

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson



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Upon Adjournment of Senate Budget and Fiscal Review Committee

**Room 4203, State Capitol
(John L. Burton Hearing Room)**

AGENDA Part 1
(Michelle Baass)

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PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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4560 Mental Health Services Oversight and Accountability Commission (MHSOAC)

1. Overview

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

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

Most of the Act’s funding is to be expended by County Mental Health 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 MHSA. The following is a brief description of the five components:

- **Community Services and Supports for Adult and Children’s Systems of Care.** This component funds the existing adult and children’s systems of care established by the Bronzan-McCorquodale Act (1991). County mental health departments are to establish, through its stakeholder process, a listing of programs for which these funds would be used. Of total annual revenues, 80 percent is allocated to this component.
- **Prevention and Early Intervention.** This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations. Of total annual revenues, 20 percent is allocated to this component.
- **Innovation.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and promote interagency collaboration. This is funded from five percent of the Community Services and Supports funds and five percent of the Prevention and Early Intervention funds.
- **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. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of \$460.8 million. Counties have 10 years to spend these funds.
- **Capital Facilities and Technological Needs.** This component addresses the capital infrastructure needed to support implementation of the Community Services and

Supports, and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of \$460.8 million. Counties have 10 years to spend these funds.

Mental Health Services Oversight and Accountability Commission. The Mental Health Services Oversight and Accountability Commission (MHSOAC) was established in 2005 and is composed of 16 voting members who meet criteria as contained in the MHSA.

The MHSOAC provides 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 MHSOAC 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 MHSOAC is to:

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

Subcommittee Staff Comment. This is an informational item.

Questions. The Subcommittee has requested MHSOAC respond to the following question:

1. Please provide a brief overview of the MHSOAC and an update on recent activities.

2. MHSOAC's Evaluation Master Plan

Background. The MHSOAC is mandated to evaluate the outcomes of investments made through the MHSA. On March 28, 2013 the MHSOAC approved an Evaluation Master Plan which prioritizes possibilities for evaluation investments and activities over a three to five year course of action.

The MHSOAC Evaluation Master Plan is the result of findings from interviews with approximately 40 key informant interviews, along with county visits. The plan focuses on individual, system, and community outcomes; provides specific evaluation activities and a general system by which to prioritize those and future evaluation activities; and identifies strategies for successful completion of all items described and prioritized in the plan. While the major focus of the plan is on the MHSA, the scope of the plan is broader.

The criteria applied to the evaluation questions include:

- **Consistency with MHSA:** Are the questions consistent with the language and values of the Act?
- **Potential for quality improvement:** Will answers to the questions lead to suggestions for and implementation of policy and practice changes?
- **Importance to stakeholders:** Are the questions a high priority to key stakeholders?
- **Possibility of partners:** Are there other organizations that might collaborate and/or partially fund the activity?
- **Context and forward looking:** Are there changes in the environment that make the questions particularly relevant? (e.g., the evolving health care environment; political concerns)?
- **Challenges:** Do the questions address areas that are creating a challenge for the system?

The criteria for the evaluation activity include:

- **Feasibility:** How likely is the evaluation activity to produce information that answers the evaluation questions?
- **Cost:** How many resources are needed to do the activity well?
- **Timeliness:** How long will it take to complete the evaluation activity?
- **Leveraging:** Does the evaluation activity build upon prior work of the MHSOAC or others?

The MHSOAC has identified the need for additional resources (staff and contracting funds) to carry out the activities specified in the Evaluation Master Plan. Specifically, it finds that six more staff and \$300,000 for contracts would be needed for the budget year.

Subcommittee Staff Comment and Recommendation—Hold Open. Since the Evaluation Master Plan was approved after the January budget was submitted to the Legislature, it is

anticipated that a proposal to address the resources identified by the MHSOAC to carry out the Evaluation Master Plan will be included as part of the May Revision.

Questions. The Subcommittee has requested MHSOAC respond to the following:

1. Please provide an overview of the Evaluation Master Plan.
2. Please provide a brief highlight of how the additional resources could further the activities outlined in the Evaluation Master Plan.

4260 Department of Health Care Services (DHCS)

1. Community Mental Health Funding and Overview

Overview of Recent Changes Regarding Community Mental Health. Over the last few years, many changes have taken place regarding the organization of community mental health programs. These include:

- **Elimination of Department of Mental Health.** The 2012 budget eliminated the Department of Mental Health (DMH) and transferred responsibilities for community mental health programs and services to various other state departments. (DMH was replaced by the Department of State Hospitals, whose primary function is to oversee state hospitals.)
- **New Responsibilities for Department of Health Care Services.** AB 102 (a 2011 budget trailer bill) transferred state administrative functions for the operation of the Medi-Cal Specialty Mental Health Services Program for adults and children and applicable functions related to federal Medicaid requirements, from DMH to DHCS. Additionally, the 2012 budget transferred Mental Health Services Act functions to DHCS.

It was intended that these transfers would improve access to culturally appropriate community-based mental health services; effectively integrate physical and mental health services to more effectively provide services; improve state accountabilities and outcomes; and provide focused, high-level leadership for mental health services within the state administrative structure.

- **Realignment of Mental Health Services.** The 2012 budget implemented the 2011 Realignment of Medi-Cal Specialty Mental Health for adults and children. The 2011-12 budget realigned these programs but provided, on a one-time basis, \$861 million in Mental Health Services Act funds to support these programs (and mental health services provided to special education students).

County Mental Health Plans. California has a decentralized public mental health system with most direct services provided through the county mental health system.

Counties (i.e., County Mental Health Plans) have the primary funding and programmatic responsibility for the majority of local mental health programs.

Specifically, counties are responsible for: (1) all mental health treatment services provided to low-income, uninsured individuals with severe mental illness (2) Medi-Cal Specialty Mental Health Services for adults and children, (3) mental health treatment services for individuals enrolled in other programs, including special education, CalWORKs, and Healthy Families, and (4) programs associated with the Mental Health Services Act of 2004 (known as Proposition 63).

Medi-Cal Specialty Mental Health Services Program. California provides Medi-Cal “specialty” mental health services under a waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children’s specialty mental health services are provided under the federal requirements of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for persons under age 21.

County Mental Health Plans are the responsible entity that ensures specialty mental health services are provided. Medi-Cal enrollees *must* obtain their specialty mental health services through the county. Medi-Cal enrollees may also receive certain limited mental health services, such as pharmacy benefits, through the Fee-For-Service system.

California’s Medi-Cal Specialty Mental Health Services Waiver is effective until June 30, 2013.

The proposed budget includes \$3.2 billion (\$1.7 billion federal funds, \$1.5 billion county funds, and \$33 million General Fund) for Medi-Cal Specialty Mental Health Services. See following table for funding summary.

Table: Medi-Cal Specialty Mental Health Services Funding Summary (in millions)

2012-13				2013-14			
General Fund	Federal Funds	County Funds	Total Funds	General Fund	Federal Funds	County Funds	Total Funds
\$13.5	\$1,556.5	\$1,472.6	\$3,042.6	\$33.3	\$1,728.3	\$1,527.7	\$3,289.2

In 2013-14, it is projected that 235,072 adults and 243,146 children will receive Medi-Cal Specialty Mental Health Services (using the accrual methodology).

As discussed at the February 21, 2013 Senate Budget and Fiscal Review Committee hearing, implementation of health care reform, the federal Affordable Care Act, will have an impact on Medi-Cal Specialty Mental Health Services. It is expected that there will be an increase in Medi-Cal caseload resulting from (1) the increase in enrollment of individuals already eligible for Medi-Cal but not enrolled, and (2) the expansion of Medi-Cal to childless adults with incomes under 138 percent of the federal poverty level. The Administration did not address this issue in the January budget.

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

The purpose of the MHSA is to expand mental health services to children, youth, adults and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources). See Overview item under the Mental Health Services Oversight and Accountability Commission for more information on the MHSA.

The budget projects \$1.4 billion in MHSA expenditures in 2013-14. See following table for MHSA expenditure summary.

Table: Mental Health Services Act Expenditure Summary

	2011-12	2012-13	2013-14
Local Assistance*	\$1,812,375	\$1,377,775	\$1,362,650
State Administrative Costs	\$29,994	\$40,005	\$40,104
Total	\$1,842,369	\$1,417,780	\$1,402,754

*Counties receive MHSA funds from the State Controller’s Office on a monthly basis.

Behavioral Health Realignment Funding. As discussed above, the 2012 budget implemented the realignment of Medi-Cal Specialty Mental Health Services. In 2011, the Drug Medi-Cal program was realigned to the counties. The table below provides a summary of realignment revenue for these two programs.

Table: Behavioral Health Realignment Funding (dollars in millions)

Account	2012-13			2013-14		
	Base	Growth	Total	Base	Growth	Total
1991 Realignment						
Mental Health Subaccount*	-	-	-	-	\$68.5	\$68.5
2011 Realignment						
Mental Health Account*	\$1,120.6	\$9.6	\$1,130.2	\$1,120.6	\$11.1	\$1,131.7
Support Services Account						
Behavioral Health Subaccount**	\$959.4	\$24.8	\$984.2	\$984.2	\$73.8	\$1,058.0
Total			\$2,114.4			\$2,258.2

*2011 Realignment changed the distribution of 1991 Realignment funds in that the funds that would have been deposited into the 1991 Realignment Mental Health Subaccount, a maximum of \$1.12 billion, is now deposited into the 1991 Realignment CalWORKs MOE Subaccount. Consequently, 2011 Realignment deposits \$1.12 billion into the 2011 Realignment Mental Health Account.

**Reflects \$5.1 million allocation to Women and Children’s Residential Treatment Services.

Subcommittee Staff Comment and Recommendation. The January budget was the first year DHCS completed the Medi-Cal Specialty Mental Health Services estimate and it did not

include detailed fiscal information that was previously provided by DMH. For example, information regarding Medi-Cal Specialty Mental Health Services, children's forecast by service type, adult's forecast by service type, approved claim information, information on unduplicated clients, and summary tables on service costs was not provided.

Stakeholders, including staff, use the detail fiscal information to track caseloads, service trends, and costs. The document provided in January does not facilitate this oversight.

Since January, staff has been working with DHCS on incorporating supplemental fiscal information into the budget documents. DHCS has committed to providing this information at the May Revision and has been very helpful in answering staff questions.

It is recommended to:

- **Hold open** the Medi-Cal Specialty Mental Health Services funding proposal as updated information will be provided at May Revise.
- **Adopt placeholder trailer bill language** to require supplemental fiscal information be included in budget documents to ensure that the Legislature and stakeholders have the information necessary to make informed decisions. This placeholder language would be consistent with Welfare and Institutions Code Section 14100.5 that requires DHCS to prepare and submit detailed information regarding Medi-Cal program assumptions and estimates for the budget.

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

1. Please provide a brief overview of community mental health and funding for these programs.
2. Please provide an update on the renewal of the Medi-Cal Specialty Mental Health Services Waiver. Does DHCS anticipate any changes to this waiver?

2. Behavioral Health Services Needs Assessment and Services Plan

Background. The state's Medi-Cal Section 1115 "Bridge to Reform" Waiver Special Terms and Conditions requires the state to complete a Behavioral Health Services Needs Assessment that includes an accounting of the services available throughout the state, as well as information on service infrastructure, capacity, utilization patterns, and other information necessary to determine the current state of behavioral health service delivery in California. (Behavioral health includes mental health and substance use disorder services.)

The waiver special terms and conditions also require the completion of a Behavioral Health Services Plan no later than October 1, 2012. This service plan will describe California's recommendations for serving the Medi-Cal expansion population, under federal health care reform, and demonstrate the state's readiness to meet the projected mental health and substance use disorder needs.

Behavioral Health Services Needs Assessment. DHCS contracted out to conduct a Mental Health and Substance Use System Needs Assessment. The primary purpose of the Needs Assessment was to review the needs and service utilization of current Medi-Cal recipients and identify opportunities to ready Medi-Cal for the expansion of enrollees and the increased demand for services resulting from health reform.

The Needs Assessment was completed in February 2012.

Key topics addressed in the Needs Assessment included:

- Prevalence of mental health and substance use service needs in California
- Analysis of Medi-Cal data for mental health and substance use services
- Medi-Cal expansion population
- Medicaid strategies for special populations
- Provider capacity and workforce analysis
- Health integration
- Behavioral information technology

Behavioral Health Services Plan. The Needs Assessment was to facilitate DHCS's development of a Behavioral Health Services Plan. The Services Plan would describe California's recommendations for serving the Medi-Cal expansion population, under federal health care reform, and demonstrate the State's readiness to meet the mental health and substance use disorder needs of this population. The Services Plan was due to the federal CMS on October 1, 2012. However, since federal guidance on the Medicaid Benchmark Benefit and Medicaid Behavioral Health Parity was not available in October 2012, the state and CMS agreed that the state could submit an outline of the Services Plan in October 2012 and that the state would have until April 1, 2013 to submit the Services Plan.

On April 1, 2013, DHCS submitted a letter to CMS and a draft Medicaid Alternative Benefit Plan Options Analysis prepared by Mercer. This Options Analysis was developed on behalf of

DHCS to provide information on the Medicaid expansion benefit options. DHCS has not been able to complete the Services Plan because a decision on the Medicaid benefit package and delivery system has not been made.

DHCS has indicated that it will submit the final Service Plan to CMS by October 1, 2013.

Subcommittee Staff Comment. The Administration has not engaged stakeholders in a discussion regarding how the state will be ready to meet the mental health and substance use disorder needs of the Medi-Cal expansion population. Additionally, the process by which DHCS decided to send the draft Options Analysis to CMS was not transparent as stakeholders were made aware of DHCS's intention only shortly before its submittal.

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

1. Please provide a brief overview of the purpose of the Needs Assessment and Services Plan.
2. What will be the process and timeline for creating and finalizing the Service Plan?
3. What has DHCS done to meaningfully engage with stakeholders in a discussion (1) on the state's readiness to meet the mental health and substance use disorder needs of the Medi-Cal expansion population and (2) on the development of the Services Plan? What more does DHCS plan to do?

3. Mental Health & Substance Use Disorder Services “Business Plan”

Background. With the transfer of community mental health and Drug Medi-Cal responsibilities to DHCS over the last few years, stakeholder concerns and suggestions for program improvements and innovations were raised.

As a result, DHCS partnered with the California Institute for Mental Health (CiMH) and the Alcohol and Drug Policy Institute (ADPI) to develop a stakeholder-informed business plan for addressing critical mental health and substance use disorder services. This business plan would be used to inform the actions of DHCS and counties in preparing for, and responding to, the changes facing the delivery of mental health and substance use disorder services in California.

A draft plan was made public in December 2012 and was organized into the following areas:

- Using Measurement to Improve Quality, Outcomes, and Ensure Accountability for Mental Health and Substance Use Delivery Systems
- Substance Use Delivery Finance
- Organizational Capacity for Current Substance Use Delivery Providers
- Reduce/Simplify Administrative Burden on Programs/Providers
- Service Integration for Mental Health, Substance Use Delivery, and Primary Care
- State and County Roles & Responsibilities
- Workforce Capacity & Skills

The last stakeholder meeting on this plan was held in December 2012.

Subcommittee Staff Comment—Informational Item. DHCS indicates that, since December, it has been working with the County Mental Health Directors Association and the California Association of Alcohol and Drug Programs Executives on finalizing the document, which will be made public at the end of April. It also indicates that it has been working with these two organizations to develop a process to prioritize issues in this plan.

Stakeholders have invested in this process in order to improve the delivery of mental health and substance use disorder services in the state, and it is important to keep momentum on this project and take action on program improvements.

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide an update on the Business Plan process. What are the next steps?
2. How will DHCS work with all stakeholders in prioritizing when items in the plans will be addressed?

4. County Mental Health Performance Contracts

Background. Since the 1991 realignment of certain mental health services to the counties, state law has required the state to maintain a county mental health services performance contract. This contract includes assurances that a county shall comply with, among other things:

- Requirements necessary for Medi-Cal reimbursement for mental health treatment services and case management programs provided to Medi-Cal eligible individuals.
- Provisions and requirements in law pertaining to patient rights.
- Data reporting requirements.
- Laws, regulations, and guidelines of the Mental Health Services Act (MHSA) (Proposition 63). This requirement was added by SB 1009 (a 2012 budget trailer bill).

As part of the Governor's 2012 budget proposal to eliminate the Department of Mental Health (DMH), the Administration proposed to eliminate county mental health services performance contracts as the last performance contract was from July 2007 until June 2010.

The Legislature rejected this proposal and (1) required that these contracts be overseen by DHCS and (2) added the provision that these contracts include the assurance that counties comply with the MHSA.

In October 2012, DHCS began meeting with stakeholders to review the previous contract (a boiler plate contract that is used with every county). It is currently working with the Mental Health Services Act Oversight and Accountability Commission to review contract language related to the MHSA and the Department of Public Health regarding contract language related to the California Reducing Disparities Project.

DHCS plans to have this contract language finalized in June and sent to the counties to be effective July 1, 2013 (without regard to the date of execution).

Requirements Related to Stakeholder Process for MHSA. Stakeholders have stressed the importance of adding contracts requirements to ensure an effective stakeholder engagement process that includes diverse stakeholder groups in MHSA mental health services planning and implementation.

Subcommittee Staff Comment and Recommendation. DHCS indicates that since these performance contracts are not related to counties receiving funding from the state, as the Medi-Cal Specialty Mental Health Services Program was realigned and counties receive direct allocations of MHSA funds, there is no clear method to ensure compliance with the performance contract.

However, DHCS maintains another contract with counties related to Medi-Cal and the drawdown of Medi-Cal federal funding for the Medi-Cal Specialty Mental Health Services Program.

It is recommended to **adopt placeholder trailer bill language** to integrate the county performance contracts and the state's contracts with counties regarding Medi-Cal Specialty Mental Health Services. One of the reasons for the transfer of community mental health programs to DHCS from DMH was to facilitate the comprehensive integration of mental health services to improve outcomes. Integrating these contracts would provide the state with the opportunity to link performance, outcomes, and program requirements.

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide an overview of county mental health services performance contracts.
2. What is the status of finalizing the performance contracts?
3. How is DHCS working with stakeholders to incorporate stakeholder suggestions, such as provisions related to a stakeholder process for MHSA?

5. Performance Standards for EPSDT Mental Health Services

Background. SB 1009 (a 2012 budget trailer bill) requires DHCS, in collaboration with California Health and Human Services Agency, and in consultation with the Mental Health Services Oversight and Accountability Commission, to create a plan for a performance outcome system for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program mental health services for children.

SB 1009 also requires that by no later than September 1, 2012, a stakeholder advisory committee shall be convened for the purpose of developing this plan and requires DHCS to provide a plan, including milestones and timelines for EPSDT mental health outcomes by no later than October 1, 2013.

In October 2012, DHCS convened a stakeholder advisory committee meeting. Since the October meeting, DHCS has (1) researched existing state and federal statutes and regulations for quality outcomes and measurement; (2) surveyed other states and county mental health plans on their existing performance and outcomes systems; and (3) developed a work plan including milestones, deliverables and timelines to move forward the performance outcome system.

In addition, DHCS has convened a smaller workgroup of subject matter experts with the intent of gaining knowledge and receiving input and recommendations on the framework and core components of a performance and outcomes measurement system.

The next stakeholder advisory committee meeting has not yet been scheduled.

Subcommittee Staff Comment. This is an informational item to get an update from the department on the status on developing this performance outcome system.

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide an update on this project.
2. Please discuss how DHCS plans to address all phases of services, screening, diagnosis, and treatment, as part of the performance outcome system.
3. How is DHCS working with Medi-Cal Managed Care Plans and County Mental Health Plans on this project?

6. Federal Bulletin on EPSDT

On March 27, 2013, the federal Centers for Medicare and Medicaid Services (CMS) issued an Informational Bulletin to help inform states about resources available to help them meet the needs of children under Early and Periodic Screening, Diagnostic and Treatment (EPSDT), specifically with respect to mental health and substance use disorder services.

Background. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is Medicaid’s (Medi-Cal in California) comprehensive preventive child health service designed to assure the availability and accessibility of health care services and to assist eligible individuals and their families to effectively use their health care resources.

The EPSDT program assures that health problems, including mental health and substance use issues, are diagnosed and treated early before they become more complex and their treatment more costly.

Under the EPSDT benefit, eligible individuals must be provided periodic screening (well child exams), as defined by statute. One required element of this screening is a comprehensive health and developmental history, including assessment of physical and mental health development. Early detection of mental health and substance use issues is important in the overall health of a child and may reduce or eliminate the effects of a condition if diagnosed and treated early. If, during a routine periodic screening, a provider determines that there may be a need for further assessment, an individual should be furnished additional diagnostic and/or treatment service.

Table: How Does EPSDT Ensure That Young Children Receive Services?

Early	Identifying problems early, starting at birth
Periodic	Checking children's health at periodic, age-appropriate intervals
Screening	Doing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnosis	Performing diagnostic tests to follow up when a risk is identified, and
Treatment	Treating the problems found.

Source: Health Resources and Services Administration’s EPSDT Program Background

Subcommittee Staff Comment. As discussed in previous items, the transfer of community mental health and Drug Medi-Cal (and the proposed transfer of most programs from the Department of Alcohol and Drug Programs, to be discussed later in the agenda) to DHCS, was intended to integrate all aspects of health care delivery into one department. This would facilitate a comprehensive view of how health care delivery programs impact individuals and how addressing health issues as early as possible improves outcomes and reduces costs.

DHCS now oversees all components of the EPSDT benefit. This recent federal bulletin highlights the importance of all steps in EPSDT and empowers states to recognize the importance and potential of this benefit.

Questions. The Subcommittee has requested DHCS respond to the following:

1. How does DHCS monitor to ensure that all components of EPSDT, early and periodic screening, diagnosis, and treatment, are being provided? Are there requirements regarding EPSDT in Medi-Cal Managed Care Plan contracts?
2. What information reported by Medi-Cal Managed Care Plans, County Mental Health Plans, and county drug and alcohol departments facilitates this monitoring? Are there HEDIS (Healthcare Effectiveness Data and Information Set) measures that are used for this monitoring?
3. How does DHCS plan to use the bulletin and the identification of additional resources to improve the state's implementation of the EPSDT benefit?

7. Medi-Cal's Mental Health Fee-For-Service Provider Adequacy

Background. Medi-Cal mental health services are provided via three different delivery systems:

- **Medi-Cal Managed Care.** Medi-Cal managed care plans cover “basic” mental health care needs that can be met by a general health care practitioner or a physical health care specialist (i.e., services that primary care physicians can provide within their scope of practice).
- **Medi-Cal Fee-For-Service.** Medi-Cal fee-for-service (FFS) covers mental health care services that cannot be met by Medi-Cal managed care and do not meet medical necessity criteria to be covered under Medi-Cal Specialty Mental Health.

If a county does not have Medi-Cal managed care, then “basic” mental health care needs are also provided by Medi-Cal FFS.

- **Medi-Cal Specialty Mental Health Services via County Mental Health Plans.** County mental health plans provide Medi-Cal specialty mental health services for adults with serious mental illness and children with serious emotional disturbance (under a Medicaid waiver). These services include: mental health services (assessment, therapy, rehabilitation, collateral, plan development); medication support services; day treatment intensive; day rehabilitation; crisis intervention; crisis stabilization; adult residential treatment services; crisis residential treatment services; psychiatric health facility services; psychiatric inpatient hospital services; targeted case management; and supplemental EPSDT services (including therapeutic behavioral services).

Medi-Cal Mental Health FFS Adequacy Unclear. A clear understanding of the breadth and geographic distribution of Medi-Cal mental health FFS providers is unknown. In the fall of 2012, DHCS performed data analysis to attempt to address questions such as:

1. Who are Medi-Cal FFS mental health providers?
2. Who is being served by Medi-Cal FFS mental health?
3. What mental health services are being covered by Medi-Cal FFS?

Because it appeared that Federally Qualified Health Centers (FQHCs) were the primary Medi-Cal FFS mental health providers, there were challenges in answering the above questions as FQHC claims information is bundled, which does not provide the ability to isolate mental health services.

Subcommittee Staff Comment. With the expansion of Medi-Cal under the federal Affordable Care Act, an understanding of the state's Medi-Cal mental health FFS network is important. Additionally, ensuring individuals receive the care they need before a more “basic” mental

health need evolves into a serious mental illness not only provides better health outcomes but could reduce costs to the systems.

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide an overview of this issue.
2. Has DHCS reached out to counties to explore options on developing the FFS network? Please explain.
3. What are Medi-Cal mental health FFS access standards?

8. Transfer of Mental Health Facility Licensing to DHCS

Budget Issue. The Administration proposes to transfer permanent positions and expenditure authority from the Department of Social Services (DSS) to DHCS for licensing and quality improvement functions related to mental health services.

DHCS will receive 12 permanent positions and expenditure authority of \$728,000 (\$337,000 General Fund, \$391,000 Mental Health Facility Licensing Fund). DHCS has existing federal authority and is not requesting an augmentation. DHCS will also have oversight of the Mental Health Facility Licensing Fund (Fund), collecting and expending revenues related to mental health licensing and certification functions.

DSS will have a corresponding decrease in position and expenditure authority of \$1,124,000 (\$337,000 General Fund, \$391,000 Mental Health Facility Licensing Fund, and \$396,000 Reimbursement).

Additionally, the Administration proposes to transfer DSS's roles and responsibilities related to Lanterman-Petris-Short Act involuntary holds (pursuant to Welfare and Institutions Code Section 5150) to DHCS. These responsibilities include the approval of facilities designated by counties for 72-hour treatment.

The Administration proposes trailer bill language to implement these changes.

Background. The 2012 budget eliminated the Department of Mental Health (DMH), effective July 1, 2012, and transferred community mental health programs to various state departments. This reorganization placed community mental health policy leadership at DHCS, with a Deputy Director for Mental Health and Substance Use Disorder Services who is appointed by the Governor and confirmed by the Senate. The majority of community mental health functions transferred to DHCS; however, licensing and quality improvement functions related to Mental Health Rehabilitation Centers and Psychiatric Health Facilities transferred to DSS.

Rationale for Transfer. The Administration indicates that after careful review it has become clear that it is more beneficial and effective for the community mental health system to house licensing, certification, and policy in one department, DHCS. Under this proposal, consumers, family members, providers, and counties will, in many cases, have one state department to contact if they have community mental health provider-specific questions or concerns.

Since the transfer on July 1, 2012, some stakeholders have identified challenges in navigating multiple departments. Moreover, with both administration of Medi-Cal Specialty Mental Health and certain responsibilities for the Mental Health Services Act now at DHCS, DHCS is the policy leader on community mental health.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the transfer of these positions and expenditure authority and to adopt placeholder trailer bill language to implement these changes. No issues have been raised regarding this proposal.

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide an overview of this budget proposal.

9. 1991 Realignment Growth Allocation Change – Proposed Trailer Bill Language

Budget Issue. The Administration proposes trailer bill language to reduce by 50 percent the share of 1991 Realignment growth funds allocated to mental health beginning in 2015-16.

If this proposal was implemented in the budget year, the mental health growth account would be reduced by \$34 million. The Administration does not have a projection for 1991 Realignment growth funds in 2015-16.

Background. The fiscal structure for 2011 Realignment was established in SB 1020 (a 2012 budget trailer bill). As part of that structure, 1991 Realignment funds that would have otherwise have been deposited into the Mental Health Subaccount are deposited instead into the CalWORKs MOE Subaccount, which is provided to counties for their CalWORKs MOE obligation. Those dollars result in a one-for-one savings of General Fund for the Department of Social Services.

Per SB 1020, 1991 Realignment funds are to be deposited into the CalWORKs MOE Subaccount until it reaches a cap of \$1.121 billion (expected to be reached in 2013-14), at which time excess funds are routed to the Mental Health Subaccount for counties to spend on mental health programs. 2011 Realignment also provides a set monthly amount for mental health, which takes the place of the 1991 Realignment funds previously allocated to the Mental Health Subaccount.

Under the SB 1020 framework, the maximum offset to General Fund expenditures for CalWORKs is \$1.121 billion, and all future growth in 1991-92 Realignment that would have gone to that account instead goes to the Mental Health Subaccount.

The Administration proposes that the SB 1020 structure for the CalWORKs MOE Subaccount was developed before the Coordinated Care Initiative proposal and the resulting In-Home Supportive Services (IHSS) maintenance of effort (MOE) were finalized. These program and policy changes will result in lower than usual Social Services Subaccount caseload growth, which will result in more general growth dollars being available to all Subaccounts in 1991-92 Realignment (Health, Mental Health, Social Services), as social services caseload growth has first call on growth dollars in 1991-92 Realignment.

Subcommittee Staff Comment and Recommendation—Reject. It is recommended to reject this proposal as it diverts funds from county mental health programs. Additionally, this proposal would not go into effect until 2015-16 and there is no reason why action would need to be taken now.

Questions. The Subcommittee has requested the Administration respond to the following:

1. Please provide an overview of this proposal.

10. Drug Medi-Cal Program Funding and Overview

Budget Issue. The Drug Medi-Cal (DMC) program provides medically necessary substance use disorder treatment services for eligible Medi-Cal beneficiaries. The proposed budget includes \$207.8 million (\$95.2 million federal funds and \$112.6 million local funds) for DMC. Since DMC was realigned in 2011, there is no longer General Fund support for this program. See following table for DMC funding summary.

At the time this agenda was prepared, DHCS had not provided unduplicated DMC caseload information.

Table: Drug Medi-Cal Program Funding Summary (dollars in thousands)

Service Description	2012-13				2013-14		
	General Fund	County Funds	Federal Funds	Total Funds	County Funds	Federal Funds	Total Funds
Narcotic Treatment Program	\$0	\$61,875	\$61,799	\$123,674	\$64,267	\$64,173	\$128,440
Outpatient Drug Free Treatment Services	\$0	\$41,705	\$25,759	\$67,464	\$43,695	\$26,078	\$69,773
Day Care Rehabilitative Services	\$0	\$11,441	\$11,441	\$22,881	\$9,494	\$9,495	\$18,989
Perinatal Residential Substance Abuse Services	\$0	\$827	\$827	\$1,654	\$673	\$673	\$1,346
Naltrexone Treatment Services	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Annual Rate Adjustment	\$0	\$0	\$0	\$0	-\$1,997	-\$1,723	-\$3,720
Drug Medi-Cal Program Cost Settlement	-\$2,827	\$0	-\$4,190	-\$7,017	-\$3,508	-\$3,509	-\$7,017
DRUG MEDI-CAL TOTAL	-\$2,827	\$115,848	\$95,636	\$208,656	\$112,624	\$95,187	\$207,811

Background. Since 1980, the DMC program has provided medically necessary drug and alcohol-related treatment services to Medi-Cal beneficiaries who meet income eligibility requirements. Services include:

- **Narcotic Treatment Services** – These services are provided to beneficiaries that are opiate addicted and have substance abuse diagnosis, and/or are Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible.
- **Outpatient Drug Free Treatment Services** – These services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with substance abuse diagnosis in an outpatient setting.

- **Day Care Rehabilitative Services** – These services include outpatient counseling and rehabilitation services that are provided at least three hours per day, three days per week.
- **Perinatal Residential Substance Use Services** – These services provide rehabilitation services to pregnant and postpartum women with substance use disorder diagnosis in a non-institutional, non-medical residential setting. (Room and board is not reimbursed through the Medi-Cal program.)
- **Naltrexone Treatment Services** – These are outpatient services provided to individuals with confirmed opioid dependence who are at least 18 years of age, opioid-free, and are not pregnant.

The DMC program was transition from the Department of Alcohol and Drug Programs to DHCS, effective July 1, 2012. As part of this transition, a stakeholder process was convened in the fall of 2011. During this process stakeholders raised various recommendations on how to improve the DMC Program.

Subcommittee Staff Comment and Recommendation. It is recommended to:

- **Hold open** the DMC Program funding proposal as updated information will be provided at May Revise.
- **Adopt placeholder trailer bill language** to require summary DMC fiscal charts and unique caseload information be included in budget documents to ensure that the Legislature and stakeholders have the information necessary to make informed decisions.

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide a brief overview of the DMC Program budget.
2. Please provide an update on how DHCS is prioritizing and addressing recommendations raised during the transition of DMC to DHCS.

11. Drug Medi-Cal Legal Representation – Position Request

Budget Issue. DHCS requests to make one limited-term staff counsel position permanent to provide ongoing legal services to the Drug Medi-Cal (DMC) Program.

The cost of this position is \$182,000 (\$73,000 General Fund and \$109,000 federal funds).

Background. DHCS conducts post-service and post-payment reviews and deters and detects DMC fraud resulting from questionable billing practices and complaint investigations. When misrepresentation of fact or suspicion of provider fraud is discovered, DHCS may refer their findings to the Department of Justice (DOJ) for criminal investigation and prosecution. The staff counsel acts as liaison between these departments, advises with respect to the suspension of the provider, and develops the necessary legal documentation to support the suspension.

In addition, DHCS notes that the staff counsel interprets policies and provides technical assistance to counties and other entities that provide DMC treatment program services; drafts amendments to the 1915(b) waiver; negotiates with the Centers for Medicare and Medicaid Services (CMS); briefs the California Health and Human Service's Agency and the Governor's Office on all DMC issues; drafts legislation necessary to implement DMC programs; and performs research and writes legal opinions on novel issues arising from realignment.

DHCS contends that continued adequate legal staff is necessary to support the DMC complaint workload, and to ensure the complaints are sufficiently addressed in a timely manner with confidentiality, consideration of program clients, and coordination of outside agencies, keeping in mind the fiscal integrity needs of the entire state.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open.

Questions. The Subcommittee has requested DHCS respond to the following question:

1. Please provide a brief summary of this proposal.