Senate Budget and Fiscal Review—Holly J. Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator William W. Monning
Senator Jeff Stone

Thursday, March 30, 2017
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

PART B

Consultant: Scott Ogus

Item **Department** **Page**

4260 DEPARTMENT OF HEALTH CARE SERVICES 3
5180 DEPARTMENT OF SOCIAL SERVICES 3
Issue 1: Pathways to Well-Being: Implementation of *Katie A. vs. Bonta* Requirements 3
Issue 2: Oversight: Foster Youth and Psychotropic Medications 6

4260 DEPARTMENT OF HEALTH CARE SERVICES 10
Issue 1: Out-of-County Foster Care Presumptive Transfer Regulations Delay 10
Issue 2: Assisted Outpatient Treatment Evaluation Report (Laura's Law) Delay 12
Issue 3: Community Mental Health - Overview 13
Issue 4: Specialty Mental Health Services – Performance Outcomes System 16
Issue 5: Drug Medi-Cal Estimate - Overview 19
Issue 6: Drug Medi-Cal – Organized Delivery System Waiver 23
Issue 7: Substance Use Disorders Licensing Workload 26
Issue 8: SAPT Block Grant – HIV Early Intervention Services Set-Aside Elimination 29

4260 DEPARTMENT OF HEALTH CARE SERVICES 31
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION 31
Issue 1: Mental Health Services Act Fiscal Reversion 31

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION 34
Issue 1: Overview 34
Issue 2: Contract Administration 36
Issue 3: Prevention and Early Intervention Plan Reviews 38

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY 40
Issue 1: Overview 40
Issue 2: Reversion of Community Infrastructure Grant Funding 45
Issue 3: Reversion of Children's Crisis Capacity Infrastructure Grant Funding 46

PUBLIC COMMENT

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, 1020 N Street, Suite 255 or by calling (916) 651-1505. Requests should be made one week in advance whenever possible.

4260 DEPARTMENT OF HEALTH CARE SERVICES
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Pathways to Well-Being: Implementation of *Katie A. vs. Bonta* Requirements

Implementation Update. *Katie A. vs. Diana Bonta* was a class action lawsuit filed on behalf of a number of foster children in California asserting the Medi-Cal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program requires the provision of “wraparound” and “therapeutic foster care” mental health services to children in foster care or at risk of foster care placement. On July 15, 2011, the parties agreed to a settlement which outlined a series of actions to transform the way children and youth who are in foster care, or who are at risk of foster care placement, receive access to mental health services.

Under the Settlement Agreement, beneficiaries meeting medical necessity criteria may receive existing services in a more intensive and effective manner. These services are referred to as Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC). These three services are to be delivered consistent with a Core Practice Model (CPM) that creates a coherent and all-inclusive approach to service planning and delivery. The Settlement Agreement also specified that children and youth who meet *Katie A.* subclass criteria are eligible to receive ICC, IHBS, and TFC. County Mental Health Plans (MHPs) are obligated to provide ICC and IHBS through the EPSDT benefit to all children and youth under the age of 21 who are eligible for full scope Medi-Cal benefits and who meet medical necessity criteria for these services. MHPs provide ICC and IHBS and claim federal reimbursement through the Short-Doyle/Medi-Cal (SDMC) claiming system.

Intensive Care Coordination. Intensive Care Coordination (ICC) is a targeted case management service that facilitates assessment of, care planning for and coordination of services, including urgent services for members of the *Katie A.* subclass. ICC services are provided within the Child and Family Team (CFT) and in accordance with the Core Practice Model (CPM). ICC service components include: assessment, service planning and implementation, monitoring and adapting, and transition. ICC services are provided to all members of the *Katie A.* subclass.

The CFT is comprised of the child and family and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child and family in attaining their goals. There must be an ICC coordinator who:

- Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized and culturally and linguistically competent manner, and that services and supports are guided by the needs of the child.
- Facilitates a collaborative relationship among the child, family and involved child-serving systems.
- Supports the parent or caregiver in meeting their child’s needs.
- Helps establish the CFT and provides ongoing support.
- Organizes and matches care across providers and child-serving systems to allow the child to be served in the community.

Intensive Home-Based Services. Intensive Home Based Services (IHBS) are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's functioning, and help the child and the child's family build skills necessary for successful functioning in the home and community. IHBS services are provided within the Child and Family Team (CFT) and in accordance with the Core Practice Model (CPM). Service activities may include assessment, plan development, therapy, rehabilitation and collateral services. IHBS is provided to members of the *Katie A.* subclass as determined medically necessary.

ICC and IHBS Implementation. County mental health plans began billing for ICC and IHBS services for dates of service starting January 1, 2013. To implement billing and collection of data on services provided to the *Katie A.* subclass, DHCS implemented changes to the SDMC claiming system. These changes included submission of ICC and IHBS claims with a Demonstration Project Identifier code of "KTA" and procedure codes for ICC (T1017, HK) and IHBS (T2015, HK).

According to the department's latest 12-month rolling report of *Katie A.* subclass SMHS services:

- The number of subclass members is 16,249 (statewide).
- Total approved amount to date is $139,450,030 (statewide).
- The total amount of ICC minutes provided to subclass members to date is 17,875,164 (statewide).
- The total amount of IHBS minutes provided to subclass members to date is 19,891,355 (statewide).
- The number of subclass members that have received ICC to date is 11,431 (statewide).
- The number of subclass members that have received IHBS to date is 8,386 (statewide).
- The total number of counties with approved claims for ICC and/or IHBS is 51.
- The total number of counties using the KTA Demonstration Project Identifier is 50.
- Not all counties have implemented the KTA identifier, which may have resulted in under-reporting of claims and members for the subclass.

Therapeutic Foster Care Implementation. The Therapeutic Foster Care (TFC) service model is a short-term, intensive, highly coordinated, trauma-informed, and individualized rehabilitative service covered under Medi-Cal. TFC is provided to children up to age 21 with complex emotional and behavioral needs who are placed with trained and intensely supervised and supported TFC parents. The TFC parents serve as key participants in the therapeutic treatment process of the child. TFC services assist the child in achieving client plan goals and objectives, improve functioning and well-being, and help the child to remain in community settings.

The TFC service model is intended for children and youth who require intensive and frequent mental health support in a one-on-one environment. The TFC service model allows for the provision of certain Medi-Cal Specialty Mental Health Services (SMHS) components available under the ESPDT benefit as a home-based alternative to high-level care in institutional settings such as group homes and, in the future, as an alternative to Short Term Residential Therapeutic Programs (STRTPs). TFC homes may also serve as a step down from STRTPs. The TFC service model is one service option in the continuum of care for eligible children.

According to DHCS, the TFC services model had a target implementation date of January 1, 2017. However, no TFC services are being provided as DHCS, the Department of Social Services (DSS), and

state and county stakeholders are still developing the details of the TFC service model and its modes of delivery. The department reports that specialty mental health providers are receiving information regarding TFC in recently developed training materials.

Subcommittee Staff Comment and Recommendation. This is an informational item.

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

1. Please provide a brief overview of DHCS and county mental health program actions completed to date implementing the provisions of the *Katie A.* Settlement Agreement.

2. Please describe how TFC providers are recruited and trained, and how this benefit is delivered.

3. How long will children be placed with TFC providers? Under what circumstances would a child be considered for a longer-term compared to a shorter-term placement with a TFC provider?

Issue 2: Oversight: Foster Youth and Psychotropic Medications

Background. Studies have shown that age, gender, and placement type impacts the prevalence of psychotropic drug use.[1] Pertaining to placement type, studies find that children in the most restrictive placement setting are the most likely to receive psychotropic medications or multiple medications. In group or residential homes, nearly half of the young people are taking at least one psychotropic drug.

Related Legislation. The Legislature has been following this issue for close to a decade. The Senate has held a series of hearings and passed various bills to ameliorate the issue:

SB 238 (Mitchell), Chapter 534, Statutes of 2015, requires data sharing agreements between DHCS and DSS, as well as between the state and county placing agencies to provide information about children and foster youth taking psychotropic medications. It requires DSS, in consultation with DHCS and stakeholders, to develop and distribute a monthly report to each county placing agency. Additionally, SB 238 requires a system to alert social workers about situations that may warrant additional follow-up. SB 238 requires robust data sharing agreements between DHCS and DSS and county placing agencies in a three-way arrangement known as the Global Interagency Agreement (GIA). Under the GIA, DHCS provides DSS with both medical and pharmacy claims level detail. DSS matches this claims data with their foster care-specific data. The combined, matched data is then provided to each county's foster care placing agency. According to the latest report from DSS, 21 of the 58 counties had data sharing agreements, and two others had separate data use agreements.

SB 484 (Beall), Chapter 540, Statutes of 2015, mandates additional review and increased standards of psychotropic medication usage in group homes, and creates new data collection and notification requirements for the Community Care Licensing Division (CCLD) within DSS in order to identify and mitigate inappropriate levels of psychotropic medication use by children in foster care residing in group homes.

SB 319 (Beall), Chapter 535, Statutes of 2015, authorizes a foster care public health nurse to monitor and oversee a child's use of psychotropic medications, and authorizes the release of health information. It also requires a foster care public health nurse to assist a non-minor dependent to make informed decisions about health care.

SB 1291 (Beall), Chapter 844, Statutes of 2016, requires annual mental health plan reviews to be conducted by an external quality review organization (EQRO) and, commencing July 1, 2018, requires those reviews to include specific data for Medi-Cal eligible minor and non-minor dependents in foster care, including the number served each year. The bill requires DHCS to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics. The bill also requires any corrective action plan to be posted on the county's website.

---

[1] Raghavan, R; Zima, BT; Anderson, RM; Leibowitz, AA; Schuster, MA; & Landsverk, J. (2005). Psychotropic medication use in a national probability sample of children in the child welfare system. Journal of child and adolescent psychopharmacology. 15(1):97.

SB 1174 (McGuire) Chapter 840, Statutes of 2016, requires DHCS and DSS, under a specified data-sharing agreement, to provide the Medical Board of California with information regarding Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services for specified children and minors placed in foster care using data provided by the two departments.

The 2016 Budget Act included $1.7 million General Fund (with an assumed federal match of $5 million) to fund the hiring of additional public health nurses to improve the monitoring of psychotropic drug use in foster care. The 2016 Budget Act also included:

1. DHCS: One full-time permanent research position and expenditure authority of $134,000 ($67,000 General Fund and $67,000 federal funds) in 2016-17, and $125,000 ($63,000 General Fund and $63,000 federal funds) annually thereafter, to implement the requirements of SB 238.
2. DSS: Expenditure authority of $149,000 ($100,000 General Fund) in contract funding to develop monthly, county-specific reports for children in foster care who are prescribed psychotropic medications through Medi-Cal.
3. DSS: Two-year, limited-term expenditure authority of $833,000 ($684,000 General Fund) to support approximately five positions (three Licensing Program Analysts, 0.5 Licensing Program Manager I, 0.5 Office Assistant, and one Associate Governmental Program Analyst), both to implement the requirements of SB 238 and SB 484.

Audit. The Senate held a hearing in the fall of 2016 in response to a requested audit. Overall, the Bureau of State Audits found that about one in eight foster youth in California is prescribed psychotropic medication, or nearly 9,500 of the 79,000 foster youth in the study. In reviews of 80 individual case files in four counties, the auditor found nearly one-third of children prescribed psychotropic medications did not receive recommended follow-up visits and a significant number did not appear to have received appropriate mental health services. Nearly a quarter of the children whose files were reviewed were authorized to take medication in dosages that exceeded the state's recommended maximum and one in three did not have evidence of required court authorization for the medications. The auditor also criticized the state's fragmented oversight system and identified a lack of communication among departments, specifically between county social services and mental health departments, as a significant gap in the system. However, the auditor acknowledged that various recent efforts are in early stages of implementation to improve oversight of the use of psychotropic medications by foster youth.

Update on State Agencies Data Sharing Agreements. DHCS currently has an interagency agreement (IA) with DSS, effective April 2015, to share information regarding the oversight and monitoring of psychotropic medication prescribing within the child foster care population. In an effort to address foster youth psychotropic medication prescribing from the provider perspective, the Medical Board of California (MBC) also entered into a data use agreement (DUA) with DHCS in April 2015.

Update on State and County Data Sharing Agreements. Additionally, DHCS has encouraged and signed DUAs with individual counties who want to monitor psychotropic medication use in their specific foster care population. In addition to these currently established DUAs, SB 238 requires more robust data sharing agreements between DHCS and DSS and county placing agencies in a three-way arrangement known as the Global Interagency Agreement (GIA). Under the GIA, DHCS will provide DSS with both medical and pharmacy claims level detail, which DSS will match with their foster care specific data. This combined, matched data will then be provided to each county's foster care placing

agency. Over time, the parameters of the data sharing under the GIA are expected to change as counties develop ways to analyze the data, which will necessitate changes in how the data is pulled and compiled by both DHCS and DSS.

SB 238 creates a mandate for DHCS and DSS to ensure foster care data is shared with all 58 county placing agencies. According to DHCS, this mandate eliminates the existing, voluntary nature of the DUAs and will result in increased research and data programming to ensure all 58 counties are represented and receiving the required foster care data. See below for information on which counties have DUAs and GIAs.

Individual County DUAs	**Global DUAs (GIA)**
Los Angeles	Alameda
Riverside	Butte
	Contra Costa
	El Dorado
	Humboldt
	Kern
	Lake
	Madera
	Mendocino
	Placer
	Sacramento
	San Diego
	San Francisco
	San Luis Obispo
	San Mateo
	Santa Clara
	Shasta
	Sonoma
	Ventura
	Yolo
	Yuba

SB 484 mandates additional review and increased standards regarding psychotropic medication usage in group homes, and creates new data collection and notification requirements for the Community Care Licensing Division (CCLD) within DSS in order to identify and mitigate inappropriate levels of psychotropic medication use by children in foster care residing in group homes.

Quality Improvement Project: Improving the Use of Psychotropic Medication among Children and Youth in Foster Care. DHCS and DSS have convened a statewide quality improvement project to design, pilot, and evaluate effective practices to improve psychotropic medication use among children and youth in foster care. In order to meet the goals of the quality improvement project, three workgroups have been created. These include the Clinical Workgroup, the Data and Technology Workgroup, and the Youth, Family, and Education Workgroup.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested DHCS and DSS to respond to the following:

1. DHCS and DSS: Please provide an update on the implementation of the enacted legislation listed in this agenda.

2. DHCS and DSS: Why don't all counties have DUAs or GIAs? How are DHCS and DSS working with counties to get these established?

3. DHCS and DSS: Do parents and social workers get a notice of action when there is a denial of services for a foster youth?

4. DHCS and DSS: Please provide an update on the "Quality Improvement Project: Improving the Use of Psychotropic Medication among Children and Youth in Foster Care."

5. DHCS and DSS: How are the two departments monitoring the usage of psychotropic drugs among foster care children?

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Out-of-County Foster Care Presumptive Transfer Regulations Delay

Trailer Bill Language Proposal. DHCS proposes trailer bill language to extend its deadline to adopt out-of-county foster care presumptive transfer regulations from July 1, 2019, to July 1, 2020.

Background. AB 1299 (Ridley-Thomas), Chapter 603, Statutes of 2016, requires DHCS to develop regulatory procedures for transferring the financial responsibility and provision of Medi-Cal Specialty Mental Health Services (SMHS) when a foster child is placed outside of their county of original jurisdiction. These regulatory procedures are described as "presumptive transfer." DHCS has worked in consultation with stakeholders including the California Department of Social Services, County Behavioral Health Directors Association of California, Child Welfare Directors Association of California, Chief Probation Officers of California, County Mental Health Plans, and the California Child Welfare Council, to develop the required procedures to allow foster children in host counties to receive medically necessary and timely SMHS. Specifically, AB 1299 requires DHCS to do the following:

1. By July 1, 2017, issue policy guidance concerning the conditions for, and exceptions to presumptive transfer. The policy guidance must ensure that:
    a. The transfer improves access to SMHS consistent with the child's mental health needs.
    b. The transfer does not disrupt continuity of care.
    c. Conditions and exceptions are applied consistently statewide with consideration of varying capabilities of small, medium, and large counties.
    d. Waivers are only granted with an individualized determination that an exception applies.
    e. Parties who disagree with an exception determination may seek judicial review.
    f. There is a procedure for expedited transfer within 48 hours of out-of-county placement.
2. By July 1, 2019, adopt regulations to implement the required transfer procedures. Until regulations are adopted, DHCS may implement and administer the new procedures through all county letters or information notices.

Implementation Timeline. According to DHCS, it has been engaging stakeholders in the development process for the new presumptive transfer procedures for several months. The department expects to have a draft of its guidance implementing the new procedures by April. After review by stakeholders, DHCS plans to issue the final guidance by the July 1, 2017, deadline contained in the statute.

AB 1299 Fiscal Estimate for Regulatory Development. According to the Senate Appropriations Committee analysis of AB 1299, the department would incur ongoing administrative costs of about $300,000 ($150,000 General Fund and $150,000 federal funds) annually to develop policies, adopt regulations, monitor disputes between counties, and monitor the provision of services under the bill. DHCS has not provided an update of expected state operations costs to implement the regulations.

DHCS proposes trailer bill language to extend its deadline to adopt the presumptive transfer regulations required by AB 1299 from July 1, 2019, to July 1, 2020; a delay of one year. AB 1299 authorizes DHCS to implement and administer its presumptive transfer procedures through all county letters or other guidance until the adoption of regulations. As noted above, the final guidance implementing the presumptive transfer procedures is expected to be released by July 1, 2017. Therefore, a delay in

promulgation of final regulations should not delay implementation of the presumptive transfer procedures at the county level.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. What resources would DHCS need to complete the regulations by the current deadline of July 1, 2019?

Issue 2: Assisted Outpatient Treatment Evaluation Report (Laura's Law) Delay

Trailer Bill Language Proposal. DHCS proposes trailer bill language to allow for a one year delay of its annual reporting requirements under the Assisted Outpatient Treatment (AOT) Program, also known as Laura's Law. The proposal would delay the report due July 1, 2017, until July 1, 2018.

Background. AB 1421 (Thomson), Chapter 1017, Statutes of 2002, established the Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law. Laura's Law was named after Laura Wilcox, a 19 year old Nevada County college student killed by an individual with severe mental illness who was not complying with prescribed mental health treatment. The law established an option for counties to utilize the courts, probation, and the mental health system to address the needs of individuals unable to participate on their own in mental health treatment programs. The former Department of Mental Health (now absorbed into DHCS) issued guidance to counties in 2003 specifying the submission requirements for implementation of an AOT program. For many years, Nevada County was the only county that implemented an AOT, known as the Turning Point Providence Center, as Laura's Law did not require counties to implement an AOT program and did not appropriate any additional implementation funding.

SB 585 (Steinberg), Chapter 288, Statutes of 2013, authorized counties to utilize Mental Health Services Act (MHSA) funding from Proposition 63 (2004) revenues to support implementation and operation of AOT programs. According to DHCS, since the passage of SB 585, the following counties have implemented or are planning to implement new AOT programs: Contra Costa, Los Angeles, Mendocino, Orange, Placer, San Diego, San Francisco, and Yolo.

The department reports one of its analysts is partially allocated to preparing the annual evaluation report required by Laura's Law. Because only one county had established an AOT program, these staff resources were sufficient to manage the collection and evaluation of data, and the preparation of the report. According to DHCS, the addition of eight new county AOT programs will add significantly to the workload required to prepare the annual evaluation report and it is unable to absorb this workload. Therefore, DHCS is proposing to delay the preparation of the report by one year, until July 1, 2018.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. What additional staff resources are needed for the increased workload related to including the eight new AOT programs in the annual report?

Issue 3: Community Mental Health - Overview

Background. 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. See table below for a summary of county community mental health funding.

Community Mental Health Funding Summary			
Fund Source	**2015-16**	**2016-17**	**2017-18**
	Total	**Total**	**Total**
1991 Realignment			
Mental Health Subaccount (base and growth)*	$128,837,000	$157,643,000	$200,561,000
2011 Realignment			
Mental Subaccount Health Account (base and growth)*	$1,127,247,000	$1,127,864,000	$1,129,876,000
Behavioral Health Subaccount (base)**	$1,168,395,000	$1,235,358,000	$1,308,486,000
Behavioral Health Growth Account	$66,964,000	$73,127,000	$93,254,000
Realignment Total	**$ 2,491,443,000**	**$2,593,992,000**	**$ 2,732,177,000**
Medi-Cal Specialty Mental Health Federal Funds	**$2,279,073,000**	**$2,450,457,000**	**$2,700,176,000**
Medi-Cal Specialty Mental Health General Fund	**$ 151,199,000**	**$136,520,000**	**$187,983,000**
Mental Health Services Act Local Expenditures	**$1,418,778,000**	**$1,340,000,000**	**$1,340,000,000**
Total Funds	**$ 6,340,493,000**	**$6,520,969,000**	**$6,960,336,000**

*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, are 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. Includes Drug Medi-Cal.

Medi-Cal Mental Health. There are three systems that provide mental health services to Medi-Cal beneficiaries:

1. **County Mental Health Plans (MHPs) -** California provides Medi-Cal specialty mental health services (SMHS) under a waiver that includes outpatient SMHS, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's SMHS is 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 SMHS is provided. Medi-Cal enrollees must obtain SMHS through the county. SMHS is a Medi-Cal entitlement for adults and children

that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria.

2. **Managed care plans –** SBX1 1 (Hernandez), Chapter 4, Statutes of 2013, expanded the scope of Medi-Cal mental health benefits and required these services to be provided by Medi-Cal managed care plans excluding those benefits provided by county mental health plans under the SMHS waiver. Generally these are mental health services to those with mild to moderate levels of impairment. The mental health services provided by managed care plans include:
   - Individual and group mental health evaluation and treatment (psychotherapy)
   - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
   - Outpatient services for the purposes of monitoring drug therapy
   - Outpatient laboratory, drugs, supplies and supplements
   - Psychiatric consultation

3. **Fee-For-Service Provider System -** Effective January 1, 2014 the mental health services listed below are also available through the fee-for-service provider system:
   - Individual and group mental health evaluation and treatment (psychotherapy)
   - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
   - Outpatient services for the purposes of monitoring drug therapy
   - Outpatient laboratory, drugs, supplies and supplements
   - Psychiatric consultation

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 MHSA funding is to be expended by county mental health departments for mental health services consistent with their approved local plans (three-year plans with annual updates) and the required five components, as required by 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 a 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.** This component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of $460.8 million. Counties have 10 years to spend these funds.

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

Counties are required to submit annual expenditure and revenue reports to DHCS and the Mental Health Services Oversight and Accountability Commission (MHSOAC). DHCS monitors county's use of MHSA funds to ensure that the county meets the MHSA and MHSA Fund requirements.

Subcommittee Staff Comments and Recommendation. This is an informational item.

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

1. Please provide an overview of community mental health programs overseen by DHCS.

Issue 4: Specialty Mental Health Services – Performance Outcomes System

Budget Issue. The budget includes $10.2 million ($5.1 million General Fund and $5.1 million federal funds) in 2016-17 and $13.7 million ($6.8 million General Fund and $6.8 million federal funds) in 2017-18 for costs to reimburse mental health plans for the costs of capturing and reporting functional assessment data as part of the Performance Outcomes System (POS) for EPSDT mental health services.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$5,087,000	$6,818,500
0890 – Federal Trust Fund	$5,087,000	$6,818,500
Total Funding Request:	**$10,174,000**	**$13,637,000**

Background. SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012, required DHCS to convene stakeholders to develop a plan for a POS for EPSDT mental health services provided to Medi-Cal eligible children. The department was required to consider the following objectives: 1) enables provision of high quality and accessible EPSDT services for eligible children and youth; 2) collects information that improves practice at the individual, program, and system levels; 3) minimizes costs by building on existing resources; and 4) generates reliable data that are collected and analyzed in a timely fashion. AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, implemented the following additional requirements for the department:

- Convene a stakeholder advisory committee to develop methods to routinely measure, assess, and communicate program information regarding informing, identifying, screening, assessing, referring, and linking Medi-Cal eligible beneficiaries to mental health services.
- The committee reviews health plan screenings for mental health illness, health plan referrals to Medi-Cal fee-for-service providers, and health plan referrals to county mental health plans. This information is to be included in the POS implemented by the department.
- Propose how to implement the updated POS plan no later than January 10, 2015.

The department's implementation plan for the POS includes the following elements:

1. Establish the POS methodology – The department is required to develop a clear methodology for specifying the purpose of the project, stakeholder and partner involvement, the target population, data availability, data limitations or strengths, reporting elements and timelines, and other relevant details necessary for implementation and development of the POS. The department has focused the methodology first on its reporting requirements from existing DHCS databases, with further development of data collection protocols expected in the future.

2. Report performance outcomes from existing DHCS databases – The department is required to utilize existing DHCS data systems to evaluate performance outcomes on a preliminary basis. The systems used are as follows:
   a. *Short Doyle/Medi-Cal (SD/MC) Claiming System* – Provides information from county mental health plans about who is receiving services, how often the services are received, and the amount claimed for federal reimbursement of services to Medi-Cal beneficiaries.

b. *Client and Services Information System* -- Collects data pertaining to mental health clients and the services they receive at the county level including information about non-Medi-Cal mental health services, Medi-Cal SMHS, client demographics, diagnoses, living arrangement, service strategy, race/ethnicity, employment, and education level.
c. *Web-Based Data Collection Reporting System - Consumer Perception Surveys* – Provides information about the client or family member's perception of satisfaction with regards to services including general satisfaction, access, quality or appropriateness of care, social connectedness, client functioning, criminal justice, and quality of life. Other data include perceived impacts to quality of life including general life satisfaction, living situation, daily activities and functioning, family and social relations, finances, legal and safety, and health.
d. *Data Collection and Reporting System* – Collects data pertaining to any client enrolled in an MHSA funded Full Service Partnership program. Data includes residential status, education, criminal justice, legal designations, co-occurring disorders, source of financial support, and emergency intervention.
e. *Management Information System/Decision Support System* – Provides data pertaining to claims and encounter data (mental health Medi-Cal, Drug Medi-Cal, managed care, pharmacy, fee-for-service Medi-Cal), Medi-Cal eligibility data, provider data, and other reference data such as National External Norms and Benchmarks.

Using existing data between 2011-12 and 2014-15, the department has produced several data reports including a statewide aggregate report and county-specific reports (for small, medium, large and rural counties). A county-level aggregate report is still in development. The reports include the following data elements: 1) unique counts of children and youth receiving SMHS; 2) penetration rates of services compared to eligible population; 3) utilization; 4) arrivals, continuance, and exiting of services; and 5) time to step down. Many of these elements are organized in the aggregate, as well as by race, age group, and gender.

3. Comprehensive Data Collection and Reporting – The department, in partnership with stakeholders and academic researchers, is developing a functional assessment tool to assess client clinical and functional status over time. This tool will be deployed at the county level to collect the data needed to assess outcomes in the POS. According to DHCS, the tool is expected to be approved within the next few weeks and provided to county stakeholders in Spring 2017. The department expects additional costs for purchasing the new tool and training 14,614 county clinical staff in its use.

4. Continuous Quality Improvement Using POS Reports – The department plans to utilize existing processes to develop a quality assurance and improvement process. This process is intended to ensure consistent, high-quality, and fiscally effective services are delivered to children and their families to improve school performance, the home environment, child safety, and involvement with the juvenile justice system.

5. Tracking Continuum of Care Screenings and Referrals – The department has required managed care plans to report data on mental health screenings and referrals to specialty mental health services since May 2014. According to DHCS, however, this data is not adequate to evaluate the linkages between managed care and the SMHS system, as required

by statute. The department is attempting to evaluate the data needed to appropriately track these linkages.

Resources Approved for Implementation. The 2015 Budget Act approved three permanent positions and annual expenditure authority of $350,000 ($175,000 General Fund and $175,000 federal funds) to implement the data collection, analysis and IT functions of the POS. Prior to these resources, existing staff were redirected from other divisions to manage the workload.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending updates at the May Revision.

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

1. Please provide an update on the development of the functional assessment tool. When will the tool be released?

2. How will county clinical staff be trained to use the new tool? What types of information will be collected and how will this assist with quality improvement?

3. What is the status of the department's quality improvement process? What conclusions has the department reached, if any, from the existing data reports on potential improvements in the delivery of SMHS or other services?

Issue 5: Drug Medi-Cal Estimate - Overview

Budget Issue. The budget includes $251.8 million ($6.1 million General Fund, $178.1 million federal funds, and $67.5 million county funds) in 2016-17 and $984.6 million ($147.3 million General Fund, $684.2 million federal funds, and $153.1 million county funds) in 2017-18 for Drug Medi-Cal.

2016-17 Drug Medi-Cal Program Funding Summary (dollars in thousands)					
Service Description	**2016-17**				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**	**Case-load**
Narcotic Treatment Program	$183,293	$1,522	$130,461	$51,310	45,674
Outpatient Drug Free Treatment Services	$23,621	$150	$17,114	$6,357	32,097
Intensive Outpatient Treatment Services	$6,502	$1,350	$4,867	$285	3,696
Residential Treatment Services	$1,833	$7	$1,113	$713	410
Organized Delivery System Waiver	$23,669	$3,115	$16,749	$3,805	-
Drug Medi-Cal Cost Settlement	$3,429	$-	$3,036	$393	-
Annual Rate Adjustment	$-	$-	$-	$-	-
Drug Medi-Cal County Administration	$9,180	$-	$4,590	$4,590	-
County Utilization Review/Quality Assurance	$300	$-	$206	$94	-
TOTAL	**$251,827**	**$6,144**	**$178,136**	**$67,547**	**81,874**
Regular Total	$238,341	$6,129	$170,782	$61,430	80,469
Perinatal Total	$4,006	$15	$2,558	$1,433	1,405
Other Total	$9,480	$-	$4,796	$4,684	-

2017-18 Drug Medi-Cal Program Funding Summary (dollars in thousands)					
Service Description	**2017-18**				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**	**Case-load**
Narcotic Treatment Program	$188,472	$3,917	$131,807	$52,748	46,487
Outpatient Drug Free Treatment Services	$23,731	$379	$16,998	$6,354	32,097
Intensive Outpatient Treatment Services	$6,568	$1,389	$4,893	$286	3,706
Residential Treatment Services	$1,730	$17	$1,040	$673	410
Organized Delivery System Waiver	$748,960	$141,606	$520,251	$87,103	-
Drug Medi-Cal Cost Settlement	$-	$-	$-	$-	-
Annual Rate Adjustment	$-	$-	$-	$-	-
Drug Medi-Cal County Administration	$6,502	$-	$3,251	$3,251	-
County Utilization Review/Quality Assurance	$8,656	$-	$5,951	$2,705	-
TOTAL	**$984,619**	**$147,308**	**$684,191**	**$153,120**	**82,700**
Regular Total	$955,495	$147,151	$666,615	$141,729	81,295
Perinatal Total	$13,966	$157	$8,374	$5,435	1,405
Other Total	$15,158	$-	$9,202	$5,956	-

Background. Established in 1980, the Drug Medi-Cal program provides medically necessary substance use disorder (SUD) treatment services to eligible Medi-Cal beneficiaries for specific, approved services.

Beginning in 2011, administration of the Drug Medi-Cal program was transferred from the Department of Alcohol and Drug Programs (DADP) to DHCS and the program was realigned to the counties as part of 2011 Realignment. Drug Medi-Cal had previously been funded with General Fund and federal funds. 2011 Realignment redirected funding for both Drug Medi-Cal and discretionary substance use disorder programs, including those supported by the Substance Abuse Prevention and Treatment block grant, to the counties. Counties provide the non-federal share of expenditures, which are matched with federal funds, for Drug Medi-Cal services as they existed in 2011 and for individuals eligible for Drug Medi-Cal under 2011 Medi-Cal eligibility rules in place before implementation of the optional Medi-Cal expansion under provisions of the federal Affordable Care Act (ACA). Because implementation of the expansion is considered optional and Proposition 30 requires state requirements imposed after September 2012 be funded by the state, DHCS is responsible for the non-federal share of expenditures for Drug Medi-Cal services provided to individuals in the expansion population.

Both DHCS and counties have specific oversight requirements for Drug Medi-Cal. DHCS is tasked with administrative and fiscal oversight, monitoring, auditing and utilization review. Counties can contract for Drug Medi-Cal services directly, or contract with DHCS, which then directly contracts with providers to deliver Drug Medi-Cal services. Counties that elect to contract with DHCS to provide services are required to maintain a system of fiscal disbursement and controls, monitor to ensure that billing is within established rates, and process claims for reimbursement. DHCS is also implementing a new Drug Medi-Cal Organized Delivery System Waiver, a pilot project to test organized delivery of an expanded benefit package for substance use disorder services. (See Issue 8: Drug Medi-Cal – Organized Delivery System Waiver)

Drug Medi-Cal is delivered through four base modalities:

- **Narcotic Treatment Program (NTP)** – An outpatient service that provides methadone maintenance services directed at stabilization and rehabilitation of persons with opioid dependency and substance use disorder diagnoses. This service includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions.

  The budget includes $183.3 million ($1.5 million General Fund, $130.5 million federal funds, and $51.3 million county funds) in 2016-17 and $188.5 million ($3.9 million General Fund, $131.8 million federal funds, and $52.7 million county funds) in 2017-18 for NTP services. In 2016-17, NTP caseload is expected to be 45,674, an increase of 2,554 (5.9 percent) compared to the 2016 Budget Act. In 2017-18, NTP caseload is expected to be 46,487, an increase of 813 (1.8 percent) compared to the revised 2016-17 caseload estimate.

- **Outpatient Drug Free (ODF) Treatment Services** – Outpatient services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with a substance abuse diagnosis in an outpatient setting. Participants receive at least two group, face-to-face counseling sessions per month. Additional counseling and rehabilitation services include admission physical

examinations, intake, medical necessity establishment, medication services, treatment and discharge planning, crisis intervention, collateral services, and individual and group counseling. The budget includes $23.6 million ($150,000 General Fund, $17.1 million federal funds, and $6.4 million county funds) in 2016-17 and $23.7 million ($379,000 General Fund, $17 million federal funds, and $6.4 million county funds) in 2017-18 for ODF services. In 2016-17, ODF caseload is expected to be 32,097, an increase of 1,415 (4.6 percent) compared to the 2016 Budget Act. In 2017-18, ODF caseload is expected to be 32,097, unchanged compared to the revised 2016-17 caseload estimate.

- **Intensive Outpatient Treatment (IOT) Services** –Outpatient counseling and rehabilitation services provided at least three hours per day, three days per week, including admission physical examinations, intake, treatment planning, individual and group counseling, parenting education, medication services, collateral services and crisis intervention.

  The budget includes $6.5 million ($1.4 million General Fund, $4.9 million federal funds, and $285,000 million county funds) in 2016-17 and $6.6 million ($1.4 million General Fund, $4.9 million federal funds, and $286,000 county funds) in 2017-18 for IOT services. In 2016-17, IOT caseload is expected to be 3,696, an increase of 264 (7.7 percent) compared to the 2016 Budget Act. In 2017-18, IOT caseload is expected to be 3,706, an increase of 13 (0.4 percent) compared to the revised 2016-17 caseload estimate.

- **Residential Treatment Services (RTS)** – Rehabilitation services to beneficiaries with a substance use disorder diagnosis in a non-institutional, non-medical residential setting. Beneficiaries live on the premises and are supported to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Services include mother/child habilitative and rehabilitative services, service access including transportation, education to reduce the harmful effects of alcohol and drugs on mother or fetus/infants, and coordination of ancillary services.

  The budget includes $1.8 million ($7,000 General Fund, $1.1 million federal funds, and $713,000 million county funds) in 2016-17 and $1.7 million ($17,000 General Fund, $1 million federal funds, and $673,000 county funds) in 2017-18 for RTS services. In 2016-17, RTS caseload is expected to be 410, an increase of 130 (46.4 percent) compared to the 2016 Budget Act. In 2017-18, RTS caseload is expected to be 410, unchanged compared to the revised 2016-17 caseload estimate.

Other Medi-Cal Substance Use Disorder benefits, that are not included in Drug Medi-Cal, include:

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further updates in caseload and expenditures at May Revision.

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

1. Please provide a brief overview of the caseload and expenditure changes in the base Drug Medi-Cal estimate.

Issue 6: Drug Medi-Cal – Organized Delivery System Waiver

Budget Issue. The budget includes $23.7 million ($3.1 million General Fund, $16.7 million federal funds, and $3.8 million county funds) in 2016-17 and $749 million ($141.6 million General Fund, $520.3 million federal funds, and $87.1 million county funds) in 2017-18 for the implementation of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver. The Waiver authorizes a pilot project to test organized delivery of an expanded benefit package for substance use disorder services.

2016-17 DMC-ODS Waiver Program Funding Summary (dollars in thousands)				
Service Description	**2016-17**			
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**
Organized Delivery System Waiver	$23,669	$3,115	$16,749	$3,805
TOTAL	**$23,669**	**$3,115**	**$16,749**	**$3,805**
Regular Total	$23,396	$3,114	$16,583	$3,699
Perinatal Total	$273	$15	$166	$106

2017-18 DMC-ODS Waiver Program Funding Summary (dollars in thousands)				
Service Description	**2017-18**			
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**
Organized Delivery System Waiver	$748,960	$141,606	$520,251	$87,103
TOTAL	**$748,960**	**$141,606**	**$520,251**	**$87,103**
Regular Total	$738,399	$141,483	$513,923	$82,993
Perinatal Total	$10,561	$123	$6,328	$4,110

Background. The Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver is a voluntary pilot program that offers California counties the opportunity to expand access to high-quality care for Medi-Cal enrollees with substance use disorders (SUD). The goal of the DMC-ODS Waiver is to demonstrate how organized SUD care improves beneficiary health outcomes, while decreasing system-wide health care costs. Counties that choose to participate in the DMC-ODS Waiver are required to provide access to a full continuum of SUD benefits modeled after criteria developed by the American Society of Addiction Medicine (ASAM). Counties are required to submit implementation plans and proposed interim rates for all county-covered SUD services, except NTP rates, which are set by DHCS.

To receive services through the DMC-ODS Waiver, beneficiaries must meet the following criteria:

1. The beneficiary must be enrolled in Medi-Cal
2. The beneficiary must reside in a county that is participating in the DMC-ODS Waiver
3. The beneficiary must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with certain exceptions, or for youth under 21, be assessed as “at-risk” for developing a SUD
4. The beneficiary must meet the ASAM Criteria definition of medical necessity for services (or ASAM adolescent treatment criteria for youth under 21).

The standard Drug Medi-Cal program covers outpatient services, intensive outpatient services, limited perinatal residential services, and narcotic treatment program services. Optional participation in the DMC-ODS Waiver allows counties to cover an expanded array of SUD services for Medi-Cal beneficiaries. The benefits offered under the DMC-ODS Waiver are as follows:

1. <u>Existing Drug Medi-Cal Services</u>
   - Non-perinatal Residential Treatment Services
   - Withdrawal Management
     - ASAM Criteria Level 1.0 – Ambulatory, without extended on-site monitoring
     - ASAM Criteria Level 2.0 – Ambulatory, with extended on-site monitoring
     - ASAM Criteria Level 3.2 – Clinically managed residential withdrawal management
   - Recovery Services
   - Case Management
   - Physician Consultation
   - Expanded Medication Assisted Treatment (MAT) (buprenorphine, naloxone, and disulfiram)

2. <u>Expanded Services Available in ODS Waiver</u>
   - Additional MAT (non-NTP providers)
   - Partial Hospitalization
   - Withdrawal Management
     - ASAM Criteria Level 3.7 – Medically monitored inpatient
     - ASAM Criteria Level 4.0 – Medically managed intensive inpatient

According to DHCS, six counties are expected to begin providing services under the DMC-ODS Waiver in 2016-17: San Mateo, Santa Cruz, Riverside, Santa Clara, Marin, and San Francisco. An additional ten counties are expected to begin providing services in 2017-18. The department reports a total of 20 counties, representing approximately 73 percent of the state's population, are participating or planning to participate in the DMC-ODS Waiver. DHCS expects additional counties to opt in over the coming months.

Resources Approved for DMC-ODS Implementation. The 2016 Budget Act approved eight permanent positions and expenditure authority of $946,000 ($473,000 General Fund and $473,000 federal funds) over two years to support fiscal oversight and programmatic monitoring requirements of the DMC-ODS Waiver.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an update on the implementation of the DMC-ODS Waiver.

2. How many counties have opted in to the waiver to date? Which ten counties are expected to provide services in 2017-18?

3. How have the counties that recently began offering services under the Waiver implemented the delivery of the services not previously available under Drug Medi-Cal?

4. Please describe the evaluation process for determining whether outcomes are improving under the DMC-ODS Waiver.

Issue 7: Substance Use Disorders Licensing Workload

Budget Issue. DHCS requests 20 permanent positions (conversion of six limited-term positions and 14 new positions) and expenditure authority of $2.5 million ($290,000 Narcotic Treatment Program Licensing Trust Fund, $1.7 million Residential and Outpatient Program Licensing Fund, and $531,000 reimbursements). If approved, these resources would support increased licensing, monitoring, and complaint investigation workload as a result of expansion of services under the federal Affordable Care Act and the Drug Medi-Cal Organized Delivery System Waiver.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0243 – Narcotic Treatment Program Licensing Trust Fund	$-	$290,000
3113 – Residential and Outpatient Program Licensing Fund	$-	$1,726,000
0995 – Reimbursements	$-	$531,000
0890 – Federal Trust Fund [non-add]	$-	[$1,046,000]
Total Funding Request:	**$-**	**$2,547,000**

Background. According to DHCS, there has been substantial growth in facilities seeking licensure and the department expects this growth will continue over the next several years. In particular, the department has seen increased licensing and monitoring workload related to facilities in counties participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver.

Licensing Workload. DHCS is required to license and certify all California facilities that provide 24-hour residential and outpatient alcohol and other drug (AOD) treatment, detoxification, or recovery services to adults. The department processes initial and renewal applications for residential, outpatient, detoxification, adolescent waivers, incidental medical services; American Society of Addiction Medicine (ASAM) designations; and conducts site visits for each initial and renewal application. DHCS also monitors compliance with state, federal and local laws, regulations and statutes by conducting reviews every two years.

DHCS currently licenses or certifies 1,777 facilities, including 356 residential facilities, 560 residential/AOD facilities, and 861 AOD outpatient facilities.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver. The Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver is a voluntary pilot program that offers California counties the opportunity to expand access to high-quality care for Medi-Cal enrollees with substance use disorders (SUD). Counties that choose to participate in the DMC-ODS Waiver are required to provide licensed Narcotic Treatment Program (NTP) services, resulting in expected increases in new program applications, licensing and monitoring. Existing NTPs in opt-in counties are also required to order, prescribe, and administer three new medications: buprenorphine, disulfiram and naloxone, in addition to optionally utilizing vivitrol. This requirement will result in regulatory amendments, revised or amended protocols from all existing NTPs utilizing the new medications, staff training and subsequent development of tracking and monitoring tools as well as additional on-site inspection policies and procedures.

The federal Centers for Medicare and Medicaid Services requires all residential providers to meet ASAM requirements and obtain a DHCS issued ASAM designation as part of their participation in the DMC-ODS Waiver. DHCS is currently implementing the ASAM Designation process, which includes the provisional and final Level 3.1, 3.3 and 3.5 designation, collection of fees and fines, and provision of technical assistance to facilities.

DHCS reports an increase in licensing workload, ASAM designation, and monitoring as a result of these expansions and new requirements. According to DHCS, insufficient staff resources has led to a backlog of 265 initial applications for providers to obtain licensure or certification and 150 renewal applications for licensure or certification. Since 2015, due to the increasing licensing backlog, the department redirected five Associate Governmental Program Analysts (AGPAs) to manage the increased workload.

Complaints Investigation. DHCS is responsible for investigating complaints brought against licensed residential treatment programs, outpatient programs, unlicensed programs, and registered or certified counselors employed by one of these programs. Unusual incidents and client deaths are reported to the department from programs statewide. Investigations may result in one of three classes of deficiencies when a program fails to comply with any provisions of state and federal laws and regulations. Class A deficiencies represent an imminent danger to a resident of a facility, in which death or physical injury is a likely consequence. Class B deficiencies relate to the operation or maintenance of the facility which has a direct or immediate relationship to the physical health, mental health, or safety of facility residents. Class C deficiencies are those relating to the operation or maintenance of the facility which DHCS determines has only a minimal relationship to the health or safety of residents. DHCS is reporting an increase in complaints workload and a subsequent backlog resulting from the expansions of services under the DMC-ODS Waiver.

DHCS is requesting the following positions:

Licensing and Certification Section - 14 positions (Six permanent, eight from limited-term resources) to address the increased licensing application workload and to clear the current application backlog

- **Five permanent AGPAs** to respond to calls and e-mail inquiries from applicants, providers, and county program representatives related to program requirements, the licensure process, and status of applications; develop and complete provider trainings and outreach on program requirements, conduct county outreach, and provide trainings to programs regarding the standards and licensure requirements.
- **One permanent Office Technician** responsible for administrative support of the AGPA staff.
- **Five-Year Limited-Term Funding** equivalent to:
    1. One Staff Services Manager I to supervise staff engaged in the oversight, analysis, and evaluation of current policy and procedures to bring the program into compliance with state and federal laws and program integrity protections.
    2. One Health Program Specialist I to assist in promulgation of regulations, act as liaison regarding bill analyses and ongoing legislation, write and analyze bills, update the AOD Certification Standards, assist in the preparation of memos and other public correspondence, update processes, conduct studies of licensing statistics, and perform data analysis.
    3. Two AGPAs responsible for assisting in the elimination of the application backlog.

- **Two-Year Limited-Term Funding** equivalent to:
  1. Four AGPAs designated for workload related to Los Angeles County specific increases in licensing applications.

Narcotic Treatment Programs Section – Four permanent positions for NTP licensing workload.

- **One permanent Staff Services Manager I** to supervise NTP staff including planning, organizing and managing field operations, leading and assisting with review of initial applications, temporary suspension orders, license revocations, and directing investigations of complex and politically sensitive complaints and patient deaths.
- **Two permanent AGPAs** responsible for reviewing initial applications, conducting annual and follow-up inspections of NTPs for compliance with State and federal laws and regulations, reviewing exceptions, and conducting complaint investigations, death investigations, and special incident investigations.
- **One permanent Office Technician** responsible for administrative support of NTP licensing activities.

Complaints Section – Ten permanent positions to address the ongoing and increasing complaints workload, including the current backlog.

1. **Nine permanent AGPAs** (five converted from limited-term) to conduct investigations of complaints brought against licensed residential treatment facilities, certified outpatient programs, unlicensed residential treatment programs, unusual incidents and allegations of counselor misconduct at programs, as well as follow-up site visits to verify that deficiencies have been corrected.
2. **One permanent Staff Services Manager I** (converted from limited-term) to supervise and review the work of staff, lead and assist with service of temporary suspension orders and inspection warrants, license revocations and directing investigations of complex and politically sensitive complaints and patient deaths.

Residential and Outpatient Program Licensing Fund (ROPLF). Health and Safety Code Section 11833.02 requires DHCS to charge fees for licensure and certification of all residential AOD recovery or treatment facilities and for certification of outpatient AOD programs. The Residential Outpatient Program Licensing Fund (ROPLF) collects all fines, fees, and penalties assessed to licensed and certified AOD providers, which are deposited and made available upon appropriation by the Legislature for supporting the licensing and certification activities of residential and outpatient facilities.

DHCS is requesting expenditure authority from the Narcotic Treatment Program Licensing Fund, the ROPLF, and reimbursements to fund this request.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 8: SAPT Block Grant – HIV Early Intervention Services Set-Aside Elimination

Background. The Substance Abuse Prevention and Treatment (SAPT) Block Grant Program provides funds to states to plan, carry out, and evaluate activities to prevent and treat substance abuse. The program is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) and represents the largest source of non-Medicaid federal funding to states for the prevention and treatment of substance use disorders. It constitutes a substantial amount of all states' budgets for substance abuse programming and serves an average of two million individuals each year nationwide. States have flexibility in determining how funds should be allocated to address local needs; however, to receive funding, states must meet specific set-aside and maintenance of effort (MOE) requirements and conduct activities designed to achieve 17 legislative goals of the program.

HIV Early Intervention Services Set-Aside. The SAPT Block Grant Program includes a set-aside program intended to allocate five percent of block grant funding for HIV early intervention services in states with a higher burden of HIV or AIDS cases. Known as the HIV Early Intervention Services (EIS) Set-Aside, the program includes a threshold for designation as an HIV EIS state of 10 or more AIDS cases per 100,000 individuals annually.

According to a report by the California HIV/AIDS Policy Research Centers, HIV EIS Set-Aside funding was used in two primary ways: 1) to integrate substance use counseling and education efforts into HIV and primary care settings, and 2) provide HIV and Hepatitis C virus (HCV) education, testing, and linkage to care through substance use services and programs. County grants supported the ability to provide substance use and behavioral health services to those at high risk for HIV, especially in rural areas. In addition, because Drug Medi-Cal does not reimburse drug treatment programs for HIV or HCV testing, the HIV EIS set-aside provided funding for testing for drug treatment clients likely to be at high risk for HIV.

Due to a variety of factors including aggressive public health strategies, increased utilization of anti-retroviral therapies, and development of pre-exposure prophylaxis medications, California has experienced a drop in HIV and AIDS cases. While the decrease in HIV/AIDS incidence is a positive public health achievement, the state is now below the threshold for designation as an HIV EIS state. Therefore, the SAPT Block Grant funding provided to counties for these purposes is no longer available. California's final year of funding for the set-aside was federal fiscal year 2015 and it received approximately $12.5 million. Pursuant to the terms of the block grant, other SAPT funding may not be allocated to these purposes once a state is no longer designated as an HIV EIS state.

Potential Alternative Sources of Funding. The SAPT Block Grant funding for integrated substance use disorder counseling in HIV settings and increased testing and linkage to care is likely to have contributed to the state's reduced incidence of HIV and AIDS, as the targeted population is at high-risk of infection. The HIV Alliance proposes funding the programs previously funded by the HIV EIS Set-Aside with a $12.5 million General Fund allocation. The California HIV/AIDS Policy Research Centers report also suggests the state evaluate whether it could use funding from the federal 21st Century Cures Act, which allocates $1 billion to states for substance use disorders. It is also unclear how the funds that had previously been allocated to the HIV EIS Set-Aside are currently being spent. The Legislature may wish to consider identifying an alternative funding source to reinvest in these programs.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. What are the restrictions on counties' use of SAPT Block Grant funding that prevents expenditures for the purposes previously supported by the HIV EIS Set-Aside?

2. How are the HIV EIS Set-Aside funds reallocated to the remaining SAPT Block Grant programs?

3. Has DHCS considered alternative funding strategies to continue to support these services at the county level? What other funding is available for this purpose?

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

Issue 1: Mental Health Services Act Fiscal Reversion

Background. In 2004, voters approved Proposition 63, the Mental Health Services Act (MHSA), to change the way California treats mental illness by expanding the availability of innovative and preventative programs, reduce stigma and long-term adverse impacts for those suffering from untreated mental illness, and hold funded programs accountable for achieving those outcomes. The act directed the majority of revenues to county mental health programs and services in the following five categories:

1. *Community Services and Supports (CSS):* 80 percent of county MHSA funding treats severely mentally ill Californians through a variety of programs and services, including full service partnerships and outreach and engagement activities aimed at reaching unserved populations.

2. *Prevention and Early Intervention (PEI):* Up to 20 percent of county MHSA funds may be used for PEI programs, which are designed to identify early mental illness, improve timely access to services for underserved populations, and reduce negative outcomes from untreated mental illness, such as suicide, incarceration, school failure or dropping out, unemployment, homelessness and removal of children from homes.

3. *Innovation:* Up to 5 percent of MHSA funds received for CSS and PEI may be used for innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

MHSA also required counties to spend a portion of their revenues on two additional components to build the infrastructure to support mental health programs. Since 2008-09, counties have the option of using a portion of their CSS funding in these areas or to build up a prudent reserve:

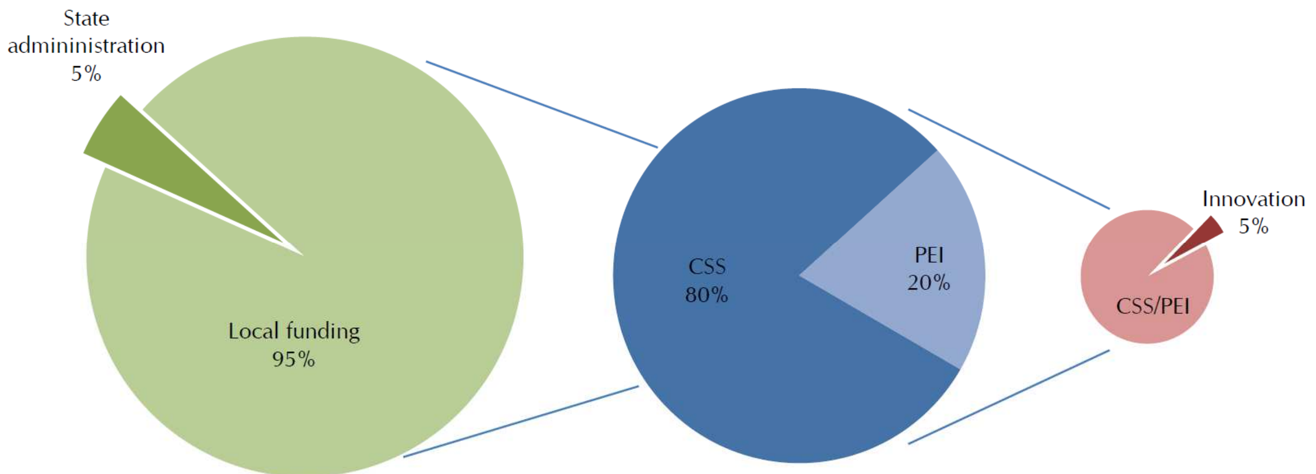
4. *Workforce Education and Training:* This component aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental illness. Counties may use funds to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs.

5. *Capital Facilities and Technological Needs:* This component finances necessary capital and infrastructure to support implementation of other MHSA programs. It includes funding to improve or replace technology systems and other capital projects.

MHSA funds are allocated to counties through a formula that weighs each county's need for mental health services, the size of its population most likely to apply for services, and the prevalence of mental illness in the county. Adjustments are made for the cost of living and other available funding resources. The formula also provides a minimum allocation to rural counties for the CSS and PEI components.

State Administration Funds. MHSA authorizes the use of up to five percent of annual revenues for state administration and specifies that these funds are to be used by state agencies to "implement all duties pursuant to the [MHSA] programs." This includes ensuring adequate research and evaluation regarding the effectiveness and outcomes of MHSA services and programs.

Apportionment of Mental Health Services Act Funds.



Source: Little Hoover Commission Report #225: *Promises to Keep: A Decade of the Mental Health Services Act* (Jan. 2015)

Reversion Requirements for Unspent County Funds. MHSA requires the reversion of unspent county funds to the state. According to Welfare and Institutions Code section 5892 (h), "any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years". However, DHCS has not reverted unspent county funds since 2008.

Concerns About Reversion Policies. Mental health advocates have expressed concerns that counties are retaining MHSA funds that could be reverted and reallocated to the provision of additional mental health services. However, counties have reported various challenges with accurate reporting of funds subject to reversion, including limitations on reporting forms from DHCS, inadequate identification of funds owed, and unclear policies for reversion.

MHSOAC Recommendations. In March 2017, MHSOAC released a discussion draft for consideration by Commission members titled *Mental Health Services Act Fiscal Reversion Policy Reconsidered: Challenges and Opportunities*. The draft identified many of the long-standing issues preventing appropriate reversion of unspent MHSA funds and made several recommendations for MHSOAC, DHCS and the Legislature. These included:

1. **"Reset" Reversion Policies** – MHSOAC recommended DHCS continue to update its fiscal reporting requirements to take effect in 2017-18 and beyond. For prior years, MHSOAC recommends three options for the Legislature to consider regarding the identification, reporting or reversion of unspent MHSA funds:
    - Hold counties harmless for reversion prior to 2017-18
    - Allow counties to retain a portion of reverted funds

- o Hold counties harmless for reversion prior to 2012-13, when responsibilities were transferred from the former Department of Mental Health to DHCS.

2. **Extend Reversion Period from Three to Five Years for Small Counties** – Because small counties experience greater challenges in funding and sustaining mental health services programs with limited MHSA allocations, MHSOAC recommends the Legislature allow small counties to apply for state approval to extend the reversion timeline for funds subject to the three year limit.
3. **Allow Counties to Revise Annual Revenue and Expenditure Reports** – MHSOAC recommends DHCS clarify whether and how counties may amend their annual revenue and expenditure reports with updated, more complete, or audited information.
4. **Establish an MHSA Reversion Fund** – MHSOAC recommends establishing an MHSA Reversion Fund to receive unspent county MHSA funds. This fund would highlight the level of unspent funds reverted to the state, enhance incentives for counties to spend MHSA allocations, and allow the Legislature to reallocate this funding to unmet mental health services needs in the state.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further discussions about improving policies regarding reversion of MHSA funds and ensuring unspent funds are reallocated in a timely manner to their intended support of mental health services programs.

Questions. The subcommittee has requested DHCS and MHSOAC to respond to the following:

1. DHCS: Please describe the challenges that have led to the extensive delay in fiscal reversion of MHSA funds.

2. DHCS: What is the current plan, if any, and expected timeframe for reversion of unspent MHSA funds?

3. DHCS: What is the status of the requirement from AB 1618, Chapter 43, Statutes of 2016 that requires DHCS to post the three-year program and expenditure plans submitted by every county?

4. MHSOAC: Please describe the recommendations in your discussion draft: "Mental Health Services Act Fiscal Reversion Policy Reconsidered: Challenges and Opportunities".

5. MHSOAC and DHCS: What is the scope of unspent funds statewide that might be available for reversion and reallocation? How would the reallocation occur?

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Overview

Mental Health Services Oversight and Accountability Commission Three-Year Funding Summary			
Fund Source	**2015-16**	**2016-17**	**2017-18**
	Actual	***Revised***	***Proposed***
0995 - Reimbursements	$-	$22,000,000	$22,000,000
3085 – Mental Health Services Fund	$48,002,000	$56,344,000	$45,146,000
Total Department Funding:	**$48,002,000**	**$78,344,000**	**$67,146,000**
Total Authorized Positions:	**26.6**	**26.2**	**29.2**

Mental Health Services Act (Proposition 63; 2004). The Mental Health Services Act (MHSA) imposes a one percent income tax on personal income in excess of $1 million. 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).

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. These members include:

Elected Officials:

- Attorney General
- Superintendent of Public Instruction
- Senator selected by the President pro Tem
- Assemblymember selected by the Speaker

12 members appointed by the Governor:

- Two persons with a severe mental illness
- A family member of an adult or senior with a severe mental illness
- A family member of a child who has or has had a severe mental illness
- A physician specializing in alcohol and drug treatment
- A mental health professional
- A county sheriff
- A superintendent of a school district
- A representative of a labor organization
- A representative of an employer with less than 500 employees
- A representative of an employer with more than 500 employees
- A representative of a health care services plan or insurer

In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

MHSOAC's responsibilities are as follows:

Review of MHSA Programs
- The MHSOAC oversees the MHSA funded programs and services through the counties' annual updates. Counties submit updates every year to reflect the status of programs and services in their counties.

Evaluations
- The MHSOAC has a statutory mandate to evaluate how MHSA funding has been used, what outcomes have resulted, and how to improve services and programs.

Research
- The MHSOAC supports collaborative research efforts to develop and implement improved tools and methods for program improvement and evaluation statewide.

Triage
- County triage personnel provide linkages and services to what may be the first mental health contact for someone in crisis. Crisis services are provided at shelters, jails, clinics and hospital emergency rooms to help link a person to appropriate services.

Stakeholder Contracts
- Statewide stakeholder advocacy contracts are focused on supporting the mental health needs of consumers, children and transition aged youth, veterans, racial and ethnic minority communities and their families through education, advocacy, and outreach efforts.

Commission Projects
- The MHSOAC selects special project topics and under the direction of a subcommittee of Commissioners, conducts research through discussion, review of academic literature, and interviews with those closely affected by the topic to formulate recommendations for administrative or legislative changes.

Technical Assistance & Training
- The MHSOAC offers technical assistance and training to counties, providers, clients and family members, and other stakeholders to support the goals of the MHSA and specific responsibilities of the Commission, such as review of counties' MHSA-funded Innovative Program plans.

Subcommittee Staff Comment and Recommendation. This is an informational item.

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

1. Please provide a brief overview of MHSOAC's mission and programs.

Issue 2: Contract Administration

Budget Issue. MHSOAC requests one position and expenditure authority from the Mental Health Services Fund of $157,000 annually. If approved, these resources would support MHSOAC's ability to implement new and expanded contracting obligations authorized by the 2016 Budget Act.

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2016-17**	**2017-18**
3085 – Mental Health Services Fund	$-	$157,000
Total Funding Request:	**$-**	**$157,000**
Total Positions Requested:	**1.0**	

Stakeholder Contract Administration. MHSOAC oversees the activities of statewide stakeholder advocacy contracts funded under Welfare and Institutions Code Section 5892(d). These contracts support the needs of mental health clients, family members, children, transition-aged youth, veterans, the LGBTQ community and organizations working to reduce racial and ethnic disparities through education, outreach and advocacy efforts. The contracts had previously been awarded on a sole source basis under the former Department of Mental Health (DMH). After the dissolution of DMH in 2011, responsibility for awarding the stakeholder advocacy contracts transferred to MHSOAC. Historically, the amount allocated for stakeholder contracts ranged from $300,000 to $669,000 per year, for a total of approximately $2 million per year, distributed between the following four populations: clients or consumers, children and youth, transition-aged youth, and families of clients or consumers. After a series of budgetary and legislative augmentations, funding for each of the seven mental health advocacy contracts is now $670,000, or a total of approximately $4.7 million in contracted funds per year.

MHSOAC reports it is working to enhance the stakeholder advocacy contract process. It has moved from a sole source strategy to a competitive process. In 2016, MHSOAC released requests for proposal (RFP) for six of the contracts. 13 proposals were submitted in response to the RFPs. Of those proposals, three did not meet the technical qualifications and only one surpassed the minimum qualifying threshold for consideration. MHSOAC is revisiting the contracting process, working with the various stakeholder communities to encourage interest in submitting advocacy proposals, and will reissue RFPs for these contracts in 2017.

Children's Crisis Services Grant Program. The 2016 Budget Act allocated $3 million of MHSA funds to support a competitive grant program for crisis services for children. In particular, $1.5 million of the grants are meant to add triage personnel who would be available at various points of access, such as clinics and schools. These personnel would provide the following services: coordination, referral, monitoring of service delivery, and placement service assistance. The remaining $1.5 million of the grants are meant to add family support services training designed to help families participate in the planning process, access services, and navigate programs. These grants were part of a package of local public safety investments included in the 2016 Budget Act to reduce people's involvement in the criminal justice system. The total investment in children's crisis services was $31 million ($17 million General Fund and $14 million MHSA funds). The budget proposes to revert the General Fund portion of the funding. (See California Health Facilities Financing Authority Issue 3: Reversion of Children's Crisis Capacity Infrastructure Grant Funding)

MHSOAC is requesting one position and expenditure authority from the Mental Health Services Fund of $157,000 annually. If approved, MHSOAC would hire one Associate Governmental Program Analyst to assist ongoing efforts to conduct outreach and more effectively administer stakeholder advocacy contracts. In addition the analyst would support administration of children's crisis contract funds through a competitive grant process.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: Prevention and Early Intervention Plan Reviews

Budget Issue. MHSOAC requests two positions and expenditure authority from the Mental Health Services Fund of $309,000 annually. If approved, these resources would allow MHSOAC to implement regulations for Prevention and Early Intervention (PEI) and Innovation programs pursuant to AB 82 (Committee on Budget), Chapter 23, Statutes of 2013.

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2016-17**	**2017-18**
3085 – Mental Health Services Fund	$-	$309,000
Total Funding Request:	**$-**	**$309,000**
Total Positions Requested:	**2.0**	

Background. AB 82 modified the Mental Health Services Act (MHSA) and directed MHSOAC to adopt regulations for programs and expenditures under both the Prevention and Early Intervention (PEI) component and the Innovation component and to continue providing technical assistance to counties to improve public mental health programs. MHSOAC adopted regulations in the summer of 2015, specifying data collection and reporting requirements for the counties under MHSA. In 2015, counties began planning to collect newly required outcome performance measurements and must begin annual and periodic PEI reporting in 2017. These new regulatory requirements have increased the need for technical assistance and training to counties to ensure compliance.

Existing Technical Assistance Resources. MHSOAC currently provides consultation on a case-by-case basis in response to requests for technical assistance. One Consulting Psychologist is dedicated to reviewing innovation plans and providing technical assistance on innovation programs. One Health Program Manager II supervises one Staff Mental Health Specialist and two Health Program Specialist I working on innovation plan reviews, as well as other county plan reviews, contract monitoring, and the development of outreach and community forums. The 2016 Budget Act approved two Health Program Specialist I/II and one Research Program Specialist I/II to work with the Consulting Psychologist and Health Program Manager II to implement the Innovation program. However, current staff resources are being redirected to provide support to the PEI program.

MHSOAC requests two positions and expenditure authority from the Mental Health Services Fund of $309,000 annually:

- One Health Program Specialist II to provide subject matter expertise and leadership in PEI program review, serve as primary point of contact and administrative lead for MHSOAC's monitoring and oversight efforts of county programs, and provide technical assistance and training consultation to counties.
- One Associate Governmental Program Analyst to provide program support to the PEI team, serve as staff analytic lead in the preparation of reviews of county PEI programs, serve as subject matter expert and project lead, and serve as staff analytic lead in preparation of technical assistance materials.

If approved, these positions under the supervision of the Health Program Manager II and in close collaboration with the Consulting Psychologist, the Innovation program unit, and existing staff, would

allow MHSOAC to develop an integrated approach to guiding, monitoring and reporting on the impact of MHSA on California's mental health system.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Have the counties been consulted and what is their response to this proposal?

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

Issue 1: Overview

Background. The California Health Facilities Financing Authority (CHFFA) was established in 1979 to help nonprofit and public health facilities reduce their cost of capital and promote health care improvement and cost containment objectives. CHFFA achieves these goals by providing cost-effective tax-exempt bond, low-cost loan, and direct grant programs. The Authority is governed by nine members, including the State Treasurer, the State Controller, the Director of Finance, two members appointed by the Senate Rules Committee, two members appointed by the Speaker of the Assembly, and two members appointed by the Governor subject to confirmation by the Senate. Of the members appointed by the Senate, one member must be a licensed physician and surgeon, and one must be a current or former health facility executive. Of the members appointed by the Assembly, one member must be trained in investment or finance and one member represents the general public. The members appointed by the Governor also represent the general public. Appointed members serve for four years.

California Health Facilities Financing Authority Three-Year Funding Summary			
Fund Source	**2015-16**	**2016-17**	**2017-18**
	Actual	***Revised***	***Proposed***
0001 – General Fund	$44,744,000	$-	$-
0904 – CHFFA Fund	$4,454,000	$8,986,000	$8,985,000
0995 – Reimbursements	$-	$2,800,000	$2,800,000
3085 – Mental Health Services Fund	$3,999,000	$15,000,000	$4,000,000
6046 – Children's Hospital Fund	$68,128,000	$40,359,000	$40,359,000
6079 – Children's Hosp. Bond Act Fund	$99,443,000	$75,178,000	$75,358,000
8073 – CHAMP Acct, CHFFA Fund	$-	$400,000	$400,000
Total Department Funding:	**$220,768,000**	**$142,723,000**	**$131,902,000**
Total Authorized Positions:	**14.9**	**17.5**	**17.5**

California Health Facilities Financing Authority Comparison to 2016 Budget Act			
Fund Source	**2016-17**	**2016-17**	**2016-17**
	Appropriation	***Revised***	***Difference***
0001 – General Fund	$84,539,000	$-	($84,539,000)
0904 – CHFFA Fund	$9,223,000	$8,986,000	($237,000)
0995 – Reimbursements	$2,800,000	$2,800,000	$-
3085 – Mental Health Services Fund	$15,000,000	$15,000,000	$-
6046 – Children's Hospital Fund	$40,357,000	$40,359,000	$2,000
6079 – Children's Hosp. Bond Act Fund	$75,178,000	$75,178,000	$-
8073 – CHAMP Acct, CHFFA Fund	$400,000	$400,000	$-
Total Department Funding:	**$227,497,000**	**$142,723,000**	**($84,774,000)**
Total Authorized Positions:	**17.5**	**17.5**	**-**

California Health Facilities Financing Authority Comparison 2016-17 (Rev) to 2017-18			
Fund Source	**2016-17**	**2017-18**	**2017-18**
	Revised	***Proposed***	***Difference***
0001 – General Fund	$-	$-	$-
0904 – CHFFA Fund	$8,986,000	$8,985,000	($1,000)
0995 – Reimbursements	$2,800,000	$2,800,000	$-
3085 – Mental Health Services Fund	$15,000,000	$4,000,000	($11,000,000)
6046 – Children's Hospital Fund	$40,359,000	$40,359,000	$-
6079 – Children's Hosp. Bond Act Fund	$75,178,000	$75,358,000	$180,000
8073 – CHAMP Acct, CHFFA Fund	$400,000	$400,000	$-
Total Department Funding:	**$142,723,000**	**$131,902,000**	**($10,821,000)**
Total Authorized Positions:	**17.5**	**17.5**	**-**

CHFFA was created to be the state's vehicle for providing financial assistance to public and non-profit health care providers in California through loans funded by the issuance of tax-exempt bonds. CHFFA has financed a wide range of providers and programs throughout the state and administers the following six major programs: 1) Children's Hospital Program, 2) Tax-Exempt Bond Program, 3) Clinic Grant Program, 4) Healthcare Expansion Loan Program (HELP II), 5) California Health Access Model Program (CHAMP), and 6) Investment in Mental Health Wellness Act of 2013.

Children's Hospital Program. In 2004, California voters approved Proposition 61, which authorized the issuance of $750 million in general obligation bonds and established the Children's Hospital Program. In 2008, Proposition 3 authorized the issuance of an additional $980 million in general obligation bonds. The purpose of both programs is to improve the health and welfare of California's critically ill children by providing a stable source of funds for capital improvement projects for children's hospitals. Eight private, non-profit children's hospitals are each eligible for $172 million and five University of California Children's Hospitals are eligible for $69.2 million each through Proposition 61 and Proposition 3 combined. As of December 2016, the following grants have been approved under Proposition 61 and Proposition 3:

- Children's Hospital and Research Center Oakland
  - Prop. 61: $73.9 million (six completed projects)
  - Prop. 3: $97.4 million (four completed projects)
- Valley Children's Health Care (formerly Children's Hospital Central California)
  - Prop. 61: $73.9 million (six completed projects)
  - Prop. 3: $59.4 million (six completed projects; $38.3 million remaining to be disbursed)
- Children's Hospital Los Angeles
  - Prop. 61: $72.2 million (one completed project)
  - Prop. 3: $97.4 million (one completed project)
- Children's Hospital Orange County
  - Prop. 61: $73.9 million (five completed projects)
  - Prop. 3: $97.4 million (one completed project)
- Earl and Loraine Miller Children's Hospital Long Beach

- Prop. 61: $74 million (one completed project)
- Prop. 3: $26.7 million (one completed project; one project in progress; $15.6 million remaining to be disbursed)

- Loma Linda University Children's Hospital
  - Prop. 61: $26.1 million (two completed projects; one project in progress; $47.9 million remaining to be disbursed)
  - Prop. 3: $- (one project in progress; $97.4 million remaining to be disbursed)
- Lucile Salter Packard Children's Hospital at Stanford
  - Prop. 61: $73.6 million (one completed project)
  - Prop. 3: $97.4 million (one project in progress)
- Rady Children's Hospital San Diego
  - Prop. 61: $73.9 million (three completed projects)
  - Prop. 3: $72.2 million (four completed projects; two projects in progress)
- Mattel Children's Hospital at UCLA
  - Prop. 61: $29.8 million (one completed project)
  - Prop. 3: $24.9 million (one completed project)
- UC Davis Children's Hospital
  - Prop. 61: $29.8 million (three completed projects)
  - Prop. 3: $18.7 million (two completed projects)
- University Children's Hospital at UC Irvine
  - Prop. 61: $29.8 million (one completed project)
  - Prop. 3: $- (no project applications received; $39.2 million remaining to be disbursed)
- UC San Diego Children's Hospital
  - Prop. 61: $29.8 million (one completed project)
  - Prop. 3: $39 million (one project in progress)
- UC San Francisco Children's Hospital
  - Prop. 61: $29.8 million (one completed project)
  - Prop. 3: $39 million (one project in progress)

Tax-Exempt Bond Program. CHFFA established the Tax-Exempt Bond Program to provide health facilities with access to tax-exempt, fixed rate financing for their equipment purchases. A borrower under the program may fund qualifying equipment purchases of $500,000 or more. The maturity of the loan must be related to the useful life of the equipment to be financed. Notes issued through the program are collateralized by the equipment that is purchased. Funds may be used to purchase or reimburse all types of qualifying equipment by an eligible health facility, including but not limited to medical and diagnostic equipment, computers, and telecommunications equipment. Funds may also be used to finance minor equipment installation costs. To qualify for funding, the proposed project must be a health facility, operated by a private nonprofit corporation or association, city, city and county, county, or hospital district.

Clinic Grant Programs. AB 2875 (Cedillo), Chapter 99, Statutes of 2000, established the Cedillo-Alarcon Community Clinic Investment Act of 2000 and allocated $50 million to CHFFA for the purpose of awarding grants to eligible primary care clinics for capital outlay projects. In 2004, as part of the Anthem-Well Point merger, $35 million dollars was allocated to CHFFA for the purpose of awarding grants to eligible health care facilities providing service to underserved communities throughout California. To qualify for funding, the proposed project must be a health facility, operated by a private,

non-profit corporation or association, city, city and county, county, or hospital district. Approximately 150 non-profit community clinics received grants for infrastructure improvement.

Healthcare Expansion Loan Program II (HELP II). CHFFA established HELP II in 1995 to assist small and rural health facilities in obtaining financing for their capital needs. Health facilities eligible for financing under HELP II must meet one of the following conditions:

- Receive no more than $30 million in annual gross revenues.
- Located in a rural Medical Service Study Area as defined by the California Workforce Policy Commission.
- A district hospital.

Eligible facilities must be non-profit or publicly operated, have been in existence for at least three years performing the same types of services, and demonstrate evidence of fiscal soundness and ability to meet the terms of the loan. Eligible health facilities may receive loans under the following general terms:

- Two percent fixed interest rate for property acquisition, construction, renovation (maximum 20 year repayment period).
- Two percent fixed interest rate for equipment (maximum five year repayment period).
- Three percent fixed interest for loan refinancing (maximum 15 year repayment period).
- Loan amounts between $25,000 and $1,500,000.

California Health Access Model Program (CHAMP). AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized CHAMP, a one-time grant program to support innovative methods of health care service delivery and improve health outcomes for vulnerable populations by bringing services to individuals where they live or congregate. These health care services include medical, mental health, or dental services for the diagnosis, care, prevention, and treatment of illness or individuals with physical, mental, or developmental disabilities. In 2014, CHAMP approved a demonstration project grant for the San Francisco Health Plan (SFHP) for up to $1.5 million. SFHP's proposed project aims to expand and evaluate an existing pilot program for high-risk, high-cost patients to improve their health outcomes and experience of care, as well as to lower costs. CHFFA is reviewing options for additional CHAMP funding rounds. If demonstration projects that receive initial grants are successful at developing new methods of delivering high-quality, cost-effective health care services in community settings that result in: 1) increased access to quality health care and preventive services, 2) improved health care outcomes for vulnerable populations or communities, or both, CHFFA is authorized to implement a second grant program that awards recipients up to an additional $5 million.

Investment in Mental Health Wellness Grant Program. SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, provided $142.5 million in one-time General Fund, $4 million in ongoing Mental Health Services Act (MHSA) funding, and $2.8 million in federal matching funds (reimbursements) to provide grants for community-based mental health crisis support. Known as the Investment in Mental Health Wellness Act of 2013, SB 82 authorized CHFFA to disburse funds to California counties or their nonprofit or public agency designates to develop mental health crisis support programs. The one-time General Fund grants support capital projects to increase capacity for crisis intervention, crisis stabilization, crisis residential treatment, and rehabilitative mental health services. The MHSA and federal funds grants support personnel costs associated with operation of mobile crisis support teams. The grants support capital improvement, expansion and limited start-up costs.

CHFFA conducted five funding rounds for competitive grant awards between November 2013, and May 2016. After completion of all five rounds, the program approved a total of 56 grants for the benefit of 41 counties. Approximately $136.5 million of capital funding (General Fund) and $4 million of MHSA funding for mobile crisis support team personnel has been encumbered. As of June 30, 2016, $37.9 million of total funding has been disbursed to 22 counties. Once projects are completed, these grants will add the following mental health crisis support resources:

- 76 mobile crisis vehicles
  - Status (Sept 2016): 61 purchased; additional 15 expected by the end of 2017
- 58.25 mobile crisis personnel
  - Status (Sept 2016): 55.65 individuals hired
- 1,185 crisis stabilization and crisis residential treatment beds
  - Status (Sept 2016):
    - 63 crisis stabilization beds added; additional 228 expected by the end of 2017
    - 56 crisis residential treatment beds added; additional 838 expected by the end of 2017
- 18 peer respite beds
  - Status (Sept 2016): None added; 18 expected by the end of 2017

Approximately 41 beds will be dedicated to youth individuals.

After the fifth and final funding round, $7 million of General Fund capital funding remained to revert back to the General Fund. The 2016 Budget Act reappropriated these funds and authorized a total augmentation of $31 million ($17 million General Fund, $14 million MHSA funds) in 2016-17 for additional expansion of community-based mental health crisis support specifically for children under 21 years of age. The budget includes a current year reversion of the $17 million General Fund previously allocated for this purpose, while preserving availability of the MHSA funding. (See Issue 3: Reversion of Children's Crisis Capacity Infrastructure Grant Funding)

Subcommittee Staff Comment. This is an informational item.

Questions. The subcommittee has requested CHFFA to respond to the following:

1. Please provide a brief overview of CHFFA's mission and programs.

2. How does CHFFA monitor progress on the grants it awards through its various funding programs?

3. Please provide a status update on the progress of mental health crisis capacity expansion funded by the Investment in Mental Health Wellness Program.

Issue 2: Reversion of Community Infrastructure Grant Funding

Budget Issue. The Administration requests reversion of $67.5 million General Fund in 2016-17. These funds were approved in the 2016 Budget Act for infrastructure grant funding to assist communities in providing mental health or substance use disorder treatment. This augmentation was part of a package of General Fund investments designed to reduce people's involvement in the criminal justice system. If the proposed reversion is approved, the Administration would reallocate this funding to other budgetary expenditures and the previously approved community infrastructure grant program would be eliminated.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	($67,500,000)	$-
Total Funding Request:	**($67,500,000)**	**$-**
Total Positions Requested:	**0.0**	

Background. The 2016 Budget Act appropriated $67.5 million to CHFFA and approved trailer bill language to establish a competitive infrastructure grant program to promote criminal justice diversion programs and services. The grant program would have achieved these goals by supporting expansion of capacity in mental health treatment facilities, substance use disorder treatment facilities, and trauma-centered service facilities.

These grants were part of a package of local public safety investments included in the 2016 Budget Act to reduce people's involvement in the criminal justice system. The $67.5 million one-time funding was intended to provide infrastructure grants to cities and counties for land purchase, construction, repairs, and upgrades to increase the local infrastructure for providing transitional housing, mental health and substance abuse treatment, services for victims of human trafficking and domestic violence, and other supportive services needs identified by the county or city.

The budget proposes to revert the $67.5 million General Fund allocation for the competitive infrastructure grant program. This proposal is one of several reductions in one-time spending commitments included in the budget to address the state's General Fund deficit. If approved, the proposed reversion of these funds is permanent and the grant program would be eliminated.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending updates to the state's General Fund condition at the May Revision.

Questions. The subcommittee has requested Department of Finance to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe the Administration's rationale for reversion of these previously approved funds and elimination of the community infrastructure grant program.

3. Please describe any expected future impact on expenditures in the criminal justice system as a result of reduced availability of diversion programs and services.

Issue 3: Reversion of Children's Crisis Capacity Infrastructure Grant Funding

Budget Issue and Trailer Bill Language Proposal. The Administration requests reversion of $17 million General Fund in 2016-17. These funds were approved in the 2016 Budget Act to increase the number of facilities providing a continuum of crisis services for children. If the proposed reversion and accompanying trailer bill language are approved, the Administration would reallocate this funding to other budgetary expenditures and the grant program would be limited to the previously allocated MHSA funds.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	($17,039,000)	$-
Total Funding Request:	**($17,039,000)**	**$-**
Total Positions Requested:	**0.0**	

Background. The 2016 Budget Act appropriated a total of $17 million to CHFFA and approved trailer bill language to establish a competitive grant program to provide a continuum of crisis services to children under 21 years of age with the following objectives:

1. Provide for early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.
2. Expand community-based services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness-, resiliency, and recovery-oriented.
3. Add at least 200 mobile crisis support teams.
4. Add at least 120 crisis stabilization and crisis residential treatment beds.
5. Add triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders in community-based service points, such as homeless shelters, schools, and clinics.
6. Expand family respite care.
7. Expand family supportive training.
8. Reduce unnecessary hospitalizations and inpatient days.
9. Reduce recidivism and unnecessary local law enforcement expenditures.
10. Provide local communities with increased financial resources to leverage public and private funding sources to improve networks of care for children and youth with mental health disorders.

These grants were part of a package of local public safety investments included in the 2016 Budget Act to reduce people's involvement in the criminal justice system. The total investment in children's crisis services was $31 million ($17 million General Fund and $14 million MHSA funds). The General Fund was composed of approximately $7 million reappropriated from unspent funds previously allocated to the Investment in Mental Health Wellness Grant Program and $10 million of new General Fund resources.

The budget proposes to revert the $17 million General Fund portion of the funding. This proposal is one of several reductions in one-time spending commitments included in the budget to address the state's General Fund deficit. According to the Administration's arguments in support of this proposal, these

funds were at an early stage of development and remained uncommitted. The remaining MHSA funds are still available for competitive grants to fulfill the objectives of the original allocation.

Trailer Bill Language Proposal. The Administration is also proposing accompanying trailer bill language to amend the statutory provisions of the grant program as follows:

1. Implements the program "[t]o the extent funds are available" and deletes references to the 2016 Budget Act allocation.
2. Removes the required numbers of mobile crisis support teams and crisis stabilization and crisis residential treatment beds.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold these issues open pending updates to the state's General Fund condition at the May Revision.

Questions. The subcommittee has requested Department of Finance to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe the Administration's rationale for reversion of these previously approved funds and reduction of the scope of the children's crisis services grant program.