Senate Budget and Fiscal Review – Mark Leno, Chair
SUBCOMMITTEE #3 on
Health & Human Services

Chair, Senator Holly J. Mitchell

Senator William W. Monning
Senator Jeff Stone, Pharm. D.

April 9, 2015

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

Room 4203, State Capitol

Part A Agenda
(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.

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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 that 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, 2015, a report on the progress of the implementation of these grant programs.

Implementation Status. CHFFA has awarded two rounds of funding totaling $85.3 million to counties to establish 866 crisis residential treatment beds, 43 vehicles for mobile crisis teams, and 58.5 mobile crisis staff. Pursuant to program regulations, each county grantee has reporting requirements in the form of status reports. These reports are due to CHFFA at least twice per year and at each time a disbursement is requested, at a minimum. The status reports include: a description of activities performed to date, the population served, costs and expenditures incurred, a summary of preliminary available evaluation results related to all outcomes identified in the application, a summary of other funding sources, and a description of remaining work to be completed.

CHFFA tracks the number of beds, vehicles, and staff that were awarded and any variances through the status reports and ongoing updates, from and communications, with the counties. The counties have, across the board, encountered significant delays in getting their programs implemented, especially for crisis residential and crisis stabilization. As such, there were not many outcomes counties could report on in the latest status reports submitted in August 2014. CHFFA is currently reviewing the status reports that were due on February 15. So far, for the mobile crisis support teams, the counties have purchased 30 out of the 43 approved vehicles and have hired 29.75 of the 58.25 approved staff individuals. As of February, there are no new beds for either the crisis residential or crisis stabilization programs yet in operation, but they are in various stages of design and construction. As the projects get further along CHFFA expects there will be more results to report.

Remaining Funding Available. As shown in the table below, about $61.2 million, of the $149.3 million, remains to be awarded. Applications for the third round of funding are due to CHFFA on March 30, 2015.

Table: SB 82 Funds Remaining after First and Second Funding Round

Purpose	**Amount**
Crisis Residential Capital	$60,638,777.03
Crisis Stabilization Capital	$184,210.52
Mobile Crisis Capital	$356,340.14
Subtotal - Capital	**$61,179,327.69**
Mobile Crisis Personnel	**$1,057.02**
Total Remaining	**$61,180,384.71**

At the February 26, 2015 CHFFA board meeting, the board discussed the merits of pursuing a re-allocation of dollars from crisis residential to crisis stabilization versus allowing the allocations to stay in place for January 1, 2016. At this time, a statewide competition (as opposed to the existing regional competitions) will be developed for any and all remaining funds. The board also entertained suggestions from stakeholders who were present at the meeting. Stakeholders suggested the board consider extending eligibility to peer respite programs in order to potentially prompt small county interest (because of an increased likelihood in sustainability) in some of the remaining crisis residential funding.

Subcommittee Staff Comment. This is an informational item.

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

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

2. Why are counties experiencing difficulties in getting their crisis residential and crisis stabilization programs implemented?

3. What is the timeline for the discussion regarding re-allocating crisis residential funding to other purposes? What criteria will the CHFFA board use to make this decision?

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. 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. 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.

Overview of MHSOAC Evaluation Efforts. On March 28, 2013 the MHSOAC approved an Evaluation Master Plan which prioritizes possibilities for evaluation investments and activities over a five year course of action. The MHSOAC five-year Evaluation Master Plan (July 2013 – June 2018) describes seven activities related to performance monitoring, ten evaluation projects, and eight exploratory/developmental work efforts. The 2013 budget provided resources for six positions to implement the Evaluation Master Plan. A listing of the current MHSOAC Evaluation Contracts and Deliverables can be found at:
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2015/March/OAC/OAC_032615_1C_EvalDash.pdf

Improving Community Mental Health Data. Current mental health data collection and reporting systems do not provide timely data that allows the MHSOAC to evaluate all aspects of the MHSA and broader public community-based mental health systems. Consequently, the MHSOAC has contracted with an outside vendor to prepare an advanced planning document and/or a feasibility study report to improve the data systems at the Department of Health Care Services (DHCS) to fully address the data needs of the MSHOAC and DHCS. This contract will identify the MHSOAC's current data and reporting needs, compare them to what is available via current data systems, and draw conclusions regarding data elements that are missing and not available.

Subcommittee Staff Comment. This is an informational item. The Subcommittee is in receipt of advocate requests to use MHSA Funds (State Administration) to:

1. CAYEN - Augment an existing MHSOAC contract with the California Youth Empowerment Network (CAYEN) by $300,000 to allow more youth to participate and to get better responses to survey strategies. This program brings transition age (16-25) perspective to development of mental health services and policies.

2. REMHDCO – Transfer the REMHDCO (Racial and Ethnic Mental Health Disparities Coalition) contract from the Department of Public Health's (DPH) Office of Health Equity to the MHSOAC, as the contract with DPH expires February 29, 2016. The three month cost of this contract (April – June) is about $187,000 and a full year cost is $560,000. REMHDCO is a statewide coalition of individuals from non-profit state-wide and local organizations whose mission is to work to reduce mental health disparities through advocacy for racial and ethnic communities.

As noted later in the agenda under Issue 1 of the Department of Health Care Services, the State Administration Cap for the MHSA Fund is estimated to be overprescribed by about $8 million. Consequently, there is no available room in the State Administration Cap for these two requests.

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

1. Please provide a brief overview of the MHSOAC.
2. Please explain how the MHSOAC ensures that services provided, pursuant to the MHSA, are cost effective and consistent with the MHSA. Does it make the findings from these reviews public?
3. Please provide a review of the MHSOAC's evaluation efforts and activities.
4. Please discuss the MHSOAC's efforts regarding improving community mental health data.

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-four counties were awarded grant funding. The MHSOAC approved 24 triage grants and allocated funds for 491 triage positions. As of March 16, 2015 counties have hired 86 triage staff and continue to expand the number of mental health personnel available to provide crisis support services that include crisis triage, targeted case management and linkage to services for individuals with mental health illness who require a crisis intervention. 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. According to the MHSOAC, counties are having extreme difficulty in hiring due to workforce shortages in the selected classification. The MHSOAC is continuing to work with counties to evaluate these hiring issues. See table below for award details.

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

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17		
Amount Allocated	**$32,000,000**	**$32,000,000**	**$32,000,000**	**$32,000,000**		
	Approved	**Approved**	**Approved**	**Approved**	**FTE's**	**FTE's as of 3-16-15**
Southern Region	**$10,848,000**	**$10,848,000**	**$10,848,000**	**$10,848,000**		
Ventura	$840,259	$2,126,827	$2,242,542	$2,364,043	23.0	14.0
Riverside	$488,257	$2,134,233	$2,307,808	$2,510,844	32.3	1.0
Santa Barbara	$933,135	$2,352,536	$2,468,608	$2,594,250	23.5	8.5
Orange	$1,250,000	$3,000,000	$3,000,000	$3,000,000	28.0	0.0
San Bernardino*	$7,174,512	$0	$0	$0	25.0	0.0
Region Total	**$10,686,163**	**$9,613,596**	**$10,018,958**	**$10,469,137**	**106.8**	**23.5**
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	183.0	0.0
Region Total	**$3,802,000**	**$9,125,000**	**$9,125,000**	**$9,125,000**	**183.0**	**0.0**
Central	**$4,576,000**	**$4,576,000**	**$4,576,000**	**$4,576,000**		
Yolo	$221,736	$505,786	$496,247	$504,465	8.3	3.0
Calaveras	$41,982	$73,568	$73,568	$73,568	1.0	0.0
Tuolumne	$74,886	$132,705	$135,394	$135,518	3.0	2.0
Sacramento	$545,721	$1,309,729	$1,309,729	$1,309,729	20.8	0.0
Mariposa	$88,972	$196,336	$203,327	$210,793	4.3	0.0
Placer	$402,798	$750,304	$667,827	$688,417	13.6	8.0
Madera	$163,951	$389,823	$410,792	$396,030	4.2	3.2
Merced	$359,066	$868,427	$882,550	$893,026	8.0	1.0
Region Total	**$1,899,112**	**$4,226,678**	**$4,179,434**	**$4,211,546**	**63.2**	**17.2**
Bay Area	**$6,208,000**	**$6,208,000**	**$6,208,000**	**$6,208,000**		
Sonoma	$351,672	$871,522	$897,281	$923,888	8.0	1.0
Napa	$126,102	$411,555	$403,665	$382,313	6.0	0.0
San Francisco	$1,751,827	$4,204,394	$4,204,394	$4,204,394	63.7	21.5
Marin	$137,065	$315,738	$320,373	$326,746	3.0	0.0
Alameda	$311,220	$765,811	$785,074	$804,692	11.6	1.0
Fresno*	$2,697,000	$0	$0	$0	11.5	0.0
Region Total	**$5,374,886**	**$6,569,020**	**$6,610,787**	**$6,642,033**	**103.8**	**23.5**
Superior	**$1,216,000**	**$1,216,000**	**$1,216,000**	**$1,216,000**		
Butte	$358,519	$514,079	$199,195	$3,277	18.0	13.5
Lake	$26,394	$52,800	$52,800	$52,800	1.0	1.0
Trinity	$60,697	$145,672	$145,672		2.5	2.5
Nevada	$289,260	$694,169	$728,878	$765,321	11.8	4.8
Region Total	**$734,870**	**$1,406,720**	**$1,126,545**	**$821,398**	**33.3**	**21.8**
Total	**$22,497,031**	**$30,941,014**	**$31,060,724**	**$31,269,114**	**490.1**	**85.9**
Balance	**$9,502,969.16**	**$1,058,985.62**	**$939,275.51**	**$730,886.16**		
Golden Gate Bridge, Highway & Transportation District**	$7,000,000	$0	$0	$0		
Remaining Balance	**$2,502,969.16**					

*Reappropriated $19.3 million of the Fiscal Year 2013-14 funds. The OAC funded two additional county Triage programs (San Bernardino and Fresno).

**Redirected $7 million of the reappropriation for suicide prevention efforts.

In 2013-14 and rolled over to the current year, $2.5 million in these MHSA grant funds have not yet been awarded. The Administration is considering options for the use of this funding.

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide an overview of this item.

2. How is MHSOAC monitoring counties' implementation of these grants? Why have counties established only 85 of the 490 positions?

3. What options is the Administration considering regarding the $2.5 million that has yet to be awarded?

4260 Department of Health Care Services

1. 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.

Table: Community Mental Health Funding Summary

Fund Source	**2013-14**	**2014-15**	**2015-16**
	Total	**Total**	**Total**
1991 Realignment			
Mental Health Subaccount (base and growth)*	$41,690,000	$64,636,000	$125,386,000
2011 Realignment			
Mental Subaccount Health Account (base and growth)*	$1,129,700,000	$1,136,400,000	$1,134,700,000
Behavioral Health Subaccount (base)**	$992,363,000	$1,051,375,000	$1,198,071,000
Behavioral Health Growth Account	$60,149,000	$146,696,000	$140,885,000
Realignment Total	**$2,223,902,000**	**$2,399,107,000**	**$2,599,042,000**
Medi-Cal Specialty Mental Health Federal Funds	**$1,425,814,863**	**$2,153,244,000**	**$2,772,568,000**
Medi-Cal Specialty Mental Health General Fund	**$5,803,134**	**$117,209,000**	**$138,004,000**
Mental Health Services Act Local Expenditures	**$1,246,741,000**	**$1,392,014,000**	**$1,362,650,000**
Total Funds	**$3,476,446,134**	**$6,061,574,000**	**$6,872,264,000**

*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, 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. Includes Drug Medi-Cal.

Medi-Cal Mental Health. As of January 1, 2014, 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 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.

California's Medi-Cal Specialty Mental Health Services Waiver is effective until June 30, 2015. See issue two of this agenda for discussion of the renewal of this waiver.

2. **Managed Care Plans (MCPs) -** Effective January 1, 2014, SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session expanded the scope of Medi-Cal mental health benefits and required these services to be provided by the Medi-Cal Managed Care Plans (MCP) 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 the MCPs 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 (FFS system) -** Effective January 1, 2014 the mental health services listed below are also available through the Fee-For-Service/Medi-Cal 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

Behavioral Health Realignment Funding. 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, pursuant 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, pursuant to 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, pursuant to 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 Behavioral Health Directors Association to ensure all counties are aware of these entitlement programs and clients cannot be denied services.

On May 19, 2014, DHCS issued Mental Health and Substance Use Disorder Services Information Notice 14-017 indicating that first priority of the Behavioral Health Growth Account funding would be given to reimburse counties for the two entitlement programs, Medi-Cal Specialty Mental Health EPSDT and Drug Medi-Cal. Specifically, this allocation provided additional funding to eight counties in which the approved claims for EPSDT and Drug Medi-Cal services in 2012-13 were greater than the funding they received in 2012-13 from the Behavioral Health Subaccount. The remaining balance of this growth account would then be distributed using the same percentage schedule used to distribute the funds allocated to the Behavioral Health Subaccount. The Administration indicates that it plans to follow the same allocation formula for the $60.1 million in 2013-14 Behavioral Health Growth Account funds that will be distributed later this spring. As displayed on the previous table, the projected 2014-15 Behavioral Health Growth Account is $146.7 million and the projected 2015-16 Behavioral Health Growth Account is $140.9 million.

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.

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

Table: 2015-16 Governor's Budget and March Annual Accrual Adjustment Mental Health Services Fund Administrative Cap (dollars in thousands)

Fiscal Year	Monthly Cash Transfers	Accruals	Interest	Total Revenue	Admin Cap	Expenditures/ Approps	Available Cap	Comments
	A	B	C	D	E	F	G	
				(A+B+C)	(D[.035 or .05])		(E-F)	
2012-13*	$1,204,000	$480,000	$721	$1,684,721	$58,965	$31,572	$27,393	Item 4265-001-3085 ($15m appropriated without regard to fiscal year in 2012 Budget Act). Item 6440-001-3085 ($12.3m appropriated in 2014 Budget Act).
2013-14	$1,187,000	$94,000	$548	$1,281,548	$64,077	$49,804	$14,273	Item 4265-001-3085 ($15m appropriated without regard to fiscal year in 2013 Budget Act).
2014-15 /e	$1,289,000	$513,000	$564	$1,802,564	$90,128	$116,034	($25,906)	2014 Budget Act appropriations: Item 4265-001-3085 ($15m appropriated without regard to fiscal year), and Items 4560-491 and 6440-001-3085 (subject to available funds through June 30, 2017).
2015-16 /e	$1,353,000	$422,000	$564	$1,775,564	$88,778	$112,674	($23,896)	2015 Governor's Budget: Item 4265-001-3085 ($15m appropriated without regard to fiscal year). The expenditures include $45m for the California Reducing Disparities Project.
TOTALS:					$301,949	$310,084	**($8,135)**	

e/ = estimate

*The administrative cap applicable in 2011-12 and 2012-13 was 3.5 percent. The cap was restored to 5 percent in 2013-14.

Departments Funded in 2015-16: Judicial Branch (0250), State Controller-21st Century HRMS (0840), State Treasurer-California Health Facilities Financing Authority (0977), Office of Statewide Health Planning & Development (4140), Department of Health Care Services (4260), Department of Public Health (4265), Department of Developmental Services (4300), Mental Health Oversight and Accountability Commission (4560), Department of Education (6110), University of California (6440), Financial Information Systems for California (8880), Department of the Military (8940), Department of Veterans Affairs (8955) and Statewide General Administrative Expenses (9900).

As noted in the chart above, the State Administrative Cap is overprescribed by about $8 million. In March, the Legislature was notified that the annual adjustment amount for fiscal year 2013-14 was $154 million less than what was estimated in the Governor's January Budget ($94 million instead of the estimated $249 million in the January budget).

Subcommittee Staff Comments. 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.

2. Please explain DHCS's activities related to oversight and monitoring of the Proposition 63 funds distributed to counties (e.g., audits, cost reporting analysis). If deficiencies are found, that tools does DHCS have to remediate the problems?

3. Please provide an update on counties reporting Proposition 63 revenues and expenditures for 2012-13 (the most current information available). When was this information due? How many counties have reported this information? How does DHCS work with counties that have not submitted this information?

2. Specialty Mental Health Waiver Renewal

Oversight Issue. The state's Specialty Mental Health Services Waiver expires on June 30, 2015. DHCS submitted an application to renew this waiver on March 30, 2015. DHCS is requesting a five-year renewal.

Background. DHCS administers a Section 1915(b) Freedom of Choice federal waiver to provide Specialty Mental Health Services (SMHS) using a managed care model of service delivery. The SMHS waiver program has been in effect since 1995. The proposed waiver term (July 1, 2015 through June 30, 2020) represents the ninth waiver renewal period. DHCS operates and oversees this waiver.

The SMHS waiver program is administered locally by each county's mental health plan (MHP) and each MHP provides, or arranges for, SMHS for Medi-Cal beneficiaries. It is the responsibility of each MHP to either provide the services directly or contract with providers to provide these services at the local level. The SMHS waiver population is all Medi-Cal beneficiaries. Therefore, all Medi-Cal beneficiaries have access to waiver services if they meet medical necessity criteria.

SMHS provided through the SMHS waiver:

a. Rehabilitative mental health services including:
    (1) Mental health services
    (2) Medication support services
    (3) Day treatment intensive
    (4) Day rehabilitation
    (5) Crisis intervention
    (6) Crisis stabilization
    (7) Adult residential treatment services
    (8) Crisis residential treatment services
    (9) Psychiatric health facility services
b. Psychiatric inpatient hospital services
c. Targeted case management services
d. Early and Periodic Screening, Diagnosis and Treatment specialty mental health services (i.e., Therapeutic Behavioral Services) for children up to 21 years of age.

The SMHS waiver renewal request was submitted to the Centers for Medicare and Medicaid Services (CMS) for their review on March 30, 2015. The effective date or this waiver renewal will be July 1, 2015.

CMS Concerns with Existing SMHS Waiver. During monthly CMS monitoring calls and in ongoing communications, CMS has asked questions on specific areas of the SMHS waiver. CMS reviews MHP triennial and External Quality Review Organization (EQRO) reports and raised concern about the findings and continued non-compliance with specific waiver requirements. CMS believes that significant improvement is needed in identified areas and expects the state to closely monitor, ensure and provide evidence of compliance. The following are the identified areas of focus:

- **24/7 telephone line with appropriate language access** - Regulations for Medi-Cal Specialty Mental Health Services in Title 9, Section 1810.405(c) and (d) require that MHPs provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries in the county. Focus will be on ensuring the toll free line is always answered and has adequate linguistic capacity with no excessive wait times 24/7 and not just during business hours.

- **System in place to track timeliness of access across the plan** - The MHPs must have an organized system to track the timeliness of beneficiary access to services across the MHP, specifically the time between an initial request for services to the time services are actually provided to the beneficiary. The goal is to produce uniform statewide standards specific to access of SMHS.

- **TARs adjudicated in 14 days** -Title 9, Section 1820.220 requires the MHP to approve or deny a Treatment Authorization Request (TAR) within 14 calendar days. The goal is to establish a specific metric for TAR adjudication as one of the statewide standards.

- **System in place to log grievances and appeals, name, date, and issue** - Title 9, Section 1850.205(d)(1) requires that MHPs maintain a grievance and appeal log that contains the beneficiary's name, date, and nature of the problem. This standard is also reviewed in the triennial system review.

- **System in place to ensure providers are certified and recertified** – Certification and recertification of Medi-Cal providers must be completed accurately and on time to ensure beneficiaries are provided with specialty mental health services that meet program requirements and that providers are qualified to provide services.

- **Disallowance rates** - CMS has expressed concern about the ongoing elevated inpatient and outpatient disallowance rates resulting from chart reviews (i.e., claims not allowable under the Medi-Cal program).

CMS has requested that DHCS explore establishing a process to enact fines, sanctions and penalties, or corrective actions as a way to ensure compliance.

2014 Budget Resources to Improve Monitoring of These Services. The 2014 budget included 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 budget request was in direct response to CMS's concerns noted above. DHCS has had difficulty filling these positions because of challenges in recruiting psychologist and nurse consultant positions. DHCS indicates that is it currently reviewing its mental health personnel classifications and will be working with the California Department of Human Resources on options.

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide an overview of the SMHS waiver renewal application.

2. How does the renewal application address CMS's concerns noted in the agenda?

3. Please provide an update on DHCS's efforts to establish timely access standards for SMHS. What is the timeline to establish these standards? How will the waiver renewal account for these standards?

4. What steps is DHCS taking to fill the positions approved in the 2014 budget to improve oversight of county mental health plans?

5. How has DHCS responded to CMS suggestions to establish a process to enact fines, sanctions and penalties, or corrective actions as a way to ensure compliance?

3. Performance Outcomes System for EPSDT Medi-Cal Specialty Mental Health Services

Budget Issue. DHCS requests three full-time permanent positions at a cost of $377,000 ($189,000 General Fund and $188,000 Federal Trust Fund) to support the program management, coordination with counties and other partners, data collection and interpretation and research needs of the Performance Outcomes System project 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 specialty mental health 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. The Performance Outcomes System will measure individual outcomes as clients receive managed care or specialty mental health services.

To carry out and support the objectives for the Performance Outcomes System, DHCS requests the following three positions**:**

- **Two Research Analysts II (RA II)**
  - Provide support in producing reports, gathering, compiling, analyzing, and applying statistical methods to data.
  - Work as a liaison with county information technology (IT) staff to clean the data and resolve any system issues.
  - Monitor county data submissions and provide training to counties on data interpretation and utilization.
  - Format reports and product.

- **One Associate Information Systems Analyst (AISA)**
  - Supports the more complex IT functions for the Performance Outcomes System and maintains the research analytics data requirements, including system connectivity and database design.
  - Leads the technology activities associated with data systems, Electronic Health Record Systems, and Health Information Exchange systems, to provide data reporting solutions for the 56 county mental health systems.
  - Assists with complex data analysis and writes complex programming logic to extract and compile data for analysis.
  - Provides recommendations for report development.
  - Performs system testing.

Background. SB 1009 requires DHCS to develop a Performance Outcomes System for Medi-Cal Specialty Mental Health Services for children and youth. Consistent with statute, DHCS has produced a Performance Outcomes System Implementation Plan. DHCS released the Performance Outcomes

System Implementation Plan with the 2014-15 Governor's budget, and a budget change proposal with initial resources (four staff) to begin to implement and operate this system.

In 2013, SB 1009 was amended through AB 82, to add the requirement for mental health screening of children/youth as part of Medi-Cal managed care. The legislation also required the development of measures for screening and referring Medi-Cal beneficiaries to mental health services and supports, making recommendations regarding performance and outcome measures, and providing an updated Performance Outcomes System plan to the fiscal and appropriate policy committees of the Legislature by October 1, 2014. The amendment also requires the department to propose how to implement the updated Performance Outcomes System plan by January 10, 2015. The Legislature has not yet received this updated system plan.

Table A. Timeline to Build the Performance Outcomes System

Milestones	**Date**
System Implementation Plan	
Draft System Implementation Plan	November 2013
Obtain input on the final draft Implementation Plan from the Performance Outcomes System Stakeholder Advisory Committee	December 2013
Deliverable: System Implementation Plan	**January 2014**
Establish Performance Outcomes System Methodology	
Facilitate stakeholder input on a performance outcomes system evaluation methodology (including standardized data sources and data collection tools used for the system, frequency of administration, etc.)	December 2014
Obtain Input on the Performance Outcomes System methodology protocol from the Performance Outcomes System Stakeholder Advisory Committee	February 2015
Deliverable: Performance Outcomes System Protocol	**March 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	December 2014
Counties remedy data quality issues	Ongoing Beginning in January 2015
Develop performance outcomes report templates	December 2014
Obtain input on the report templates from the Performance Outcomes System Stakeholder Advisory Committee	February 2015

Milestones	Date
Deliverable: Statewide and County Reports on Initial Performance Outcomes Using Data from Existing DHCS Databases	**Ongoing Beginning in February 2015**
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 Outcomes System from the Stakeholder Advisory Committee	April 2014
Deliverable: Performance Outcomes System Plan Update	**January 2015**
Deliverable: Performance Outcomes System Implementation Plan Update	**February 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 Outcomes System methodology.	2014-15
Obtain input on the report templates from the Performance Outcomes System Stakeholder Advisory Committee	Fall 2015
Deliverable: Statewide and County Reports on Comprehensive Performance Outcomes Using Existing and Expanded Data	**2016-2017**
Continuous Quality Improvement Using Performance Outcomes Reports	
Develop trainings to support interpretation of the performance outcomes reports (initial and comprehensive)	Ongoing Beginning in April 2015
Develop quality improvement plan process	Ongoing Beginning in May 2015
Obtain input on the quality improvement plan process from the Performance Outcomes System Stakeholder Advisory Committee	Spring 2015
Deliverable: Quality Improvement Plan Process	**Summer 2015**
Support and monitoring of quality improvement	Ongoing

DHCS indicates that it has experienced unanticipated delays in implementing the Performance Outcomes System and has determined that additional resources are needed. According to DHCS, these ongoing challenges include:

- The work to identify the reporting metrics was more labor-intensive than originally anticipated, and is expected to be an ongoing and changing process as different data reporting needs are

identified by the Subject Matter Expert Workgroup, the larger System Stakeholder Advisory Committee, DHCS and its partners (e.g., counties, other state agencies).

- The incorporation of the Katie A. data reporting requirements into the system, which involves continuous collaboration with the California Department of Social Services staff. (The *Katie A. vs. Bonta* case was first filed on July 18, 2002, as a class action suit on behalf of children, who were not given services by both the child protective system and the mental health system in California. See Part B of this agenda for more information on Katie A.)
- The continuous nature of working with counties to improve the quality of the data submitted to DHCS, which are critical and more labor-intensive than originally anticipated.

Initial Performance Outcomes System Statewide Reports. On March 24, 2015, DHCS posted initial performance outcomes system statewide reports: http://www.dhcs.ca.gov/individuals/Pages/POSReports.aspx.

The first reports focus on the demographics of the children and youth under 21 who are receiving Specialty Mental Health Services, based on approved claims for Medi-Cal eligible beneficiaries. The statewide reports establish a foundation for ongoing reporting and will be updated every six months.

Three reports will be provided: statewide aggregated data (which was released on March 24th); county groups; and county-specific data. Additionally, in the future, DHCS indicates that foster care information will be delineated in these reports.

Subcommittee Staff Comment and Recommendations—Hold Open. It is recommended to hold this item open as DHCS not yet provided an updated system plan or implementation plan.

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

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

2. When will the Legislature receive the Performance Outcomes System Plan Update (due October 2014) and the Performance Outcomes System Implementation Plan Update (due January 2015)?

3. How is DHCS preparing for the incorporation of Medi-Cal managed care referrals to county mental health plans into the POS?

4. How does DHCS plan to analyze the data included in the POS to identify issues and make system improvements?

4. Drug Medi-Cal Overview

Budget Issue. The Drug Medi-Cal (DMC) program provides medically necessary substance use disorder treatment services for eligible Medi-Cal beneficiaries. The proposed budget includes $401.8 million for DMC in 2015-16. See the following table for DMC funding summary.

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

	2014-15				2015-16			
Service Description	**GF**	**County Funds**	**FF**	**TF**	**GF**	**County Funds**	**FF**	**TF**
Narcotic Treatment Program		$59,580	$72,494	$132,074		$60,655	$77,949	$138,604
Residential Substance Use Services*		$5,704	$5,792	$11,496	$19,610	$7,738	$44,277	$71,625
Outpatient Drug Free Treatment Services		$30,564	$33,512	$64,076		$25,205	$36,657	$61,862
Intensive Outpatient Services**	$24,400	$10,482	$56,519	$91,401	$32,811	$10,938	$72,846	$116,595
Provider Fraud Impact		-$27,850	-$27,850	-$55,700		-$27,850	-$27,850	-$55,700
Drug Medi-Cal Program Cost Settlement		$393	$3,036	$3,429		$393	$3,036	$3,429
Annual Rate Adjustment					$793	$2,409	$4,605	$7,807
County Administration	$1,617	$7,005	$13,465	$22,087	$2,113	$6,553	$15,629	$24,295
County Utilization Review and Quality Assurance		$4,990	$9,268	$14,258		$11,644	$21,626	$33,270
3rd Party Validation of Providers	$125		$125	$250				
Total	**$26,142**	**$90,868**	**$166,361**	**$283,371**	**$55,327**	**$97,685**	**$248,775**	**$401,787**

*Previously named "Perinatal Residential Substance Abuse Services

**Previously name "Day Care Rehabilitative Services"

Background. In 2011, funding for the DMC program was transferred from the Department of Alcohol and Drug Programs (DADP) to DHCS as part of the Public Safety Realignment initiated by AB 109 (Committee on Budget), Chapter 15, Statutes of 2011. Prior to the realignment of the DMC program, DMC was funded with General Fund and federal funds. Enactment of the 2011 Public Safety Realignment marked a significant shift in the state's role in administering programs and functions related to substance use disorder (SUD). Realignment also redirected funding for DMC and discretionary substance use disorder programs to the counties. Consequently, counties are responsible for providing the non-federal match used to draw down federal Medicaid funds for DMC services as they existed in 2011 and for individuals eligible for DMC under 2011 Medi-Cal eligibility rules (pre-health care reform).

Additionally, the enactment of 2012-13 and 2013-14 state budgets transferred the responsibility for the SUD programs including DMC, from the former DADP to DHCS.

Current regulations create requirements for oversight of DMC providers at both the state and county levels. DHCS is tasked with administrative and fiscal oversight, monitoring, auditing and utilization review. Counties can contract for DMC services directly, or contract with DHCS, which then directly contracts with DMC providers to deliver DMC services. Counties that elect to contract with DHCS to provide DMC 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. As of November 2013, DHCS contracts with 44 counties for DMC services. Another county has direct provider contracts thus resulting in DMC services being offered in 45 total counties. DHCS also has 15 direct provider contracts for DMC services in five counties (Imperial, Orange, San Diego, Solano, and Yuba-Sutter).

Health Care Reform Expansion of SUD Benefits. The federal Affordable Care Act (ACA) requires states electing to enact 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 to the Medicaid expansion population. The ACA included mental health and substance use disorder services as part of the EHB standard, and because California adopted the alternative benefit package it was required to cover such services for the expansion population.

SB 1 X1 (Hernandez and Steinberg), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session, required Medi-Cal to provide the same mental health and substance use disorder services for its enrollees that they could receive if they bought a particular Kaiser small group health plan product designated in state law as the EHB benchmark plan for individual and small group health plan products. SB 1X 1 required this benefit expansion for both the expansion population and the pre-ACA Medi-Cal population. Consequently, those individuals previously and newly-eligible for Medi-Cal will have access to the same set of services.

For SUD-related services, SB 1 X1:

- Expanded residential substance use services to all populations (previously these benefits were only available to pregnant and postpartum women);

- Expanded intensive outpatient services to all populations (previously these benefits were only available to pregnant women and postpartum women and children and youth under 21); and

- Provided medically necessary voluntary inpatient detoxification (previously this benefit was covered only when medically necessary for physical health reasons).

DHCS received approval from CMS to expand intensive outpatient services to all populations and to provide medically necessary voluntary inpatient detoxification in general acute hospital settings. However, CMS asked the state to remove the expansion of residential substance use services to all populations and the provision of inpatient voluntary detoxification in other settings in its state plan amendment (SPA) because of the Institutions for Mental Disease (IMD) payment exclusion, which is discussed in greater detail later.

Medi-Cal Substance Use Disorder Services. Substance use disorder services are provided through both the Drug Medi-Cal program and also through Medi-Cal managed care and fee-for-service.

Drug Medi-Cal program services include:

- **Narcotic Treatment Services** – An outpatient service that utilizes methadone to help persons with opioid dependency and substance use disorder diagnoses detoxify and stabilize. 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.

- **Residential Treatment 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.) Prior to SB 1 X1 this benefit was only available to pregnant and postpartum women. Although, SB 1 X1 expanded this benefit to the general population, it is only currently being provided to pregnant and postpartum women as the state has not yet received federal approval to expand this benefit due to the IMD payment exclusion.

- **Outpatient Drug Free Treatment Services** – These outpatient services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with a substance abuse diagnosis in an outpatient setting. Services include individual and group counseling, crisis intervention, and treatment planning.

- **Intensive Outpatient Treatment Services** – These services include outpatient counseling and rehabilitation services that are provided at least three hours per day, three days per week. Prior to SB 1 X1 this benefit was only available to pregnant and postpartum women and children and youth under 21.

Other Medi-Cal SUD benefits, that are not included in DMC, 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 FFS, 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 FFS.

- **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. This service is provided via Medi-Cal managed care or Medi-Cal FFS, depending on which delivery system the patient is enrolled.

Proposed Drug Medi-Cal Waiver. DHCS is pursuing a DMC Organized Delivery System Waiver as an amendment to the current Section 1115 Bridge to Reform Demonstration Waiver. DHCS proposes that this amendment would demonstrate how organized substance use disorder care increases successful outcomes for DMC beneficiaries. The state's proposal is currently under federal CMS review. DHCS anticipates hearing back from CMS by the end of April.

DHCS states the waiver will give state and county officials more authority to select quality providers to meet drug treatment needs. DHCS indicates the waiver will support coordination and integration across systems, increase monitoring of provider delivery of services, and strengthen county oversight of network adequacy, service access, and standardize practices in provider selection.

Key elements of the proposed waiver amendment include:

- **Continuum of Care:** Participating counties will be required to provide a continuum of care of services available to address substance use, including: early intervention, physician consultation, outpatient treatment, case management, medication assisted treatment, recovery services, recovery residence, withdrawal management, and residential treatment.
- **Assessment Tool:** Establishing the American Society of Addiction Medicine (ASAM) assessment tool to determine the most appropriate level of care so that clients can enter the system at the appropriate level and step up or step down in intensive services, based on their response to treatment.
- **Case Management and Residency:** Case management services to ensure that the client is moving through the continuum of care, and requiring counties to coordinate care for those residing within the county.
- **Selective Provider Contracting:** Giving counties more authority to select quality providers. Safeguards include providing that counties cannot discriminate against providers, that beneficiaries will have choice within a service area, and that a county cannot limit access.
- **Provider Appeals Process:** Creating a provider contract appeal process where providers can appeal to the county and then the State. State appeals will focus solely on ensuring network adequacy.
- **Provider Certification:** Partnering with counties to certify DMC providers, with counties conducting application reviews and on-site reviews and issuing provisional certification, and the State cross-checking the provider against its databases for final approval.
- **Clear State and County Roles:** Counties will be responsible for oversight and monitoring of providers as specified in their county contract.

- **Coordination:** Supporting coordination and integration across systems, such as requiring counties enter into memoranda of understanding (MOUs) with Medi-Cal managed care health plans for referrals and coordination and that county substance use programs collaborate with criminal justice partners.
- **Authorization and Utilization Management:** Providing that counties authorize services and ensuring Utilization Management.
- **Workforce:** Expanding the pool of Medi-Cal eligible service providers to include licensed practitioners of the healing arts for the assessment of beneficiaries, and other services within their scope of practice.
- **Program Improvement:** Promoting consumer-focused evidence-based practices including medication-assisted treatment services and increasing system capacity for youth services.

This proposed waiver will only be operational in counties that elect to opt into this organized delivery system. However, DHCS has stated that the early phases are considered demonstration projects but the goal is for the model to be eventually implemented statewide. Counties that opt into this waiver will be required to meet specified requirements, including implementing selective provider contracting (selecting which providers participate in the program), providing all DMC benefits, monitoring providers based on performance criteria, ensuring beneficiary access to services and an adequate provider network, using a single-point of access for beneficiary assessment and service referrals, and data collection and reporting. In a county that does not opt-in, there will be no change in services from the current delivery system.

DHCS proposes a phasing-in of this waiver, and anticipates that Phase 1 will be the Bay Area counties and would occur April – June of 2015.

Potential Relief from IMD Payment Exclusion. DHCS has also indicated that it has received informal approval from CMS that under this waiver proposal, the Institutions for Mental Disease (IMD) payment exclusion would not apply for counties that opt-into this demonstration. Consequently, federal funds would be available to provide residential treatment services to all eligible adults and inpatient voluntary detox in chemical dependency treatment facilities and freestanding psychiatric facilities. (See below for background information on the IMD exclusion.)

On October 21, 2014, the Senate Budget and Fiscal Review Committee and the Senate Health Committee held a joint oversight hearing on this proposed Drug Medi-Cal waiver. For more information on the wavier and the Drug Medi-Cal program, please see:
http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/FullC/10212014SBFRHearingAgernda.pdf

Background - Institutions for Mental Disease (IMD) Exclusion. In preparing to implement the newly expanded residential DMC benefit for all adults, as required by SB 1 X1, DHCS encountered an issue with the Institutions for Mental Disease (IMD) federal Medicaid payment exclusion. IMDs are inpatient facilities of more than 16 beds whose patient roster is more than 51% people with severe mental illness.

The IMD exclusion prohibits federal financial participation (FFP) from being available for any medical assistance under federal Medical law for services provided to any individual who is under age 65 who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. The IMD exclusion was designed to ensure that states, rather than the federal government, continue to

have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group. The IMD exclusion is unusual in that it is one of the very few instances in which federal Medicaid law prohibits FFP for care provided to enrolled beneficiaries.

Based on CMS current interpretation of the IMD exclusion, DHCS is prohibited from using federal funds to reimburse for any Medi-Cal service when a Medi-Cal beneficiary is receiving SUD services in residential facilities larger than 16 beds. In February 2014, DHCS indicated that there are 783 licensed SUD residential treatment facilities in California, with a total statewide licensed capacity of 18,155 beds. However, because of the federal IMD exclusion, DHCS estimates that only 1,825 beds (of the 18,155 licensed beds) are reimbursable under Medi-Cal.

Additionally, federal funding is not available for facilities that provide inpatient voluntary detoxification that are chemical dependency treatment facilities or freestanding psychiatric facilities, as the IMD payment exclusion applies to these facilities.

DHCS requested that CMS employ a different interpretation of the IMD exclusion that recognized California's unique market. However, CMS did not approve the request. Consequently, the residential benefit has not yet been expanded and voluntary detoxification can only be provided in general acute hospitals.

Drug Medi-Cal Program Integrity. 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. 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.

As of March 27, 2015, this review has resulted in a total of 79 temporary provider suspensions (at 217 sites). Many of these cases (96) have been referred to the California Department of Justice for criminal investigation and prosecution.

Subcommittee Staff Comment. This is an informational item.

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

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

2. Please provide a brief overview of the proposed Drug Medi-Cal waiver.

5. Drug Medi-Cal Provider Enrollment

Oversight Issue. Concerns have been raised that the process to certify and recertify Drug Medi-Cal (DMC) providers is cumbersome and unreasonable and will prove to be an impediment to the success of the proposed Drug Medi-Cal waiver as there will be an insufficient number of Drug Medi-Cal providers (particularly residential treatment providers) available to provide these services. Providers are reporting it taking over one year to complete this application process. Currently new providers who are attempting to become certified to be Medi-Cal providers and existing providers who make changes such as moving locations or adding new sites must submit applications manually to the Provider Enrollment Division (PED).

As a result of the expanded DMC benefit, the allegations of fraud that have come to light, and new requirements under the Affordable Care Act, there is a temporary, but substantial increase in the PED work load. Existing providers must be recertified and/or more closely scrutinized and new providers are needed to meet the increased demand for services.

As noted in the table below, of the 427 new applications/changes to existing certification, 204 (47 percent) have been processed and only 77 (or 18 percent) have been approved. Additionally, of the 306 non-continued certification applications (see below for definition of these applications) submitted to PED after January 1, 2014, 111 (36 percent) have been processed and only 25 (or eight percent) have been approved.

Table: Provider Enrollment Division – Drug Medi-Cal Applications (as of March 20, 2015)

		1. Inventory	2. Total Sites Targeted	3. Decertified	4. Apps Received for processing	5. Hold	6. Apps Assigned to Analyst for Review	7. Deficient	8. Awaiting Remediation Submittal	9. Remediation Submitted	10. Approved	11. Decertified/ Denied	12. Terminated App Review	13. % Total Apps Assigned/Deficient
Non-Targeted Inventory	Backlog	N/A	N/A	121	3	0	120	0	25	52	13	28		99.17%
	Non-Continued Cert.	N/A	N/A	306	26	29	231	34	82	25	76	10		84.97%
	TOTAL	0	0	427	29	29	351	34	107	77	89	38		88.99%
Phased Targeted Inventory	1	337	139	198	28	1	197	16	105	35	15	0		100.00%
	2	226	49	177	0	41	130	26	91	8	5	0		96.61%
	3	243	49	194	4	19	117	21	49	4	43	0		70.10%
	TOTAL	806	237	569	32	61	444	63	245	47	63	0		88.75%
Pending Targeted Inventory	4 (NTP)	131	0	48	1	1	4	1	3	24	0	0		10.42%
	Reconciliation	55	0	2	0	0	1	1	0	0	0	0		50.00%
	TOTAL	186	0	50	1	1	5	2	3	24	0	0		12.00%

Note - Definition of Categories:

- Non-Targeted Inventory: Backlog applications include new entities/sites/modalities/changes to existing certifications that were submitted to Substance Use Disorder Services Division (SUDS) prior to 1/1/2014 and reassigned to PED for review/processing on 4/3/2014. Non-continued certification applications are decertification appeals, new entities/sites/changes to existing certifications submitted directly to PED after 1/1/2014. These two buckets contain duplicate applications requesting different actions that have been counted separately.
- Phased Targeted Inventory: Phases 1-3 are continued recertifications of existing providers. Per the Affordable Care Act, Medi-Cal providers must be recertified on a regular-basis.
- Pending Targeted Inventory: Phase 4 (Narcotic Treatment Providers (NTP) and reconciliation has not yet been conducted.
- Phased targeted and pending targeted providers are certified providers in good standing with DHCS, able to provide services and bill. Non-Targeted providers also include some providers that are in good standing with DHCS, able to provide services and bill and are in this category solely due to a change that requires a full application.

Budget Issue. PED requests to extend 11 limited term positions that expire June 30, 2015 for one more year for work associated with certifying and recertifying Drug Medi-Cal providers. According to DHCS, these requested positions are essential to address provider fraud, waste, and abuse in the DMC program by certifying only providers meeting standards of participation in Medi-Cal, and decertifying fraudulent providers by conducting a thorough screening including collecting disclosure statements, performing monitoring checks, and making referrals to the DHCS Audits and Investigations Division for onsite reviews. In addition, DHCS has internally redirected six positions for this workload.

According to DHCS, the new workload related to DMC provider certification requirements includes:

- Requiring the enrollment of medical licensed staff. Current DMC program certification standards state that each substance abuse clinic must have a licensed physician designated as the medical director and that the medical director assumes medical responsibility of all of its patients.

- Requiring the submission of provider agreements. Although it is a federal requirement to have provider agreements from participating Medi-Cal providers, most DMC providers had not signed a provider agreement. The provider agreement serves as the contract between the provider and DHCS and is mandatory for participation or continued participation as a provider in the Medi-Cal program pursuant state and federal law.

- Requiring the submission of fingerprinting and criminal background checks. DHCS has designated new DMC certification applicants and DMC providers applying for recertification at the high categorical risk level. Providers designated at the high-risk categorical level must submit to fingerprinting and are subject to a criminal background check. PED will be required to review conviction information and work with the Office of Legal Services in determining the eligibility of the applicants to participate in the DMC program if a conviction is identified through the criminal background process.

- Timely reporting of changes that affect certification, such as ownership changes.

Additionally, database checks will be performed on a monthly basis to determine if DMC providers and their managing employees, owners, agents, or those with a control interest appear on the List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), Medicaid and Children's Health Insurance Program, CHIP, State Information Sharing System (MCSIS), and Social Security Death Match databases. A test sample of over 2,700 DMC providers run against these databases showed as many as 55 percent had matches.

Provide Application and Validation for Enrollment (PAVE). PED is automating its enrollment processes. PAVE will transform provider enrollment from a manual paper-based process to a web-based portal that providers can use to complete and submit their application, verifications, and to report changes. In the spring of 2014, DHCS indicated that PAVE would be up-and-running in September 2014 and that this system would help facilitate the workload to certify Drug Medi-Cal providers. However, implementation of PAVE has been delayed until at least September 2015.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal and the certification of Drug Medi-Cal providers.

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

1. Please provide an overview of the Drug Medi-Cal provider certification and re-certification process.

2. Please describe the efforts DHCS has undertaken to assist providers in certification, such as provider call lines and training webinars.

3. Does PED have timeframes (e.g., 60 days) by which it must process applications? If not, why not?

4. Has PED considered expediting applications from providers who already certified for a different location or service? If not, why not? What is the risk in expediting these applications?

5. Has DHCS identified particular services or regions that have severe access inadequacies that could be remedied with a speedier certification process?

6. Why was the implementation of PAVE delayed?

7. What steps is PED taking to ensure that providers in counties opting-into the Drug Medi-Cal waiver are prioritized in the PED certification process?

6. Drug Medi-Cal Provider Monitoring

Budget Issue. DHCS requests 10 positions in its Substance Use Disorder Prevention, Treatment, and Recovery Services Division for workload associated with monitoring Drug Medi-Cal (DMC) providers.

According to DHCS, these positions would be used to increase program integrity within the program and mitigate the risk of fraud, waste, and abuse. For example, these positions would review the on-site operations of every DMC provider at least once every five years (approximately 133 sites annually) and be responsible for follow up with DMC providers on all corrective action plans to ensure any deficiencies DHCS identifies are rectified by the DMC providers.

Additionally, these positions would be used to design and implement a DMC system monitoring protocol similar to the department's "Program Oversight and Compliance Annual Review Protocol for Consolidated Mental Health Services and Other Funded Services." This protocol includes monitoring for access; authorization; beneficiary protection; funding, reporting, and contracting requirements; provider relations; program integrity; quality improvement; and chart review. (This protocol can be found at:
http://www.dhcs.ca.gov/formsandpubs/Documents/14_027_Encl_1.pdf)

Background. Upon the transfer of the administration of the DMC program and applicable Medicaid functions to DHCS (from the former Department of Alcohol and Drug Programs) in June 2012, DHCS began a review of the DMC program. Based on issues it identified, DHCS initiated a complete review of the DMC program in an effort to address fraud, waste, and abuse allegations. One of the findings from this review was that monitoring of DMC providers was not occurring.

According to DHCS, identified health and safety issues would be avoided in the future with the implementation of on-site monitoring of the operations of DMC providers. Some of the issues recently identified with DMC providers that would be rectified with a DMC monitoring program are: DMC providers who should not be operating due to their status on federal excluded lists; medical directors with suspended or other action against their license; non-qualified staff providing services; beneficiary health and safety at risk due to unsanitary facilities; providers operating facilities out of compliance with local use permit requirements; inaccessible facilities; inadequate or no policies and procedures to guide operations; lack of adequate staffing to provide services; non-treatment services being provided; etc. Additionally, this monitoring function would strengthen the department's ability to ensure DMC providers are in compliance with specific requirements related to operating a DMC program on a school site, as well as ensuring the students' ability to receive treatment services safely and confidentially.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal. While the goal of program integrity and developing a DMC system-wide monitoring system is worthwhile, discussions continue on the level of staff necessary for these purposes.

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

1. Please provide an overview of this request.

2. For a county that opts-into the Drug Medi-Cal waiver, what are its responsibilities in regard to monitoring DMC providers? How do these responsibilities differ from the proposed activities outlined in this proposal?

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

7. Substance Abuse – Recovery and Treatment Services (AB 2374, 2014)

Budget Issue. DHCS requests to establish two permanent, full-time positions at a cost of $246,000 (General Fund) due to the enactment of AB 2374 (Mansoor), Chapter 815, Statutes of 2014.

AB 2374 requires a counselor certifying organization (CO), prior to registering or certifying a counselor, to contact DHCS-approved COs to determine whether a counselor has previously had a certification or registration revoked. The requested positions would be used to address this new workload.

AB 2374 also requires licensed residential treatment facilities to report resident deaths to DHCS by phone and in writing. The report requires the inclusion of specific information, including a description of the follow-up action that is planned, including, but not limited to, steps taken to prevent a future death. The death reporting requirements of AB 2374 closely align and expand upon the requirements that currently exist in the California Code of Regulations Title 9 § 10561 and DHCS's internal death investigation policy. For this reason, DHCS requests no resources for this component of AB 2374.

Background. Prior to the approval of AB 2374, DHCS only had the authority to ensure that COs maintained a business office in California and remained accredited with the National Commission for Certifying Agencies (NCCA). Once approved, DHCS had no authority to monitor, suspend or revoke approval of a CO unless they lost their NCCA accreditation. Ten COs were originally approved in regulations to register and certify individuals providing AOD counseling in California's licensed and/or certified AOD facilities. DHCS currently recognizes four approved counselor COs. The other six COs lost their accreditation with the NCCA, thereby, losing approval from DHCS. Those four organizations have approximately 28,000 SUD counselors, of which roughly half are certified and half are registered while working towards certification.

AB 2374 establishes new requirements for DHCS' oversight of COs. This new oversight authority includes periodic reviews of the COs and administrative tasks related to periodic reviews to properly monitor the approved COs' adherence to state requirements. DHCS will develop regulations to clarify the CO provisions in AB 2374. DHCS currently has no staff devoted to CO oversight and no funding intended for that purpose. According to DHCS, the anticipated workload associated with AB 2374 is beyond DHCS's ability to absorb and continue to provide the levels of service that existing mandates require.

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

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

1. Please provide an overview of this budget request.