

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn



March 11, 2010

9:30 a.m. or
Upon Adjournment of Session
Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

<u>Item</u>	<u>Department</u>	<u>Page</u>
4120	Emergency Medical Services Authority	2
	I. Overall Background	2
	II. Vote Only Calendar	3
	III. Issue for Discussion	5
4560	Mental Health Services Oversight & Accountability Commission	6
	I. Overall Background	6
	II. Issue for Discussion	9
4440	Department of Mental Health	11
	I. Overall Background	11
	II. Vote Only Calendar	13
	III. Issues for Discussion:	
	A. State Administration	14
	B. Community Mental Health	16
	C. State Hospitals	29

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. *Please* see the Senate File for dates and times of subsequent hearings. Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee or by calling 916-324-9335. Requests should be made one week in advance whenever possible. Thank you.

Item 4120--Emergency Medical Services Authority

I. OVERALL BACKGROUND

Purpose and Description of Department. The overall responsibilities and goals of the Emergency Medical Services Authority (EMS Authority) are to: **(1)** assess statewide needs, effectiveness, and coordination of emergency medical service systems; **(2)** review and approve local emergency medical service plans; **(3)** coordinate medical and hospital disaster preparedness and response; **(4)** establish standards for the education, training and licensing of specified emergency medical care personnel; **(5)** establish standards for designating and monitoring poison control centers; **(6)** license paramedics and conduct disciplinary investigations as necessary; **(7)** develop standards for pediatric first aid and CPR training programs for child care providers; and **(8)** develop standards for emergency medical dispatcher training for the “911” emergency telephone system.

During an emergency, the role of the EMS Authority is to respond to any medical disaster by mobilizing and coordinating emergency medical services’ mutual aid resources to mitigate health problems.

Table: Summary of Emergency Medical Services Authority

Summary of Expenditures (dollars in thousands)	Actual	Estimated 2009-10	Proposed 2010-11	\$ Change
Program Source				
Emergency Medical Services	\$21,749	\$21,568	\$24,231	\$2,645
Funding Source				
General Fund	\$11,459	\$8,422	\$9,016	\$594
Emergency Medical Services Personnel	\$1,415	\$1,426	\$1,565	\$139
Emergency Medical Services Training	\$342	\$400	\$440	\$40
Emergency Medical Services Technician	--	--	\$1,459	\$1,459
Federal	\$1,973	\$2,398	\$2,525	\$127
Reimbursements	\$6,578	\$8,940	\$9,226	\$286

II. VOTE ONLY (Pages 3 and 4)

1. Workload for Paramedic Licensing Activities and Fee Adjustment

Budget Issues. First, the EMSA requests an increase of \$86,000 (Emergency Medical Services Personnel Fund) to support a Program Technician II position to address workload associated with various paramedic licensing activities. The EMSA contends additional resources are necessary in order to ensure the timely licensing of paramedics, to identify any discrepancies in reporting, and to monitor required continuing education information reported by paramedics. There are about 17,000 paramedics in California and all workload has increased correspondingly.

The EMSA unit is staffed with three permanent employees and three retired annuitants. This staff is charged with (1) receiving, reviewing and processing paramedic applications; (2) issuing licenses; and (3) providing technical assistance to paramedics regarding licensing and enforcement issues. The additional position will facilitate this workload as well.

Second, the EMSA proposes to increase fees effective as of July 1, 2010 as provided for in AB 2917, Statutes of 2008. Existing law enables the EMSA to increase fees as appropriate to administer this program. According to the EMSA, public meetings were held and the rulemaking is anticipated to be completed by Spring 2010. The proposed increase is shown below. The EMS Commission is the entity that will approve all fee adjustments.

EMSA Fee Proposal

Activity	Applicants	Revised Fee	Revenue
Renewal Application	8,450	\$160	\$1,352,000
New Applicant Licensure	1,300	\$160	\$208,000
In-State Initial	1,200	\$50	\$60,000
Out-of-State Initial	100	\$100	\$10,000
State Licensure Match	8,450	\$5	\$42,250
Late Fee	400	\$50	\$20,000
TOTAL Revenues			\$1,692,250

Background on Paramedic Licensing Program. Paramedics are required to be licensed and to re-license every two years. The EMSA administers the licensing and enforcement program is authorized to charge licensing fees, as applicable, for various aspects of the licensing process (initial application, renewals and related items).

Subcommittee Staff Recommendation—Approve. No issues have been raised with this proposal and it is recommended for approval.

2. Emergency Medical Technician 2010 Project

Budget Issue. The EMSA proposes an increase of \$1.2 million (Emergency Medical Technician Certification Fund) to implement AB 2917, Statutes of 2008, which established the EMSA's authority to (1) establish fees in regulation; (2) have a centralized, statewide registry of Emergency Medical Technicians; (3) conduct background checks; and (4) reimburse Administrative Law Judges for emergency medical technician discipline hearings.

Specifically, the \$1.2 million will be used to (1) support four permanent positions to implement the requirements of the legislation; (2) support one two-year limited-term position to conduct research and develop reports regarding the background checks; (3) fund data processing, storage and software maintenance associated with a centralized registry; and (4) reimburse Administrative Law Judges for disciplinary hearings (about \$300,000).

The EMSA has received approval from the Office of the State Chief Information Officer (OCIO) in April 2009 for the centralized registry. Generally, this system augments the current paramedic licensing system with a web-based system

Subcommittee Staff Recommendation—Approve. No issues have been raised. The proposal appears to be consistent with the intent of the legislation and the need of the workload.

III. ISSUE FOR DISCUSSION

1. Pharmaceutical Cache (Stand By) for Mobile Hospital

Budget Issue. The EMSA requests an increase of \$448,000 (General Fund) to fund a pharmaceutical cache for the Mobile Field Hospitals (total of three).

The EMSA states that this funding would ensure a fresh supply of pharmaceuticals to be on-hand and delivered within 48 hours of the deployment of a Mobile Field Hospital. Pharmaceutical caches consist of medications, treatment kits, intravenous solutions, and other medical supplies.

An allocation of \$18 million (General Fund, one-time only) was provided in 2006 for the purchase of pharmaceutical drugs, maintenance, medical supplies and related materials. In addition, \$1.7 million (General Fund, ongoing) was provided for pharmaceutical drugs, storage, staff and maintenance. The EMSA contends that only \$24,000 of the \$1.7 million (General Fund) is available for ongoing pharmaceutical supplies.

Subcommittee Staff Recommendation-- Deny. In the event of an emergency, the Governor can authorize increased funding for medical supplies, including pharmaceuticals. Further, the state operates under a "mutual aid" agreement where by local governments also play significant roles in providing assistance, along with the federal government.

Due to the short shelf life of most pharmaceuticals (about 2/3rds have a 12-month shelf life with the remaining 1/3 having about an 18-month shelf like) the EMSA would need on-going support even if no emergency requiring pharmaceuticals occurred.

On-going support General Fund support is not feasible at this time. It should be noted that this same request has been denied for the past two-years due to the fiscal crisis. If necessary, the Governor can authorize appropriate funding in an emergency.

Questions. The Subcommittee has requested the OAC to respond to the following questions.

1. EMSA, Please provide a brief summary of the request.

Item 4560--Mental Health Services Oversight & Accountability Commission

I. OVERALL BACKGROUND (Pages 6 through 8)

Purpose and Description of Commission. The Mental Health Services Oversight and Accountability Commission (OAC) was established in 2005 and is composed of 16 voting Members who meet criteria as contained in the MHSA Act.

The (OAC) provides the vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure Californians understand mental health is essential to overall health. The OAC holds public systems accountable and provides oversight for eliminating disparities, promoting mental wellness, recovery and resiliency and ensuring positive outcomes for individuals living with serious mental illness and their families.

Among other things, the role of the OAC is to:

- Ensure that services provided pursuant to the Act are cost effective and provided in accordance with best practices which are subject to local and State oversight;
- Ensure that the perspective and participation of Members and others with severe mental illness and their family members are significant factors in all of its decisions and recommendations; and
- Recommend policies and strategies to further the vision of transformation and address barriers to systems change, as well as providing oversight to ensure funds being spent are true to the intent and purpose of the Act.

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

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

Most of the Act’s funding is to be expended by County Mental Health for mental health services consistent with their approved local plans (3-year plans with annual updates) *and* the required five components as contained in the Act. The following is a brief description of the five components:

- **Community Services and Supports.** This component represents the programs and services identified by each County Mental Health Department through its stakeholder process to serve unserved and underserved populations, with an emphasis on eliminating disparity in access and improving mental health outcomes for racial/ethnic populations and other unserved and underserved populations.

- **Prevention and Early Intervention.** This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations.
- **Innovation.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and to promote interagency collaboration.
- **Workforce Education and Training.** The component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness.
- **Capital Facilities and Technological Needs.** This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports, and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs.

In addition to the five components above, the MHSA allows for up to five percent of the total revenues received by the fund in each fiscal year to be expended on State support, including the OAC, Department of Mental Health, Mental Health Planning Council and other State entities.

Mental Health Services Act Fund Fiscal Report—January 2010. The Department of Mental Health (DMH) is required to provide two annual fiscal updates—in January and May - to the Legislature regarding revenues and expenditures of MHSA Funds. This report reflects the following information for revenues and expenditures.

Table 1: DMH Report on Mental Health Services Act Funds as of January 2010

Proposed Revenues and Expenditures of MHSA	Actual 2008-09	Estimated 2009-10	Proposed 2010-11
1. MHSA Deposited Receipts	\$1,292,600,000	\$1,428,900,000	\$1,030,800,000
2. Total Expenditures	\$1,120,959,000	\$1,330,797,000	\$1,597,355,000
• Local Assistance	\$1,084,523,000	\$1,284,000,000	\$1,102,700,000
• Governor’s Proposed Diversion of MHSA for State Programs	--	--	\$452,332,000
• State Administration	\$36,136,000	\$46,797,000	\$42,323,000
3. Difference: Receipts & Expenditures	\$171,641,000	\$98,103,000	-\$566,555,000
4. Adjusted Beginning Balance*	\$2,232,750,000	\$2,149,360,000	\$1,691,453,000
5. Reserve (Items 3 + 4)	\$2,404,391,000	\$2,247,463,000	\$1,124,898,000

*All figures are from the DMH January 2010 Report, except for item 4 which is from the Fund Condition Statement for the MHSA Funds (Page 158, Volume 2, Governor’s Budget).

Table 2: Mental Health Services Act: Local Assistance Expenditures

DMH Report: Local Expenditure by Component	Actual 2008-09	Estimated 2009-10	Proposed 2010-11
1. Community Services & Supports	\$650,000,000	\$900,000,000	\$783,600,000
2. Prevention and Early Intervention	\$252,900,000	\$310,000,000	\$196,500,000
3. Innovation	\$71,000,000	\$71,000,000	\$119,600,000
4. Workforce Education & Training, and State Level Projects	\$2,523,000	\$3,000,000	\$3,000,000
5. Capital Facilities & Technology	\$108,400,000	--	--
Local Assistance Total	\$1,084,523,000	\$1,284,000,000	\$1,102,700,000

The DMH states that over \$3.2 billion (MHSA Funds) have been expended through 2008-09. Additionally, \$1.3 billion (MHSA Funds) is estimated to be expended in 2009-2010 and \$1.6 billion (MHSA Funds) in 2010-11.

Table 3 below reflects MHSA Funds expended for State Administration which cannot exceed five percent of the annual MHSA revenues. It should be noted that the 2010-11 amounts reflect the Governor's proposal to reduce on a pro-rata basis in order to stay within the five percent cap. This issue will be discussed further below.

Table 3: Mental Health Services Act: State Administrative Expenditures

DMH Report: State Administrative Expenditures	Actual 2008-09	Estimated 2009-10	Proposed 2010-11
Judicial Branch	\$395,000	\$1,000,000	\$893,000
State Controller's Office	21,000	295,000	727,000
Consumer Affairs Regulatory Boards	236,000	306,000	91,000
Office of Statewide Health Planning & Dev.	499,000	929,000	583,000
Aging	93,000	236,000	218,000
Alcohol & Drug Programs	501,000	254,000	272,000
Health Care Services	670,000	968,000	752,000
Managed Risk Medical Insurance Board	86,000	173,000	159,000
Developmental Services	1,030,000	1,121,000	984,000
Mental Health	26,604,000	34,305,000	30,739,000
Mental Health Oversight & Acct Commission (OAC)	4,089,000	4,089,000	4,115,000
Rehabilitation	162,000	220,000	198,000
Social Services	759,000	734,000	712,000
Education	430,000	921,000	613,000
CA State Library	72,000	171,000	165,000
Board of Governor's—Community Colleges	37,000	158,000	208,000
Military Department	--	451,000	406,000
Department of Veterans Affairs	452,000	466,000	460,000
Department of Finance—FISCAL	--	--	28,000
Total State Administration	\$36,136,000	\$46,797,000	\$42,323,000

II. ISSUE FOR DISCUSSION

1. Independence of Mental Health Services Oversight & Accountability Commission

Budget Issue. The budget proposes to **(1)** transfer \$4.589 million (MHSA Funds) and 22 positions from the Department of Mental Health (DMH), *and* **(2)** reduce by \$474,000 (MHSA Funds) to reflect a proposed pro rata reduction of State administration to be within the 5 percent administrative cap requirements of the Mental Health Services Act. *Therefore*, the total amount proposed for the Mental Health Services Oversight & Accountability Commission (OAC) is \$4.115 million (MHSA Funds) for 2010-11.

All of the 22 positions being transferred were originally established specifically for the OAC operations, and they include the following:

Position Title	Positions
Executive Officer	1
Staff Counsel III	1
Mental Health Administrator	1
Mental Health Program Supervisor	2
Consulting Psychologist	1
Staff Mental Health Specialist	8
Associate Mental Health Specialists	3
Information Officer II	1
Staff Services Analyst	2
Office Technician	2
Total	22

According to the OAC, the transferred resources will enable them to, among other things, conduct and continue the following activities:

- Review, comment and approve County Plans for the various components of the MHSA;
- Develop policy related to the implementation of the MHSA and associated statutory mandates;
- Provide for a comprehensive evaluation of the MHSA (two phases);
- Provide community outreach and education;
- Convene monthly OAC meetings;
- Continue work with the five committees within the OAC framework (Client and Family Leadership; Services; Evaluations; Cultural and Linguistic; and Funding and Policy);
- Provide vision, leadership, and oversight necessary to prevent mental illness from becoming severe and disabling and transform the public and private systems charged with providing services, and support to Californians living with mental illness;
- Develop strategies to combat and overcome stigma related to mental illness;
- Advise the Governor and Legislature regarding actions the State may take to improve care and services for individuals experiencing mental illness; and

- Identify critical issues related to the performance of County Mental Health programs and refer the issues to the Department of Mental Health.

Assembly Bill 5 (Third Extraordinary Session), Statutes of 2009. Among other things, this budget trailer bill made statutory changes to the MHSA Act to assist in the implementation and effectiveness of the Act, including the following:

- Clarifies the OAC shall administer its operations separate and apart from the DMH;
- Clarifies the OAC may enter into contracts, obtain data and information from the DMH, or other State and local entities that receive MHSA Funds regarding programs and projects; and
- Provides for the OAC to participate in the joint State-County decision-making process for training, technical assistance, and regulatory resources to meet the mission and goals of the State's mental health system.

Mental Health Services Act—"Administrative Cap" of Five Percent. The MHSA allows up to five percent of the total annual revenues in each fiscal year to be used for State administrative expenditures, including the OAC and other State entities.

As discussed more comprehensively under the Department of Mental Health later in this Agenda, the Administration is proposing a "pro-rata" reduction in administrative expenditures for 2010-11 due to an expected drop in total MHSA Fund revenues and the need to stay within the five percent cap as required by the Act.

Subcommittee Staff Comment and Recommendation. Though the OAC was established in 2005, in prior years its appropriation has been budgeted within the Department of Mental Health. Over time, concerns were raised regarding the need for the OAC to have its own appropriation item and to operate separate and apart from the DMH, as intended by the MHSA Act. With the passage of budget trailer bill AB 5 (Third Extraordinary), Statutes of 2009, a transfer of funds from the DMH to a separate line-item for the OAC is warranted.

However, the Administration is also proposing to reduce the OAC by \$474,000 (MHSA Funds) to address *potential* concerns regarding the need to maintain the "administrative cap" of 5 percent. It is recommended to reject this "pro rata" reduction since the OAC is a core component within the MHSA Act. If necessary, reductions to other State departments should be taken and the OAC should be *held harmless*.

Therefore it is recommended to approve the full transfer amount of \$4.589 million and to reject the five percent reduction.

Subcommittee Questions. The Subcommittee has requested the OAC to respond to the following questions.

1. OAC, Please provide a brief description of the Commission's core functions and recent accomplishments. What is envisioned for 2010-11?
2. OAC, Please summarize the Commission's framework for performance measures and outcomes with regards to MHSA Funding and the Act.

Item 4440--DEPARTMENT OF MENTAL HEALTH

I. OVERALL BACKGROUND (Pages 11 through 12)

Purpose and Description of Department. The Department of Mental Health (DMH) administers state and federal statutes pertaining to mental health treatment programs, including programs that serve Medi-Cal enrollees.

The department also directly administers the operation of five State Hospitals—Atascadero, Coalinga, Metropolitan, Napa and Patton--, and two acute psychiatric programs at the California Medical Facility in Vacaville and the Salinas Valley State Prison.

Purpose and Description of County Mental Health Plans: Though the department oversees policy for the delivery of mental health services, Counties (i.e., County Mental Health Plans) have the primary funding and programmatic responsibility for the majority of local mental health programs as prescribed by State-Local Realignment statutes enacted in 1991 and 1992.

Specifically counties are responsible for: **(1)** all mental health treatment services provided to low-income, uninsured individuals with severe mental illness, within the resources made available, **(2)** the Medi-Cal Mental Health Managed Care Program, **(3)** the Early Periodic Screening Diagnosis and Testing (EPSDT) Program for children and adolescents, **(4)** mental health treatment services for individuals enrolled in other programs, including special education, CalWORKs, and Healthy Families, and **(5)** programs associated with the Mental Health Services Act of 2004 (known as Proposition 63).

Background—Overview of Medi-Cal Mental Health Services Waiver. California provides “specialty” mental health services under a comprehensive Waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services.

County Mental Health Plans are the responsible entity that ensures services are provided and Medi-Cal clients *must* obtain their specialty mental health services through the County. The DMH is responsible for monitoring and oversight activities of the Counties to ensure quality of care and to comply with federal and State requirements. The DHCS is the “single State agency” as designated by the federal CMS for overall responsibility of California’s Medi-Cal Program. The DHCS delegates the responsibility for the administration of mental health programs to the DMH. Ultimately, both departments are responsible for the administration of this program.

Description of Mental Health Services for Medi-Cal Enrollees. Medi-Cal enrollees may receive mental health services through the Medi-Cal Mental Health Managed Care system or through the Medi-Cal Fee-For-Service system. The Mental Health Managed Care system is administered by the DMH through contracts with counties (County Mental Health Plans). County Mental Health Plans may directly provide services and/or contract with local providers to provide services. If the County Mental Health Plans contract with local providers, it selects and credentials its provider network, negotiates rates, authorizes services and provides payment for services rendered.

Services provided through the Fee-For-Service system are general mental health services offered through individual providers who contract with the Department of Health Care Services or service provided through managed care health plans.

Summary of Funding for Department of Mental Health as Proposed by the Governor.

The table below displays the Governor’s proposed budget for Community Mental Health Programs and the State Hospitals. A total of almost \$4.6 billion (\$1.5 billion General Fund) is proposed for 2010-11. This appropriation level does not include County Realignment Funds of about \$1 billion which is separately administered by County Mental Health Plans.

The Agenda will discuss each of these programmatic areas separately under the discussion section below.

Table—Summary of Department of Mental Health as Proposed by the Governor

Summary of Expenditures (dollars in thousands)	Actual	Estimated 2009-10	Proposed 2010-11	\$ Change
Program Source				
1. Community Services Program	\$3,245,352	\$3,356,269	\$3,160,667	-\$195,602
2. Long Term Care Services	\$1,301,726	\$1,239,264	\$1,400,568	\$161,304
3. MHSA Oversight & Accountability	\$2,912	\$4,739	--	transferred
Total, Program Source	\$4,549,990	\$4,600,272	\$4,561,253	-\$39,019
Funding Source				
General Fund	\$1,914,497	\$1,697,777	\$1,459,342	-\$238,435
General Fund, Proposition 98	\$2,743	\$27,257	\$15,000	-\$12,257
Mental Health Services Fund (Proposition 63 of 2004)	\$1,112,993	\$1,319,394	\$1,582,771	\$263,377
Federal Funds	\$64,362	\$64,055	\$64,230	\$175
Reimbursements (mainly federal)	\$1,453,912	\$1,490,134	\$1,439,427	-\$50,707
Traumatic Brain Injury Fund	\$1,141	\$1,172	--	transferred
CA State Lottery Education Fund	-\$8	\$104	\$99	-\$5
Licensing & Certification Fund	\$350	\$379	\$384	\$5
Total Department	\$4,549,990	\$4,600,272	\$4,561,253	-\$39,019

II. VOTE ONLY CALENDAR

1. Transfer Traumatic Brain Injury Responsibilities

Budget Issue. Among other things, Assembly Bill 398, Statutes of 2009, transfers the administrative responsibility for Traumatic Brain Injury program from the Department of Mental Health (DMH) to the Department of Rehabilitation (DOR). The Governor's budget proposes to transfer \$1.172 million (Traumatic Brain Injury Fund) and one position from the DMH to the DOR to reflect this transfer.

Subcommittee Staff Recommendation--Approve. The budget conforms to enacted legislation and no issues have been raised. It is recommended to approve this proposal.

2. Transfer of San Mateo Pharmacy and Laboratory Services Program

Budget Issue. The DMH proposes a decrease of \$2.4 million (\$932,000 General Fund and \$1.5 million federal reimbursements) for 2010-11 to reflect the transfer of this program to the Department of Health Care Services effective as of July 1, 2010.

This program was operated as a "field test" for many years and has now been incorporated into San Mateo's comprehensive health care system. Based upon analyses and discussions with San Mateo and the DHCS, it was agreed to transfer the administration of this program to the DHCS

Subcommittee Staff Recommendation--Approve. This action is consistent with discussions regarding this program.

III. ISSUES FOR DISCUSSION:

A. State Administration Issues

1. Expenditure of Mental Health Services Act (MHSA) Funds for State Support

Budget Issues. The DMH has overall responsibility for administering and managing the Mental Health Services Act (MHSA) Funds. They propose three changes for State administrative functions. These are as follows:

- a. Transfer \$4.589 million (MHSA Funds) to the MHSA Oversight and Accountability Commission as designated by Chapter 20, Statutes of 2009 (AB 3X 5). (This proposal conforms to the OAC item on today's Agenda, above.)
- b. Pro-rata reduction of \$4.8 million (MHSA Funds) to 17 State departments to comply with the administrative cap requirements within the MHSA Act. (Discussed below.)
- c. Increase of \$113,000 (MHSA Funds) to convert a limited-term Staff Counsel position to permanent. (Discussed below.)

Pro Rata Reduction. There are 17 State departments that receive MHSA Funds for administrative purposes for a total of \$46.8 million for 2009-2010 (current-year). The DMH contends that due to an expected drop in the receipt of MHSA revenues for 2010-11, a reduction of \$4.8 million (MHSA Funds), or about 10 percent, is necessary to keep State administrative expenditures within the MHSA Act required five percent cap.

Department of Mental Health's MHSA Pro-Rata Reduction for Administration	Proposed Pro-Rata Reduction	Total 2010-11
Judicial Branch	-\$100,000	\$893,000
State Controller's Office	--	727,000
Consumer Affairs Regulatory Boards	-31,000	91,000
Office of Statewide Health Planning & Dev.	-65,000	583,000
Aging	-25,000	218,000
Alcohol & Drug Programs	-29,000	272,000
Health Care Services	-99,000	752,000
Managed Risk Medical Insurance Board	-18,000	159,000
Developmental Services	-112,000	984,000
Mental Health	-3,538,000	30,739,000
Mental Health Oversight & Acct Commission	-474,000	4,115,000
Rehabilitation	-22,000	198,000
Social Services	-80,000	712,000
Education	-71,000	613,000
CA State Library	-17,000	165,000
Board of Governor's—Community Colleges	-17,000	208,000
Military Department	-45,000	406,000
Department of Veterans Affairs	-48,000	460,000
Department of Finance—FISCAL	--	28,000
Total State Administration	-\$4,791,000	\$42,323,000

Staff Counsel Position—Convert to Permanent. The DMH presently has three Attorneys who are assigned to the MHSA area. One of these positions sunsets as of June 30, 2010 and the DMH proposes an increase of \$113,000 (MHSA Funds) to make it permanent.

The DMH states this position needs to be made permanent due to “growing legal needs” related to the MHSA, such as regulations development, contract and policy document development, administrative proceedings, and litigation work.

Further they note that implementation of the auditing of MHSA funded programs will commence soon and there is a legal need to establish an appeals process for disputed audit findings, as well as the drafting of additional regulations for this process.

Subcommittee Staff Comment and Recommendation—Deny Pro Rata, and Approve Position. The DMH request to reduce State administrative expenditures to remain within the five percent MHSA cap is premature and should be denied.

The DMH calculation of revenues for determining the cap was based upon May 2009 data, not January 2010 data, and is out-of-date. The DMH contends that this budget proposal is a “place-holder” and will be updated at the May Revision. Since the MHSA revenues are presently higher than projected last May, it maybe that no adjustment is needed in 2010-11.

Further, if an adjustment is needed to stay within the five percent cap, the Administration should prioritize how the reduction is taken, and not simply propose a pro-rata reduction. In some instances, a pro-rata reduction would simply not make sense. (For example funding two-thirds of a full-time position, or reducing “core” functions at the same level as other less-central functions.).

It is suggested that *if* the DMH needs to propose an adjustment at the May Revision, they consult with the Mental Health Services Oversight and Accountability Commission (OAC) on prioritizing State administrative resources.

Finally, no issues have been raised on the Staff Counsel position.

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

1. DMH, Please provide a *brief* description of the proposed “pro rata” reduction to the 17 State departments in order to meet the 5 percent State administrative cap requirements.
2. DMH, Please provide a *brief* description of why the Staff Counsel position should be made permanent.

III. ISSUES FOR DISCUSSION (Continued):

B. Community Mental Health Issues

1. Oversight: Federal Concerns with State's Mental Health Services Waiver

Oversight Issue—Only One-year Extension for Waiver & Need for Changes. The DHCS was informed by the federal Centers for Medicare and Medicaid (CMS) in September 2009 that California's comprehensive Medi-Cal Specialty Mental Health Services Waiver would *only* be approved for one-year, to September 30, 2010, instead of the requested two-year renewal period which is standard.

Changes to the Waiver and California's State Medi-Cal Plan will need to be made and several of these changes are due to continued federal audit concerns related to State administration of the program. How these changes may affect services to people with serious mental illness is not clear at this time. The Waiver covers two programs within the DMH: (1) the Early and Periodic, Screening Diagnosis and Treatment (EPSDT) Program for children; and (2) Mental Health Medi-Cal Managed Care Program.

Under an agreement reached between the State (DHCS and DMH) and the federal CMS, California must submit an amendment for the Medi-Cal Program (referred to as a "State Plan Amendment") in order for California to have the Waiver extended for another year (to September 30, 2011).

According to the DHCS and DMH, a *draft* State Plan Amendment has been submitted to the federal CMS. The DHCS states this draft is confidential since they are negotiating directly with the federal CMS, but portions of it have been shared with County Mental Health Plans for comment. According to the Administration, the required State Plan Amendment is to address the following key concerns:

- Updating Coverage. The State must provide updated language for specialty mental health services, provider descriptions and qualifications and a description of the medical necessity criteria that Medi-Cal clients must meet to be eligible for these services. These changes are critical and must be approved by the federal CMS for the Waiver to continue beyond September 2010.
- Reimbursement Processes. All Medi-Cal Waivers must demonstrate cost-effectiveness to the federal government. In turn, the federal government requires certain reporting to monitor and track cost-effectiveness. Due to federal audit concerns, discussed below, considerable changes must be made regarding the State's accounting and reimbursement processes.

First, the State must provide updated procedures and methodologies regarding the use of "certified public expenditures" (CPEs) provided by County Mental Health Plans (using County Realignment Funds and where applicable, Mental Health Services Act Funds, or other revenues) to obtain federal matching funds. This is a critical issue since California relies on funding sources outside of General Fund revenues to operate the specialty mental health care system.

Second, the State must better define what is considered an “allowable” cost for the purpose of reimbursement. The federal CMS was concerned that the State was reimbursing for actual costs instead of allowable costs which are more narrowly defined.

Third, the State must revise various cost-reporting documents to report, track and reconcile both psychiatric inpatient services and all outpatient services. A comprehensive “oversight” plan must be provided to the federal CMS after finalization of these revised documents.

Fourth, the State must issue revised instructions to the Counties on claiming procedures and must provide new training to ensure compliance with all of the cost-reporting documentation requirements.

In a September 28, 2009 letter to the DHCS, the federal CMS conveys the need for the changes and to have regular monitoring meetings with them on progress. Further the letter notes that if the program is not updated as directed, a “renewal application” for this Waiver should be submitted by July 1, 2010.

Federal CMS Concerns Stem from Audit Issues. The federal CMS has expressed considerable concerns regarding the operation of this Waiver through two “final” audits which are public and one “draft” audit which is *not* public but was provided to the Administration in September 2009.

The draft audit—“Review of Certified Public Expenditures Used to Finance Medi-Cal Payments in CA’s Specialty Mental Health Services Program”—reviewed five counties to examine financial components to the program, including the use of CPEs to obtain federal funds, payment reconciliation processes, and final cost settlement processes. The selected counties included Los Angeles, Sacramento, San Diego, San Francisco, and Orange. In addition the review encompassed the State’s rules for calculating certain payments (upper payment limit) and the definition of mental health specialty services.

Many of the outcomes from this draft, confidential federal CMS audit generated the need for the State Plan Amendment and Waiver changes.

The two previously released audits noted the following *key* concerns:

- The DHCS and DMH systems are not adequate to comply with federal requirements, resulting in total mental health program expenditures likely to be significantly misstated.
- The DHCS does not appear to provide adequate oversight over the Medi-Cal Mental Health Services Program, specifically over the processing of DMH invoices.
- California’s existing provider reimbursement methods, processes, and policies are not fully consistent with federal law, particularly regarding interim payment, reconciliation and cost-settlement processes.
- California must implement controls to ensure that the process used to count County Realignment Funds (i.e., “certified public expenditures”—CPEs) towards the federal match, meets federal requirements.

Background--Continued Concerns with Fiscal Integrity. Significant fiscal management issues have continued to be raised regarding the State's administration of the overall Medi-Cal Specialty Mental Health Waiver.

The Subcommittee has discussed fiscal integrity issues regarding operations for the past five years, including five reports prepared by the independent Office of Statewide Audits and Evaluations, as well as the two released fiscal audits by the federal CMS.

As discussed below, additional resources were provided by the Legislature for more oversight and the CHHS Agency was statutorily required to provide an Action Plan (receipt pending) to more comprehensively implement needed changes from all of these previous fiscal reviews and audits.

CA Health & Human Services Agency "Action Plan" Is Overdue. Due to concerns discussed in the Subcommittee last year regarding fiscal integrity and coordination between the DHCS and DMH, trailer bill legislation as contained in AB 5 (Fourth Extraordinary Session), Statutes of 2009, required the CHHS Agency to provide the Legislature with an Action Plan.

The Action Plan was due to the Legislature as of February 1, 2010 in order to fully problem solve and remedy continued concerns, as well as to facilitate any needed discussion and review through the Legislature's budget and policy committee processes. On March 3, the CHHS Agency informed Subcommittee staff that this Action Plan would be forthcoming in the next couple of weeks.

The purpose of the Action Plan is to facilitate coordination of core programmatic functions between the DHCS and DMH regarding the following items:

- Activities for the development and maintenance of the State's Medi-Cal Mental Health Waiver;
- Reimbursement of County Mental Health Plans and providers of mental health services
- Implementation of the State's "Short-Doyle II" Data System; and
- Implementation of federal CMS audits, fiscal reviews, and related items.

It is important for this Action Plan to be provided soon to the Legislature.

Additional Resources Provided to DHCS for the Waiver in Budget of 2009. As discussed by the Subcommittee last year (April 23rd hearing), the DHCS was provided an increase of \$331,000 (total funds) for three positions to enable them to respond to federal CMS audits and to continue making improvements in the coordination and management of the Medi-Cal Mental Health Waiver.

Mental Health Supplemental Payments Program to be Included in Amendment. The Budget Act of 2009 established a *new* “Mental Health Services Supplemental Payment Program” to authorize the use of County CPE’s for costs of mental health services provided to Medi-Cal clients that exceed their current payment levels. Participation in the program by Counties is voluntary.

The supplemental payment would consist of the difference between the current Fee-for-Service rate being paid for these services and the actual costs to the counties to provide the mental health services. It is anticipated that supplemental federal payments will provide a total of \$27.7 million (federal funds) for 2008-09, \$55.4 million (federal funds) for 2009-2010, and \$27.7 million (federal funds) in 2010-11. There is no General Fund impact to this program.

To-date, no federal funds have been received since the State Plan Amendment needed from implementation is now part of the overall Waiver and audit change package being negotiated with the federal CMS.

Background—Overview of Medi-Cal Mental Health Services Waiver. California provides “specialty” mental health services under a comprehensive Waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. County Mental Health Plans are the responsible entity that ensures services are provided and Medi-Cal clients *must* obtain their specialty mental health services through the County.

The DMH is responsible for monitoring and oversight activities of the Counties to ensure quality of care and to comply with federal and State requirements.

The DHCS is the “single State agency” as designated by the federal CMS for overall responsibility of California’s Medi-Cal Program. The DHCS delegates the responsibility for the administration of mental health programs to the DMH. Ultimately, both departments are responsible for the administration of this program.

Subcommittee Staff Comment and Recommendation. The Medi-Cal Mental Health Waiver provides over \$1.7 billion (total funds) in vital mental health treatment services to people. Though the Administration was notified by the federal CMS in September 2009 regarding concerns, including only a one-year extension (to September 2010), the Legislature was not informed. The Administration has acknowledged this communication gap but there is still much that is unknown regarding the future of this Waiver.

Another federal CMS final audit is pending which cannot yet be provided to the Legislature, and the State is negotiating a State Plan Amendment on the Waiver that is not yet public as well. As such, it is not fully clear how this Waiver may need to evolve. Of particular concern is the potential for mental health service definitions being changed, and issues regarding reimbursement payments (such as “upper limit payments”) and the use of “certified public expenditures” (CPEs). Further, it is not clear when the Administration can or will provide detailed information.

It is recommended to adopt “placeholder” trailer bill legislation to require the DHCS, as the State’s Medi-Cal agency, to provide the fiscal and policy committees of the Legislature with semi-annual updates regarding all of California’s Medi-Cal Waivers (about 16 presently) to be provided in March and October of each year. This would provide a mechanism for the Administration to regularly convey the status of Waivers to the Legislature.

It is recommended for the Administration to meet with constituency groups, including legislative staff, to more fully convey the contents of the pending State Plan Amendment and to clarify more details regarding specific federal CMS concerns.

It is also recommended for the Administration to provide a written update on the status of this Waiver as part of the DMH May Revision estimate package.

The DHCS was required through trailer bill legislation in 2009 to provide the Legislature with *final* audits provided to the State by the federal CMS so the audit regarding the DMH should be forthcoming when considered final.

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

1. DHCS and DMH, Please provide an update on the Waiver and the key concerns of the federal CMS in only providing the State with a one-year approval.
2. DHCS and DMH, What are the key aspects of the State Plan Amendment?
3. DHCS and DMH, Is it likely that California will need to redefine key aspects of the existing Waiver, such as definitions of mental health services, reimbursement payment methodologies and other key items?
4. DHCS and DMH, Are there any other key aspects for which the Subcommittee should be informed?

2. Oversight: Implementation of Short-Doyle System--Phase II (DHCS and DMH)

Oversight Issue—Implementation in Progress. Changes to the Short-Doyle system, a critical system for claims processing for Medi-Cal specialty mental health services, have been on-going for several years. As referenced in the background section below, a revised Short-Doyle system is necessary to address critical payment system problems and various State and federal audit control issues.

As of January 2010, the Administration proceeded with a phased-in approach to bring Counties and certain direct providers into the modified system. As of March, the Administration states that 24 Counties have submitted claims for processing with additional Counties expected to submit claims as they work through a variety of technical issues. Los Angeles County will not be submitting claims until April 1st.

The Administration states they are providing technical assistance to Counties and will also be “re-engineering” some of their own business practices within the DMH to ensure that payments are made to Counties and providers within 30-days (upon completion of changes). (See Subcommittee Hand-Out package for a diagram of this entire process.)

At this time, more information is needed in order to better understand the Administration’s progress with the overall system, including changes to existing business practices internal to the departments.

According to the DHCS and DMH, the *key benefits* to Short-Doyle Phase II are the following:

- “Clean” claims from Counties and other providers to be paid within 30-days as contained in State statute (Section 927 of the Government Code).
- Payment data is reconciled (warrants and payments are matched).
- Claim adjustments are automated, and prompt notification of denied claims will be made.
- Claim data is standardized for reporting purposes.
- Availability of claim status inquiry and response.
- Uses industry standard software for administration and operation.
- Electronic data flow to departmental accounting systems.

Summary of Existing Contracts. Based on information provided by the DHCS in Fall 2009, the following table provides a summary of contracts regarding implementation of Short-Doyle II.

Table: DHS Description of Contracts for Short-Doyle Project (\$6.9 million total)

Date of Award	Contractor Name	Role of Contractor	Contract Term	Total Funds
5/2007	Eclipse Solutions	Independent Validation and Verification	34 months	\$289,850
11/2007	Trinity Technology	Design, Develop and Implement the system	3 years	\$5.1 million
5/2007	Hubbert Systems	HIPAA Project Manager	1 year	\$253,400
6/2008	Hubbert Systems	HIPAA Technical Support	1 year	\$249,800
5/2009	Hubbert Systems	Project management support and special reporting	18 months	\$450,000
7/2009	Hubbert Systems	Conduct external test activities with Counties and vendors	1 year	\$292,000
6/2008	Visionary Integration	Independent Project Oversight	25 months	\$116,160
6/2008	Celer Systems	Build and Maintain the physical environment	1 year	\$161,000

Background Summary. The Short-Doyle computer system processes Medi-Cal claims regarding behavioral health and drug and alcohol treatment services from Counties and select direct providers with the DMH, and the Department of Alcohol and Drug. The current system is operated jointly by the DHCS, DMH and DADP.

The system processes about 1.5 million claims monthly with annual approved claims of over \$1 billion. The current mainframe claims adjudication system was built in the early 1980's.

With the implementation of the federal Health Insurance Portability and Accountability Act (HIPAA) in 2002, considerable modifications needed to be made to the system (Phase I). These changes were generally completed in 2004 as a stop-gap measure.

From 2004 to present concerns were raised regarding the system, including the following:

- State and federal audit concerns identified serious flaws, including payment information was not matched (warrants and payments were not captured), and adjustments to claims were done outside of the system.
- Payment cycle for claims was far below standards and reimbursement to Counties and providers took from 90 to 120 days to be provided.
- Adjudicated claim data was not compatible with other Medi-Cal data and could not be effectively cross-checked.
- Long-term technical support was not feasible for many reasons, including the need to operate in manual batch mode and having antiquated codes.

Since 2006, the Administration has focused its efforts on the Short Doyle Phase II portion of the project to have a more fully integrated, function claims adjudication system. The system is to be operational in Spring 2010.

Subcommittee Staff Comment. The need for system change is evident and the Administration is working diligently to complete tasks, but there are concerns.

First, as noted in the Hand-Out, the overall system for processing claims is quite involved and relies not only on the Short-Doyle Phase II system operations but also additional interactions within the DMH and DHCS, and finally the State Controller's Office for actual payment to be provided to Counties and providers. The Administration needs to ensure the Counties and others that the business practices to be re-engineered at the State level are fully functional, in addition to the operations of the Short-Doyle Phase II system.

Second, there are several unresolved issues regarding the Short-Doyle system itself. The State is still in the process of clarifying how certain Medi-Cal/Medicare claims (dual eligibles) are to be managed and how this will impact Counties and system processing. This critical issue needs to be resolved expeditiously.

Third, over 30 Counties, including Los Angeles, have not yet submitted claims. The DMH anticipates all remaining counties, except for Los Angeles, will be submitting claims in March since this will be their *only* option for payment. (The prior claims processing system will not be available, except to Los Angeles.) As such March, April and May will be mission critical months as the remaining Counties transition to the system and claims volume increases substantially.

Fourth, the DHCS notes that initial management reports are still under development but the first priority is for the DMH invoice report to be operational. This invoice report will be used to help reduce the claim payment cycle, which is good. But management reports need to be completely soon for system oversight functions to be operating appropriately.

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

1. DHCS and DMH, Please provide a *brief* overview of key components to Short-Doyle Phase II and progress on implementation, including how community mental health partners are involved.
2. DHCS and DMH, What key implementation steps are pending and what risks are involved with next steps? Is the Medi-Cal/Medicare dual eligibles claiming process being clarified?
3. DMH, How is the re-engineering of related business practices for claims processing proceeding?
4. DHCS and DMH, Will the Administration be providing Counties with an up-to-date Claims and Billing Manual consistent with changes associated with Short-Doyle Phase II?

3. Medi-Cal Mental Health Managed Care

Summary of Budget and Issues. The DMH proposes total expenditures of \$350 million (\$89.2 million General Fund, \$61.2 million Mental Health Services Act Funds, and \$199.6 million federal reimbursements) for the Mental Health Managed Care Program in 2010-11.

The DMH proposal assumes the following key changes for 2010-11:

- **Proposes to Redirect Mental Health Services Act Funds.** Redirects \$61.2 million in Mental Health Services Act Funds from locals to backfill for General Fund support through legislation to amend the Mental Health Services Act of 2004 which would require voter approval.

This issue was discussed extensively in the Special Session (January 26th hearing in the Senate) and was *not* adopted.

- **Program Cost Increases.** Provides an increase of \$23.4 million (\$11.7 million General Fund and \$11.7 million federal reimbursements) due to increased caseload and utilization of services.
- **Receipt of Federal Funds—ARRA Extension.** Assumes savings of \$25.4 million (General Fund) due to increased federal funding of 61.59 percent in Medi-Cal through the American Recovery and Reinvestment Act (ARRA). The Governor assumes this level of ARRA funding will be extended for another six months to June 30, 2010. This extension is in President Obama's proposed federal budget. This savings is contained within Control Section 8.65 of the Budget Bill.
- **Receipt of Federal Funds—Increase Base to 57 Percent.** Assumes savings of \$30.6 million (General Fund) through federal law changes which would increase California's "Federal Medical Assistance Percentage" (FMAP) to an average received by other states nationwide. This is part of the Governor's overall federal request. This savings is contained within Control Section 8.65 of the Budget Bill.
- **Continues Reduction From Budget Act of 2009.** Continues as a baseline adjustment the reduction of \$64 million (General Fund) as proposed by the Governor.

Summary of Budget Actions Taken in 2009 (July). The Budget Act of 2009 (July) resulted in an appropriation of \$295.3 million (\$113.3 million General Fund and \$182.1 million federal funds) for Mental Health Managed Care. Key adjustments included the following:

- Reduced by \$64 million (General Fund) as proposed by the Governor based on data from the DMH which stated these funds were expended on outpatient services that were not federally reimbursable. As such, the DMH noted that Counties could choose to provide these services using their own funds, and not state General Fund support intended for Medi-Cal clients.
- Recognized increased federal funds of \$53.3 million (federal funds) from enhanced funds (61.59 percent) received through the American Recovery and Reinvestment (ARRA) Act to backfill for General Fund support.

It should be noted that no cost-of-living-adjustment has been provided by the State for this program since the Budget Act of 2000, due to Governor's vetoes.

Background—How Mental Health Managed Care is Funded: Under this model, County Mental Health Plans generally are at risk for the state matching funds for services provided to Medi-Cal recipients and claim federal matching funds on a cost or negotiated rate basis. County MHPs access County Realignment Funds (Mental Health Subaccount) for this purpose and can use Mental Health Services Act Funds where appropriate.

An annual state General Fund allocation is also provided to the Counties. The State General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have included changes in the number of eligibles served, factors pertaining to changes to the consumer price index (CPI) for medical services, and other relevant cost items. The State's allocation is contingent upon appropriation through the annual Budget Act.

Based on the most recent estimate of expenditure data for Mental Health Managed Care, County MHPs provided a 49 percent match while the state provided a 51 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

Background—Overview of Medi-Cal Mental Health Managed Care. California provides "specialty" mental health services under a comprehensive Waiver, as previously referenced.

County Mental Health Plans are the responsible entity that ensures services are provided and Medi-Cal clients *must* obtain their specialty mental health services through the County. Under Medi-Cal Mental Health Managed Care, adults receive psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, through their specific county.

The DMH is responsible for monitoring and oversight activities of the County Mental Health Plans to ensure quality of care and to comply with federal and state requirements. This Waiver expires as of September, 2010 and must be renewed with the federal CMS.

Subcommittee Staff Comment and Recommendation. It is recommended to keep this issue open pending receipt of the Governor's May Revision. Both caseload adjustments and any federal funding adjustments can be made at that time.

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

1. DMH, Please provide a *brief* summary of the program and budget proposal.

4. The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)

Summary of Budget and Issues. The DMH proposes total expenditures of \$1.191 billion (\$391.156 million Mental Health Services Act Funds, \$61.176 million General Fund, \$653.8 million federal reimbursements, and \$84.9 million County Realignment Funds) for the EPSDT Program for 2010-11. This reflects a *net* increase over the current-year of \$123.8 million (total funds).

The DMH proposal assumes the following *key* changes to EPSDT for 2010-11:

1. Proposes to Redirect Mental Health Services Act Funds. Redirects \$391.2 million in Mental Health Services Act Funds from locals to backfill for General Fund support through legislation to amend the Mental Health Services Act of 2004 which would require voter approval.

This issue was discussed extensively in the Special Session (January 26th hearing in the Senate) and was *not* adopted.

2. Estimate Cost Adjustments. Increases by \$106.9 million (General Fund) to reflect increases in costs, utilization, and some caseload.
3. Emily Q. Plan. Provides a total of \$16.8 million (General Fund), to address issues related to the Emily Q. plan. The Emily Q. Plan is the result of a legal settlement in which a Special Master has crafted a nine-point plan for the provision of Therapeutic Behavioral Services which the DMH and County Mental Health Plans are required to implement. This plan is being phased-in over time.
4. Reimburses for County Deferral. Increases by \$15.796 million (General Fund) to reimburse County Mental Health Plans for deferred payments from 2009 to be paid in 2010.
5. Past Audit Settlements on EPSDT. Increases by \$16.1 million (\$2.2 million General Fund) for audit settlements due from the DMH to the counties for fiscal years 1998-99 through 2004-05. The DHCS and DMH need to clarify if the federal CMS will provide federal matching funds for this purpose.
6. Receipt of Federal Funds—ARRA Extension. Assumes savings of \$61.2 million (General Fund) due to increased federal funding of 61.59 percent in Medicaid (Medi-Cal) through the American Recovery and Reinvestment Act (ARRA). The Governor assumes this level of ARRA funding will be extended for another six months to June 30, 2010. This extension is in President Obama's proposed federal budget. This savings is contained within Control Section 8.65 of the Budget Bill.
7. Receipt of Federal Funds—Increase Base to 57 Percent. Assumes savings of \$73.9 million (General Fund) through federal law changes which would increase California's "Federal Medical Assistance Percentage" (FMAP) to an average received by other states nationwide. This is part of the Governor's overall federal request. This savings is contained within Control Section 8.65 of the Budget Bill.

Summary of Budget Actions Taken in 2008. Due to fiscal constraints, three changes were enacted in the EPSDT Program in 2008. These changes were significantly less drastic than the Governor's overall proposals for the program.

Specifically, the Legislature adopted two of the Governor's proposals to: **(1)** establish a unit within the DMH to monitor EPSDT claims; and **(2)** eliminate the Cost-of-Living-Adjustment using the federal home health market basket which is applied to the Schedule of Maximum Allowances used for rates. These actions, taken in Special Session (AB 3X 5, 2008), were to save \$29.2 million (\$14.6 million General Fund) in 2008-09. These changes are presently ongoing.

In addition, in lieu of more drastic reductions, the Legislature enacted statutory changes to require the DMH to implement a "*Performance Improvement Project (PIP)*" for the EPSDT Program. This action was taken in lieu of yet other reductions proposed by the Governor that would have potentially eliminated some children from treatment. The PIP was assumed to save \$12.1 million General Fund in 2008-09 by targeting coordination and integration of care for children through case management, and by achieving certain administrative efficiencies. This is also an ongoing change.

Summary of Budget Actions Taken in 2009 (July). The revised Budget Act of 2009 provided a total of \$1.038 billion (\$364.8 million General Fund and \$674.1 million federal reimbursements) for the EPSDT Program. This reflected the following key adjustments:

- Increased by \$226.7 million (General Fund) to reflect the lack of passage of Proposition 1E (May 2009) and its proposed use of Mental Health Services Act Funds.
- Decreased by \$122.1 million (General Fund) to reflect receipt of enhanced federal American Recovery & Reinvestment Act (ARRA) funds.
- Reduced by \$53.4 million (General Fund) to reflect elimination of State funding for county programs developed using Mental Health Services Act Funds that the Administration contends increases services within the EPSDT Program.
- Increased by \$19 million (General Fund) to reflect Emily Q court order requiring the department to implement a nine point plan regarding certain services.
- Decreased by \$4.9 million (General Fund) to reflect revised technical caseload and expenditure adjustments.
- Deferred \$15.8 million (General Fund) in payments to counties to reimburse prior year cost settlement claims for the EPSDT Program.

Background--How the EPSDT Program Operates. Most children receive Medi-Cal services through the EPSDT Program. Specifically, EPSDT is a federally mandated program that requires States to provide Medicaid (Medi-Cal) recipients under age 21 any health or mental health service that is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, including services not otherwise included in a state's Medicaid (Medi-Cal) Plan. Examples of mental health services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling.

Though the Department of Health Care Services (DHCS) is the “single state agency” responsible for the Medi-Cal Program, mental health services including those provided under the EPSDT, have been delegated to be the responsibility of the Department of Mental Health (DMH). Further, County Mental Health Plans are responsible for the delivery of EPSDT mental health services to children

In 1990, a national study found that California ranked 50th among the states in identifying and treating severely mentally ill children. Subsequently due to litigation (T.L. v Kim Belshe’ 1994), the DHCS was required to expand certain EPSDT services, including outpatient mental health services. The 1994 court’s conclusion was reiterated again in 2000 with respect to additional services (i.e., Therapeutic Behavioral Services—TBS) being mandated. The state has lost several lawsuits and is required to expand access to EPSDT mental health services.

County MHPs must use a portion of their County Realignment Funds to support the EPSDT Program. Specifically, a “baseline” amount was established as part of an interagency agreement in 1995, and an additional 10 percent requirement was placed on the counties through an administrative action in 2002. According to the DMH, about \$84.9 million (County Realignment) is estimated to be expended in 2010-11 to meet this county requirement.

Background—Proposition 1E of May 2009. Proposition 1E was defeated by voters in the special election of May 2009 (66.4 percent voted no). This Proposition would have authorized a fund-shift of \$226 million in 2009-2010 and \$234 million in 2010-11 from Mental Health Services Act funds to backfill for General Fund support in the EPSDT Program.

Subcommittee Staff Comment and Recommendation. It is recommended to keep this issue open pending receipt of the Governor’s May Revision. Both caseload adjustments and any federal funding adjustments can be made at that time.

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

1. DMH, Please provide a brief description of the program and budget proposal.

C. State Hospital Issues

Overall Background Section (Pages 29 through 30)

Expenditures for State Hospitals—Ever Increasing. Expenditures for the State Hospital system have increased exponentially in the past several years from \$775.1 million (\$624.4 million General Fund) in 2004 to over \$1.373 billion (\$1.289 billion General Fund) as proposed for 2010-11. *This represents an increase of about \$665 million in General Fund support, or a 107 percent General Fund increase in only six-years.*

The DMH contends these increased expenditures are attributable to: **(1)** compliance with the continued implementation of a settlement agreement with the federal government regarding the Civil Rights for Institutionalized Persons Act (CRIPA); **(2)** employee compensation adjustments required by the Coleman Court; **(4)** increasing penal code-related commitments; **(4)** continued activation of Coalinga State Hospital; and **(5)** expansion of Salinas Valley Psychiatric Program

Governor's Proposed Budget for State Hospitals. The DMH directly administers the operation of five State Hospitals—Atascadero, Coalinga, Metropolitan, Napa and Patton--, and two acute psychiatric programs at the California Medical Facility in Vacaville and the Salinas Valley State Prison.

The Governor's January Budget proposes expenditures of \$1.373 billion (\$1.289 billion General Fund) for 2010-11 which reflects a net increase of \$16.5 million (increase of \$19.1 million General Fund) for 2010-11 as compared to the current-year. This adjustment will be discussed in detail below.

Key Adjustments to State Hospitals in Budget Act of 2009 (July). The following key adjustments were enacted in July for 2009-2010:

- Reduction of \$136.7 million (\$128.2 million General Fund) through Control Section 3.90 regarding furloughs.
- Increase of \$25 million (General Fund) to address State Hospital bed issues related to the Coleman Court.

Classifications of Patient Populations & Funding Sources. Patients admitted to the State Hospitals are generally either **(1)** civilly committed, or **(2)** judicially committed. These referrals come from County Mental Health departments, the courts, and the CA Department of Corrections and Rehabilitation (CDCR).

As structured through the State-Local Realignment statutes of 1991/92, County Mental Health Plans contract with the state to purchase State Hospital beds for civilly-committed individuals when appropriate (versus using community-based services). Counties reimburse the state for these beds using County Realignment Funds.

Judicially committed patients are treated *solely* using state General Fund support. The majority of the General Fund support for these judicially committed patients is appropriated

through the Department of Mental Health (DMH), along with some reimbursement from the CDCR, primarily for services provided at the two acute psychiatric programs.

Penal Code-related patients include individuals who are classified as: **(1)** not guilty by reason of insanity (NGI); **(2)** incompetent to stand trial (IST); **(3)** mentally disordered offenders(MDO); **(4)** sexually violent predators (SVP); and **(5)** other miscellaneous categories as noted.

The DMH uses a protocol for establishing priorities for penal code placements. This priority is used because there are not enough secure beds at the State Hospitals to accommodate all patients. This is a complex issue and clearly crosses over to the correctional system administered by the CDCR. The DMH protocol is as follows:

1. Sexually Violent Predators have the utmost priority due to the considerable public safety threat they pose.
2. Mentally Disordered Offenders have the next priority. These patients are former CDCR inmates who have completed their sentence but have been determined to be too violent to parole directly into the community without mental health treatment.
3. *Coleman v. Schwarzenegger* patients must be accepted by the DMH for treatment as required by the federal court. *Generally* under this arrangement, the DMH must have State Hospital beds available for these CDCR patients as required by the Special Master, J. Michael Keating Jr. If a DMH bed is not available the inmate remains with the CDCR and receives treatment by the CDCR.
4. Not Guilty by Reason of Insanity is the next priority.
5. Incompetent to Stand Trial is the last priority. It should be noted that there are about 250 to 300 individuals who are incompetent to stand trial who are presently residing in County jails due to the shortage of beds within the State Hospital system.

(Discussion issues for the State Hospitals begins on the next page.)

ISSUES FOR DISCUSSION

1. Oversight: Update on Civil Rights for Institutionalized Persons Act (CRIPA)

Oversight Issue. Based on recent fiscal data, the Legislature has approved about \$29.4 million (General Fund) to enhance care at the four hospitals under the Consent Judgment (Coalinga State Hospital has not been formally included by the DOJ) to meet CRIPA requirements.

The Legislature receives periodic updates from the DMH regarding compliance. The Subcommittee has requested the DMH to provide an update, and has posed specific questions as noted below.

Background—Deficiencies at State Hospitals Lead to US DOJ Consent Judgment Regarding CRIPA. In July 2002, the U.S. DOJ completed an on-site review of conditions at Metropolitan State Hospital. Recommendations for improvements at Metropolitan in the areas of patient assessment, treatment, and medication were then provided to the DMH. Since this time, the U.S. DOJ identified similar conditions at Napa, Patton, and Atascadero (Coalinga was not involved). The Administration and US DOJ finally reached a Consent Judgment for an “Enhanced Plan” of operations on May 2, 2006.

The Consent Judgment also appointed a Court Monitor to review implementation of the Enhanced Plan and to ensure compliance. Failure to comply with the Enhanced Plan would result in legal proceedings against the DMH and possible Receivership.

Under the Consent Judgment, the DMH has until *November 2011* to fully comply with the “Enhanced Plan” to improve patient treatment and hospital conditions. At this time the Court Monitor will depart and the DMH is to assume full responsibility for compliance.

The Enhanced Plan provides a timeline for the Administration to address the CRIPA deficiencies and included agreements related to treatment planning, patient assessments, patient discharge planning, patient discipline, and documentation requirements. It also addresses issues regarding quality improvement, incident management and safety hazards in the facilities.

Wellness and Recovery Model Support System. The DMH has developed and implemented the Wellness and Recovery Model Support System (WaRMSS), a real-time application used to assist with treatment. WaRMSS allows clinical teams to tailor individualized treatment plans, document patient goals, document progress toward goals, and modify treatment plans as needed. The DMH states that WaRMSS will enable them to assume an effective long term self-monitoring and oversight role.

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

1. DMH, Please provide a *brief* summary of the CRIPA compliance status on key variables.
2. DMH, Which key areas are proceeding well and which key areas need more improvement?
3. DMH, What are the next *key* steps in 2010-11 for compliance to be achieved?

2. Oversight: Update on Coleman Court and DMH Activities

Oversight Issue. The Budget Act of 2009 (July) appropriated \$25.3 million (General Fund) to the DMH in response to a March 29, 2009, order from the Coleman Court to develop proposals to meet certain short-term, intermediate, and long-term State Hospital beds needs of this plaintiff class.

The \$25.3 million (General Fund) amount assumed the establishment of 162 beds, mainly at the acute-psychiatric and Intermediate Care levels and the hiring of 250 positions, including clinical staff and security personnel to provide mental health treatment services and security. The Coleman Court approved the DMH plan on June 18, 2009.

At the Subcommittee's request, the DMH has provided the following table to reflect the current status of the short-term projects funded in the Budget Act of 2009 (July).

DMH Project Description	Completion Date	Status
1. Convert 25 Acute Beds at Atascadero to Intermediate Care Beds	June 2009	Complete
2. Add 4 Intermediate Care Beds to Salinas Valley	June 2009	Complete
3. Convert 116 Beds at Salinas Valley to Intermediate Care Beds which are "high custody"	June 2009	On Schedule
4. Double bunk 10 beds at Salinas Valley	February 2010	Complete
5. Convert 44 Beds used for day treatment at Vacaville to Intermediate Care Beds	September 2009	Complete
6. Transfer a prison wing to Vacaville Psychiatric Program and use for 32 Acute Beds	June 2010	On Schedule
7. Convert 36 Beds at Vacaville from Intermediate Care to Acute	October 2009	Complete

Background on Coleman Class Patients at DMH. The DMH provides inpatient mental health treatment to Coleman class inmate-patients referred by the CA Department of Corrections and Rehabilitation (CDCR). System-wide, the DMH operates a total of 886 beds for Coleman of which 336 beds are in the State Hospitals and 550 beds are in psychiatric programs within the CDCR institutions (Salinas and Vacaville prisons). These beds and services are located as follows:

- Atascadero State Hospital 256 Intermediate Care Beds
- Coalinga State Hospital 50 Intermediate Care Beds
- Patton State Hospital 30 Intermediate Care Beds
- Salinas Valley Psychiatric 254 Intermediate Care Beds
- Vacaville Psychiatric 114 Intermediate Care Beds & 182 Acute Beds, and four Beds for suicide prevention

The DMH states that two other large projects are also underway which pertain to the Coleman class of inmate-patients. A 64-bed Intermediate Care Facility addition for Vacaville is scheduled to be completed in August 2012 (CDCR Long-Range Bed Project) and the DMH would begin its activation and the admission of patients four-months after its completion. The DMH budget proposes an increase of \$840,000 (General Fund), as discussed below in issue #3, to begin activities associated with this project.

Another component of the CDCR Long-Range Plan is an integrated 1,722 medical and mental health hospital to be operated by the CDCR and DMH. As part of this arrangement, the DMH is committed to operate 475 licensed inpatient mental health beds for high custody Coleman class inmate-patients. These 475 beds will be comprised of 432 Intermediate Care Beds and 43 Acute Care Beds. Though this project is currently in the planning stage, it is expected to be fully-occupied by December 2013.

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

1. DMH, Please provide an update on key Coleman Court-related activities, and any key concerns with implementation issues.

3. Current Year State Hospital Population Over-Budgeted

Budget Issue. The State Hospital budget for the current-year assumes a caseload of 6,202 patients which is significantly higher than the trend reflected in the actual patient census. As shown in Table 1 below, the most recent patient census reflects a caseload of only 5,727 patients, or 475 patients *less* (7 percent) than provided for in the current-year budget.

Table #1-- DMH State Hospital Patient Caseload: Current Year (2009-2010)

Category of Patient	Current Year Budgeted Caseload	Actual Census March 3rd	Difference
Sexually Violent Predators (SVPs)	858	806	-52
Mentally Disorder Offenders (MDOs)	1,225	1,166	-59
Not Guilty by Reason of Insanity (NGI)	1,238	1,233	-5
Incompetent to Stand Trial (ISTs)	1,189	1,105	-84
Penal Code 2684s & 2974s (Referred for treatment by CDCR)	1,048	788	-260
Other Penal Code Patients (various)	143	146	+3
CA Youth Authority Patients	30	20	-10
County Civil Commitments	471	463	-8
TOTAL PATIENTS	6,202	5,727	-475

At the request of the Subcommittee, the Legislative Analyst's Office (LAO) has updated their analysis from January and is recommending a current-year *reduction* of \$10 million (General Fund).

The LAO reduction accounts for patient population decreases for the IST, MDO and NGI categories, but does not include the CDCR category of commitments since these pertain to the Coleman Court and other matters which pertain to correctional inmates. The reduction assumes a \$67,242 bed cost which equates to the half-year cost of a bed. This calculation corresponds to the methodology agreed to with the Administration in 2002.

Background—DMH Estimate Method. The DMH uses a regression analysis formula of patient census and historical costs to project anticipated patient caseloads and expenditures. The DMH uses a current-year adjustment factor to correct patient caseload projection variances exceeding 2.5 percent. Level-of-Care staffing ratios (i.e., clinical staff) are then applied to the patient population. For operating expenses, the DMH uses expenditures for the past three years and applies a straight-line regression analysis to project expenditures for the budget year.

Subcommittee Staff Recommendation— Concur with LAO. Subcommittee staff concurs with the LAO recommendation to reduce by \$10 million (General Fund). This reduction may be updated at the Governor's May Revision when additional data is available to do a final adjustment on the current-year.

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

1. DMH, Please provide your analysis of the current-year trends.
2. LAO, Please provide your analysis of the \$10 million (General Fund) reduction.

4. Proposed Budget-Year Adjustments for the State Hospitals

Budget Issue. The DMH proposes an increase of \$16.5 million (increase of \$19.1 million General Fund) for 2010-11 as compared to the current-year. This increase is attributable to three proposals as follows:

- **Proposed Population Increase.** Based on a regression analysis, the DMH contends the State Hospital patient population will increase by 180 patients for a total caseload of 6,382 patients. An increase of \$16.9 million (General Fund) to fund 188 Level-of-Care staff for this estimated population adjustment is assumed. As noted in the current-year adjustment above, the population estimate needs to be re-tooled. As such, the May Revision will likely significantly modify this projection.

Table #1-- DMH State Hospital Caseload Summary Projection (DMH Estimate)

Category of Patient	Current Year as Estimated by DMH	Budget Year as Estimated by DMH	Proposed Increase
Sexually Violent Predators (SVPs)	858	920	62
Mentally Disorder Offenders (MDOs)	1,225	1,264	39
Not Guilty by Reason of Insanity	1,238	1,235	-3
Incompetent to Stand Trial	1,189	1,202	13
Penal Code 2684s & 2974s** (Referred for treatment by CDCR)	1,048	1,112	64
Other Penal Code Patients (various)	143	148	5
CA Youth Authority Patients	30	30	0
County Civil Commitments	471	471	0
TOTAL ESTIMATED PATIENTS	6,202	6,382	180

** Of this caseload, 766 patients in 2010 would reside in Psychiatric Programs at Vacaville and Salinas, and 346 patients would be in State Hospital facilities.

- **Coalinga SH activation.** An increase of \$1.7 million (General Fund) to fund 15 Non-Level-of-Care positions is proposed to continue the activation of Coalinga State Hospital, a 1,500 bed secured facility which is designed specifically to serve the Sexually Violent Predator (SVP) patient population. The DMH states that these positions will be used to support CRIPA staffing ratios and to support a Forensic Unit at the facility.
- **Coleman Bed Expansion at Vacaville.** An increase of \$840,000 (General Fund) to support 9 positions as part of the phase-in of staffing for the 64-bed high custody Intermediate Care Facility at Vacaville is proposed. Of this amount, \$218,000 is for the positions (both clinical and administrative) and \$622,000 is for equipment and furnishings for office space for the treatment staff.

Background—CA Department of Corrections & Rehabilitation (CDCR) Referral to the DMH. Specified sex offenders who are completing their prison sentences are referred by the CDCR and the Board of Parole Hearings to the DMH for screening and evaluation to determine whether they meet the criteria as SVP.

When the DMH receives a referral from the CDCR, the DMH does the following:

- *Screening.* The DMH screens referred cases to determine whether they meet legal criteria pertaining to SVPs to warrant clinical evaluation. Based on record reviews, about 42 percent are referred for evaluation. Those not referred for an evaluation remain with the CDCR until their parole date.
- *Evaluations.* Two evaluators (Psychiatrists and/or Psychologists), who are under contract with the DMH, are assigned to evaluate each sex offender while they are still held in state prison. Based on a review of the sex offender records, and an interview with the inmate, the evaluators submit reports to the DMH on whether or not the inmate meets the criteria for an SVP. If two evaluators have a difference of opinion, two additional evaluators are assigned to evaluate the inmate.

Offenders, who are found to meet the criteria for an SVP, as specified in law, are referred to District Attorneys (DAs). The DAs, then determine whether to pursue their commitment by the courts to treatment in a State Hospital as an SVP.

If a petition for a commitment is filed, the clinical evaluators are called as witnesses at court hearings. Cases that have a petition filed, but that do *not* go to trial in a timely fashion may require updates of the original evaluations at the DA's request.

The amount of time it takes to complete the commitment process may vary from several weeks to more than a year depending on the availability of a court venue and the DA's scheduling of cases. While these court proceedings are pending, offenders who have not completed their prison sentences continue to be held in prison. *However*, if an offender's prison sentence has been completed, he or she may be held either in county custody or in a State Hospital.

Background—SB 1128 (Alquist), Statutes of 2006. This legislation made changes in law to generally increase criminal penalties for sex offences and strengthen state oversight of sex offenders. For example, it requires that SVPs be committed by the court to a State Hospital for an undetermined period of time rather than the renewable two-year commitment provided under previous law.

This law also mandates that every person required to register as a sex offender is subject to assessment using the State-Authorized Risk Assessment Tool for Sex Offenders (SARATSO) a tool for predicting the risk of sex offender recidivism.

Background—Proposition 83 of November 2006—"Jessica's Law". Approved in November 2006, this proposition increases penalties for violent and habitual sex offenders and expands the definition of an SVP. The measure generally makes more sex offenders eligible for an SVP commitment by (1) reducing from two to one the number of prior victims

of sexually violent offenses that qualify an offender for an SVP commitment, and **(2)** making additional prior offenses “countable” for purposes of an SVP commitment.

Subcommittee Staff Recommendation—Hold Open. It is recommended to hold “open” this issue open pending receipt of the May Revision since patient caseload is anticipated to change considerably.

Further, it is recommended for the Administration to assertively review all State Hospital contracts, operating expenses and equipment needs to reduce expenditures in the May Revision package.

The State Hospital expenditures are increasing at an *exorbitant rate* growing from \$775.1 million (\$624.4 million General Fund) in 2004 to over \$1.373 billion (\$1.289 billion General Fund) as proposed for 2010-11. *This represents an increase of about \$665 million in General Fund support, or a 107 percent General Fund increase in only six-years.* As such, a cost containment proposal at the May Revision is warranted.

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

1. **DMH,** Please provide a *brief* summary of the *key* population changes.

5. Office of Patient Rights

Budget Issue. Based upon information provided by the DMH at the request of Subcommittee staff, it would be cost-beneficial for the DMH to lengthen the contract term, as contained in existing statute, for its Patients' Rights services.

Section 5370.2 of Welfare and Institutions Code requires the DMH to contract with a single nonprofit agency that meets specified criteria for the purpose of providing patients' rights services for persons with mental illness residing in State Hospitals. The DMH is to contract on a multiyear basis for a contract term of up to three years.

Information provided by the DMH shows that considerable staff time is utilized by the Administration to conduct the contract process. Specifically, it takes from 13 to 16 months to develop a bid package and proceed through the various State procedural processes. If the contract term were lengthen to five-years, administrative time would be saved.

Subcommittee Staff Recommendation. It is recommended to adopt trailer bill language to simply strike the reference to the three-year term and to insert the reference for a five-year term.

Question. The Subcommittee has requested the DMH to respond to the following question.

1. DMH, Please provide a brief summary of the contracting process and would it be cost-beneficial to change the term from three-years to five-years?