SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Ellen Corbett

Senator Bill Monning
Senator Mimi Walters

April 3, 2014

9:30 a.m. or Upon Adjournment of Session

Room 4203, State Capitol

Agenda – Part B
(Michelle Baass)

PLEASE NOTE:

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

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

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. Thank you.

Community Mental Health Overview

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

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

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

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

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

California's Medi-Cal Specialty Mental Health Services Waiver is effective until June 30, 2015. See below for budget summary.

Table: Medi-Cal Specialty Mental Health Services Funding Summary

2013-14		2014-15	
General Fund	**Federal Funds**	**General Fund**	**Federal Funds**
$28,981,000	$1,891,641	-$6,000,000	$1,835,949

In 2014-15, it is projected that 242.843 adults and 261,507 children will receive Medi-Cal Specialty Mental Health Services (using the accrual methodology). It should be noted that these projected caseload estimates do not include the anticipated caseload growth as a result of the optional Medi-Cal expansion as provided by AB 1 X1 (Pérez), Chapter 3, Statutes of 2013-14 of the First Extraordinary Session.

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

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

The budget projects $1.587 billion in MHSA revenues in 2014-15, of this $1.36 billion is for local assistance and about $80 million is for state administration. For 2013-14, the budget projects $1.375 billion in MHSA revenues, of this about $69 million is for state administration. Counties receive MHSA funds from the State Controller's Office on a monthly basis.

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

Table: Behavioral Health Realignment Funding (dollars in millions)

Account	**2013-14**			**2014-15**		
	Base	**Growth**	**Total**	**Base**	**Growth**	**Total**
1991 Realignment						
Mental Health Subaccount*	-	$0.237	$0.2	-	$76.3	$76.3
2011 Realignment						
Mental Subaccount Health Account*	$1,120.6	$8.0	$1,128.6	$1,120.6	$19.8	$1,140.4
Behavioral Health Subaccount**	$992.3	$52.8	$1,045.1	$1,045.3	$184.3	$1,229.6
Total			**$2,173.9**			**$2,446.3**

*2011 Realignment changed the distribution of 1991 Realignment funds in that the funds that would have been deposited into the 1991 Realignment Mental Health Subaccount, a maximum of $1.12 billion, is now deposited into the 1991 Realignment CalWORKs MOE Subaccount. Consequently, 2011 Realignment deposits $1.12 billion into the 2011 Realignment Mental Health Account.
**Reflects $5.1 million allocation to Women and Children's Residential Treatment Services.

0977 California Health Facilities Financing Authority (CHFFA)

1. Investment in Mental Health Wellness Act of 2013

Oversight Issue. SB 82 (Committee of Budget and Fiscal Review), Chapter 34, Statutes of 2013, enacted the Investment in Mental Health Wellness Act of 2013 which appropriated $149.8 million to CHFFA as follows:

- Crisis Residential Treatment Beds – $125 million one-time General Fund to provide grants to expand existing capacity by at least 2,000 crisis residential treatment beds over two years. These funds are to be used to leverage other private and public funds.

- Mobile Crisis Teams - $2.5 million one-time ($2 million General Fund and $500,000 Mental Health Services Act Fund State Administration) to purchase vehicles to be used for mobile crisis teams and $6.8 million ongoing ($4 million Mental Health Services Act Fund State Administration and $2.8 million federal funds) to support mobile crisis support team personnel.

- Crisis Stabilization Units - $15 million one-time General Fund to provide grants to increase the number of crisis stabilization units.

- $500,000 in one-time General Fund for CHFFA to develop the above-specified grant programs.

Additionally, SB 82 required CHFFA to submit to the Legislature, on or before May 1, 2014 and on or before May 1, 2015, a report on the progress of the implementation of these grant programs.

Implementation Status. As required by SB 82, CHFFA conducted public forums throughout the state in the fall of 2013 to gather stakeholder input into the design of this competitive grant program. It also adopted emergency regulations to implement the grant program.

Per SB 82 and the implementing emergency regulations, the scoring for these applications was weighted more towards applications that proposed to develop this crisis treatment infrastructure in a community-based residential setting instead of a institutional or hospital-like setting.

CHFFA has completed its review of the first round of applications and anticipates announcing the recommended grant awards by the first week of April. These recommendations must be adopted by the CHFFA board and are tentatively scheduled to be heard at the April CHFFA board meeting. Counties would have an opportunity to appeal the CHFFA recommendations. Depending on if counties appeal and the nature of the appeals, grant awards could be distributed as early as the end of April and likely no later than the end of May.

The following counties applied for these grants: Alameda, Butte, Contra Costa, El Dorado, Fresno, Humboldt, Kern, Los Angeles, Lake Marin, Mendocino, Merced (with Calaveras, Tuolumne, Mariposa, Madera), Monterey, Napa, Nevada, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta (to serve Siskiyou, Trinity, Modoc, Lassen, Tehama), Solano, Sonoma, Stanislaus, Ventura, and Yolo.

The total first round of capital funding recommended by CHFFA for approval by the board is $76.5 million (out of the $142.5 million available). This funding would support 835 new crisis beds and 52 new mobile crisis vehicles.

The total personnel funding recommended by CHFFA for approval by the board is about $6.5 million (of the $6.8 million for personnel).

According to CHFFA, a second funding round for crisis residential treatment programs appears very likely. The second funding round will begin immediately following awards made by the CHFFA board for the first funding round. Whether a second funding round will also include crisis stabilization or mobile crisis programs is not yet clear. An update on funding for these programs will be provided as soon as CHFFA knows for certain whether additional funds remain.

Subcommittee Staff Comment. This is an informational item.

Questions.

1. Please provide an overview and update on this item.

2. Please discuss how SB 82 and the emergency regulations to implement this competitive grant program are focused on developing a crisis treatment infrastructure that is community-based.

4560 Mental Health Services Oversight and Accountability Commission

1. Overview

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

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

Most of the Act's funding is to be expended by county mental health departments for mental health services consistent with their approved local plans (three-year plans with annual updates) and the required five components, as contained in the MHSA. The following is a brief description of the five components:

- **Community Services and Supports for Adult and Children's Systems of Care.** This component funds the existing adult and children's systems of care established by the Bronzan-McCorquodale Act (1991). County mental health departments are to establish, through its stakeholder process, a listing of programs for which these funds would be used. Of total annual revenues, 80 percent is allocated to this component.

- **Prevention and Early Intervention.** This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations. Of total annual revenues, 20 percent is allocated to this component.

- **Innovation.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and promote interagency collaboration. This is funded from five percent of the Community Services and Supports funds and five percent of the Prevention and Early Intervention funds.

- **Workforce Education and Training.** The component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of $460.8 million. Counties have 10 years to spend these funds.

- **Capital Facilities and Technological Needs.** This component addresses the capital infrastructure needed to support implementation of the Community Services and

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

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

The Commission consists of 16 voting members as follows:

- The Attorney General or his or her designee.
- The Superintendent of Public Instruction or his or her designee.
- The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.
- The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.
- The following are 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.

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

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

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

Subcommittee Staff Comment. This is an informational item.

Questions.

1. Please provide a brief overview of the MHSOAC and an update on recent activities and explain how they are in furtherance of its mandate.

2. What efforts does the MHSOAC have underway to utilize its evaluations regarding the successes and challenges of MHSA programs?

2. Investment in Mental Health Wellness Act of 2013 – Triage Personnel

Oversight Issue. SB 82 (Committee of Budget and Fiscal Review), Chapter 34, Statutes of 2013, enacted the Investment in Mental Health Wellness Act of 2013 which appropriated $54.4 million to the MHSOAC as follows:

- $54 million ($32 million Mental Health Services Act [MHSA] State Administration and $22 million federal) in ongoing funding to add 600 mental health triage personnel in select rural, urban, and suburban regions. Also required the MHSOAC to provide a status report to the Legislature on the progress of allocating the triage personnel funding. This report was submitted to the Legislature on February 28, 2014.

To conduct a competitive grant process for this funding, the MHSOAC developed Request for Applications guidelines for submitting grant proposals. In this process, MHSOAC gathered subject matter experts to advise staff on the grant criteria. Additionally, the MHSOAC used the five regional designations utilized by the California Mental Health Directors Association to ensure that grants would be funded statewide in rural, suburban, and urban areas. As such, the $32 million of MHSA funds available annually was divided between the following regions:

Southern	$10,848,000
Los Angeles	$9,152,000
Central	$4,576,000
Bay Area	$6,208,000
Superior	$1,216,000
Total	$32,000,000

Grants cover four fiscal years, with grant funds allocated annually for 2013-14 (for five months), 2014-15, 2015-16, and 2016-17.

A total of 47 grant applications were submitted to the MHSOAC. Twenty-two counties received the highest score within their region and were awarded grant funding.

A total of 478.6 triage personnel (184 are for peer positions) will be added through the awarding of these MHSA grant funds. These positions will be mobile and able to travel to respond to mental health crises, including crisis involving law enforcement. These personnel will be located in hospitals, emergency rooms, jails, shelters, high schools, crisis stabilization and wellness centers, and other community locations where they can engage with persons needing crisis services. See table below for award details.

Table: Investment in Mental Health Wellness – Triage Personnel Grant Awards

	2013-14	2014-15	2015-16	2016-17		FTEs
Amount Allocated	**$32,000,000**	**$32,000,000**	**$32,000,000**	**$32,000,000**		
Southern Region	**$10,848,000**	**$10,848,000**	**$10,848,000**	**$10,848,000**	**County Total**	
Ventura	$840,259	$2,126,827	$2,242,542	$2,364,043	$7,573,671	23.0
Riverside	$488,257	$2,134,233	$2,307,808	$2,510,844	$7,441,142	32.3
Santa Barbara	$933,135	$2,352,536	$2,468,608	$2,594,250	$8,348,529	23.5
Orange	$1,250,000	$3,000,000	$3,000,000	$3,000,000	$10,250,000	28.0
Region Total	**$3,511,651**	**$9,613,596**	**$10,018,958**	**$10,469,137**		**106.8**
Los Angeles	**$9,152,000**	**$9,152,000**	**$9,152,000**	**$9,152,000**		
Los Angeles	$3,802,000	$9,125,000	$9,125,000	$9,125,000	$31,177,000	183.0
Region Total	**$3,802,000**	**$9,125,000**	**$9,125,000**	**$9,125,000**		**183.0**
Central	**$4,576,000**	**$4,576,000**	**$4,576,000**	**$4,576,000**	**County Total**	
Yolo	$221,736	$505,786	$496,247	$504,465	$1,728,234	8.3
Calaveras	$41,982	$73,568	$73,568	$73,568	$262,686	1.0
Tuolumne	$74,886	$132,705	$135,394	$135,518	$478,503	3.0
Sacramento	$545,721	$1,309,729	$1,309,729	$1,309,729	$4,474,908	20.8
Mariposa	$88,972	$196,336	$203,327	$210,793	$699,428	4.3
Placer	$402,798	$750,304	$667,827	$688,417	$2,509,346	13.6
Madera	$163,951	$389,823	$410,792	$396,030	$1,360,596	4.2
Merced	$359,066	$868,427	$882,550	$893,026	$3,003,070	8.0
Region Total	**$1,899,112**	**$4,226,678**	**$4,179,434**	**$4,211,546**		**63.2**
Bay Area	**$6,208,000**	**$6,208,000**	**$6,208,000**	**$6,208,000**	**County Total**	
Sonoma	$351,672	$871,522	$897,281	$923,888	$3,044,363	8.0
Napa	$126,102	$411,555	$403,665	$382,313	$1,323,635	6.0
San Francisco	$1,751,827	$4,204,394	$4,204,394	$4,204,394	$14,365,009	63.7
Marin	$137,065	$315,738	$320,373	$326,746	$1,099,922	3.0
Alameda	$311,220	$765,811	$785,074	$804,692	$2,666,797	11.6
Region Total	**$2,677,886**	**$6,569,020**	**$6,610,787**	**$6,642,033**		**92.3**
Superior	**$1,216,000**	**$1,216,000**	**$1,216,000**	**$1,216,000**	**County Total**	
Butte	$358,519	$514,079	$199,195	$3,277	$1,075,070	18.0
Lake	$26,394	$52,800	$52,800	$52,800	$184,794	1.0
Trinity	$60,697	$145,672	$145,672	$145,672	$497,713	2.5
Nevada	$289,260	$694,169	$728,878	$765,321	$2,477,628	11.8
Region Total	**$734,870**	**$1,406,720**	**$1,126,545**	**$967,070**		**33.3**
Total	**$12,625,519**	**$30,941,014**	**$31,060,724**	**$31,414,786**		**478.6**
Surplus	**$19,374,481**	**$1,058,986**	**$939,276**	**$585,214**		

Contracts between the MHSOAC and county mental health departments receiving grant awards are expected to be executed in March. with funding available to counties shortly thereafter.

In the current year, $19 million in these MHSA grant funds were not awarded due to the time it took to develop this competitive program. The Administration is considering options for the use of this funding.

Subcommittee Staff Comment. This is an informational item.

Questions.

1. Please provide an overview of this item.

4260 Department of Health Care Services

1. Community Mental Health Overview

As discussed in detail in the "Community Mental Health Overview" section of the agenda, California has a decentralized public mental health system with most direct services provided through the county mental health system.

Counties (i.e., County Mental Health Plans) have the primary funding and programmatic responsibility for the majority of local mental health programs. Specifically, counties are responsible for: (1) all mental health treatment services provided to low-income, uninsured individuals with severe mental illness (2) Medi-Cal Specialty Mental Health Services for adults and children, (3) mental health treatment services for individuals enrolled in other programs, including special education and CalWORKs, and (4) programs associated with the Mental Health Services Act of 2004 (known as Proposition 63).

Subcommittee Staff Comments. This is an informational item. However, it should be noted that the January Medi-Cal Specialty Mental Health estimate did not include a forecast of the utilization of these services by individuals eligible for Medi-Cal through the optional expansion implemented by AB 1 X1. Even though these services would be fully funded by the federal government, it is important to have an understanding of the projected changes in utilization of these services as a result of the Medi-Cal expansion.

The Administration indicates that the projected impact of the optional Medi-Cal expansion on Medi-Cal Specialty Mental Health will be included in the May Revise.

Questions.

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

2. 2011 Realignment – Behavioral Health Subaccount Growth Allocation

Budget Issue. The formula to allocate 2011 Realignment Behavioral Health Subaccount Growth funds has not yet been determined. These growth funds are estimated at $27.9 million in 2012-13, $52.8 million in 2013-14, and $184.3 million in 2014-15.

The Department of Finance, in consultation with the appropriate state agencies and the California State Association of Counties, is required to develop a schedule for the allocation of these funds to the counties.

The Administration indicates that it is still in discussions with counties to finalize the Behavioral Health Subaccount Growth schedule. As part of these discussions, the Administration is looking at the most recent expenditure data available to determine which counties are over and under Behavioral Health Subaccount allocations and where growth funding could fund entitlements.

Background. SB 1020 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2012, created the permanent structure for 2011 Realignment. SB 1020 codified the Behavioral Health Subaccount which funds Medi-Cal Specialty Mental Health Services (for children and adults), Drug Medi-Cal, residential perinatal drug services and treatment, drug court operations, and other non-Drug Medi-Cal programs. Medi-Cal Specialty Mental Health and Drug Medi-Cal are entitlement programs and counties have a responsibility to provide for these entitlement programs.

Government Code Section 30026.5(k) specifies that Medi-Cal Specialty Mental Health Services shall be funded from the Behavioral Health Subaccount, the Behavioral Health Growth Special Account, the Mental Health Subaccount (1991 Realignment), the Mental Health Account (1991 Realignment), and to the extent permissible under the Mental Health Services Act, the Mental Health Services Fund. Government Code Section 30026.5(g) requires counties to exhaust both 2011 and 1991 Realignment funds before county General Fund is used for entitlements. A county board of supervisors also has the ability to establish a reserve using five percent of the yearly allocation to the Behavioral Health Subaccount that can be used in the same manner as their yearly Behavioral Health allocation, per Government Code Section 30025(f).

Consistent with practices established in 1991 Realignment, up to 10 percent of the amount deposited in the fund from the immediately preceding fiscal year can be shifted between subaccounts in the Support Services Account with notice to the Board of Supervisors, per Government Code Section 30025(f). This shift can be done on a one-time basis and does not change base funding. In addition, there is not a restriction for the shifting of funds within a Subaccount, but any elimination of a program, or reduction of 10 percent in one year or 25 percent over three years, must be duly noticed in an open session as an action item by the Board of Supervisors, per Government Code Section 30026.5(f). Government Code Section 30026.5(e) also requires 2011 Realignment funds to be used in a manner to maintain eligibility for federal matching funds.

DHCS issued Mental Health Services Division Information Notice 13-01 on January 30, 2013, to inform counties that 2011 Realignment did not abrogate or diminish the responsibility that, "they must provide, or arrange for the provision of, Medi-Cal specialty mental health services, including specialty mental health services under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit." As noted above, Government Code Section 30026.5(k) specifies fund sources for Medi-Cal Specialty Mental Health Services. The Administration continues to work with the California State Association of Counties and the California Mental Health Directors Association to ensure all counties are aware that entitlement programs and clients cannot be denied services.

Additionally, the Administration cites that Section 1810.226 of the California Code of Regulations defines a mental health plan to be an entity that contracts with the Department of Health Care Services to provide directly or arrange and pay for specialty mental health services to beneficiaries in a county as provided in Chapter 11 of Title 9 of the California Code of Regulations. The Department has executed contracts with the county mental health departments to be the mental health plans for Medi-Cal where the county agrees to provide directly or arrange and pay for the provision of Medi-Cal specialty mental health services to beneficiaries in a county. Statute also provides DHCS the ability to investigate complaints and the authority to impose sanctions on counties that do not fulfill its obligations as a mental health plan. Those sanctions may include fines or penalties.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as the Administration has not yet released its proposed formula. Key considerations when evaluating the proposed formula include:

- Does the proposed formula reflect actual expenditures for Medi-Cal Specialty Mental Health and Drug Medi-Cal?

- Does the proposed formula make it clear to counties that funding for entitlement programs is not capped and that counties need to provide the entitled services?

- Does the proposed allocation of growth funds incentivize improvement in the delivery of services?

- Will the allocation of growth funds be done on a timely basis so counties can budget and rely on the prompt allocation of these funds?

Questions.

1. Please provide an overview of this item and an update on when the Administration will release the proposed allocation formula.

2. Please confirm that Medi-Cal Specialty Mental Health and Drug Medi-Cal are entitlement programs that the counties must fully fund. How does the state monitor to

ensure that counties are not capping services and are not providing less comprehensive services for these entitlement programs.

3. SB 1 X1 - Mental Health and Substance Use Disorder Benefit Expansion

Budget Issue. In order to implement SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session, which expanded Medi-Cal mental health and substance use disorder (SUD) benefits, the Governor's budget proposes the following:

1. **Mental Health Benefit Expansion -** $300 million ($119 million General Fund, $181 federal funds).

2. **Substance Use Disorder (SUD) Services Benefit Expansion -** $206 million ($79 million General Fund, $127 million federal funds).

3. **Additional Positions to Implement SUD Expansion -** DHCS requests 10 permanent positions and 12 two-year limited-term positions to implement new requirements set forth in the Affordable Care Act (ACA), and enacted in SB 1 X1 and as a part of the 2013-14 budget, for enhanced Medi-Cal substance use disorders services.

   According to DHCS, these positions would provide program oversight and monitoring, policy development, program integrity and compliance with applicable state and federal policies, statutes and regulations. The total proposed funding for the 22 positions is $2,748,000 ($1,303,000 General Fund and $1,445,000 federal funds).

Background. The ACA requires states electing to participate within the Act's Medicaid expansion to provide all components of the "essential health benefits" (EHB) as defined within the state's chosen alternative benefit package that comports with federal requirements. The ACA regulations have delineated mental health and substance use disorder services as part of the EHB standard and require all alternative benefit plans under Section 1937 of Title XIX of the Social Security Act to cover such services.

California is required to meet these federal standards for the Medi-Cal expansion population. The EHB standard must also be met by non-grandfathered private health plans in a state's individual and small group markets. SB 1 X1 addressed the EHB standard by specifying that Medi-Cal would provide the same services for its members that they could receive if they bought a non-grandfathered health plan in the state's individual and small group markets for mental health and substance use disorder services. Consequently, those individuals previously and newly-eligible for Medi-Cal will have access to the same set of services.

Starting in 2014, the array of mental health and substance use disorder services will expand to better meet the needs of individuals eligible for Medi-Cal. See Appendix A for more information.

The following mental health benefits will be available through Medi-Cal managed care plans or the fee-for-service delivery system:

- Individual and group mental health evaluation and treatment (psychotherapy)

- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies, and supplements
- Psychiatric consultation

Specialty mental health services currently provided by County Mental Health Plans will continue to be available.

The following substance use disorder services benefits will also be made available to eligible Medi-Cal beneficiaries:

- Voluntary Inpatient Detoxification
- Intensive Outpatient Treatment Services
- Residential Treatment Services
- Outpatient Drug Free Services
- Narcotic Treatment Services

Status of the Mental Health Benefit Expansion. According to DHCS, the mental health benefit expansion is operational. DHCS completed readiness assessments for all new mental health benefits for all Medi-Cal Managed Care Plans (MCPs). A few plans are refining their policies and procedures based on ongoing communication with DHCS. DHCS expects to complete review during spring 2014.

For the period of January 1 - June 30, 2014, DHCS finalized mental health rates for the optional expansion population and the plans are currently receiving those payments as part of the optional expansion rates. For the non-expansion population, DHCS is in the process of submitting capitation rates. Once those rates are approved, payments to plans will be retroactive to January 1, 2014. The rates for 2014-15 have not been finalized.

DHCS finalized the Medi-Cal Managed Care contract amendments. The amended contracts are in the process of being executed. DHCS worked with stakeholders and created Memorandum of Understanding (MOU) templates to be used by Medi-Cal Managed Care Plans and Mental Health Plans. Plans are required to submit signed MOUs to DHCS, by June 30, 2014.

These MOUs are critical in that they outline the agreed upon process between Medi-Cal Managed Care Plans and Mental Health Plans for referrals, common screening tools, and dispute resolution, for example.

Status of SUD Benefit Expansion. Effective January 1, 2014, providers are able to offer the new substance use disorder benefits. However, for these specific providers, they cannot receive reimbursement through the Drug Medi-Cal program until the Centers for Medicare and Medicaid Services (CMS) approves California's pending State Plan Amendment for reimbursement of these services. As of February 25, 2014, no claims have been submitted for the expanded services available through SB 1 X1.

SB 1 X1 authorizes all Medi-Cal beneficiaries with a medical need for the service to receive Day Care Rehabilitation (to be renamed Intensive Outpatient Treatment) and Residential Treatment services. These services will no longer be restricted to specific subpopulations. DHCS anticipates these services will be available as soon as CMS approves the relevant State Plan Amendment (SPA) 13-038.

IMD Exclusion. Additionally, in implementing the new expanded residential Drug Medi-Cal benefit for all adults, DHCS has encountered an issue. Based on CMS current interpretation of the Institutions for Mental Disease (IMD) Exclusion, DHCS is prohibited from using federal funds to reimburse for any Medi-Cal service when a Medi-Cal beneficiary is receiving substance use disorder services in residential facilities larger than 16 beds. Ninety percent of the residential treatment beds in California exceed the current IMD limit.

DHCS is currently working with CMS to address and resolve outstanding issues associated with approval of SPAs 13-038 and 13-035, as well as with the interpretation of the IMD definition as it relates to residential SUD residential treatment facilities.

DHCS is in the process of re-certifying Drug Medi-Cal providers; however, existing providers are still certified while they are going through the re-certification process. DHCS is working to ensure there will be enough providers. DHCS recently mapped the locations of DMC treatment providers. As expected, most providers are located in major population areas, with far fewer DMC providers in rural areas. DHCS will continue to work with county partners and stakeholders to track issues related to provider capacity.

Proposed rates for expanded Drug Medi-Cal services are part of SPA 09-022, which has not yet been approved by CMS.

Definition of "Moderate" Mental Illness. The definition of "moderate" mental illness has not been agreed upon by the state, Medi-Cal managed health care plans, and county mental health plans. This definition is important to ensure that a person can easily access needed services and does not have to navigate back and forth between the managed care plan and the county health plan to receive the service.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic.

Questions.

1. Please provide an overview of this issue.

2. How did DHCS notify existing Medi-Cal enrollees about these new Medi-Cal mental health and substance use disorder services benefits?

3. Are there any examples of best practices or innovative models from how the plans have implemented this?

4. Are there any recent updates regarding discussions with the federal government and the IMD exclusion?

5. What steps is DHCS taking to work with managed care plans and county mental health plans to define “moderate” mental illness? Have there been any issues with consumers not receiving services because this definition is not clear?

6. Do all Medi-Cal managed care plans have existing MOUs with county mental health plans? What is the status of MOU amendments or new MOUS? Please provide an overview of the new components of the MOU regarding the expanded mental health benefits.

7. Does DHCS track issues or consumer difficulties related to the interaction between managed care plans and county mental health plans? Please explain.

8. Is DHCS tracking utilization of these new benefits?

4. Monitoring of County Mental Health Plans

Budget Issue. DHCS requests seven positions and $1,145,000 ($314,000 General Fund and $831,000 federal funds) to increase the scope, frequency, and intensity of monitoring and oversight by DHCS of County Mental Health Plans (MHPs).

This request is in direct response to concerns which the Centers for Medicare and Medicaid Services (CMS) has communicated to DHCS regarding the following areas: (1) timely access to services in the Medi-Cal Specialty Mental Health Services (SMHS) Program; (2) the availability of interpreter services, especially for Spanish speaking beneficiaries; and (3) significantly elevated rates of non-compliance observed during DHCS compliance system reviews of MHP operations, California External Quality Review Organization (EQRO) reviews, as well as the continuing high rates of claim disallowance resulting from both outpatient and inpatient medical record reviews.

CMS has made clear its expectation that DHCS will take effective remedial action immediately to bring the levels of non-compliance and claims disallowance down to acceptable levels.

Background. CMS sent DHCS a letter dated June 27, 2013, stating that it had approved DHCS's SMHS Waiver Renewal Application for a two-year period, rather than the five-year period which DHCS had requested. The letter states that:

> *".....CMS harbors concerns about access challenges faced by some County Mental Health Plans… CMS will be carefully analyzing the State's monitoring activities and corrective action plans to ensure all necessary actions are implemented and improvement occurs."*

The letter also requests that DHCS begin submitting *"all triennial monitoring reports to CMS within 30 days of completion,"* for its review, and expresses concerns regarding the frequency of reviews and what appears to be a lack of follow-up on areas identified as being out of compliance.

In a follow-up telephone call to the June 27, 2013 letter, CMS reiterated concerns about the continuing elevated rates of disallowance resulting from inpatient and outpatient medical record reviews, stating that a non-compliance or disallowance rate above three percent is considered high.

California's current disallowance rates are as follows:

- The average MHP non-compliance rate for system reviews of MHPs for fiscal years 2011-2012 and 2012-2013 was 23 percent.

- The average MHP disallowance rate for outpatient medical record reviews for fiscal years 2011-2012 and 2012-2013 was 32 percent.

- The average MHP disallowance rate for the 18 Short-Doyle/Medi-Cal acute psychiatric inpatient hospitals resulting from inpatient medical record reviews from 2002 to the present was approximately 50 percent.

Without the additional resources being requested in this proposal, DHCS indicates it will not be able to address the concerns stated by CMS and will not be able to increase the scope, frequency and intensity of monitoring which is needed.

Position Details. DHCS requests the following seven additional positions in the Mental Health Services Division:

1. Program Oversight and Compliance Branch—Compliance (4.0 Positions): Increase scope, intensity, and frequency of oversight and monitoring of the county MHPs and identified providers.

2. Program Policy and Quality Assurance Branch—County Support (2.0 Positions): Increase the level of monitoring and technical assistance provided to the MHPs by the county support unit, including clinical technical assistance in order to ensure they are in compliance with state and federal requirements, and increasing the level of follow-up when out-of-compliance areas are identified.

3. Program Policy and Quality Assurance Branch—Appeals (1.0 Positions): Establish staffing for appeals within the branch which includes licensed clinical staff who will be responsible for reviewing appeals and making appeal decisions.

Subcommittee Staff Comment and Recommendation—Approve. No concerns have been raised regarding this proposal. It is critical that DHCS take immediate action to address CMS's concerns and ensure that county mental health plans comply with Medi-Cal rules.

Questions.

1. Please provide an overview of this request.

2. Please explain how this proposal will ameliorate CMS concerns?

3. What are some examples of sanctions or corrective actions that have been undertaken by plans?

5. Performance Outcomes System Plan for EPSDT Medi-Cal Mental Health Services

Budget Issue. DHCS requests ongoing funding of $563,000 ($242,000 General Fund and $321,000 federal funds) for four permanent positions to implement a Performance Outcome System for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services as required by SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012 and AB 82 (Committee on Budget), Chapter 34, Statutes of 2013.

The purpose of the Performance Outcome System is to provide the capability to understand the statewide outcomes of these services provided, in order to best ensure compliance with the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirement. Although the non-federal share of funding for the Medi-Cal Specialty Mental Health program has been realigned to the counties, the state maintains a responsibility for ensuring access to the federal entitlement for the Medi-Cal Specialty Mental Health program. For children and youth up to age 21 in this program, federal law further requires EPSDT to ensure access to medically necessary specialty mental health services.

Background. SB 1009 required DHCS to: (1) convene a stakeholder advisory committee no later than September 1, 2012, (2) submit to the Legislature by October 1, 2013, a Performance Outcomes System Plan, and (3) submit to the Legislature by January 10, 2014, a Performance Outcomes System Implementation Plan.

DHCS convened the Stakeholder Advisory Committee in September 2012, and held the first meeting in October 2012 to discuss how best to approach the development of a Performance Outcome System to evaluate California's Medi-Cal specialty mental health services for children and youth. This committee included participation by representatives of youth family members and/or caregivers; county staff; child/youth advocates; other California state-level entities, including the Legislature, and the Mental Health Services Oversight and Accountability Commission (MHSOAC); as well as other members of the interested public.

Informed by input from the Stakeholder Advisory Committee and Subject Matter Expert Workgroup, DHCS produced a System Plan that sets forth a framework from which specialty mental health services outcomes may be measured. It described next steps that must be taken to identify an evaluation methodology (e.g., specifying the evaluation questions, identifying the target population, selecting valid and reliable measurement tools) and to develop a continuous reporting and quality improvement process between the state, counties, and their providers.

In January 2014, DHCS submitted its Performance Outcomes System Implementation Plan to the Legislature. This implementation plan discusses the steps necessary to implement a fully operational performance outcomes system and includes a timeline to achieve this. See below for timeline.

Table: Timeline to Build the EPSDT Performance Outcome System

Milestones	Date
System Implementation Plan	
Draft System Implementation Plan	November 2013
Obtain input on the final draft Implementation Plan from the Stakeholder Advisory Committee	December 2013
Deliverable: System Implementation Plan	**January 2014**
Establish Performance Outcome System Methodology	
Facilitate stakeholder input on the Performance Outcome System evaluation methodology (including standardized data sources and data collection tools used for the system, frequency of administration, etc.)	October 2014
Obtain Input on the Performance Outcome System methodology protocol from the Stakeholder Advisory Committee	December 2014
Deliverable: Performance Outcome System Protocol	**February 2015**
Initial Performance Outcomes Reporting: Existing DHCS Databases	
Identify performance outcomes data elements in existing DHCS databases	May 2014
Assess data integrity	July 2014
Develop county data quality improvement reports	September 2014
Counties remedy data quality issues	Ongoing Beginning in October 2014
Develop performance outcomes report template(s)	November 2014
Obtain input on the report template(s) from the Stakeholder Advisory Committee	December 2014
Deliverable: Statewide and County Reports on Initial Performance Outcomes Using Data from Existing DHCS Databases	**Ongoing Beginning in December 2014**
Continuum of Care: Screenings and Referrals	
Convene Performance Outcomes System Stakeholder Advisory Committee to discuss Continuum of Care	December 2013
Obtain input on screening and referral information needed for the performance outcome system from the Performance Outcomes System Stakeholder Advisory Committee	April 2014

Milestones	Date
Deliverable: Performance Outcome System Plan Update	**October 2014**
Deliverable: Performance Outcome System Implementation Plan Update	**January 2015**
Comprehensive Performance Outcomes Reporting: Expanded Data Collection	
The activities associated with this task are dependent on the number and scope of additional data elements adopted as part of the Performance Outcome System methodology.	FY 2014-15
Obtain input on the report template(s) from the Stakeholder Advisory Committee	Summer 2015
Deliverable: Statewide and County Reports on Comprehensive Performance Outcomes Using Existing and Expanded Data	**Summer 2016**
Continuous Quality Improvement Using Performance Outcomes Reports	
Develop trainings to support interpretation of the performance outcomes reports (initial and comprehensive)	Ongoing Beginning in January 2015
Develop quality improvement plan template(s)	Ongoing Beginning in March 2015
Obtain input on the quality improvement plan template(s) from the Stakeholder Advisory Committee	Spring 2015
Deliverable: Quality Improvement Plans	**Summer 2015**
Support and monitoring of quality improvement plans	Ongoing

According to DHCS, the success of this Performance Outcome System requires adequate and appropriate staff resources. Research and information technology staff are needed to support the development of the Performance Outcome System evaluation methodology, as well as to extract, compile, and analyze the data to produce reports. Furthermore, technical assistance and quality improvement staff are required to provide counties with the support that is necessary to interpret reports and develop strategies to monitor and improve local performance and outcomes.

The major steps for the positions requested are:

- Collaborate with mental health stakeholders to define the information needed in the Performance Outcome System
- Assess what information is currently available at DHCS, the counties, and providers

- Design, develop and implement the Performance Outcome System, including production of preliminary counties reports and establishment of a quality improvement process
- Prepare and train DHCS staff and collaborate with counties on the necessary training for county staff who will analyze and make decisions based on the outcomes information
- Identify system improvements and methods to include additional data

To support these development, implementation, and ongoing efforts, DHCS requests the following four positions:

- One Research Program Specialist (RPS) III
    - Leads the research activities associated with the most complex efforts (such as POS)
    - Independently analyzes complex matters and makes recommendations
    - Acts as the research/evaluation subject matter expert
    - Coordinates with high-level staff and officials
    - Completes deliverables and products
- One Staff Programmer Analyst/Specialist (SPA/S)
    - Maintains the research analytics data requirements, including system connectivity and database design.
    - Works as a liaison with information technology staff
    - Leads the technology activities associated with data systems, Electronic Health Record Systems, and Health Information Exchange systems, to provide data reporting solutions that work with county systems
    - Assists with complex data analysis
    - Writes complex programming logic to extract and compile data for analysis
    - Provides recommendations for report development
    - Performs system testing
- One Health Program Specialist (HPS) II
    - Works with Stakeholders to identify and utilize tools to measure the administrative data elements
    - Monitors implementation of the Performance Outcome System plan
    - Analyzes data reported by the counties using the indicators from the Performance Outcome System
    - Provides technical assistance and guidance to DHCS, counties, and providers in interpreting and utilizing the administrative Performance Outcome System report information at the program and system levels
    - Provides consultation and technical assistance as needed to local Quality Improvement (QI) Committees to ensure consistency in utilization of the administrative Performance Outcome System data
    - Assists mental health plans (MHPs) to identify ways to integrate review and analysis of administrative Performance Outcome System information within existing QM work plans and QI Committee processes

  - Provides technical assistance to counties on data collection, timely submission, and refinement of administrative performance and outcomes measures

- One Consulting Psychologist (CP)
  - Works with Stakeholders to identify and utilize tools to measure the clinical data elements
  - Monitors implementation of the Performance Outcome System plan
  - Analyzes data reported by the counties using the indicators from the Performance Outcome System
  - Provides technical assistance and guidance to DHCS, counties, and providers in interpreting and utilizing the clinical Performance Outcome System report information on their clinical and practice improvements at the individual and provider levels
  - Provides consultation and technical assistance as needed to local QI Committees to ensure consistency in utilization of the clinical Performance Outcome System data
  - Assists MHPs to identify ways to integrate review and analysis of clinical Performance Outcome System information within existing quality improvement work plans and QI Committee processes.
  - Provides technical assistance to counties on data collection and refinement of clinical performance and outcomes measures.

Subcommittee Staff Comment and Recommendations—Approve. No issues have been raised regarding this proposal. The findings from this Performance Outcome System will help ensure that consistent, high quality, and fiscally effective services are delivered to children and youth and that these services improve the lives of children and youth.

Questions.

1. Please provide an overview of this proposal and the timeline to develop this Performance Outcome System.

2. Is DHCS confident that it can fill these positions in a timely manner to ensure that there are no delays in implementing this system?

6. Implementation of SB 82 and SB 364 – Staff Request

Budget Issue. DHCS requests the authority to establish three permanent, full-time positions due to the enactment of SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, the Investment in Mental Health Wellness Act of 2013, and the enactment of SB 364 (Steinberg), Chapter 567, Statues of 2013, which broadens the types of facilities that can be used for the purposes of 72-hour treatment and evaluation under Welfare and Institutions Code (WIC) Section 5150.

The cost for these positions is $353,000 ($177,000 General Fund and $176,000 Federal Fund). Two positions would support the workload related to SB 82 and one position would support the workload related to SB 364.

SB 82 – Investment in Mental Health Wellness Act of 2013. SB 82, the Investment in Mental Health Wellness Act of 2013, set goals of adding at least 25 mobile crisis support teams, and 2,000 crisis stabilization and/or treatment beds for use in California communities over the next two years. As discussed in an earlier agenda item, 835 beds will be added in the first round of grant awards and priority was given to proposals that were community-based versus institution-based.

DHCS finds that SB 82 would increase its workload related to (1) conducting initial and annual site certifications for residential facilities; (2) conducting initial and triennial certifications of mobile crisis teams and crisis stabilization units; and (3) carrying out tasks related to DHCS approval of 5150 designated facilities related to the new facilities that are added through SB 82.

SB 364 – 72-Hour Treatment Facilities. SB 364 broadens the types of facilities that can be used for 72-hour treatment and evaluation under WIC 5150. WIC 5150 provides that, "when a person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, he or she may, upon probable cause, be taken into custody by a peace officer, member of the attending staff of an evaluation facility, designated members of a mobile crisis team, or other designated professional person, and placed in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services."

DHCS contends that implementation of SB 364 would increase workload related to (1) maintaining a statewide list of all 5150-designated facilities, (2) updating 5150 regulations, (3) conducting statewide site-reviews of these facilities, and (4) investigate complaints related to these facilities.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open. Part of the estimated workload for these proposed positions is based on the assumption that 2,000 crisis beds would be up in 2014-15; however, awards to develop only 835 have been recommended by the California Health Facilities Financing Authority (CHFFA). Additionally, it is estimated that SB 82 and SB 364 would increase the workload

related to the 5150 designation, however, it is not clear if this workload would materialize (1) given that the CHFFA grants focused on community-based residential treatment and (2) because it is not clear if DHCS has received any requests related to the broadening of facility types that can be used per WIC 5150 as allowed by SB 364.

Questions.

1. Please provide an overview of this proposal.

2. Has DHCS received requests related to designating new facilities as 5150 per SB 364?

7. Drug Medi-Cal Overview and Major Issues

Budget Issue. The Drug Medi-Cal (DMC) program provides medically necessary substance use disorder treatment services for eligible Medi-Cal beneficiaries. The proposed budget includes $392.2 million for DMC in 2014-15, a $134.4 million increase over the current year. This increase reflects the increased costs of the enhanced substance use disorder (SUD) benefits that were adopted in SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session, as discussed in an earlier agenda item. See the following table for DMC funding summary.

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

- **Narcotic Treatment Services** – These services are provided to beneficiaries that are opiate addicted and have a substance abuse diagnosis, and/or are Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible.

- **Residential Substance Use Services** – These services provide rehabilitation services to persons with substance use disorder diagnosis in a non-institutional, non-medical residential setting. (Room and board is not reimbursed through the Medi-Cal program.)

- **Outpatient Drug Free Treatment Services** – These services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with substance abuse diagnosis in an outpatient setting.

- **Intensive Outpatient Services** – These services include outpatient counseling and rehabilitation services that are provided at least three hours per day, three days per week.

- **Naltrexone Treatment Services** – These are outpatient services provided to individuals with confirmed opioid dependence who are at least 18 years of age, opioid-free, and are not pregnant. It is projected that there will be no claims for this service in the current year and budget year.

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

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

	2013-14				2014-15			
Service Description	**GF**	**County Funds**	**FF**	**TF**	**GF**	**County Funds**	**FF**	**TF**
Narcotic Treatment Program		$54,437	$55,944	$110,381		$54,363	$57,938	$112,301
Residential Substance Use Services*	$21,016	$1,768	$32,255	$55,039	$50,345	$3,082	$77,684	$131,111
Outpatient Drug Free Treatment Services		$45,942	$27,083	$73,036		$50,013	$31,226	$81,250
Intensive Outpatient Services**	$7,823	$12,820	$24,336	$44,979	$18,642	$14,769	$42,654	$76,065
Provider Fraud Impact		-$14,650	-$14,650	-$29,300		-$14,650	-$14,650	-$29,300
Drug Medi-Cal Program Cost Settlement		$393	$3,036	$3,429		$396	$3,033	$3,429
Annual Rate Adjustment					-$248	-$2,426	-$2,359	-$5,033
County Administration					$4,197	$7,403	$10,529	$22,129
3rd Party Validation of Providers	$125		$125	$250	$125		$125	$250
Total	**$28,964**	**$100,710**	**$128,129**	**$257,814**	**$73,061**	**$112,950**	**$206,180**	**$392,202**

*Previously named “Perinatal Residential Substance Abuse Services
**Previously name “Day Care Rehabilitative Services”

Drug Medi-Cal Fraud. In July 2013, an investigation by the Center for Investigative Reporting (CIR) and CNN uncovered allegations of widespread fraud in California's Drug Medi-Cal (DMC) program. The investigative report alleged that, over the past two fiscal years, the DMC program paid $94 million to 56 drug and alcohol rehabilitation clinics in Southern California that have shown signs of deceptive or questionable billing. Most of the examples of alleged fraud occurred in Los Angeles County and ranged from incentivizing patients with cash, food, or cigarettes to attend sessions, to billing for clients who were either in prison or dead. Most of the providers that were the focus of the investigation primarily offered counseling services and rely on Medi-Cal as the sole payer for services.

The reports suggested that the state's oversight and enforcement bodies were not working well in tandem: county audits of providers identified a number of serious deficiencies, but failed to terminate contracts or prevent the problems from continuing.

In July and August 2013, the DHCS ordered temporary suspensions against 48 alcohol and drug treatment programs at 132 sites where DHCS established credible allegations of fraud. According to the DHCS, these actions were the first phase of an ongoing review of the DMC program by the department's Audits and Investigations (A&I) Division.

Since then, the DHCS has implemented a process requiring all DMC providers to become recertified in order to continue to participate in the program. As of December 17, 2013, the review had resulted in the suspension of 61 DMC providers at 177 locations and 68 of referrals to the California Department of Justice for criminal investigation and prosecution. The DHCS will also be conducting field reviews of all facilities in March and April.

Internal Department Audit. In response to the fraud allegations, DHCS conducted an internal audit of its DMC program. The review concluded that the DMC program's weak internal control structure has exposed DHCS to financial and legal risks as well as increased risks to fraud, waste, and abuse within DMC program. Processes that are intended to serve as vital checks and balances within the program were not effective. DHCS also observed an organization that has historically focused more heavily on programmatic deliverables and services for DMC beneficiaries than measures associated with program integrity.

According to the internal audit, under the former DADP, management's attitude towards program integrity could have been strengthened, as evidenced by the following broad observations made during its limited scope review:

- Weak performance / certification standards for participating providers.
- No re-certification of DMC providers.
- Inconsistent monitoring of both DMC providers and counties for compliance with certification standards and State/county contract requirements, respectively.
- Lack of adequate financial oversight of Narcotic Treatment Programs.
- Minimal sanctions or penalties imposed on DMC providers in the past.
- Staff integrity issues.

As a result of this internal audit, DHCS prepared an implementation plan to act on the findings and recommendations from the audit. This implementation plan identifies action steps to address the problems identified in the audit.

Additionally, a Bureau of State Audit's audit of the Drug Medi-Cal program is in progress and is expected to be released in June 2014.

Proposed Drug Medi-Cal Waiver. In January, DHCS announced its intent to request a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to operate the Drug Medi-Cal Program (DMC) as an organized delivery system.

DHCS hopes to address the following issues with a waiver:

- ***Integration through Coordination.*** The need to maximize services for the beneficiary, with integration through improved coordination of substance use disorder treatment with county mental health and public safety systems and primary care.
- ***Building Upon the Mental Health System.*** The opportunity to build upon the experience and positive results California has achieved in the state administered and county operated Medi-Cal Specialty Mental Health program. In 54 of the 58 counties, mental health and substance use disorder programs are consolidated in the same department.
- ***Medi-Cal Eligibility and Benefit Expansion.*** The expansion of eligibility and substance use benefits in the Medi-Cal program under the Affordable Care Act and enacted in the 2013-14 Budget Act. This will result in tens of thousands of additional potential Medi-Cal beneficiaries seeking enhanced substance use disorder treatment.
- ***Improving Drug Medi-Cal.*** Need to improve the DMC program, in light of recent significant program integrity issues.

Additionally, DHCS contends that the waiver would give state and county officials more authority to select quality providers to meet drug treatment needs. This would strike an appropriate balance between ensuring access to these vital services while also ensuring that drug treatment services are being provided consistent with program goals.

Federal law allows states seeking to improve the performance of Medicaid programs to seek permission from the federal government to deliver those programs in innovative ways in their state. The process for making the change involves seeking a *waiver* of federal Medicaid law.

The waiver would only be operational in counties that elect to opt into this organized delivery system for DMC. DHCS will work with counties to move forward with implementation, particularly in light of 2011 Realignment, which provided counties with the financial and administrative responsibilities for DMC services. Given the spectrum of county infrastructure and resources, DHCS does expect some counties to implement sooner than others. However, DHCS encourages all counties to implement this new model.

DHCS describes a variety of goals of the waiver, such as improving care, increasing access to services, strengthening county oversight of network adequacy, and standardizing provider selection practices. They also cite the following two primary goals:

- ***Elimination of Unscrupulous Providers.*** Currently, the state is required to contract with any provider who fails to acquire a contract with their county, which DHCS believes results in a greater number of fraudulent providers participating in the program; and

- ***Creation of a Single Point of Entry.*** Currently, a Medi-Cal beneficiary seeking substance use disorder treatment services can seek and receive those services from any provider anywhere in the state. There is no organized system to determine if that person is receiving duplicate services or the most appropriate services. DHCS hopes to create a no-wrong-door approach wherein beneficiaries seek many different types of services through counties, and counties would be responsible for conducting medical necessity assessments and providing appropriate, effective referrals.

Proposed Waiver Comparable to Medi-Cal Specialty Mental Health Waiver. DHCS expects that this waiver will improve quality of care, access to services, and program integrity similar to the experience with the Medi-Cal Specialty Mental Health waiver. DHCS finds that this waiver:

- Helps promote a higher quality of provider and increases beneficiary protections. It does this through selective provider contracting based on uniform and federally-approved performance standards (such as HEDIS Measures) and oversight requirements.
- Provides increased administrative authority for counties to select and maintain the highest-quality service providers in all regions of counties.
- Provides for a single-point of beneficiary assessment to determine medical necessity and provide appropriate service referrals.
- Allows for better monitoring oversight by the county and the state through annual external and triennial audits which ensures that providers are meeting expected standards and regulations.

Stakeholder Engagement. DHCS has convened stakeholder calls to discuss, at a very high-level, this proposal. It plans to hold all-day stakeholder meetings on April 2, April 15, and April 30, to further discuss this proposal and solicit stakeholder feedback. No other timeline has been provided by DHCS.

Stakeholder Comments on Proposed Waiver. Although the details of the waiver have not been worked out, stakeholders have provided general comments on the concept of the waiver. For example, the County Mental Health Directors Association and the County Alcohol and Drug Program Administrators Association of California generally support the concept of the proposed waiver as they find that an organized delivery system for SUD services would improve care, increase efficiency, and reduce costs in the Drug Medi-Cal program. Additionally, they find that the proposed waiver would allow counties and the state to better select quality providers to provide these services.

In contrast, some providers, such as the California Opioid Maintenance Providers (COMP), have significant concerns with DHCS' intent to pursue a waiver. COMP finds that a waiver of federal law could limit access to services and could remove entitlement protections.

Additionally, COMP finds that a single-point of entry at counties for Drug Medi-Cal services could impose a barrier for individuals who show-up at a narcotic treatment provider seeking immediate services.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on these issues. Specifically:

- **Drug Medi-Cal Program Integrity.** As discussed in the next agenda item, DHCS plans to recertify all Drug Medi-Cal providers by the end of the budget year. This is an important step in ensuring that these providers meet standards to participate in Medi-Cal and is a critical component to ensure program integrity. However, there are other issues that must be acted upon by DHCS, such as strengthening and clarifying the regulations regarding the requirements and responsibilities of providers and medical directors and developing data mining protocols that could identify "high risk" providers. It will be important for the Legislature to hold DHCS accountable for taking all steps necessary to ensure the integrity of this program.

- **Proposed Drug Medi-Cal Waiver.** At the time of this agenda, DHCS had not yet presented a clear detailed proposal on the waiver. Questions on what an "organized delivery system" means still remain. For example, would this organized delivery system meet Knox Keene requirements or would these requirements be waived; if this organized delivery system is still under a fee-for-service model, how would coordination be ensured and who would pay for the coordination services?

  DHCS points to the Medi-Cal Specialty Mental Health waiver as an example of an organized delivery system that has improved access, quality of care, and program integrity. However, as discussed earlier in the agenda, the federal government has significant concerns with this program, including concerns about timely access to services and language access for non-English speakers.

Questions.

<u>Drug Medi-Cal Overview</u>

1. Please provide an overview of the Drug Medi-Cal program and budget.

<u>Drug Medi-Cal Program Integrity</u>

2. Please provide an overview of the Drug Medi-Cal program integrity issues uncovered this past summer and fall.

3. What steps has DHCS taken to address these program integrity issues?

4. Please describe the different types of programs and providers within Drug Medi-Cal, the various types of licenses and certifications different types of providers are required to have,

and what patterns of fraud have been uncovered related to these different categories of providers. Is there evidence that most of the provider fraud is occurring within one (or more than one) category of providers (or type of treatment)?

5. Does DHCS find that statutory or regulatory changes are necessary to ensure Drug Medi-Cal program integrity? Does DHCS find that a federal waiver is necessary to ensure Drug Medi-Cal program integrity?

6. Is DHCS monitoring to ensure that access to services has not been impacted as a result of suspended/decertified providers? Please explains.

Proposed Drug Medi-Cal Waiver

7. Please provide an overview of the proposed Drug Medi-Cal waiver. What existing problems is the proposed waiver attempting to address?

8. Please explain how DHCS finds that this proposed waiver would improve access to Drug Medi-Cal services.

9. In view of significant CMS concerns with specialty mental health waiver, what is DHCS proposing that will ensure program integrity, quality control, and consumer protections?

10. Does this proposed waiver relate to the expansion of SUD benefits per SB 1 X1? If so, please explain.

11. Please explain how DHCS would work with stakeholders on the development of the proposed waiver. What is the timeline for this process? Who is on the Waiver Advisory Group?

8. Re-Certification of Drug Medi-Cal Providers

Budget Issue. DHCS requests 21 one-year limited-term positions at a cost of $2.2 million ($1.1 million General Fund) to recertify all providers in the Drug Medi-Cal program (DMC). These positions would continue efforts commenced in the current year to improve DMC program integrity and recertify only providers meeting standards of participation in Medi-Cal. DHCS redirected 21 positions in 2013-14 to begin this work.

Background. The administration of the DMC program was previously delegated to the California Department of Alcohol and Drug Programs (DADP) through an Interagency Agreement with DHCS. DADP received Medi-Cal funding from DHCS for eligible services provided to eligible Medi-Cal beneficiaries. At the local level, county welfare departments determined the eligibility of beneficiaries for Medi-Cal and were reimbursed by DADP for the cost of those activities.

The 2012-13 budget transferred administration of the DMC program and applicable Medicaid functions from DADP to DHCS, effective July 1, 2012. Upon the transfer of the program, DHCS began a review of the DMC program. Based on issues it identified, DHCS has initiated a complete review of the DMC program in an effort to address fraud, waste and abuse allegations. As of December 17, 2013, the review had resulted in the suspension of 61 DMC providers at 177 locations and 68 of referrals to the California Department of Justice for criminal investigation and prosecution.

In July 2013, DHCS sent a Notice of Intent to all 1,059 DMC providers that are active billers, notifying them of this recertification process. DMC providers will be mailed recertification packets in three phases beginning with Southern California in July 2013 and ending in Northern California in December 2014. Providers will have 30 days to respond with a submission of an application package and supporting documentation to confirm that the provider continues to meet certification requirements; those who fail to respond will be decertified. All DMC providers that respond will receive an unannounced on-site visit by the DHCS's Audits and Investigations Division (A&I) to confirm they meet standards of participation in the DMC program. DHCS anticipates concluding its recertification efforts by the end of 2014.

The DMC program certification and recertification is a new process for the Provider Enrollment Division (PED) staff which will entail developing the necessary job skills and institutional knowledge to maintain, enhance, and enforce DMC policies and safeguards. In addition, the DMC program certification and program standards have not been updated in years; PED staff will need to become familiar with federal and state laws and regulations governing the DMC program, perform policy review, analysis and interpretation, recommend policies, rules and regulations on program matters, strengthen standards of the certification requirements, and provide recommendations for any necessary State Plan Amendments.

Table: Drug Medi-Cal Program (DMC) –Recertification Timeline

Activity	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Locations	Los Angeles, Orange, San Diego, Riverside, San Bernardino	Remaining Southern Locations, Central Valley & Coastal Counties	Northern California	Narcotic Treatment Providers Statewide	Reconciliation
	Projected Completion Dates				
Notice of Intent to Recertify all DMC providers*	07/15/2013	07/15/2013	07/15/2013	07/15/2013	TBD
Notices returned undeliverable - immediate A&I onsite.					
Redetermination packet mail date	07/31/2013	11/15/2013	12/31/2013		
Provider to submit packet	08/31/2013	12/15/2013	01/31/2014		
Non-responders will be decertified.					
DHCS - Program requirements review Request additional information or forward for onsite	04/17/2014	09/25/2014	12/25/2014		
Provider response to deficiencies	6/27/2014	12/03/2014	3/05/2014		
DHCS Review: Complete deficiency response review and forward to onsite	08/27/2014	01/10/2014	4/15/2015		
A&I onsite reviews and findings report	0827/2014 through 02/27/2014	01/10/2014 through 07/10/2015	4/15/2015 through 10/15/2015		
DHCS – Final Review Recertify or decertify	03/27/2015	08/10/2015	11/15/2015		

*** DMC providers billing in 2012-13**

Tables: Drug Medi-Cal Recertification Applications and Decertifications

PHASE I County	# of Apps Accepted	Sites Decertified
L.A. County	115	106
Orange	1	0
Riverside	24	32
San Diego	30	0
San Bernardino	16	3
Totals	**186**	**141**

PHASE II County	# of Apps Accepted	Sites Decertified
Fresno	54	11
Imperial	9	8
Kern	17	3
Kings	3	0
Madera	2	3
Mariposa	1	0
Merced	4	0
Monterey	0	1
San Benito	0	5
San Joaquin	4	0
San Luis Obispo	4	0
Santa Barbara	14	1
Santa Cruz	13	10
Stanislaus	1	0
Tulare	18	6
Ventura	7	3
Totals	**151**	**51**

PHASE III County	# of Apps Received	Sites Decertified
Alameda	11	1
Butte	4	0
Contra Costa	7	1
El Dorado	5	5
Glenn	2	0
Humboldt	2	0
Lake	2	3
Lassen	1	3
Marin	0	0
Mendocino	3	0
Napa	4	0
Nevada	5	1
Placer	4	1
Sacramento	44	21
San Francisco	4	1
San Mateo	1	0
Santa Clara	30	11
Shasta	3	1
Solano	6	1
Sonoma	8	0
Yolo	2	1
Yuba	1	0
Totals	**149**	**51**

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal. The recertification of Drug Medi-Cal providers is a critical component in ensuring the program integrity of the Drug Medi-Cal program. Prior to this process, Drug Medi-Cal providers have not been recertified or evaluated on a regular basis.

Questions.

1. Please provide an overview of this request. How many Drug Medi-Cal providers have been recertified?

2. Please describe the efforts DHCS has undertaken to assist providers in recertification.

3. How is DHCS monitoring changes to access to Drug Medi-Cal services as a result of the recertification efforts (since it is anticipated that some Drug Medi-Cal providers would be decertified through this process)?

4. Please explain how this process will improve program integrity and prevent recurrences of prior problems?

9. Substance Use Disorder Program Integrity – Counselor and Facility Complaints

Budget Issue. DHCS requests $739,000 and six three-year limited-term positions to investigate complaints related to counselors and facilities that provide 24-hour, non-medical residential and outpatient alcohol and other drug (AOD) detoxification, treatment, or recovery services to adults. DHCS states that it is currently backlogged with investigating provider and counselor complaints and is not complying with the state mandate of investigating complaints regarding counselor misconduct within the ninety days of receipt.

The requested position authority and resources would be funded from the Residential and Outpatient Program Licensing Fund (ROLF) and contingent on approval of proposed fee increases for licensed and certified facilities. See table below for current and proposed fees.

Fee Type	Current Fee	Proposed Fee
Initial Residential Licensure Application Fee	$2,773	$3,050
Biennial Residential Licensure Fee	$147 (per bed)	$324 (per bed)
Adolescent Waiver Application Fee	$1,370	$1,507
Facility Relocation Fee	$916	$1,008
Additional Services Fee	$940	$1,034
Initial Combined Residential Licensure and Certification Fee	$3,698	$4,068
Biennial Combined Residential Licensure and Certification Initial/Extension Fee	$147 (per bed)	$324 (per bed)
Initial Outpatient Certification Application Fee	$2,664	$2,931
Biennial Outpatient Certification Initial/Extension Fee	$3,452	$3,798

Background. DHCS licenses and certifies facilities that provide 24-hour, non-medical residential and outpatient AOD detoxification, treatment, or recovery services to adults. There are 796 of these facilities in the state. DHCS also determines the appropriate skills and qualifications of an individual providing AOD counseling to clients in licensed residential and/or certified facilities, narcotic treatment facilities, programs certified to receive Medi-Cal reimbursement; and driving under the influence facilities. Approximately 36,000 alcohol and drug counselors are certified in the state.

DHCS investigates facility and counselor complaints, unlicensed facilities, and death reports. Facility complaints include all complaints involving licensed, unlicensed and/or certified residential and outpatient AOD programs to determine whether the allegations are substantiated. Counselor certification complaints include all complaints of inappropriate conduct by certified counselors and those who are registered with a certifying organization, or working in a state-licensed or certified facility. If allegations are substantiated, it may result in a suspension or revocation of the counselor's certification. Complaints are received from current and former clients, current and former facility staff, other state agencies, and the general public. Complaints are processed for investigation based on the seriousness of the offense.

Over the last five years, the state has experienced an increase in non-medical AOD facilities providing medical services and/or operating outside the scope of their licensure, and has therefore increased revocation of these licenses when corrective action is non-responsive or not an appropriate option based on the violation.

Currently, DHCS is experiencing a backlog of 500 open complaints from 2010-2011. The current staffing levels were initially determined based on the workload necessary to conduct facility complaint investigations received; however, the workload associated with unlicensed facility complaints and the revocation of a license or certification was not factored into currently approved staffing levels. On average, about 300 complaints are received each year.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal.

Questions.

1. Please provide an overview of this budget request.

2. Please provide an overview of the state laws regarding investigating provider and counselor complaints.

10. Continuance of Driving Under the Influence (DUI) Program Evaluation

Budget Issue. DHCS requests $96,000 (DUI Program Licensing Trust Fund) to renew a contract to continue its evaluation of the Driving-Under-the Influence (DUI) Programs licensed and monitored by the state.

The evaluation would run from 2014-15 through 2015-16, at an annual cost of $96,000. According to DHCS, the continuation of this program evaluation will ensure that specific recommendations provided in the previous and existing evaluation will be acted upon. If approved, the next two years' scope of work will focus on establishing critically needed program benchmarks and performance measures, outcomes, and suggested recommendations for related regulations.

Background. Since 1978, individuals convicted of a DUI have been mandated by the court to attend DUI programs, which are regulated and licensed by the state. Licensing and monitoring of DUI programs had been done by the former-Department of Alcohol and Drug Programs (DADP), until that department was eliminated in 2013, and the program was transferred to DHCS.

The DHCS Substance Use Disorder Compliance Division licenses and monitors all DUI programs statewide, which seek to reduce the number of repeat DUI offenders and address drivers' substance use disorders. DHCS licenses 492 DUI programs throughout California that offer programs for first-offenders, multiple-offenders, and 30-month services.

The DUI Program Licensing Trust Fund receives licensing fees, enrollment fees, fines, and penalties collected from DUI programs, and these revenues are used to offset costs incurred by DHCS in administering the program. DUI programs pay a one-time $400 licensing fee, and each enrollee pays $10 which is then paid to DHCS.

The 2008 Budget Act appropriated $96,000 (DUI Trust Fund) to DADP for two years to review the DUI program structure at both the state and provider levels, and develop recommendations in order to improve service delivery. DADP contracted with San Diego State University (SDSU) to conduct the review. According to DHCS, this study was exploratory in nature and has laid the groundwork for future evaluations to identify and promote the effective components of DUI programs. The purpose of this proposal would be to pursue further recommendations from this study.

Accordingly, DHCS expects this request to do all of the following:

1. Continue an in-depth analysis of the system improvements recommended in the first DUI descriptive study.

2. Provide continued systematic assessment of DUI program providers.

3. Reveal best practices in program processes, data collection and monitoring.

4. Establish program benchmarks, performance measures, and outcomes.

5. Revisit recommendations provided in the descriptive study to determine which have and have not been addressed by the state.

6. Provide DHCS with future direction on how to best collect participant data, determine and develop program performance benchmarks, and develop outcome measures needed to measure DUI program success.

7. Identify what is working in the first and multiple offender programs in order to develop a statewide, standardized curriculum for DUI participants which takes in account variables such as culture, gender, and age.

8. Establish critically needed program benchmarks and performance measures, outcomes, and suggested recommendations for related regulations.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal.

Questions.

1. Please provide an overview of this proposal.

Appendix A

Medi-Cal Mental Health (MH) and Substance Use Disorder (SUD) Benefits

Source: Department of Health Care Services

County Mental Health Plan (MHP)

Target Population: Children and adults who meet medical necessity or EPSDT criteria for Medi-Cal Specialty Mental health Services

Outpatient Services

- ✓ Mental Health Services (assessments plan development, therapy, rehabilitation and collateral)
- ✓ Medication Support
- ✓ Day Treatment Services and Day Rehabilitation
- ✓ Crises Intervention and Crises Stabilization
- ✓ Targeted Case Management
- ✓ Therapeutic Behavior Services

Residential Services

- ✓ Adult Residential Treatment Services
- ✓ Crises Residential Treatment Services

Inpatient Services

- ✓ Acute Psychiatric Inpatient Hospital Services
- ✓ Psychiatric Inpatient Hospital Professional Services

County Alcohol & Other Drug Programs (AOD)

Target Population: Children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal Substance Use Disorder Services

Outpatient Services

- ✓ Outpatient Drug Free
- ✓ Intensive Outpatient **(newly expanded to additional populations)**
- ✓ Residential Services **(newly expanded to additional populations**)
- ✓ Narcotic Treatment Program
- ✓ Naltrexone

New Services

- ✓ Inpatient Detoxification Services
- ✓ (Administrative linkage to County AOD still being discussed)

Medi-Cal Managed Care Plans (MCP)

Target Population: Children and adults in Managed Care Plans who meet medical necessity or EPSDT for Mental Health Services

MCP services to be carved-in effective 1/1/14

- ✓ Individual/group mental health evaluation and treatment (psychotherapy)
- ✓ Psychological testing when clinically indicated to evaluate a mental health condition
- ✓ Outpatient services for the purposes of monitoring medication treatment
- ✓ Psychiatric consultation
- ✓ Outpatient laboratory, medications, supplies and supplements
- ✓ Screening and brief intervention