SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

April 12, 2012

10:30 AM

Room 4203
(John L. Burton Hearing Room)
Part 1 Health 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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VOTE ONLY CALENDAR

A. 4265 Department of Public Health

The following issues were discussed at the Subcommittee #3 Hearing on March 8, 2012:

A. Safe Drinking Water State Revolving Fund

- Subcommittee Staff Recommendation—Approve as budgeted.

B. Renewal of Proposition 50 Limited-Term Positions

- Subcommittee Staff Recommendation—Approve as budgeted.

C. Small Water System Program

- Subcommittee Staff Recommendation—Approve as budgeted.

D. California Home Visiting Program

- Subcommittee Staff Recommendation—Approve as budgeted.

E. Maternal, Child and Adolescent Health - Reduction in Federal Funds

- Subcommittee Staff Recommendation—Approve as budgeted.

F. Expand California's Newborn Screening Program

- Subcommittee Staff Recommendation—Approve as budgeted.

G. Federal Special Projects – Position Conversion

- Subcommittee Staff Recommendation—Approve as budgeted.

H. Loan from Childhood Lead Poisoning Prevention Fund

- Subcommittee Staff Recommendation—Approve a $15 million loan from the Childhood Lead Poisoning Prevention Fund (CLPPF) to the General Fund that would be paid back to the CLPPF in 2014-15.

ISSUES FOR DISCUSSION

A. Community Mental Health

I. BACKGROUND

California has a decentralized public mental health system with most direct services provided through the county mental health system. In 2011-12, major changes to the state's oversight and responsibility for these programs were initiated. (These changes are described in detail below.) Prior to 2011-12, the Department of Mental Health (DMH) was the lead state agency responsible for administering state and federal statutes pertaining to mental health treatment programs.

County Mental Health Plans. 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, within the resources made available, (2) the Medi-Cal Specialty Mental Health Managed Care Program, (3) the Early Periodic Screening Diagnosis and Testing (EPSDT) Program for children and adolescents, (4) mental health treatment services for individuals enrolled in other programs, including special education, CalWORKs, and Healthy Families, and (5) programs associated with the Mental Health Services Act of 2004 (known as Proposition 63).

Specialty Mental Health Services Managed Care. California provides "specialty" mental health services under a comprehensive Waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. These specialty mental health services are "carved out" of the Medi-Cal Program administered by the Department of Health Care Services (DHCS), which provides physical health care.

County Mental Health Plans are the responsible entity that ensures that 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.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. EPSDT is a federally mandated program that requires the state to provide Medi-Cal beneficiaries under age 21 with any physical and mental health services that are deemed medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, including services not otherwise included in the state's Medicaid plan.

2011 Realignment and Mental Health Services. The 2011-12 budget realigned many public safety and health and human services, including Medi-Cal Specialty Mental Health and

EPSDT. However, in March 2011, the Governor signed AB 100, which amended the Mental Health Services Act (MHSA) to allocate, on a one-time basis, $861 million in MHSA funds to counties to support EPSDT, Medi-Cal Specialty Mental Health managed care, and mental health services provided to special education students. (In separate legislation, the mandate on county mental health departments to provide mental health services to special education students was repealed, thereby transferring the federal mandate back to school districts.) It was the intention that these programs would be fiscally realigned in 2012-13.

Prior to the 2011 Realignment, County Mental Health Plans were funded with 1991 Realignment funds, General Fund, and federal funds and EPSDT was funded by the General Fund and federal funds with the counties paying a 10-percent share of cost above a specified baseline.

In addition to the one-time funding shift of MHSA funding, AB 100 also made changes to MHSA administration, including reducing the percentage amount available from MHSA revenues for state administration from 5 percent to 3.5 percent, requiring monthly distributions from the MHSA Fund, having the "state" (instead of DMH) administer the MHSA Fund, and having the Mental Health Services Oversight and Accountability Committee provide technical assistance to counties. AB 100 was point-in-time legislation that was developed with the intention of coming back to define a process to restructure the state's mental health system.

Administrative Transfer from DMH to Department of Health Care Services. AB 102 (Statutes of 2011, signed by the Governor in June 2011) continued the process to restructure the state's mental health system. AB 102 transfers from DMH to the Department of Health Care Services (DHCS), effective July 1, 2012, the state administrative functions for the operation of Medi-Cal Specialty Mental Health Managed Care, the EPSDT Program, and applicable functions related to federal Medicaid requirements.

It required DHCS, in collaboration with DMH and the California Health and Human Services Agency (Agency), to create a state administrative and programmatic transition plan, in consultation with stakeholders that included specified components to guide the transfer of Medi-Cal Specialty Mental Health managed care and the EPSDT Program to DHCS.

AB 102's legislative intent is that the transfer occur in an efficient and effective manner, with no unintended interruptions in service delivery to clients and families, and that the transfer accomplish improved access to culturally appropriate community-based mental health services; effectively integrate the financing of services to more effectively provide services; improve state accountabilities and outcomes; and provide focused, high-level leadership for behavioral health services within the state administrative structure.

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

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

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

- **Community Services and Supports 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 to promote interagency collaboration. This is funded from 5 percent of the Community Services and Supports funds and 5 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 Act.

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 Act 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 Act.

1991 Realignment – Mental Health Services. Among other things, the Bronzan-McCorquodale Act realigned certain mental health services to the Counties. The Mental Health Subaccount receives revenues originating from Sales Tax and Vehicle Licensure Fees. About $1.1 billion (continuous appropriation) is presently available for the following services:

- **Community-Based Mental Health Services (Systems of Care).** Each county is charged with the responsibility of developing and coordinating a comprehensive system of programs to meet its residents' (children and adults) mental health needs, referred to as systems of care. These programs address the problems of acute and chronic mental disorders.
- **State Hospital Services for County Patients.** Counties contract with the Department of Mental Health (Department of State Hospitals in the budget year) for State Hospital beds for county patients who are civilly committed.
- **Institutions for Mental Disease (IMDs).** The IMDs, administered by independent contractors, generally provide short-term nursing level care to the seriously mentally ill.

II. ISSUE FOR DISCUSSION

1. 2011 Realignment of Medi-Cal Specialty Mental Health and EPSDT

Budget Issue. The Administration proposes to implement the realignment of Medi-Cal Specialty Mental Health services and EPSDT. The 2011-12 budget realigned many public safety and health and human services, including Medi-Cal Specialty Mental Health and EPSDT. However, since AB 100 (as discussed above) provided one-time MHSA funding for Medi-Cal Specialty Mental Health and EPSDT, these programs are not realigned until 2012-13.

The table below identifies the proposed "2011 Realignment" funding for mental health services.

Table: 2011 Realignment Funding – Local Revenue Fund (dollars in millions)

	2011-12		**2012-13**	
	2011 Budget Act	Proposed	June 2011 Estimate	Proposed
Medi-Cal Specialty Mental Health	-	-	$183.7	$188.8
EPSDT	-	-	$629.0	$544.0
1991 Mental Health Responsibilities	$1,083.6	$1,104.8	$1,119.4	$1,164.4

Note: The June 2011 Estimate for EPSDT for 2012-13 reflects full-year implementation of the *Katie A.* lawsuit and the Healthy Families Program transfer to Medi-Cal. Whereas, the proposed 2012-13 EPSDT funding includes only partial year funding (as these changes are proposed to be phased-in in 2012-13).

Medi-Cal Specialty Mental Health. The $5.1 million increase, noted in the table above, in Medi-Cal Specialty Mental Health (i.e., the mental health managed care program) principally reflects a 2.6 percent growth in eligible consumers.

EPSDT Estimate. The EPSDT Local Revenue Fund estimate above reflects:

1. A decrease of $77.3 million (compared to the 2011 Budget Act) based on a forecast of decreased approved claims. Statewide implementation of the Short Doyle Medi-Cal (SDMC) Phase 2 system changes began in January 2010 and billing issues and claim delays occurred throughout 2010 and 2011. The Administration notes that this forecasted decrease could be a result of the implementation of SDMC Phase 2. The Administration expects the May Revise to more accurately reflect claim information as the SDMC Phase 2 system changes will be fully implemented.

2. An increase of $6.1 million for the transition of Healthy Families Program children to Medi-Cal starting in October 2012.
3. An increase of $5.3 million for the *Katie A.* lawsuit, as services to Foster Care youth are anticipated to begin in January 2013 as a pilot for at least one large, medium, and small county. This increase is 20 percent of the full annual implementation cost ($53.5 million) for mental health services related to *Katie A.*

Subcommittee Staff Comment and Recommendation—Hold Open. The trailer bill language regarding the realignment of these mental health services is not yet available. Consequently, the Legislature cannot evaluate the manner in which funds will be distributed to counties for these programs, nor can it evaluate how the Administration has addressed the existing statutes that give counties the voluntary option of contracting with the state to serve as the County Mental Health Plan. Since these programs are realigned, counties would have the responsibility for these programs.

Additionally, concerns have been raised that the Administration's EPSDT figures do not reflect adequate funding for these services and do not include a mechanism to ensure funding for future growth and penetration of these services. It is recommended to hold this item open as it is anticipated that the May Revise estimates will more accurately reflect the true estimate of approved claims for mental health services.

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

1. Please provide an overview of this proposal.

2. Please discuss the differences between the June 2011 EPSDT estimate for the budget year and the Administration's January estimate.

3. What is the status of the trailer bill language regarding the realignment of mental health services?

2. Transfer of State Administration of Medi-Cal Specialty Mental Health

Budget Issue. The Administration proposes trailer bill language to proceed with statutory changes necessary to transfer the administrative functions for Medi-Cal Specialty Mental Health managed care plan services and EPSDT from DMH to DHCS.

Background. AB 102 (Statutes of 2011) transferred the administration of the Medi-Cal Specialty Mental Health Services Program from DMH to DHCS, effective July 1, 2012. The intent of the transfer is to:

- Improve access to culturally appropriate community-based mental health services, including a focus on client recovery, social rehabilitation services, and peer support;
- Effectively integrate the financing of services, including the receipt of federal funds, to more effectively provide services;
- Improve state accountabilities and outcomes;
- Provide focused, high-level leadership for behavioral health services within the state administrative structure.

Effective September 1, 2011, 118.5 DMH Medi-Cal positions were transferred to DHCS.

AB 102 required DHCS, in collaboration with DMH and the California Health and Human Services Agency (Agency), to create a state administrative and programmatic transition plan, in consultation with stakeholders that included specified components to guide the transfer of Medi-Cal Specialty Mental Health managed care and the EPSDT Program to DHCS.

DHCS was required to provide the transition plan to all fiscal committees and applicable policy committees of the Legislature by October 1, 2011. AB 102 required the state administrative transfer to conform to the state administrative transition plan provided to the Legislature. Finally, AB 102 also authorized the transition plan to also be updated by the Governor and provided to the Legislature upon its completion, but no later than May 15, 2012.

DHCS submitted the required transition plan, and two updates to that plan. Issues raised by stakeholders in the October 1, 2011 transition plan included the following:

- That DHCS improve business practices (examples include maximizing the claiming of federal funds; improving the claims reimbursement system, streamlining the cost reporting and settlement processes; eliminating redundancies in the provider certification process; facilitating same day billing for mental and physical health care services; integrating audits; integrating information technology systems; and, reducing processing times);
- That DHCS assure access and improve services (examples include adopting community-based best practices, such as peer support and maximizing the use of social rehabilitation services; increasing the use of telepsychiatry; focusing on prevention and early intervention; ensuring state staff are knowledgeable about mental health services; assuring children's mental health policy expertise; assuring providers can continue to serve clients during and after the transfer; continuing progress in assuring cultural

competence of services; addressing racial, ethnic, and cultural disparities in access to care and outcomes; reducing discrimination and stigma experienced by clients; eliminating disparity in access to services; integrating services; facilitating coordination with non-Medi-Cal mental health services; incentivizing the use of community settings; and assuring accountability in the mental health system and, of its providers and administrators);

- That DHCS ensure stakeholder participation (examples include providing regularly scheduled venues for regular stakeholder engagement; consulting with stakeholders on program changes, efficiencies, regulations, State Plan Amendments, and waiver amendments; engaging stakeholders in ongoing quality improvement, including county representation in assessment of legal issues and court decisions that require county implementation; facilitating stakeholder participation by funding travel to meetings; and, clearly identifying individuals that serve as state contacts for programs and services).

Subcommittee Staff and Recommendation—Hold Open. The Administration's proposal is consistent with state law. However, pieces of this proposed trailer bill language directly relate to the realignment proposal. Given that the Legislature does not yet have the realignment trailer bill language, it is recommended to keep this item open.

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

1. Please provide an overview of this proposal and the planning process that occurred in the summer and fall of last year.

2. Please explain how DHCS plans to address stakeholder concerns and suggestions regarding program improvements and innovations (i.e., the development of a business plan). What is the timeline for this process?

3. Transfer of Non Medi-Cal Community Mental Health Programs

Budget Issue. The Governor's budget proposes to eliminate the Department of Mental Health (DMH), establish the Department of State Hospitals to provide long-term care and services to individuals with mental illness at state hospitals, and redirect funding and positions for all remaining mental health services to other departments.

The reorganization of behavioral health began in 2011-12, as discussed above. The Administration intends that this proposal completes these efforts by transferring the remaining mental health programs to various state departments that perform related or similar functions. The Administration believes the consolidation of mental health, substance use disorder, and physical health at DHCS will provide for a continuum of care for consumers in preparation for health care reform in 2014.

The Administration proposes to transfer the remaining non-Medi-Cal community health programs, including 58 positions and budget authority of $104.7 million ($16.3 million state operations, $88.3 million local assistance) ($15.6 million General Fund) from DMH to six other departments as described in the chart below.

Table: Behavioral Health Reorganization: Department of Mental Health Functions

FUNCTION OR PROGRAM	RECIPIENT DEPARTMENT POSITIONS/TOTAL FUNDING
Financial Oversight, Certification Compliance/Quality Improvement, MHSA State Level Issue Resolution, County Data Collection and Reporting, MHSA Statewide Projects (Suicide Prevention, Student Mental Health Initiative, Stigma and Discrimination Reduction Project), Co-Occurring Disorders, Veterans Mental Health, Substance Abuse and Mental Health Services Administration Block Grant, Projects for Assistance in Transition from Homelessness (PATH), Training Contracts – California Institute for Mental Health (CIMH), California Health Interview Survey (CHIS), Policy Management, MHSA Housing Program, Administrative Staff-Accounting, IT, California Mental Health Planning Council	**Department of Health Care Services** $72.3 million ($256,000 General Fund, $6.9 million Mental Health Services Fund, $65.1 million federal funds) 41.0 Positions
Office of Multicultural Services Disaster Services and Response	**Department of Public Health** $2.3 million Mental Health Services Fund 4.0 Positions
Licensing/Quality Improvement (Mental Health Rehabilitation Centers, Psychiatric Health Facilities)	**Department of Social Services** $1.1 million ($337,000 General Fund, $391,000 Licensing and Certification Fund, $396,000 Reimbursements) 12.0 Positions
Early Mental Health Initiative	**Department of Education** $15 million General Fund 0.0 Positions
MHSA Workforce Education and Training (WET)	**Office of Statewide Health Planning and Development** $12.3 million Mental Health Services Fund 1.0 Positions
Training Contracts – Consumer Groups, MHSA Technical Assistance, MHSA Program Evaluation	**Mental Health Services Oversight and Accountability Commission** $1.7 million Mental Health Services Fund 0.0 Positions

Department of Health Care Services. The majority of existing community mental health programs and functions are proposed to be transferred to a new Division of Mental Health and Substance Use Disorders Services within DHCS. In addition to the transfer of these programs, the Administration proposes to create a new Deputy Director, Mental Health and Substance Use Disorder Services, who would lead this new division. The new Deputy Director would be a Governor's Appointee and would require Senate confirmation. The following functions would be transferred to DHCS:

- **Oversight of Certain MHSA Components.** DHCS would be responsible for the collection of data relating to certain MHSA programs (Full Service Partnerships). In addition, DHCS would be responsible for MHSA state-level issue resolution which is a process by which

consumers and stakeholders have a mechanism to resolve issues related to MHSA. And finally, DHCS would be responsible for MHSA Statewide Prevention and Early Intervention Projects (Suicide Prevention, Student Mental Health Initiative, and Stigma and Discrimination Reduction Programs).

- **Certification of Mental Health Programs at Facilities.** DHCS would assume responsibilities for the certification of mental health treatment programs at Skilled Nursing Facilities with Special Treatment Programs, Community Residential Treatment Systems (also known as Social Rehabilitation Programs), and Community Treatment Facilities.

- **Oversight of Federal Grants.** In addition, DHCS would be responsible for the oversight and administration of federal mental health funds including the Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant and the Projects for Assistance in Transition from Homelessness (PATH). The SAMHSA block grant can be used to establish or expand an organized community-based system of care for providing non-Medi-Cal mental health services to children with serious emotional disturbances and adults with serious mental illness. The state administers this block grant and allocates the funds each year to 58 local county mental health agencies. The county mental health departments and contracted providers deliver a broad array of treatment and support services that include over 150 individual programs supported by the block grant. PATH funds community-based outreach, mental health and substance abuse services, case management, and limited housing services for people experiencing serious mental illness who are experiencing homelessness or are at risk of becoming homeless.

- **Oversight of Contracts and Other Mental Health Programs.** Finally, DHCS would be responsible for the oversight of certain administrative and training contracts related to the above-mentioned programs and the coordination of efforts related to veteran's mental health and co-occurring disorders.

Department of Public Health (DPH). As discussed later in the agenda, the Administration proposes to transfer the Office of Multicultural Services (OMS) to DPH's new Office of Health Equity. Additionally, the $60 million in MHSA funds for the California Reducing Disparities Project (CRDP) would be transferred to DPH. The CRDP is a project under the Prevention and Early Intervention component of the Mental Health Services Act. The initiative is focused on five populations: African Americans; Asian/Pacific Islanders; Latinos; Lesbian, Gay, Bi-sexual, Transgender, Questioning; and Native Americans. The project will develop population-specific reports that will form the basis of a statewide comprehensive strategic plan to identify new approaches to reduce disparities.

This proposal also transfers DMH's Disaster Services Unit to DPH. The Disaster Services Unit is responsible for the statewide coordination of disaster mental health responses to major disasters in support of local mental health agencies. This includes the development and maintenance of the mental health section of the State Emergency Plan and training and technical assistance to local mental health agencies on planning, preparedness, and mitigation for a disaster.

The DPH is the designated lead state agency for public health emergency preparedness and response.

Department of Social Services (DSS). The Administration proposes to transfer DMH's facility licensing and quality improvement efforts to the Department of Social Services (DSS). DMH currently licenses mental health rehabilitation centers (MHRCs) and psychiatric health facilities (PHFs). MHRCs provide community-based intensive support and rehabilitation services designed to assist persons, 18 years or older, with mental disorders who would have been placed in a state hospital or another mental health facility to develop the skills to become self-sufficient and capable of increasing levels of independent functioning. There are currently 20 MHRCs with a total of 1,363 beds.

PHFs offer acute inpatient psychiatric treatment to individuals with major mental disorders in a nonhospital setting. PHFs mainly provide acute psychiatric treatment services to individuals subject to involuntary commitment under the Lanterman-Petris-Short Act. There are 25 PHFs in California with 432 beds. These facilities are locked facilities.

The Administration argues that these facilities are similar to other residential facilities that are licensed by DSS.

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

Department of Education. The proposal transfers the Early Mental Health Initiative (EMHI) program to the Department of Education. The EMHI is a school-based program funded with Proposition 98 funds. The Senate Budget Subcommittee #1 will discuss this proposed transfer at its April 26 hearing.

Office of Statewide Health Planning & Development (OSHPD). The Administration proposes to transfer the MHSA workforce education and training (WET) component to OSHPD. The MHSA WET targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness.

OSHPD currently operates a mental health loan assumption program and the Administration believes it has the existing infrastructure, experience and technical ability to effectively monitor grants and program activities. The Administration also states that this transfer will increase efficiency, reduce duplication, and align the program with health care reform planning.

Mental Health Services Oversight & Accountability Commission (MHSOAC). The budget proposes to transfer training contracts for consumer groups, technical assistance, and program evaluation to the MHSOAC.

The Administration states that these functions are consistent with the role of the MHSOAC and that placing these functions within the MHSOAC will reduce duplication as the MHSOAC currently has similar contracts with stakeholder entities.

Subcommittee Staff Comment and Recommendation—Hold Open. The proposed reorganization of non-Medi-Cal community mental health is consistent with Legislative action on the 2011-12 budget. However, it is recommended to keep this item open as discussions continue regarding the reorganization and realignment of mental health programs.

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

1. Please provide a summary of this proposal.

2. How has the Administration reached out to stakeholders to solicit feedback on this reorganization?

4. Proposition 63 – Mental Health Services Act

Budget Issue. In addition to the reorganization of non-Medi-Cal community mental health, the Administration's proposed trailer bill language makes changes to the Mental Health Services Act (MHSA), including:

- Changes approval of the MHSA innovation programs from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to the county board of supervisors.
- Removes MHSOAC's authority to issue guidelines for MHSA innovation programs.
- Requires each county mental health program to prepare and submit a three-year plan adopted by its county board of supervisors to MHSOAC.
- Eliminates performance contracts between the state and counties.

Background. AB 100 (Statutes of 2011) made several changes to the Mental Health Services Act (MHSA). These changes include:

- Deleted the requirement that the Department of Mental Health (DMH) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) annually review and approve county plans and updates.
- Deleted the requirement that a county annually update the 3-year plan but still required that there be updates.
- The "state," instead of DMH, would administer the Mental Health Services Fund (MHSF).
- Starting July 1, 2012, the State Controller shall distribute, on a monthly basis, to counties all unexpended and unreserved funds on deposit in the MHSF as of the last day of the prior month.
- Reduced the administrative funds for state departments from 5 percent to 3.5 percent.

AB 100 also contained language specifying that it was the Legislature's intent to ensure continued state oversight and accountability of the MHSA and that in eliminating state approval of county mental health programs, the Legislature expects the state to establish a more effective means of ensuring that county performance complies with the MHSA.

AB 100 Workgroup. Because several changes made by AB 100 needed clarification before they could be implemented, a workgroup was convened in an effort to try to develop consensus recommendations. This workgroup included representatives from DMH; the California Mental Health Planning Council; MHSOAC; the California Mental Health Directors; the National Alliance on Mental Illness; the California Network of Mental Health Clients; the Mental Health Association, California; and United Advocates for Children and Families.

Recommendations from the AB 100 workgroup include:

- Implement the MHSA state level issue resolution process as a mechanism to assure county level compliance with the MHSA values.
- Charge MHSOAC with MHSA performance outcome evaluation.
- Continue MHSA programs through a performance contract.

Performance Contracts. Performance contracts were developed during the 1991 realignment as a way to ensure county accountability. These contracts provide for county assurance and reports and provide a mechanism to address noncompliance.

Subcommittee Staff Comments and Recommendation—Hold Open. It is recommended to hold this item open. Discussions regarding state oversight of MHSA funds and compliance with the MHSA (including the nonsupplantation requirement and MHSA component funding requirements); performance contracts; and the role of the MHSOAC are continuing. Additionally, discussions are still underway between the Administration and counties on how the State's Controller's Office will distribute MHSA funds to counties.

Lastly, it should be noted that SB 1136 (Steinberg) will propose changes to the MHSA and is to be discussed in the Senate Health Policy Committee on April 25, 2012. This legislation pertains to the budget as a follow-up to AB 100 (discussed above) as well as issues raised by the Administration in their proposed trailer bill legislation.

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

1. Please provide an overview of the Administration's proposed changes to the MHSA.

2. What is the Administration's perspective on the role of the state with regards to ensuring the integrity of the MHSA?

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5. Caregiver Resource Centers

Budget Issue. The Administration proposes to eliminate $2.9 million General Fund for the Caregiver Resource Centers (CRCs).

Background. CRCs provide services and supports to families and caregivers of persons with cognitive disorders such as Alzheimer's disease, stroke, dementia, and others. The assistance provided by CRCs allows persons with these disorders to stay in familiar home environments while family members provide care. The 11 CRCs located throughout the state provide free and low-cost services and supports to families regardless of income.

LAO Comment. The LAO finds that the role of CRCs should be considered in the context of the Governor's Coordinated Care Initiative and other state efforts to provide seniors and persons with disabilities with community-based services instead of institutional care. The LAO also notes that CRC administrators report that this proposal would result in a federal funding reduction to CRCs of $3.9 million due to federal matching requirements that would no longer be met.

Subcommittee Staff Comments and Recommendation–Reject. It is recommended to reject this proposal. CRCs provide valuable services to family caregivers. These services enhance family caregivers' ability to provide care over the long-term; thereby, preventing or delaying placement in nursing homes or hospitals. Since DMH is proposed for elimination, it is recommended to transfer the CRC program to DHCS' Long-Term Care Division.

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

1. Please provide a summary of this proposal.

6. California Youth Empowerment Network (CAYEN)

Budget Issue. The 2011-12 budget eliminated the California Youth Empowerment Network (CAYEN) contract at DMH. Concerns have been raised indicating that this elimination was not based on policy, but rather a misunderstanding of how this contract was categorized. The contract was for $250,000 (MHSA funds).

Background. The CAYEN contract supports advocacy efforts for transition-age-youth (age 15-26) regarding the mental health system. CAYEN ensures that counties include transition-age-youth in mental health community planning and that services that young people say work are being identified and put into practice. CAYEN also encourages young people to get involved in their county planning process to make sure the transition-age-youth perspective is incorporated. This contract has been supported since 2007-08.

During the 2011-12 budget deliberations, this contract was eliminated because it was misclassified as an administrative-related contract. The 2011-12 budget reduced the percent of total annual revenues for state administrative expenditures for MHSA from 5 percent to 3.5 percent.

Subcommittee Staff Comment and Recommendation. It is recommended to reinstate this contract for $300,000 at the Mental Health Services Oversight and Accountability Commission. Since severe mental illness most often first manifests during the transition-age-youth years of age, the perspective and consultation of participants in this age group is critical to mental health community planning. The increase of $50,000 (from the original contracted amount) would provide additional funds for youth participants to attend meetings, such as the meetings of the Mental Health Services Oversight and Accountability Commission and meetings with state and county officials, and an inflationary increase.

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

1. Please provide an overview of this contract and the action taken in 2011-12.

2. Does the Administration have any concerns with the reinstatement of this contract?

7. Community Treatment Facilities

Budget Issue. The Administration proposes to eliminate $750,000 General Fund that is paid as a supplemental rate to Community Treatment Facilities (CTFs). The Administration argues that since this is not a statewide program, counties can use local funds to fund these CTFs at their discretion. (There are no federal funds for CTFs.)

Background. Community Treatment Facilities (CTFs) provide secured residential care for the treatment of children diagnosed as being seriously emotionally disturbed (SED). These are locked facilities and provide intensive treatment. Generally, CTFs were created as an alternative to out-of-state placement and state hospitalization for some children.

The Budget Act of 2001, and related legislation, provided supplemental payments to CTFs. The CTF supplemental rate provides additional funding up to a maximum of $2,500 per month, per child. These supplemental payments consist of both state (40 percent or $1,000) and county (60 percent or $1,500) funding.

There are two active CTFs in California:

- Starview Children and Family Services in Los Angeles County (40 beds)
- Vista Del Mar Child and Family Services in Los Angeles County (21 beds)

The San Francisco Community Alternatives Program in San Francisco County is in the process of closing and is performing assessments on all of its clients in order to refer each one to other programs and services in the area.

The $750,000 General Fund supplemental rate was based on three CTFs being operational in the state.

Subcommittee Staff Recommendation—Hold Open*.* It is recommended to hold this item open as discussions continue. Given the state's fiscal situation and since there are only two facilities in the state, it is likely that these costs can be absorbed by counties who use these facilities.

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

1. Please provide a summary of this proposal.

B. 4265-Department of Public Health and 4260-Department of Health Care Services

1. Office of Health Equity

Budget Issue. The Administration proposes to create a new Office of Health Equity (OHE) at the Department of Public Health. This office would take a more comprehensive and integrative approach to address the issues of health disparity and promote healthy communities.

The OHE would be created by consolidating the following entities:

- Office of Multicultural Health (OMH) at DPH
- Office of Women's Health (OWH) at the Department of Health Care Services (DHCS)
- Office of Multicultural Services (OMS) at the Department of Mental Health (DMH)
- Health in All Policies Task Force (HiAP) at DPH
- Healthy Places Team at (HPT) DPH

Proposed Office of Health Equity Organization Chart

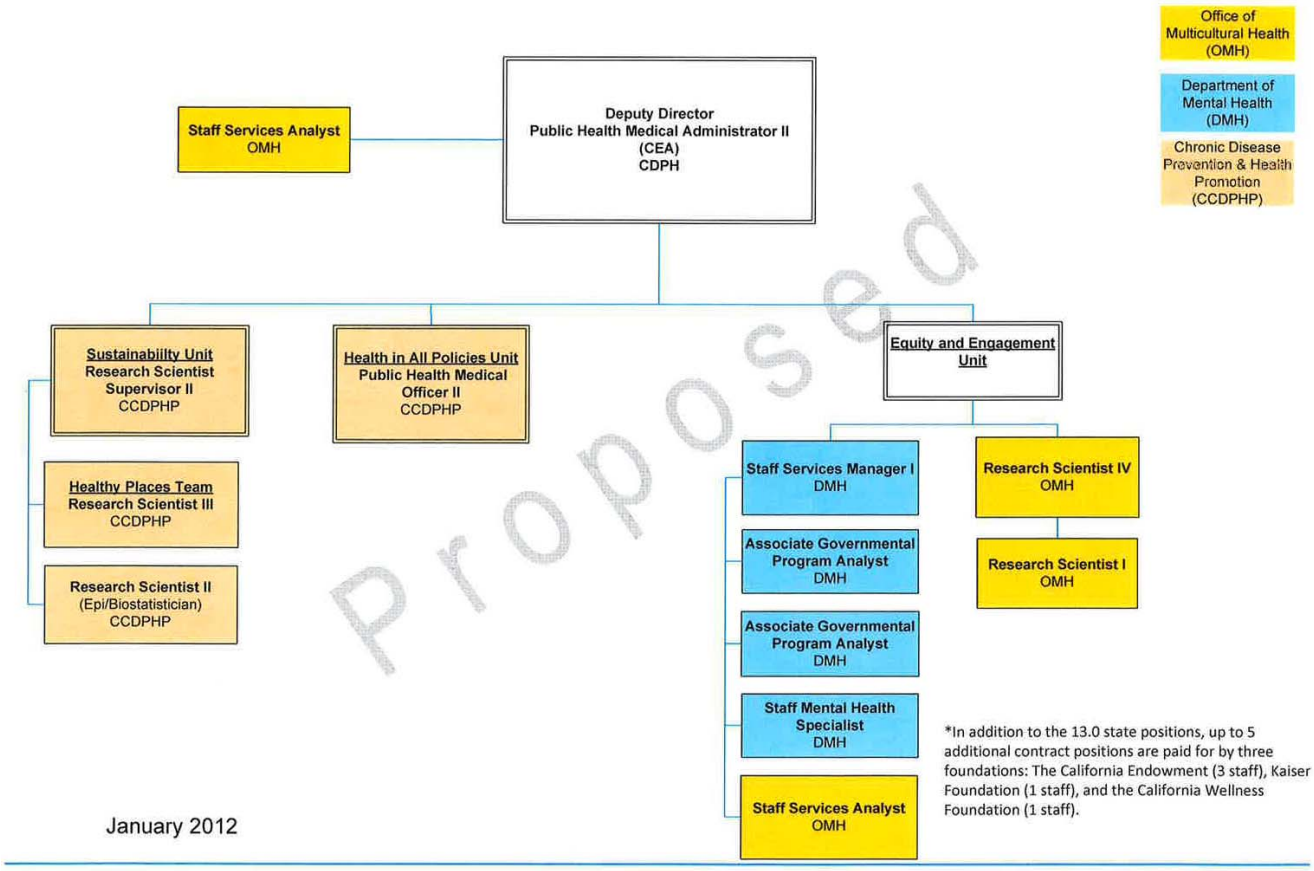

Table: Proposed Office of Health Equity Budget

Office of Health Equity				
Fund Source	**Appropriation Amount**		**Position Classifications**	**Count**
General Fund Program Function Health in All Policies Unit and Healthy Places Team	Personal Services	$268,000	Public Health Medical Officer II	1.0
			Research Scientist III	1.0
	Contracts	0		
	OE&E	38,000		
	Total	**$306,000**	**Position Total**	**2.0**
Mental Health Services Fund Program Function Equity and Engagement Unit (EEU)	Personal Services	$329,000	Staff Services Manager I	1.0
			Associate Governmental Program Analyst	2.0
			Staff Mental Health Specialist	1.0
	Contracts	1,959,000	Master Multi-Provider Cultural Competency; Mental Health Association of California; etc.	
	OE&E	61,000		
	Total	**$2,349,000**	**Position Total**	**4.0**
Federal Trust Fund Program Function Office of Multicultural Health	Personal Services	$199,000	Staff Services Analyst	2.0
			Research Scientist I	1.0
	Contracts	0		
	OE&E	57,000		
	Total	**$256,000**	**Position Total**	**3.0**
Prop. 99 Unallocated Account Program Function Sustainability Unit and Healthy Places Team	Personal Services	$226,000	Research Scientist Supervisor II	1.0
			Research Scientist II	1.0
	Contracts	0		
	OE&E	38,000		
	Total	**$264,000**	**Position Total**	**2.0**
Distributed Administration Program Function OHE Deputy Director and EEU	Personal Services	$316,000	Public Health Medical Administrator II	1.0
			Research Scientist IV	1.0
	Contracts	61,000	• Consultant Contract • Women's Health Survey	
	OE&E	110,000		
	Total	**$487,000**	**Position Total**	**2.0**
Total		**$3,662,000**		**13.0**

Advisory Committee. The proposal requires the OHE to establish an Advisory Committee, which would include "representatives of appropriate state agencies and representatives of appropriate stakeholder communities that represent the diverse demographics of the state." According to DPH, the Advisory Committee would assist the department in the development of the mission, vision, goals, and performance metrics of the OHE.

The following existing advisory bodies would be eliminated:

- The OWH's Women's Health Council
- The OMH's Council on Multicultural Health
- The OMS's Cultural Competency Advisory Committee

The Administration notes that the new OHE Advisory Committee would be representative of the above advisory bodies. It also notes that current committee/council members would be encouraged to apply for the OHE Advisory Committee.

Department of Health Care Services. In addition to the new OHE, the Administration proposes to redirect the five positions at the Office of Women's Health to address healthy equity issues from the health care delivery system perspective at the Department of Health Care Services. According to DHCS, the multiple health care programs at DHCS are complex with multiple eligibility groups, variations in benefits, and a range of business rules. In addition, the scope of programs is expanding substantially with the addition of mental health and substance abuse services. Thus, it takes a sophisticated, in-depth understanding of the various DHCS programs to analyze health disparities and to design appropriate interventions to eliminate them. Specifically, the administration proposes:

Office of Medical Director. DHCS will be directing three positions to work in the Office of the Medical Director. One of these positions (a Medical Program Consultant) would:

1. Develop, plan, and implement programs and policies that advance and improve the health of the population.
2. Optimize the patient care experience.
3. Reduce the per capita cost of care.

Two of the positions (a Research Scientist and Health Program Specialist) would help develop the DHCS Quality Strategy (QS). The QS will align with the National Quality Strategy mandated by the Affordable Care Act. The QS will address important domains including: patient safety, prevention, patient and family engagement, population health, and health disparities. The Research Scientist will analyze large datasets to assist in quality improvement efforts tied to the QS. The Health Program Specialist will focus on developing, monitoring, and evaluating the interventions.

According to the Administration, these three positions would work closely with OHE so that OHE is informed on the issues of disparities in the health care sector and so that DHCS can dovetail with the overall public health approach to eliminating disparities led by OHE.

These positions will be funded via Distributed Administration (or approximately 40 percent General Fund, 60 percent other funds).

New Division of Mental Health and Substance Use Disorders Services. The two remaining positions (Associate Governmental Program Analysts) will be redirected to the new division to serve as cultural competency technical advisors to the County Mental Health Plans. These positions would be funded with MHSA funds.

Coordinated Approach to Health Equity. According to the Administration, by merging the functions of the five entities listed above, the OHE can take a more holistic approach to mental health and public health issues. On the whole, there is a net reduction of one position (the Career Executive Assignment position at the Office of Multicultural Health) with this proposal.

The Administration finds that the functions of the OWH, OMH, and OMS are more critical than ever, as California's population continues to become more diverse and issues of health disparity more pronounced. Several trends and recent developments suggest that the state needs to take a different approach to tackling issues of health disparities by integrating mental health and physical health, expanding the state's understanding of health disparities, and generating economies of scale.

In addition to merging these three Offices, CDPH proposes to consolidate its HiAP Task Force and HPT, both of which currently reside in the Center for Chronic Health and Health Promotion (CCHHP), and integrate them into the new OHE.

The proposed OHE provides an opportunity for the state to leverage multiple existing resources for a more coherent, coordinated, innovative, and systematic approach to work across programs, engage multiple stakeholders and departments, and address critical health issues related to health inequities. Roles of the OHE will include:

- Providing leadership to increase public awareness of health disparities, both in terms of public health and mental health.
- Encouraging the development of programs that address disparities in public health and mental health services and outcomes.
- Implementing policies and programs that result in a sustainable improvement in the health and mental health status of underserved and disparate communities by working with policy makers, insurers, health care providers, mental health providers, and communities.
- Working to eliminate health disparities in California through the collaboration of state agencies, academic institutions, community-based organizations, health and mental health partners, providers and others in the public and private sectors.

Background. Health equity issues are currently addressed in multiple offices and departments in the state.

Office of Multicultural Health (OMH). In August 1993, the OMH was created in the CDPH by Executive Order W-58-93, and established in statute in 1999. Key areas of responsibility for

OMH include health planning and policy development, technical assistance and training, health initiatives/program services, impact of program activities on communities and program evaluation. OMH's mission is to eliminate health disparities and improve access to quality health care for California's diverse populations.

Office of Women's Health (OWH). The OWH was established within the Director's Office of the California Department of Health Services (CDHS) in 1993 by Governor's Executive Order W-57-93. In 1994, the office was permanently established in statute. Subsequent legislation places the OWH in two departments, the DHCS and the CDPH. The mission of the office is to guide women's health policy in an effective and comprehensive fashion to promote health and reduce the burden of preventable disease and injury among the women and girls of California.

Office of Multicultural Services (OMS). The Department of Mental Health's OMS was established in 1998 to coordinate efforts to reduce disparities in access and quality of care for California's racial, ethnic, and cultural un-served and underserved communities. OMS works in partnership with stakeholders to foster change in policy, access, language, clinical practice, research, and intervention practices in mental health programs and services.

Health in All Policies (HiAP). The HiAP Task Force provides a venue for several State agencies and departments to advance multiple goals towards a healthier and more sustainable California. HiAP leverages the various areas of expertise each of these State agencies and departments brings to identify and address the social, political, and environmental determinants of health outcomes in California. Currently, the HiAP Task Force is developing a core set of indicators to measure attributes of a healthy community. HiAP recognizes that the policies and programs of many non-health related agencies have significant impacts on health, both positive and negative. The HiAP Task Force provides a structure for a more systematic exploration of the ways in which agencies across state government can promote better health outcomes through public policy and programs to improve community health environments.

Healthy Places Team (HPT). The HPT serves a coordinating function for multiple programs that address ways to improve health outcomes through urban greening and sustainable communities planning. Additionally, HPT brings together data from multiple sources to develop cross-cutting analysis (e.g. development of a core set of indicators to measure attributes of a healthy community, assessment of the impacts of alternative transportation strategies).

Subcommittee Staff Comment and Recommendation—Hold Open. The goal of the Administration's proposal is valuable and worthwhile. However, the proposed language is vague and provides no metrics to hold this new office accountable for improving health equities. It is recommended to hold this item open as the Administration, stakeholders, and the Legislature work together to strengthen this proposal.

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

1. Please provide a summary of the proposal.

2. What are the department's short-term and long-term goals for OHE?

3. Please describe how the department plans to develop and convene the Advisory Committee.

4. What are some examples of performance metrics that could be used to evaluate the success of the OHE?

5. How does the Administration propose to ensure the OHE works across state agencies and with DHCS, in particular?