug use among non-dependent users and a reduction in alcohol consumption to a lower risk level by 50 percent of non-dependent drinkers.

QUESTIONS:

Subcommittee Request and Questions. The Subcommittee has requested a response to the following questions:

To DADP: Please describe the federal award, the goals of the program, and the methods of evaluating success.

What types of impact do non-dependent users have on themselves, their families, and the health, social service, child welfare, and criminal justice systems?

ISSUE 2: PERFORMANCE PARTNERSHIP GRANTS (PPG) STAFFING

BACKGROUND:

Pursuant to federal law, the Substance Abuse Prevention and Treatment (SAPT) Block Grant funds will be subject to new Performance Partnership Grant (PPGs) requirements. Prior to implementing the requirements for the federal PPGs, an extensive review and redesign of ADP processes is necessary, the DADP contends. Additionally, the DADP states that changes to statutory and regulatory authority, program and fiscal policies, and related data, research, and program operations will be required. **The Department estimates the required resources will be $260,000 for 2.0 two-year limited-term positions and 1.0 permanent position. The fund source would be an anticipated Federal Fiscal Year 2004 SAPT Block Grant Award increase out of the total anticipated award of $251.8 million.**

The Children's Health Act of 2000 requires the Federal Secretary for Health and Human Services "in conjunction with the States and other interested groups (to) develop a plan . . . for creating more flexibility for States and accountability based on outcome and other performance measures." States are to begin collecting data starting in October 2004 (FFY 2005) or negotiate a timetable for submission of performance data. In December 2002, SAMHSA, which administers the SAPT Block Grant, published its proposal regarding PPGs in the Federal Register.

As currently understood, performance measurements for the Center for Substance Abuse Treatment PPG will require states to measure systems of service using the metrics of effectiveness and efficiency. State will collect data on "core" outcome indicator areas and state-selected indices, as well as assess the State's performance against negotiated objectives or targets using a continuous quality improvement framework.

Under the Center for Substance Abuse Prevention PPG, states will report capacity, process, and outcomes data from prevention providers. Data will be required from all states for specified core indicator areas as well as state selected indices. States will be required to measure current performance, set targets, and adjust system activities and priorities based on performance relative to their negotiated objectives and apply results within a continuous quality improvement framework.

In their justification for additional staff for implementation of the PPG requirements, the Department states that the PPGs and its performance measure obligations are a significant change for California, requiring broad systems' evaluation and redesign. Failure to secure the necessary resources will compromise the evaluation, planning, and transition from ADP's existing system to PPGs. ADP does not anticipate a delay in the timetable for the PPG program. As a result, the State would begin collecting data as soon as October 2004. The compressed timeline further limits ADP's ability to adjust for and implement the major system changes necessary for success. If ADP fails to adequately address the identified core performance measures and unique target outcomes, California may risk losing federal funding and jeopardize the State's system of care.

The staffing identified reflects the need for resources in programmatic impact evaluation; research; the determination, negotiation, and establishment of target measures; development of regulations and policies; and the implementation and monitoring of the PPG system. Until the PPG system is fully implemented and all systems are reviewed, it may be necessary to run duplicate fiscal and accountability systems. ADP must revise and/or develop processes, methods, and mechanisms to enable providers and counties to collect and submit data to demonstrate progress toward and/or achievement of target outcomes.

QUESTIONS:

Subcommittee Request and Questions. The Subcommittee has requested a response to the following questions:

To DADP: Please describe the new federal mandates of the PPGs.

ISSUE 3: DRUG MEDI-CAL LAO REPORT

BACKGROUND:

There are several components to the Drug Medi-Cal service.

Narcotic Treatment Program. The NTP services are a Drug Medi-Cal modality using methadone and/or levoalphacetylmethadol (LAAM) as narcotic replacement drugs, directed at as stabilization and rehabilitation of persons who are opiate addicted and have substance abuse diagnoses. This program does not include detoxification treatment. Services within NTP include: intake, treatment planning, medical direction, body specimen screening, physician and nursing services related to substance abuse, medical psychotherapy, individual and/or group counseling, admission physical examinations and laboratory tests, and medication services. Services also include the provision of methadone and/or LAAM, as prescribed by a physician to alleviate symptoms of withdrawal from opiates rendered in accordance with the legal requirements.

Day Care Habilitative. DCH is a DMC modality designed to provide outpatient counseling and rehabilitation services at least three hour per day, three days per week to persons with substance abuse diagnoses, who are pregnant or in the postpartum period, and/or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)- eligible beneficiaries. DCH services include: intake, admission physical examinations, medical direction, treatment, planning, individual and group counseling, body specimen screens, medical services, collateral services, and crisis intervention, provided by staff who are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure.

Outpatient Drug Free Treatment Services. ODF is a DMC modality designed to stabilize and rehabilitate persons with substance abuse diagnoses in an outpatient setting. Services within ODF include: admission physical examinations, intake, medical direction, medication services, body specimen screens, treatment, and discharge planning, crisis intervention, collateral services, group counseling and individual counseling, provided by staff who are lawfully authorized to provide, prescribe, and/or order these services within the scope of their practice or licensure.

Perinatal Residential Substance Abuse Services. The Perinatal Residential Substance Abuse Services program is non-institutional, non-medical DMC residential program that provides rehabilitation services to pregnant and postpartum women with substance abuse diagnoses. Perinatal residential substance abuse services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills. Each beneficiary lives on the premises and is supported in her efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Programs provide a range of activities and services for pregnant and postpartum women. Supervision and treatment services are available day and night, seven days a week. Services include: intake, admission physical examinations and laboratory tests, medical direction, treatment planning, individual and group counseling, parenting education, body specimen screens, medical services, collateral services, and

crisis intervention services, provided by staff who are lawfully authorized to provide and/or order these services within the scope of their practice or licensure.

Naltrexone Treatment Services. NTS is a DMC outpatient treatment modality directed at serving detoxified opiate addicts who have a substance abuse diagnosis by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction. NTS shall be provided only to a beneficiary who has a confirmed, documented history of opiate addiction, is at least 18 years of age, is opiate-free, and is not pregnant. NTS includes: intake, admission physical examinations, treatment planning, provision of medication services, medical direction, physician and nursing services related to substance abuse, body specimen screens, individual and group counseling, collateral services, and crisis intervention services, provided by staff who are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure.

Drug Medi-Cal Report from the LAO: "Remodeling" the Drug Medi-Cal Program
In summary, the LAO finds that California's program for substance abuse treatment services to Medi-Cal beneficiaries, known as Drug Medi-Cal, provides a patchwork of services with an inconsistent level of support for different modes of treatment and for different treatment populations. The LAO recommends an approach for addressing these concerns which would provide greater authority and resources for community-based services, contain the fast-growing costs of methadone treatment, and integrate a new and potentially more cost-effective mode of treatment into Drug Medi-Cal that does not require a net increase in State General Fund resources.

How State Spending for Drug Medi-Cal Has Changed Over Time

Dollars in Thousands

	1994-95		2004-05		Percentage Change	
Type of Service	General Fund	All Funds	General Fund	All Funds	General Fund	All Funds
Day Care Rehabilitative	$5,977	$11,947	$2,457	$4,913	-58.9%	-58.9%
Outpatient Drug Free	8,408	16,816	12,544	19,101	49.2	13.6
Naltrexone	3	6	--	--	-100.0	-100.0
Narcotic Treatment Program	13,531	27,062	41,746	83,489	208.5	208.5
Residential Perinatal	389	778	1,051	2,102	170.2	170.2
Total	**$28,308**	**$56,609**	**$57,798**	**$109,605**	**104.2%**	**93.6%**

Major findings of the LAO Report include:

- Significant inconsistencies exist in the resources being provided to support different modes of treatment.
- A disproportionately small share of the Drug Medi-Cal budget is spent on services for children and female Medi-Cal beneficiaries.
- Significant variations exist in the availability and extent of Drug Medi-Cal services from one county to another in California.

- The state is failing to take full advantage of available federal support for community substance abuse treatment services.
- Drug Medi-Cal is a rigidly controlled program that is relatively complex and costly to administer.
- The state is incurring substantial costs for the hospitalization of Medi-Cal beneficiaries whose substance abuse problems have gone untreated.

The LAO concludes that the problems with Drug Medi-Cal are primarily the result of inherent flaws in the way the program and the statewide delivery system for treatment services are designed. The LAO suggests that building a better community-based treatment system would rely on shifting funding and programs to local control and implementing a cost containment system for methadone.

Shift funding and programs to local control:

- Shift various state funding allocations for drug or alcohol treatment services to counties.
- Make counties responsible for nonfederal share for Drug Medi-Cal services (except narcotics treatment).
- Abolish state laws and regulatory constraints and thereby provide more county flexibility in service delivery.
- Ensure continued state role of administering federal rules, setting and enforcing health and safety standards, and providing statewide leadership for the treatment system.

Medi-Cal Hospitalization Costs for Individuals with a Substance Abuse Diagnosis			
Facility Type	**Number of Discharges**	**Average Charge per Stay**	**Sum of Reported Charges (in millions)**
Primary diagnosis was a substance abuse-related problem			
Acute Care	1,860	$18,099	$33.3
Skilled Nursing	28	55,864	1.6
Psychiatric Care	821	6,692	5.5
Chemical Dependency	39	11,800	0.3
Rehabiliation Care	3	28,340	0.1
Totals	**2,751**	**$14,808**	**$40.7**
Secondary diagnosis was a substance abuse-related problem			
Acute Care	31,642	$35,870	$1,123.0
Skilled Nursing	888	58,961	52.4
Psychiatric Care	11,024	11,328	124.8
Chemical Dependency	3	3,243	0.0
Rehabiliation Care	499	98,473	49.1
Totals	**44,056**	**$30,628**	**$1,349.4**
Total for all patients with substance abuse problems	**46,807**	**$29,698**	**$1,390.1**

Implement cost containment for methadone:

- Shift funding and responsibility for narcotic treatment programs to the state.
- Review state licensing and certification rules to see which duplicate or exceed federal requirements.
- Reexamine the "cost-plus" structure for setting rates.
- Conduct an external review of cases where clients receive methadone maintenance for extended periods of time.
- Screen clients for eligibility for treatment by the federal Veterans Authority health system.
- Eliminate LAAM services due to withdrawal of the product by its manufacturer.
- Make statutory and regulatory changes to formally integrate buprenorphine as a treatment method.

QUESTIONS:

Subcommittee Request and Questions. The Subcommittee has requested a response to the following questions:

To LAO: Please describe the most significant findings of the report and the recommendations for reform of the Drug Medi-Cal system.

To DADP: Please respond to the issues raised by the LAO.

ITEM 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 1: TRADEOFFS BETWEEN STATE HOSPITALS AND COMMUNITY MENTAL HEALTH PROGRAMS

BACKGROUND:

This purpose of this issue is to gain an understanding of the pressures that cause augmentations in state hospital spending and reductions in community program funding.

QUESTIONS:

Subcommittee Request and Questions. The Subcommittee has requested a response to the following questions:

To DMH:
1) How do statutory requirements cause differences in funding between hospitals and community programs?
2) Do judges consider offenders' proclivity to treatment prior to commitment?

To LAO:
1) What are potential solutions to prioritize funding for community programs?
2) What can we do this year?

ISSUE 2: EARLY MENTAL HEALTH INITIATIVE

BACKGROUND:

The Governor's Budget includes a 50 percent reduction in the Early Mental Health Initiative for a $5 million General Fund savings by eliminating funding for half of the remaining grants.

The Early Mental Health Initiative (EMHI) was authorized by Chapter 757, Statutes of 1991 (AB 1650). The goals of the program are to minimize the need for more intensive and costly services as students grow older and to increase the likelihood that students experiencing mild to moderate school adjustment difficulties will succeed in school. The program targets school-aged children between kindergarten and third grades. EMHI is the only funding source currently designated for provisions of such services to this population in California. It is important to note that California ranks 40th in the nation in the ratio of school psychologists to students (1:1,665).

EMHI grants implements researched-based program services. The key elements of the program include the provision of services that are school-based and low cost to appropriate students in the target population from low income families or who are in out-of-home placement or who are at risk of out-of-home placement. EMHI uses a systematic selection process of student most likely to benefit from program participation. The program collaborates with the County Mental Health Departments while also utilizing alternative personnel, such as child aides, to provide direct services to identified students. EMHI also maintains a commitment to outcomes based practices through ongoing monitoring and evaluation of program services, and ensuring the implementation of programs that are based on adoption or modification, or both, of existing program models that have been shown to be effective and which are based on sound research. Over 84 percent of student participants receive only one cycle of services (once a week for 12 – 15 weeks).

Budget History—Cost Effective and Efficacious Program for Young Pupils. EMHI is funded on a three-year grant cycle. The average cost per student for the program is $656. In the current fiscal year, 86 school districts participated in EMHI in 30 counties at 329 school sites with 137 total grants. These figures are a substantial drop-off from the 2002-03 Fiscal Year in which 496 school sites participated with 206 total grants. In 2002-03, EMHI served 23,000 at-risk students in K – 3 with direct services of the Primary Intervention Program and small group services. "Enhanced" EMHI programs served an additional 12,000 students each year with classroom violence prevention, character education, and parent education services.

In the Budget Act of 2003, the Early Mental Health Initiative was reduced by one-third, by not renewing funding for the three-year grants that were up for renewal in the current year. Governor Davis initially proposed a complete elimination of the program.

EMHI served a total of 33,372 children in 2002-03, when the program was complete with three grant cycles. After the program lost one grant cycle, it is estimated that 20,600 children will participate in the program. This is a 38 percent reduction in children served.

Convincing Research. There is data to show that the EMHI program is substantially effective in improving the long-term social competence and school adjustment issues presented by children in the target population.

An independent contractor completed a treatment-versus-control-group study for the Department of Mental Health in 2000. It compared students who participated in the program in the fall, who were more severely in need of services, with other students who were waiting to start the program in the spring. The data demonstrated that the children who were served in EMHI in the fall showed improved scores on social competence and school adjustment by the end of their program in winter. The comparison group children, who were waiting to begin services, did not show comparable growth during the same time period, and in fact worsened in their social competency and school adjustment scores. The findings were statistically significant ($p<.001$) and lend additional support that participation in EMHI-funded services to led to improvement.

The same independent contractor examined the maintenance of improvements among students over a two-year period following participation in EMHI-funded services. The data demonstrated a large improvement (14 percentile points) in social competence and school adjustment related behaviors between the baseline and year-one follow-up. Most, if not all, of these gains occurred during the approximately four-month period that participants received services. Equally important, the comparison between Year 1 and Year 2 follow-up data showed that these gains were maintained into the second year following services.

COMMENTS:

EMHI providers argue that the program is cost-effective: "By utilizing paraprofessionals as the primary services providers, EMHI provides effective, short-term interventions at a cost of approximately $600 per child. Without early intervention services, students require more intensive and much more costly academic, behavioral, and mental health interventions. For example: Mental health and academic interventions provided by professionals typically cost three to four times as much as EMHI interventions. Incarceration of one child in the CA Youth Authority costs over $40,000 per year. In addition to improvements in classroom behavior and social-emotional health of students, schools report improvements in student attendance, school environment, home-school partnerships, and faculty stress as benefits of EMHI programs."

EMHI providers also state that services prevent serious, future problems: "By building skills and addressing the emotional stressors and difficult life transitions that interfere with children's learning, EMHI reduces the likelihood of school/academic failure, bullying, social isolation, and school violence, and high-risk behaviors such as alcohol/drug abuse, criminal behavior, and sexual activity. By addressing these concerns early, EMHI prevents conditions associated with future need for more costly interventions such as mental health treatment services, academic remediation, and incarceration."

QUESTIONS:

Subcommittee Request and Questions. The Subcommittee has requested a response to the following questions:

To DMH: Please explain the outcome data regarding student participation in the EMHI program.

To EMHI Providers: Please describe the impact to the children who are eligible for the service, but who will not receive it due to the reduction of the program.
Please describe the consequence of the reduction on the future of the EMHI program.

ISSUE 3: CHILDREN'S SYSTEM OF CARE

BACKGROUND:

The Governor is proposing to eliminate funding for the Children's System of Care program for a savings of $20 million General Fund.

The Governor's budget summary states that…"given the availability of a wide range of medically necessary services and large numbers of needy children and young adults receiving services under the EPSDT Program, it is no longer necessary to continue the Children's System of Care Program."

Background. Existing law authorizes counties to develop a comprehensive, coordinated children's mental health service system as provided under the Children's Mental Health Services Act. The target population includes individuals 18 years of age and under who have a diagnosed mental disorder in which the disorder results in substantial impairment in two or more areas (such as self care, school performance, family relationships and ability to function in the community). As noted by the DMH, the children served through the program have complex needs and require multi-agency services.

The basic elements of the program include interagency coordination and collaboration, child/family-centered services, culturally competent services, and case management services. Families of the children are full participants in all aspects of the planning and delivery of services. When children with serious emotional disturbances learn to manage behavior through therapy, medication, education, rehabilitative and social services, they are more likely to stay out of trouble, improve school performance and remain stable in their living situation.

Under the program, accountability of services is required through measurable performance outcome goals. Past evaluations of the program have concluded that the program has been very successful and cost-beneficial, including savings in service expenditures for group homes, special education, and juvenile justice.

Existing categorical funding for Child Welfare, juvenile justice, alcohol and other drug and mental health services are highly regulated. Accompanying regulations define mandates and limitations that can create obstacles to solutions for these problems. The California Children's System of Care Program was created to address these criticisms for the system, serving children with serious emotional disturbance. It provides a small amount of vital flexible funding that supports locally designed solutions to system shortcomings.

Outcome Measures. In an evaluation published by the DMH in September 2003, results for 3,198 children were reviewed and the evaluators found that the Children's System of Care Program is successful at helping children stay out of trouble, improve school attendance, and live at home or in another safe environment. It should be noted that the majority of the children in this evaluation had a history of juvenile justice system involvement.

Among other things, the report sites the following key findings:

Staying Out of Trouble: Following participation in the program, there were 55 percent fewer misdemeanors and 65 percent fewer felony arrests for the children. A conservative cost savings amount of $1.3 million was identified for this component.

Less Psychiatric Hospitalization Services: The program's community-based services and supports optimize the potential for psychiatric inpatient services reduction. Over 46 percent of the children evaluated at the time of the enrollment were identified by history or initial assessment as being at risk of psychiatric hospitalization. However following participation in the program (during the six-month update period), only 10.6 percent required psychiatric hospitalization, or a reduction of 57.2 percent in need for inpatient care. A projected cost savings estimate of $1.1 million was identified.

In School Outcome: Children identified as having a serious emotional disturbance are more likely to miss school, fail more classes, and have lower graduation rates than other children with disabilities. The enhanced special day classes and wraparound services of the program are also used to supplement individualized education plan services. Because services are accessible in the school setting, children are more likely to attend school. Sixty-six percent of the children evaluated at the time of enrollment into the program were identified by history or initial assessment as being at risk for poor school attendance. According to the evaluation, over 82 percent of children identified who are at risk of poor school attendance improved or are maintaining good or excellent levels of school attendance.

Overall: Children's System of Care services help children manage mental health symptoms, develop emotion-management skills, learn positive social skills, and build family cohesion. The development of these skills helps children choose appropriate behaviors and avoid behaviors that lead to arrest and further juvenile justice system actions.

COMMENTS:

Constituency Comments: Recipients of services contend that without a system of care approach, many children will not have coordinated services or receive mental health services unless they are placed in a Group Home (where they become eligible for Medi-Cal), the juvenile justice system (where they have a constitutional right to mental health care), or are placed in special education (where there is a federal entitlement to mental health services). In each of these institutional settings, the cost of mental health treatment is likely to be greater than it would have been had it been provided before the children reached this level of care. Advocates note that without the $20 million for the Children's System of Care Program, increased funding would be needed in many other areas.

QUESTIONS:

Subcommittee Request and Questions. The Subcommittee has requested the DMH to respond to the following questions:

1. DMH, Please describe the impact of the elimination of the program on children who are not Medi-Cal eligible.

2. DMH, Please briefly describe the results of the evaluation. Is the program producing measurable results and is it successful?
3. DMH, Please briefly describe what data has been obtained from the counties and what the DMH thoughts are about the data.

ISSUE 4: EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT

BACKGROUND:

The Governor's Budget includes three budget change proposals on the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Medi-Cal service for severely emotionally disturbed children:

1. **An augmentation of $472,000 ($236,000 General Fund) for two positions to apply for a federal 1115 demonstration project waiver for EPSDT.**
2. **A reduction of $11,312,000 (an increase of $844,000 General Fund and a decrease of $12.2 million in reimbursements from Department of Health Services (DHS)) to reflect an increased accountability and oversight of the Specialty Mental Health Component of the EPSDT Program.**
3. **An increase of $317.6 million in reimbursements from DHS for EPSDT caseload growth.**
4. **A reduction of $60 million ($40 million General Fund) to re-base the Schedule of Maximum Allowances.**

BACKGROUND

California's State Medicaid Plan currently covers children and youth who are medically needy and who themselves or whose parents have incomes above the mandatory (categorically needy) population poverty levels. Almost all of these beneficiaries under age 21 are entitled to services under the EPSDT benefit. EPSDT services were expanded in 1995 by DHS in accordance with federal regulations and statues that require states to provide any medically necessary health and/or mental health treatment services needed to correct or ameliorate the mental or physical health condition of a full scope Medi-Cal beneficiary under the age of 21. Part of the impetus for the change was the settlement of a lawsuit T.L. v. Belshè, that put forth the position that California had not fully complied with these federal regulations and statutes.

DHS concluded that, in order to meet the needs of severely emotionally distributed (SED) children and youth, the logical providers for these expanded EPSDT services were the county mental health departments. To provide State and local mental health agencies with the funding necessary to meet this mandate, DHS agreed to provide the State General Fund (SGF) matching dollars necessary to expand access to mental health services for SED children and youth.

Based on a number of studies which estimate the prevalence of children exhibiting various levels of functional impairment, it is estimated that 20 percent of children suffer from a diagnosable mental disorder, and up to 13 percent of these children are estimated to be seriously emotionally disturbed. Given these estimates it is likely that between 500,000 to 1.3 million children and adolescents in California have a severe emotional disturbance.

As a comparison, the statewide average EPSDT penetration rate is about 5.2 percent (as of 2001-02) for all ages. This varies from county to county and by age group. For example, for Los Angeles for children ages 9 to 17 years has a penetration rate of 7.7

percent, Sacramento has a rate of 9.4 percent and Solano has a rate of 8.7 percent for the same group.

It should be noted that the Little Hoover Commission's report (October 2001) on the existing inadequacies in the children's mental health system considered the potential savings if children's mental health utilization increased by 10 percent—the estimated prevalence rate. In one year, they estimated that California would save $44 million in juvenile justice, $27 million in CYA costs, $78 million in residential treatment and $1.4 million at Metropolitan State Hospital. A total of $110 million in savings.

The funding mechanism for EPSDT. A baseline amount is established for each county that is equivalent to the sum of 1) the cost-settled EPSDT mental health services provided by the county in FY 1994-95, 2) the amount of state funds provided under Phase II consolidation for the EPSDT eligible population, and 3) an annual cost of living increase to the FY 1994-95 component of the baseline when justified by realignment growth. The county mental health plans (MHP) are required to provide a maintenance of effort amount each year.

Recent program changes for EPSDT include an additional county matching requirement, effective FY 2002-03, which mandates MHPs to provide ten percent of the State's matching requirement for growth in the state cost of EPSDT services above the FY 2001-02 level. The match was implemented to establish a financial incentive at the county level to ensure that funds are spent efficiently. The current arrangement regarding State funding of expanded EPDST mental health services was made with the understanding that once the financial risk for these services could be reasonably assessed, a fixed funding amount would be transferred to the counties. Because of the continued growth of the program and changes in service expectations due to statutory changes and litigation, a mutually agreeable fixed allocation has not been possible to negotiate.

1. FEDERAL DEMONSTRATION WAIVER

The DMH requests an augmentation of $472,000 ($236,000 from SGF and $236,000 in FFP) from the DHS) to implement the Department's portion of a collaborative effort with the DHS to explore options to increase state flexibility regarding federal requirements for EPSDT specialty mental health benefit.

Under the authorities of Section 1115 of the Social Security Act, other states have successfully implemented health care reform waivers as part of the Health Insurance Flexibility and Accountability (HIFA) Demonstrative Initiative. These states include: Oregon, Arizona, New Mexico, and Maine. Those with pending HIFA waivers still under federal review include: Washington, Minnesota, and Michigan. It should be noted that Oregon's request for federal funding to provide children services in Intensive Treatment Services programs with a six-month Medicaid expansion for transition services from residential psychiatric into their family homes was denied.

The Administration argues that during this time of both national and state budget deficits, all States have the responsibility to look at options for providing health/mental health services in the most efficient, effective, and cost-neutral way possible. Because of the resources in this BCP are specifically focused on developing a federal demonstration waiver, DMH may match any SGF used in conducting the study with federal financial participation (FFP) dollars. The impact to this department of other State departments if a

waiver is granted cannot be determined without an in-depth study. The development and implementation of the EPSDT specialty mental health services waiver proposed through this BCP will be compatible with, and a subset of the larger strategy developed by DHS.

The waiver would not seek to end the provision of such services overall, but would instead allow the state to establish a more formal definition of which EPSDT services were "medically necessary" and therefore necessary to provide to eligible Medi-Cal beneficiaries. Absent such a definition, the administration has indicated, the state is subject to a more vague standard of having to provide any services that "ameliorate" the medical condition of someone with a mental health condition.

Thus far, the administration has not indicated specifically how it would use this more narrow definition of medical necessity to modify the existing EPSDT services to achieve state savings. The administration has proposed that the effort to reform EPSDT be part of a larger federal waiver request to achieve savings in the Medi-Cal Program.

2. INCREASED ACCOUNTABILITY AND OVERSIGHT OF THE SPECIALTY MENTAL HEALTH COMPONENT OF EPSDT PROGRAM

The DMH requests an augmentation of $1,688,000 ($844,000 from SGF and $944,000 in FFP from the DHS) to support contractual assistance for additional review and oversight of EPSDT expenditures. This effort will result in the recoupment of an estimated $13 million annually ($6.5 million General Fund) and is expected to further slow program growth. The $13 million in savings in reflected in this proposal and is also discussed in the EPSDT estimate for Fiscal Year 2004-05. The level of savings assumes that 5.6 percent of paid claims that were subject to review each year would have disallowed costs. This estimate is based on the DMH's most recent experience with reviewing charts that included therapeutic behavioral services.

DMH is proposing to contract for the audit of a total of 18,798 charts on a three-year cycle beginning in FY 2004-05. This sample size was derived by eliminating all individual and group providers because of the limited state costs associated with services provided by these groups and the complexity and expense of auditing them. This process left a total of 664 legal entities which includes both counties and their contractors. A legal entity can have more than once provider site and a provider site can serve clients in more than one county. A second cut was taken to provide that those legal entities to be reviewed would have at least 50 clients per county served. This reduced the total number of legal entities to 323, which would include more than 89 percent of the total paid claims for FY 2002-03. Each of these 323 legal entities will be reviewed during the three-year cycle and the sample size for each will be the larger of either five percent of the total EPSDT caseload or 50 clients. This will provide for a review of approximately 6,300 charts per year.

The funding estimate was developed by assuming that each chart that is audited will require an average of four hours at an estimate cost of $61.50 per hour. This should provide adequate time to review a complete calendar of notes and compare them with paid claims information, as well as develop a written report of findings. The $61.50 reflects the average hourly cost DMH had paid in the past for the review of therapeutic behavioral services. The remaining funding (approximately $138,000) would support clerical assistance, the purchase of supplies and equipment and additional office space as needed.

3. FUNDING ADJUSTMENTS FOR EPSDT SERVICES

The DMH requests an increase in the budget year of $317,575,000 to reflect additional program costs. Second, this request includes an increase in local assistance reimbursements from the DHS of $13,100,000 in the current year to reflect additional costs for the provision of services through the EPSDT program.

The actual amount of state spending for EPSDT specialty mental health services in the current year will be significantly less than the amount appropriated in the *2003-04 Budget Act*. The initial budgeted level was about $370 million from the General Fund, but this would be adjusted to $254 million under the Governor's budget plan, primarily to reflect a technical shift made in 2003-04 from accrual to cash accounting. The actual growth in the program, absent the changes from accrual to cash and the changes in state rates of participation, from preliminary data from the counties based on claims through January is about 15.8 percent. It is estimated that the county claims through March will show an 8 percent rate of growth.

A variety of factors have contributed to the continued expansion of EPSDT, including legal decisions, recent Medi-Cal Program expansions, recent Medi-Cal reimbursement adjustments for Psychologist and Psychiatrist services, and the fact that several counties were delayed in initially expanding their EPSDT services in the first place.

It should be noted that when counties agreed to administer the EPSDT Program in 1995, a part of the understanding was that counties would endeavor to expand the program to meet the state's legal obligations under EPSDT (due to the litigation).

After the 2000 court decision regarding Therapeutic Behavioral Services (TBS), counties were once again urged by the state to act and assure that TBS services were available to any Medi-Cal eligible child in need of the service.

Further, in a 2001 report to the Legislature by the DMH entitled Utilization of the EPSDT Benefit, the DMH notes:

"At least preliminarily, it appears that during the initial years of EPSDT implementation, County MHPs focused on increasing access to services for those EPSDT eligible children who needed them; thus the number of clients served increased. As the program has matured, counties are finding that they need to increase the intensity of services to many young clients with the most severe emotional disturbances in order to achieve positive outcomes and to keep youth in their homes, functioning in school and out of the juvenile justice system. This has resulted in higher paid claims per client in a number of counties that were unable to provide these levels of service prior to EPSDT."

The LAO's analysis indicates that the existing cost containment measures have curbed some of the EPSDT expenditure growth. The rate of growth of state expenditures for EPSDT peaked several years ago and has since begun to decline. This decline suggests that the state is making some progress at containing EPSDT expenditures. However, the total cost of the program continues to grow. Under the Governor's 2004-05 budget proposal, total spending for EPSDT services would surpass $1 billion once all funding sources for the program have been taken into account.

4. RE-BASING RATES FOR EPSDT SERVICES

Lastly, the DMH includes in the caseload estimate the impact of a proposal to re-base the Schedule of Maximum Allowance which will result in a reduction of $60,000,000 ($40 million in General Funding) in EPSDT funding for FY 2004-05.

The Medi-Cal State Plan Amendment (SPA) that established rates for services provided by MHPs, effective July 1, 1993, used actual cost information from FY 1989-90 annually adjusted for inflation. The SPA provided that the state would continue to update rates annually until they were re-based "in no more than three years" using more current actual cost information. An adjustment is proposed in this estimate that would re-base these rates for the first time. The new rates would become effective July 1, 2004.

Actual rates paid for services have been the lowest of 1) the provider's published charge to the general public (unless the provider is a nominal fee provider); 2) the provider's negotiated rates, based on historic cost, approved by the State; and 3) the statewide maximum allowances. In addition to rebasing the statewide allowances, the state proposes obtaining federal Medicaid authority to obtain federal funds up to allowable costs for public providers even when these costs exceed the maximum allowances. The expected impact of these changes is a reduction of $40,000,000 in SGF for EPSDT payments and $45,000,000 ($20,000,000 for EPSDT) in federal funds for non-public providers of Short Doyle/Medi-Cal inpatient hospital services and most non-inpatient hospital specialty mental health services.

If the Legislature considers approving the administration's estimated $40 million in General Fund savings from re-basing statewide maximum provider rates, it should recognize that there are some risks associated with this estimate. Currently, the maximum rates established for EPSDT and other mental health services provided by the counties are based on cost information dating back to 1989-90, which has been adjusted for inflation. The state was to have updated these rates at least every three years by using more current cost information, but has not done so.

The administration is proposing that the statewide rates be re-based for the first time since 1993. Its estimate of $40 million in state savings is based on a preliminary analysis of 2001-02 cost reports. The actual magnitude of the savings, however, is uncertain and will not be known until a consultant to be retained by DMH has completed extensive re-basing calculations.

COMMENTS:

The LAO concurs with the administration's current estimates of EPSDT expenditures, and recognizes that they will be updated by the administration at the time of the May Revision. Given the continuing growth in the cost of EPSDT services, the Analyst concurs with the Administration's request for additional staff and contract funding to initiate steps to rebase provider rates in line with current actual costs, to audit county and contract providers, and pursue a federal waiver to tighten the definition of what services must be provided.

These measures would (1) ensure that provider rate limits better reflect actual costs, (2) provide stronger accountability and oversight of EPSDT expenditures at the local level,

and (3) promote a more cost-efficient use of state resources only for medically necessary treatment and services.

QUESTIONS:

Subcommittee Request and Questions. The Subcommittee has requested the DMH to respond to the following questions:

To DMH:
1) What is the impact of the audit on the services provided to children?
2) How does the EPSDT waiver reform proposal and the Medi-Cal reform redesign affect each other?

To LAO:
1) What are the consequences of the waiver on access to care?

ISSUE 5: AB 3632 SPECIAL EDUCATION PUPILS

BACKGROUND:

The budget plan appropriates $69 million (federal special education funds) within the Department of Education for County Mental Health Plans' AB 3632 programs. This continues the appropriation from last year's Budget Act of 2003.

Background. Mental Health Services to Special Education Pupils includes the Education for All Handicapped Children Act and the Individuals with Disabilities Education Act (IDEA), which mandates states to provide services to children enrolled in special education, including all related services as required to benefit from a free and appropriate education. Related services include mental health services, occupational and physical therapy and residential placement.

In California, County MHPs are responsible for providing mental health services to students when required in the pupil's Individualized Education Program (IEP). This is because AB 3632 (W. Brown), Statutes of 1984, shifted responsibility for providing these services from School Districts and transferred them to the counties.

These services are an entitlement and children can receive services irrespective of their parent's income-level. In addition, County MHPs cannot charge families for these services because the children are entitled to a free and appropriate public education under federal law.

What Mental Health Services Are Mandated. Services to be provided, including initiation of service, duration and frequency of service, are included on the student's IEP and must be provided as indicated. Services can only be discontinued on the recommendation of the County MHP and the approval of the IEP team, or by parental decision. Among other things, mental health services include assessments, and all or a combination of individual therapy, family therapy, group therapy, day treatment, medication monitoring and prescribing, case management, and residential treatment.

History of Funding for AB 3632 (Prior to 2003). For the past decade or so, counties have supported the program through a combination of the following:

- <u>Categorical funding</u> provided by the DMH as appropriated through the state budget process (was $12 million General Fund annually but was eliminated by the state in the Budget Act of 2002);
- <u>Mandate reimbursement claims</u> as obtained via the State Commission on State Mandates process (referred to as the SB 90 process, was suspended in the Budget Act of 2002 and the Budget Act of 2003);
- <u>Realignment funds</u> (only when other resources are not available due to the deferral of the mandate process as noted above);
- <u>Third-party health insurance</u> when applicable, though parents can chose not to access their insurance for this purpose if they so decide (federal law).

<u>Use of Special Education Funds</u>—Budget Act of 2003: Through the Budget Act of 2003, $69 million in new federal special education funds were appropriated under Item 6110

(Department of Education) for County MHPs to use to partially off-set the costs for these services. However, these funds have as yet to be allocated to the counties.

California will receive an additional $139.5 million in new federal special education funds in 2004-05. The Governor's January budget proposes to expend only $74.5 million of this amount. As such, $65 million in federal funds is unscheduled at this time.

COMMENTS:

The County Mental Health Directors Association states that County MHPs provide AB 3632 mental health services to about 27,000 special education pupils for a total annual cost of about $120 million. Though the Governor's budget continues to provide the $69 million in federal special education funds, this amount is insufficient to meet the existing and ongoing need. The LAO estimates that as of November 2003, the counties have expended $226 million for this program without reimbursement. CMHDA is concerned about the $150 million to $175 million in unpaid SB 90 claims for this program. This predicament is also detrimental to other county health and human services programs.

This situation has created significant budgeting problems for them and is forcing many counties to significantly reduce services to indigent children and adults in order to fund this education mandate.

Senator Burton has introduced SB 1895 regarding potential policy changes to how mental health services are provided to special education students and related administrative issues. This legislation is in a spot bill format with constituency group meetings presently occurring.

QUESTIONS:

Subcommittee Request and Questions. The Subcommittee has requested the DMH to respond to the following questions:

To DMH:
1) What is the Department's role in working through the disbursement issues?
2) What is the Department doing about past unpaid county claims for services provided to AB 3632 children?

To Advocates:
1) Please describe the problem the counties and children are facing.
2) Please describe the recent litigation filed by counties.
3) What are potential solutions?

ISSUE 6: SEXUALLY VIOLENT PREDATORS

BACKGROUND:

In short, the Governor's Budget includes:

(1) $1.1 million General Fund increase of to support an increase in the number of SVP evaluations to be performed in the budget year, as well as additional costs for evaluators to provide court testimony;

(2) $10.7 million General Fund reduction of associated with proposed statutory changes that will require the transfer of 100 pre-commitment SVPs from the state hospitals back to local jurisdictions pending the final adjudication of their SVP commitment;

(3) $2 million General Fund reduction of for Trailer Bill Language to set SVP commitments to an indeterminate period of time; and

(4) $823,000 General Fund savings of to restructure State Hospital SVP Treatment.

BACKGROUND

(1) Definitions and Demographics.

Sexually Violent Predators (SVP) have committed two felony acts of sexually violent crimes, as defined in law: rape, child molestation, and variations therein. They also have a diagnosed mental illness that predisposes them to re-offend.

An "SVP respondent" is defined as a person who had a petition for civil commitment filed by a District Attorney, probable cause found by a court, and is waiting for an SVP trial. In the SVP law, a finding of probable cause requires the person to be detained in a "secure facility." Because DMH has evaluated such persons as having a mental disorder, courts often order pre-trial SVP respondents, who have completed their prison sentence, into Atascadero State Hospital (ASH), which is a secure treatment facility.

There are currently nearly 500 individuals at Atascadero State Hospital who are SVPs. Generally, SVPs are male and older than the typical hospital population. There is only one woman who is an SVP in state hospitals in California. Nearly every county in the state has committed SVPs from their jurisdictions into the state hospitals. However, Los Angeles and San Diego have the largest numerical share of SVP commitments.

There have been two SVPs released as of March 2004. Brian DeVries has been on conditional release since August 2003, living on the grounds of Salinas Prison in a trailer. Cary Verse was released in February 2004 and has been forced out of every housing situation.

The DMH has contracted with Liberty Health Care to conduct the Conditional Release program for SVPs. DMH anticipates the release of 6 more SVP in the budget year and expects that there will be 5 SVPs released in the current year.

(2) Treatment Process.

All SVPs first serve their sentence in a CDC prison. About six months prior to the end of their sentence, they are referred to DMH for treatment evaluation. DMH orders

evaluations to determine whether the offender potentially qualifies for a sexually violent predator commitment.

The Superior Courts are the arbiters of commitments. If a jury or judge find that it is likely that an individual would re-offend, then the individual is committed to the DMH for treatment and supervision. The statutory length of commitment is two years. DMH states that almost all SVPs are recommitted every two years.

The Sex Offender Commitment Program (SOCP) designed for SVP patients is organized into five phases. The treatment model is based on relapse prevention. The first four phases are inpatient. The fifth phase of the treatment program is intended to be outpatient and will be conducted under the auspices of the Conditional Release Programs (CONREP/Liberty Health Care).

The patient graduates to the next phase based on their completion of specific tasks, rather than a time line. Because of a variety of factors such as the waxing and waning of patient motivation over time, it will take each patient a different length of time to complete a particular phase of treatment. The material covered and the specific tasks required for completion of a phase are described below.

The Treatment Team is responsible for assessing when the patient is appropriate to be reviewed for advancement to the next phase of treatment. A staffing panel, made up of clinicians who are not on the patients treatment team, are given the task of assessing whether or not the patient has in fact completed the necessary tasks.

Phase I – Treatment Readiness. Treatment Readiness prepares the patient to begin the work of learning cognitive-behavioral methods for preventing re-offense. This phase primarily uses didactic methods. Patients are not required to acknowledge or discuss their crimes in any specific way. The patients receive an overview of the SOCP and the five phases of treatment. Topics include: The law (WIC 6600 *et seq.*), prison vs. hospital attitudes, interpersonal skills, anger management, mental disorders, victim awareness, cognitive distortions, relapse prevention, and discharge planning.

The patient remains in Phase I until he/she volunteers for Phase II and meets the following criteria:

- Acknowledges committing past sexual offenses and expresses a desire to reduce his risk of re-offending in the future;
- Demonstrates a willingness to discuss his past offenses;
- Agrees to participate in the required assessment procedures;
- Shows an ability to conduct himself appropriately in a group setting.

Patients who wish to progress to more advanced phases of treatment are required to sign an informed consent statement.

In addition to the regular Phase I groups, a Phase I Alternate Group has been provided since October 1998. It is designed to assist patients in a small group format to resolve concerns that inhibit them from entering Phase II.

Phase II – Skills Acquisition. This phase marks the shift from education and preparation to personal therapy. In this phase of treatment, patients acquire new fundamental skills for preventing re-offense. Due to the intensive nature of this phase, group size is

between six and ten patients. They learn how to use basic relapse prevention tools (such as behavior chains and decision matrices). They also learn to identify their personal cognitive distortions, how to alter their distorted thinking patterns, and how to cope in high-risk situations. They begin the process of developing an awareness of the trauma that victims typically experience after being sexually abused. They write an autobiography that gives them the opportunity to examine their personal history and to discover how present attitudes, feelings, and behavior have been affected by their past experiences and observations. In addition to the Phase group, patients may also be assigned to special skill building groups such as human sexuality, interpersonal relationships, anger management, covert sensitization, and depression management during this phase of treatment.

In order to progress into Phase III of treatment, a panel of clinicians, who are not members of his/her treatment team, must determine that the patient has met the following criteria:

Atascadero Skills Profile (ASP) scores on the deviant sexual behavior domain will be as follows:

- Accepts responsibility for his/her past deviant sexual behavior – consistently adequate;
- Understands the trauma resulting from his/her sexual crimes – mostly adequate;
- Can correct deviant thoughts that promote sexual offending – mostly adequate;
- Demonstrates ability to manage deviant sexual urges and impulses – non-responder, unknown, or partially adequate;
- Demonstrates ability to cope with high risk factors for sexual re-offending – mostly adequate;
- Successfully completed Phase II assessments and demonstrated a willingness to cooperate with further required assessments;
- Fully acknowledged his/her past sexual offenses and accepts them as his/her responsibility;
- Articulated a commitment to abstinence which is reflected in his/her current behavior;
- Understands that the goal of treatment is management and control, not “cure”;
- Satisfactorily completed behavior chains, decision matrices, and any other Phase II assignments;
- Indicated an awareness of his/her cognitive distortions and an ability to correct them;
- Understands and has described all identified high-risk factors;
- Successfully completed prescribed specialty groups; and
- Identified typical victim responses to sexual abuse.

<u>Phase III – Skills Application</u>. In this phase, offenders integrate the skills they learned during Phase II in a rigorous and consistent manner into their daily lives. Their skills in relapse prevention, coping with cognitive distortions, and developing victim awareness are deepened and broadened. Their daily experiences in unit life are examined and subjected to cognitive-behavioral interventions through the intensive use of journals and logs. During this phase, based on individual patient need, they may be assigned to specialty groups and treatments that include sexual arousal modification, family relationships, and family or couples counseling sessions with their significant community support systems.

For a patient to advance to Phase IV, his/her treatment team recommends that he/she be reviewed by a panel of clinicians, who are not members of the patients' treatment team, to determine that the following criteria exist:

- Describes fully the negative impact of abuse on his victims;
- Continues to acknowledge his/her past sexual offenses and accepts them as his/her own responsibility;
- Continues to articulate a commitment to abstinence which is reflected in his current, daily behavior;
- Recognizes and corrects all cognitive distortions that lead to offenses using behavioral and cognitive restructuring techniques;
- Shows an on-going ability to control his/her deviant sexual urges and interests;
- Describes a complete range of prospective high-risk factors and internal warning signs that signal increased risk of re-offending and demonstrates effective coping with risk factors in the hospital setting

Phase IV – Skills Transition**.** During this phase, a detailed Community Safety Plan is developed in conjunction with the offender's assigned out patient supervision and treatment provider. It provides the patient with the opportunity to prepare for his/her discharge to a supervised setting in the community via CONREP or Liberty Health Care. He/ She continues to develop his/her skills in relapse prevention, managing cognitive distortions, developing victim empathy, and using journals and logs. Particular attention is paid to how these skills will generalize into the community. The patient has an opportunity to involve family members and significant others directly into his relapse prevention plan. The patient learns about specific resources available in his placement.

The outpatient provider becomes directly involved at this point in treatment planning, and specific work is done to develop the terms and conditions under which the patient will be released. Also in-depth release planning is done that includes conditions of community treatment, supervision, housing, employment, and safe community activities. Community notification and registration laws are thoroughly reviewed so the offender is clear about his/her responsibilities and potential community reactions upon his/her release.

In addition to the core group, the offender may continue in couples or family therapy, addressing issues of adjustment to the community and family settings. The Family Support Group, which meets once monthly, may be augmented with additional sessions for a particular patient and his/her support group. The offender may be required to continue in the sexual arousal management group emphasizing booster and maintenance sessions, and other specialty groups.

Phase V- Community Outpatient Treatment. The outpatient phase of treatment is intended to provide patients with ongoing relapse prevention treatment as well as supervision and monitoring and requires approval of the committing Superior Court.

This phase of treatment is accomplished by the use of standardized, intensive outpatient treatment, supervision and assessment services and collaborative case management. The collaboration involves all the parties who are working to help the offender maintain a crime-free lifestyle. These parties include: the Regional Coordinator (Liberty Healthcare); the sex offender specific treatment provider; the mental health treatment provider; the alcohol/drug treatment provider; the clinical polygrapher; local law enforcement; family members; clergy/church groups; attorneys (both government and defense); landlord;

employer; neighbors; and victim advocates. Key members of this team form the Community Safety Team that manage supervision issues of each release.

The Regional Coordinator uses the following supervision and monitoring tools: announced and unannounced face-to-face visits; collateral contacts with significant people in the SVP's life; covert surveillance; GPS monitoring; random drug screens; random phone checks; unannounced residence, vehicle, and personal searches; and approval of schedules, locations of outings and routes of travel for all time outside of residence.

Additional monitoring tools used in conjunction with treatment professionals include: treatment contacts at least twice weekly which include assessments of functioning; polygraph on a quarterly basis; and a number of other assessments which measure deviant sexual arousal.

Liberty HealthCare is responsible for all aspects of SVP Phase V treatment throughout California. The Liberty Contract now costs $886,602 which includes the initial start up costs for the central office and staff; housing and housing searches; arranging for professional services for clients i.e. sex offender treatment, tests, medications, etc.; coordinating community safety teams; monitoring including the use of GPS, clients who are out; and interfacing with police and courts. These costs will decrease on a per client basis as more SVPs are released into CONREP due to the impact of economies of scale. Liberty currently supervises two SVPs in the community; they are attending court hearings, developing community safety plans and conducting housing searches for two additional SVPs that have court approved Welfare and Institutions Code 6608 petitions and they participate in hospital visits for all other committed SVPs.

(3) Constitutional Issues.

The SVP statute has been in effect since January 1, 1996. There have been 3 conditional releases of SVPs. The current length of commitment is two years. Almost all SVPs are recommitted every two years. But, the California and US Supreme Courts have said that there must be a light at the end of the tunnel—the mental health treatment is not allowed to be an extension of their sentence. Without this provision the constitutionality of the statute could be challenged.

The Court has found that the SVP statute is constitutional because treatment is the cornerstone for mentally ill offenders. It is believed to be unconstitutional to keep SVPs in the hospitals in perpetuity. The Courts have further found that if there is not a conditional release program available to the SVPs, then they must be released outright.

(4) Current Situation.

Brian DeVries and Cary Verse are the only SVPs to graduate from the Sex Offender Commitment Program at Atascadero State Hospital. DeVries has been on conditional release since August 2003, living on the grounds of Salinas Prison in a trailer. Public outrage has forced Verse, the most recent graduate, to be continually moving residences.

Police officers in the cities Verse has moved into recently have been frustrated by the Department of Mental Health because they were not given prior warning that a high-risk sex offender would be entering their communities. Verse is a four-time convicted sex

offender, and has been chemically castrated, has completed treatment, and has his movements tracked electronically.

The uproar from Verse's release mirrors the reaction that DeVries received when he was released. DeVries was released by a judge to live in a downtown San Jose hotel. The community reaction forced DMH officials to house DeVries, a child molester who voluntarily underwent surgical castration, in a trailer at Soledad State Prison.

The experience of these two graduates demonstrates that state policy is lacking in certain conditional release provisions for newly released offenders and that the public lacks understanding of the SVP process. These two offenders have been praised by officials for their commitment to treatment, yet have drawn unrelenting scrutiny from the public. In the meantime, 30 other sex offenders who were declared SVPs at one time who didn't complete treatment have left the state hospital with no fanfare.

(5) Current Legislation—AB 493 (Salinas).

AB 493 would require that persons civilly committed as Sexually Violent Predators (SVPs) who are not parolees would, upon conditional release, be placed on outpatient treatment status in the county of commitment unless the court finds that extraordinary circumstances require placement outside the county civil of commitment. "Extraordinary circumstances" are defined as those which would limit the department's ability to provide for conditional release in the county of civil commitment. This bill would also provide that the county of civil commitment would notify DMH of the county agency or program that would provide assistance and consultation for locating and securing housing in the county for persons who are about to be conditionally released. Finally, this bill would create a mandate and is an urgency statute.

This bill would aid DMH, the courts and local authorities in determining the most appropriate placement for SVPs that are about to be conditionally released. It provides a clear assignment of county responsibility, reduces the potential for delays in SVP placements and, eliminates the possibility of the courts "exporting" local SVPs to other jurisdictions or states unless there are extraordinary circumstances that would preclude placement in the county of civil commitment.

There are no provisions in the SVP statutes that specify where SVPs should be placed once the court has ordered the individual's conditional release into the community, unlike the Penal Code which specifies that parolees, under most circumstances, will be paroled to their county of legal residence. WIC Section 6608(d) provides that the court may order, based upon DMH's recommendation, the conditional release of an SVP into an appropriate forensic conditional release program.

DMH has encountered, and expects to continue to encounter, intense "not in my backyard" (NIMBY) objections as each SVP approaches readiness for conditional release. The Department is also concerned about patient-initiated or court-initiated placements that may prevail in the courts as has occurred in the past. DMH has determined that there are currently six SVPs in Phase IV of the treatment program at Atascadero; one of whom has been ordered to be conditionally released, and only needs housing to be provided. There are 18 SVPs in Phase III of the treatment program. At any time, any one of these SVPs could petition the courts for conditional release.

BUDGET PROPOSALS

(1) Evaluations.

The Sex Offender Commitment Program (SOCP) has been administered by the Department of Mental Health (DMH) for eight years. The first SVP evaluations were completed towards the end of 1995 and the first commitment occurred in July 1996. Since its implementation, the program has undergone considerable activity and growth. Psychiatrists and psychologists, under contract with the DMH, have completed over 5,000 evaluations on both California Department of Corrections (CDC) inmates and persons currently committed (recommitment evaluations) resulting in 432 SVP commitments by the California Courts.

The funding for the SOCP has increased over the last several years, by means of Governor's Budget Proposals, May Revision increases, and deficiency requests. The DMH assumes the base funding level of $5,895,000 for SVP evaluation activities will be continued into FY 2004-05. DMH has requested over a one million dollar augmentation due to continued program growth. The data on program growth is derived from a one-year regression analysis. DMH states that existing resources do not cover the contracted costs with psychiatrists and psychologists for providing services. DMH argues that insufficient funding prevents the department from fulfilling its legislative mandates.

Initial Evaluation and Testimony Procedures.

- The first step in the SVP process is the CDC and the Board of Prison Terms refer potential SVP cases to the DMH. The average number of monthly referrals has increased from 49 to 54 between 2001-02 and 2002-03.
- The second step is for DMH to complete a Record Review of referred cases to ascertain whether basic legal requirements are present prior to referring the case for clinical evaluation. Based on record reviews, 60 percent (33 individuals per month) were referred for evaluation in 2002. This is an increase from the previous referral rate of 26 individuals per month in 2001.
- Next, two contract evaluators are assigned to each individual, who may be at any one of 32 possible prison locations. Based on a review of records and an interview with the inmate, the evaluators submit reports to DMH. If two evaluators have a difference of opinion, two additional evaluators are assigned to the case. This split decision occurs in 21 percent of the cases.
  - DMH uses a flat rate plan for evaluator costs of $2,000 for initials and $2,400 for recommitment evaluations. DMH also provides for extensive travel expenses. The initial evaluations average $2,450. Recommitment evaluations average $2,536.
  - During FYs 2000-01, 2001-02, and 2002-03, DMH evaluators completed 498, 619, and 930 evaluations, respectively. A one-year regression analysis of monthly initial evaluation data projects that DMH will complete a total of 1,548 evaluation in FY 2004-05. So, total costs for initials are estimated at $3,793,000.
- SVP cases evaluated as meeting specified criteria are referred to the local district attorney (DA) with a recommendation for SVP commitment. If a petition for commitment is filed, clinical evaluators are called as witnesses at court hearings. The number of testimony episodes rose from 337 to 371 between FY 2000-01 and 2002-03. A one-year regression analysis projects that evaluators will complete 360 testimony episodes in 2004-05. The average cost per testimony is $1,830. So, the total costs for testimony in FY 2004-05 are estimated at $659,000.

Recommitment Evaluation and Testimony Services. All persons ending their two-year SVP commitment must be evaluated again by at least two clinicians, as opposed to other types of commitments, which require only a single evaluation. DMH relies upon both contract evaluators and state hospital staff to complete these recommitment evaluations.

- Since FY 2000-01, the number of yearly recommitment evaluations completed by contract evaluators has more than tripled. Based on a one-year regression analysis, DMH estimates that contract evaluators will be asked to complete 300 recommitment evaluations in FY 2004-05, a decrease from 326 in FY 2002-03.
- Since FY 2000-01, the number of yearly testimony has increased five-fold. A one-year regression analysis projects evaluators to complete 585 recommitment court appearances in FY 2004-05, an increase from 220 in FY 2002-03.

Budget Assumptions. There are several court decisions, amended statutes, changes in the prediction methods of sex offender risk, and increasing pressure for contract evaluators which lead the DMH to believe there will be continued program growth for the SVP program.

- The California Supreme Court ruled in People v. Torres (May 2001) that a "predatory relationship" was not a necessary criterion for SVP qualifying prior convictions. DMH argues that this will cause an increase in SVP evaluations, since in prior years, many individuals were screened out by record reviewers. The DMH argues that the number of contract evaluations and total costs will increase throughout all phases of the SVP commitment and recommitment processes, since there will be a required review of more extensive hospital treatment information.
- The case of People v. Ghilotti was decided by the California Supreme Court, which broadened the definition of "likely to re-offend." This finding in conjunction with the Torres decision has resulted in a significant increase in the number of cases found to meet SVP criteria.
- In FY 2002-03, DMH replaced an hourly payment rate with a flat rate for initial and recommitment evaluations performed by contract evaluators. This was intended to allow for a more accurate prediction of evaluation costs and limit overall program costs. The DMH states that the costs for update evaluations, travel, and court preparation and testimony are largely out of their control, making establishment of fixed rates for these services unrealistic.
- DMH is assuming that professional consultation costs, which represent about one percent of the total contract evaluation expenditures, will remain stable during the remainder of the current and budget years.

LAO Analysis. The LAO has reviewed more updated caseload data on the number of referrals from the Board of Prison Terms (BPT) to the DMH for SVP evaluations and has found that the data does not justify the administration's request. Data available through the end of calendar year 2003 indicates that the number of BPT referrals, as well as the number of SVP cases being referred to evaluators, is declining, not increasing. If current trends continue, LAO argues, the number of SVP evaluations could stay level or even decrease in the budget year.

SVP Referrals and Assignments of Evaluations are Declining			
Type of Activity	**2002**	**2003**	**Percentage Change**
Referrals of SVP cases from BPT	636	558	- 12 %
Cases referred for evaluation	352	283	-20 %

The LAO recommends the Legislature reject the $1.1 million augmentation proposed by the administration for these activities.

(2) Transfer of Pre-Commitment SVPs to Local Jails.
The DMH includes in their state hospital caseload projections consideration of the impact of requiring California Department of Corrections inmates who have not completed the SVP commitment process to be housed in local jails. The modification of the way the state manages its SVP population is estimated to obtain a $10.7 million state savings in 2004-05.

The existing SVP Act makes reference to placement in a "secure facility" following a finding of SVP probable cause. The Administration proposes amended language to be placed in the Welfare and Institutions Code 6602 directing that persons, for whom a petition has been filed and probable cause found, must be housed in local facilities.

The budget proposes to conduct the commitment proceedings at an earlier date before such individuals are due to be released from state prisons in order to reduce the state hospital population.

The Governor's proposal would not increase county government costs since the entire cost of the SVP population is the responsibility of the state. Counties could obtain reimbursement from the state to offset any additional costs they would incur for holding pre-commitment SVPs who had been diverted from the state hospital system to county jails.

Currently, 170 of the individuals who are awaiting court proceedings for an SVP commitment are being held in the state hospital system while their cases proceed. Some additional individuals are still being held in state prison as these proceedings occur, while still others who have been released from prison are held in county jails.

The goal of the administration's proposal is to shift a portion of the pre-commitment SVPs to persons willing to accept treatment. The DMH has indicated that individuals who are awaiting legal proceedings that could result in their commitment as SVPs are generally unwilling to engage in treatment activities. This is because standard therapy for sex offenders often involves efforts to get individuals to discuss and admit their history of sex crimes. As a result, many individuals who are being held in the state hospitals while they await their SVP commitment hearings are not actively engaged in treatment.

LAO Analysis. The LAO indicates that the proposal could have a larger impact on caseloads and achieve a greater state savings than estimated by the administration. The Governor's budget plan assumes that the changes that it proposes would reduce the

hospital population by 100 in 2004-05. However, up to 160 pre-commitment SVPs are presently in the state hospital system. Thus, it is possible that the savings from the Governor's proposed changes to the SVP statute could be greater than estimated in the budget plan.

The LAO recommends to shift a portion of the pre-commitment SVPs to the local jails while they await the verdict on their commitment hearing, and to expedite the commitment proceedings of others before their release from state prison. While the budget plan reflects $10.7 million in savings to the General Fund from the shift of 100 SVPs, the LAO estimates that the state could eventually achieve as much as $5 million in additional savings from the shift of all pre-commitment SVPs (currently at 160) to the local level.

Lastly, the LAO acknowledges that there could be some offsets to the savings because more persons would be held in local jails. However, the cost to the state of reimbursing counties for the use of their jail beds would be much lower than the cost of using an equivalent number of state hospital beds—perhaps as much as 20 percent lower.

(3) Implementation of an Indeterminate SVP Commitment Period.
The Governor has proposed trailer bill language to amend Sections 6604 and 6604.1 of the Welfare and Institutions Code, which would implement an indeterminate sentence length for SVP commitments.

The DMH argues that in a review of 13 states with SVP commitment laws, California was the only state with a determinate commitment period. California has a period of two years, after which the entire commitment process must be repeated, including new evaluations, a new commitment petition and a new trial.

The Administration proposes, as under current law, that a person confined as an SVP would continue to have the right to petition the courts once each year for his/her release from a state hospital. The DMH states that the recommitment process results in significant General Fund costs for the state and locals. The DMH believes that replacing the current two-year SVP commitment period with an indeterminate period is expected to save $2,000,000 annually in the DMH budget and also capture savings in local mandate costs through eliminating the need to litigate every two years.

In addition, the DMH reasons that this reform would encourage persons committed as SVPs to more actively engage in treatment programs and reduce the possibility that courts will grant requests by SVPs for conditional release when clinical staff still consider the person dangerous.

The DMH argues that there are significant negative consequences to a two-year commitment period:

- Requires the local prosecutor to carry the burden of proof that the individual remains an SVP, leading to the release of persons still thought to be dangerous by DMH.
- Leads to more requests by SVPs for conditional release, and in a few cases, courts have granted such requests, sometimes resulting in persons being deemed safe to treat in the community, without the concurrence of DMH.
- Conflicts with the foundation of SVP treatment, which is considered long term. The current commitment period sets up an expectation that treatment and time in custody will be brief, which does not provide for the realization of treatment benefits.

LAO Analysis. The LAO recommends that the modification to extend the period of commitment for SVPs to an indeterminate length be considered as an important policy matter in the normal legislative process.

(4) Restructure State Hospital SVP Treatment.
The Administration proposes to restructure the supervision and treatment services provided to SVP patients in state hospitals, including the establishment of a new secure SVP residential licensing category. The DMH plans to improve the security and safety for patients, staff, and the public by treating patients in residential units that are organized to more efficiently and effectively provide for the varying custody and supervision needs of the SVP patient population. The reorganized treatment services are proposed to ensure that SVP patients receive the individualized treatment they need throughout the course of their commitment.

The SVP Relapse Prevention Program consists of four inpatient Phases. As the SVP population has grown, DMH has identified at least three groupings of patients among the population. The Administration proposes to separate these three groups since their custody and treatment needs differ. The DMH argues that continuing to treat SVP patients as a homogenous group no longer optimizes treatment access of treatment effectiveness. The DMH proposed groups would be categorized as following:

Passive Treatment Group—Phase I. The DMH proposes to house this group in residential units and would attend assessments, treatment, and other appropriate activities in centralized locations during the day. This group generally requires close custody supervision. They do not suffer from symptoms of major mental illnesses and do not require 24-hour nursing care. The DMH reasons that this group's appropriate supervising needs are a secure residential environment and that they can attend treatment on an outpatient basis.

Active Treatment Group—Phases II, III, and IV of the Relapse Prevention Program. These patients do not require 24-hour nursing care, such as is provided in a traditional health facility, but they do require 24-hour custody supervision in a secure residential facility. Their treatment will be provided in central locations in the facility on an outpatient basis.

Third Group. This group would be composed of SVP patients who have mental or physical illnesses that require care in a licensed health facility. The patients in this third group would include: (a) those just being admitted to the facility and undergoing initial evaluation and screening; (b) those in need of psychiatric hospital care; and (c) those who need medical care in a hospital setting.

DMH proposes that implementation will be in two steps. Step one involves changes to be implemented by January 2005 at ASH and will include adding a relatively small number of Hospital Police Officers to provide enhanced custody supervision in the SVP treatment units. The professional treatment staff will be relocated to central treatment areas of the hospital where the SVP patients will attend treatment activities on an outpatient basis. This more focused and more efficient method of providing treatment will result in some savings during the Budget Year.

DMH states that it is not fiscally or operationally prudent to make the changes that would be required to fully implement this restructuring concept while the SVP patients are at ASH. For example, separation of the groups of SVP patients at ASH would require modifications to the physical structure of several parts of the hospital, including the addition of a new sally port. This remodeling work would require time and funding to complete. ASH also has very little space that could be redirected for central treatment areas. Also, the full implementation of this concept would require the establishment of a new facility licensing law.

Step two involved the changes to be made at Coalinga State Hospital to begin in August 2005. The physical structure of the Coalinga facility will allow for separation of the SVP patient population into the three groupings described above.

A new secure SVP residential facility license will be crafted and included in the language of the trailer bill to the 2004-05 budget. DMH states that it will be essential that this new facility license be available if the proposed savings are to be realized when Coalinga opens in August 2005.

COMMENTS:

The restructuring of the SVP Program is a significant policy issue which should be addressed in the normal legislative policy process. It is has been recommended to the Administration that the item be referred, without prejudice, to the policy process.

QUESTIONS:

Subcommittee Request and Questions. The Subcommittee has requested a response to the following questions:

To DMH:

1) Please explain the paradox of high contract costs for the SVP Conditional Release Program and enormous problems placing SVPs in the community. What steps is the department taking to ameliorate this?

2) What are the potential safety issues in transferring pre-commitment SVPs to the local county jails?

3) Please address the constitutional concerns regarding the indeterminate commitment proposal.

4) At what rate are the costs for SVP evaluations increasing every year? Is it possible to re-negotiate rates with psychiatrists and psychologists for evaluations? Why have the costs been increasing?

5) Is there another term that is less emotionally charged than Sexually Violent Predator?

ISSUE 7: COALINGA STATE HOSPITAL

BACKGROUND:

The Governor's Budget includes a $27.7 million General Fund augmentation for the continued activation of the new Coalinga State Hospital (CSH). This funding includes provision of:
1) $8.7 million for Phase IV and V staffing;
2) $12.2 million for operating expenses and equipment;
3) $3.2 million for recruitment and retention pay differentials and salaries that would exceed standard levels for certain positions at CSH;
4) $3.6 million (net increase) to pay the full-year cost in 2004-05 of CSH staff added in 2003-04 to help prepare the facility for its opening.

The proposal would add almost 146 new positions for CSH in the budget year. The plan also includes an augmentation of $770,000 for about 20 staff positions to activate for the first time 147 of the 500 temporary beds at Atascadero and Patton State Hospitals. The Administration anticipates the opening of CSH in August 2005.

Beginning in 2000, the state initiated steps to construct a new 1,500-bed secure mental health treatment facility, to be known as Coalinga State Hospital (CSH), to provide DMH with additional capacity to treat patients involuntarily committed under the SVP law. The DMH began construction in 2001, and construction is scheduled to be completed by May 2005. The construction project will be funded by lease-revenue bonds, which are scheduled to be sold in the spring or fall of 2004. To date, the state has committed more than $380 million for the construction and preliminary staffing of CSH.

In addition to this construction project, the state has taken several steps in recent years to ensure that there is sufficient space in the state hospital system for the treatment of offenders who require high security, such as SVPs. Among other actions, the Legislature provided $6.9 million in 2001-02 to purchase modular buildings for placement at Patton State Hospital (PSH) and Atascadero State Hospital (ASH) and to convert program areas into temporary patient living space to accommodate up to 500 additional patients. Additional funding for the state hospital system to staff the 500 additional beds has not been provided to date because the overall hospital population has grown significantly less than DMH had previously projected.

Population Projections. According to DMH's own population projections, the number of patients requiring secured housing will not grow, but will instead decline by 47 patients during the budget year as a result of proposals to (1) cap the populations of two groups of forensic patients and (2) divert from the state hospital system persons who have been referred for SVP commitment but have not yet been determined by the court to be SVPs.

In light of these projected population estimates, the LAO analysis indicates that DMH will have a surplus of approximately 600 beds in the budget year. The DMH has estimated it will need to house a total of 3,776 secure patients in the state hospitals by June 2005. However, the state hospitals have the capacity to hold up to 4,376 patients in secured treatment settings (including the 500 temporary beds at ASH and PSH) in 2004-05. The anticipated decline in the state hospital populations and the resulting surplus of beds suggest that a delay in the activation of CSH would be possible.

Administration Objections. In discussions about the possibility of delaying the activation of the facility in order to achieve General Fund savings, the administration has raised several objections.

First, the administration has indicated that delaying the activation of CSH could complicate the sale of the lease-revenue bonds if no date for activation of the facility is specified. Bond underwriters, we are advised, may request that such a date be finalized before bonds could be sold.

Also, the administration has asserted that allowing the facility to sit idle could generate significant new costs by allowing the condition of unused equipment to deteriorate. It has also voiced concern that students who are expected to complete educational programs at a nearby community college in preparation for work at CSH could leave the Coalinga area and obtain employment elsewhere.

Finally, the administration has raised concerns that the use of the temporary beds at ASH and PSH beyond August 2005 may not be permitted by DHS and the State Fire Marshall. The DMH asserts that the continued use of the beds beyond that date could result in licensing violations or require funding to bring the space used for patient care into compliance with licensing, earthquake, and fire safety codes and regulations.

COMMENTS:

The LAO's analysis of the Governor's budget request indicates that the state could delay the activation of CSH and still have more than sufficient capacity to meet the projected need for secure treatment beds in the budget year, and beyond.

Precedents Exists for Facility Delay. In light of the state's budget difficulties, the LAO recommends that the Legislature delay the activation of CSH from August 2005 until March 2006 for a state General Fund savings of up to $20.1 million. In the past, the Legislature has delayed the activation of state prison facilities, including a new high-security facility in Delano (Kern County), to help address budgetary shortfalls. The LAO believes a similar approach is warranted for CSH, given the considerable resources being requested to bring the facility on line, the severity of the state's current fiscal problems, and their findings that the state hospital system has more than enough secure beds to meet patient needs. The LAO also believe it is possible to address most of the concerns voiced by the administration about a potential delay.

The LAO approach would fund operating expenses and equipment and staff recruitment costs necessary for a March 2006 opening of the hospital to move ahead in the budget year. It would also provide the additional funding needed to support the Phase III expansion of staff already authorized for the current fiscal year to proceed without any disruption. Given that these activities would continue in the budget year at CSH, LAO sees little risk that a seven-month delay in the arrival of patients would result in major costs from the deterioration of any equipment purchased for the facility.

The Legislature could take steps to ensure that the sale of the bonds would proceed. The state recently encountered and resolved a similar issue when it delayed the activation of the Delano II state prison. To ensure that the state's intention to occupy the facility is clear to prospective bondholders, LAO proposes that the Legislature adopt the following budget bill language:

Provision X. In order to address the state's fiscal problems, it is the intent of the Legislature to achieve savings in the 2004-05 fiscal year by delaying some staffing and funding for activation of Coalinga State Hospital until 2005-06. It is further the intent of the Legislature that patients occupy beds at CSH no later than March 2006.

The LAO acknowledges that a delay in staffing and opening CSH might cause some community college graduates who would otherwise take jobs at the new state hospital to go elsewhere after graduation. However, these nursing and psychiatric technician graduates could be recruited to help address state staffing shortages in these professions, which exist at other state facilities.

The LAO believes it is unlikely that the use of ASH and PSH beds for an additional seven months will pose a serious problem. In 2002-03, DMH itself had proposed to activate these beds for almost as long a period of time (15 months) as LAO is proposing (20 months). In LAO's view, the department's contention that these beds cannot be used to meet the state's interim needs for secure beds is inconsistent with its prior funding requests for the $6.9 million; the money that was spent to make these 500 beds available for just this purpose.

If Activation Proceeds, Request Should Be Reduced. Should the Legislature adopt the Governor's proposal and decide not to delay the activation of CSH, LAO recommends that it reduce the funding request to address several concerns. Specifically, LAO recommends that the Legislature take the following actions:

Delete Training-Related Travel Funding for New Hospital Police Officers. The budget proposal includes $1.3 million for the cost of staff travel to ASH for the 88 new hospital police officers for CSH. This funding request translates into approximately $15,000 per new CSH employee, and assumes that every new officer for CSH will require training. This assumption does not appear to be justified, given that some existing staff at ASH and other state hospitals have indicated an interest in relocating to Coalinga. Therefore, LAO recommends deletion of the funding in its entirety. The DMH could resubmit a request later this spring for a reduced level of funding for this purpose after it has determined how many new CSH staff will actually be required to travel to ASH for training.

Contract Food Service Activities. Generally under current state law, the state may contract personal services to achieve cost savings when the contract does not cause the displacement of civil service employees. It has already done so for other state facilities, and the administration proposes to expand on this approach next year. Nevertheless, the budget plan would provide $360,000 in 2004-05 to hire state employees for food service operations instead of contracting for these services at CSH beginning in the budget year. Assuming that contracting resulted in a 10 percent savings, the state could achieve $36,000 in savings in the budget year, and approximately $380,000 in annual savings once the hospital is fully operational.

QUESTIONS:

Subcommittee Request and Questions. The Subcommittee has requested a response to the following questions:

To LAO: Please describe the proposal to delay the activation of Coalinga State Hospital.

To DMH: What are the consequences of delaying activation? Please describe the SVP licensing requirements and the community interest surrounding placements of SVPs at other state hospitals.

ISSUE 8: ADDITIONAL RESOURCES FOR HIPAA IMPLEMENTATION

BACKGROUND:

The Governor's Budget includes a request for an augmentation of $246,000 (General Fund) for support of three associate level positions and operating expense costs to absorb the workload required to successfully implement and maintain the Health Insurance Portability Act (HIPAA) regulation standards primarily in the state hospitals and inpatient psychiatric programs.

HIPAA's primary intent and purpose is to protect health insurance coverage for workers and their families when they change or lose their jobs. To reduce some of the burden this law would place on health care providers, payers, and clearinghouses, the law required Administrative Simplification. Although the DMH has been planning for HIPAA since August 1998, it has not completed the assessment or remediated identified gaps.

The initial efforts for HIPAA compliance have been largely centered in the Short-Doyle Medi-Cal Program. DMH has identified the need for three analyst staff in order to accelerate DMH's compliance efforts in three areas:

1) Remediation of policies in the State Hospitals;
2) Remediation of the existing policies and procedures for non hospital staff;
3) Preparation and planning for the HIPAA Security Rule scheduled for implementation on April 2005.

DMH has emphasized its HIPAA work in the Short-Doyle Medi-Cal Program. However, DMH's current risk now lies with the state hospital facilities. Because DMH acts as a direct health provider, on behalf of the state in these facilities, it is most vulnerable to complaints and HIPAA privacy issues. The majority of the requested resources are to address the HIPAA compliance needs for hospital operations and previously unapprised areas.

QUESTIONS:

Subcommittee Request and Questions. The Subcommittee has requested a response to the following questions:

To DMH: Please explain the justification for three analyst positions.

ISSUE 9: QUALITY IMPROVEMENT FEES

BACKGROUND:

Medicaid law permits states to impose fees on certain health care service providers and in turn repay the providers through increased reimbursements. Because the costs of Medicaid reimbursements to health care providers are split between states and the federal government, this arrangement provides a mechanism by which states can draw down additional federal funds for the support of their Medicaid programs. These funds can then be used to offset state costs.

Federal Medicaid law recognizes a state's authority to levy such assessments on a broad range of Medicaid providers. These providers are: (1) inpatient hospital services; (2) outpatient hospital services; (3) nursing facility services; (4) services of Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs); (5) physicians' services; (6) home health care services; (7) outpatient prescription drugs; (8) services of a Medicaid managed care organization; and (9) other services as established by federal regulation.

The Governor's 2004-05 budget plan proposes to impose such a charge, which it terms a quality improvement assessment fee, for Medi-Cal managed care health plans. The administration estimates that the current proposal will result in net financial gain to the state of $75 million in 2004-05 while also providing additional reimbursements to health plans. (Such fees are also commonly called "quality improvement" or "quality assurance" fees.)

Such a fee mechanism was adopted and is already being successfully implemented by the Department of Health Services (DHS) in regard to ICF/DDs in order to generate an estimated $17.5 million in savings for the state. More than a dozen other states have also imposed such fees for various types of medical providers in keeping with the provisions of federal law.

LAO Recommendation. The LAO's analysis indicates that it may also be possible for the state to impose quality improvement fees on mental health managed care plans. The financial gains which can result from drawing down additional federal funds through quality improvement fees could be split differently between the state and providers. However, the LAO estimates, under one possible scenario, that the state could achieve a net General Fund financial gain as much as $70 million annually while providing a net increase in resources available to counties for mental health care of as much as $23 million.

The Department of Mental Health's initial written assessment indicated it rejected this option on the grounds that the state's managed care contracts are with counties who in turn provide the funds used to match federal dollars. According to the department, in lieu of paying the fee to the state as a means to obtain additional federal funding, the counties could use their resources to instead draw down the federal funds on their own.

The LAO concurs that counties could in theory independently leverage additional federal funds. However, the LAO contends that, as a practical matter, most counties lack the extra resources to do so on their own. The LAO indicates that its alternative could

potentially generate sufficient additional resources through the quality improvement fee mechanism to provide counties with as much as a 45 percent increase from the state General Fund in allocations for the mental health managed care program.

In regard to other technical aspects of the LAO option, DMH has requested assistance from the DHS in analyzing this issue, indicating that its expertise in this area is limited.

The LAO recommends that, given the state's serious fiscal problems, the Legislature further explore the option of imposing a quality improvement fees on mental health managed care plans. Specifically, the LAO recommends that DHS and DMH jointly report at the May budget hearings on the feasibility of imposing quality improvement fees for these providers, the potential revenues that could be generated from such fees, and any significant operational issues that would affect their implementation.

QUESTIONS:

Subcommittee Request and Questions. The Subcommittee has requested a response to the following questions:

To LAO: 1) Please explain your proposal.
2) Please provide a response to the concerns of the Department.

To DMH: 1) Please provide your reasons for your objection to this proposal.