Senate Budget and Fiscal Review—Scott Wiener, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Caroline Menjivar, Chair
Senator Susan Talamantes Eggman, Ph.D.
Senator Shannon Grove
Senator Richard D. Roth

Thursday, May 2nd, 2024
9:30 am, or upon adjournment of session
1021 O Street – Room 1200

Consultant: Scott Ogus

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PUBLIC COMMENT

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4260 Department of Health Care Services
4265 Department of Public Health
4560 Mental Health Services Oversight and Accountability Commission

Issue 1: Fiscal and Programmatic Implications of the Behavioral Health Services Act

Legislative Oversight – Fiscal and Programmatic Implications of the Behavioral Health Services Act. SB 326 (Eggman), Chapter 790, Statutes of 2023, and Proposition 1, approved by the voters in March 2024, authorized significant reforms to the state's behavioral health programs over the next few years. Known as the Behavioral Health Services Act (BHSA), these reforms will have substantial impacts on the fiscal structure and programmatic operations of behavioral health programs administered by the county behavioral health departments, the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), the Department of Health Care Access and Information (HCAI), and the Mental Health Services Oversight and Accountability Commission (MHSOAC).

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

1. *Community Services and Supports (CSS):* 76 percent of county MHSA funding treats severely mentally ill Californians through a variety of programs and services, including full service partnerships and outreach and engagement activities aimed at reaching unserved populations. 51 percent of CSS funds, or approximately 37 percent of total MHSA funding, is required to be spent on full service partnerships.

2. *Prevention and Early Intervention (PEI):* Up to 19 percent of county MHSA funds may be used for PEI programs, which are designed to identify early mental illness, improve timely access to services for underserved populations, and reduce negative outcomes from untreated mental illness, such as suicide, incarceration, school failure or dropping out, unemployment, homelessness and removal of children from homes.

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

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

4. *Workforce Education and Training:* This component aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental illness. Counties may use funds

to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs.

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

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

State Administration Funds. MHSA authorizes the use of up to five percent of annual revenues for state administration and specifies that these funds are to be used by state agencies to "implement all duties pursuant to the [MHSA] programs." This includes ensuring adequate research and evaluation regarding the effectiveness and outcomes of MHSA services and programs. State Administration funds have been used for a variety of state-directed purposes, including behavioral health workforce programs, the Mental Health Student Services Act, triage programs,

Local Mental Health Boards and County Three-Year Plans. The Bronzan-McCorquodale Act requires each community mental health service to have a mental health board consisting of 10 to 15 members to serve in an advisory role to the county board of supervisors. The mental health board is required to review and evaluate the local public mental health system and advise the county board of supervisors on the delivery of mental health services in the county.

MHSA requires each county mental health program to prepare and submit to DHCS and MHSOAC a three-year program and expenditure plan, with annual updates, adopted by the county's board of supervisors. The plan must include: 1) a program for prevention and early intervention; 2) a program for services to children; 3) a program for services to adults and seniors; 4) a program for innovations; 5) a program for technological needs and capital facilities; 6) identification of shortages in personnel to provide services and additional assistance needed from education and training programs; 7) establishment and maintenance of a prudent reserve to ensure stability of program funding; 8) certification by the county behavioral health director and county auditor-controller that the county has complied with MHSA requirements and other fiscal accountability requirements. MHSA also requires each three-year program and expenditure plan and update to be developed with local stakeholders, including adults and seniors with severe mental illness; families of children, adults, and seniors with severe mental illness; youths or youth mental health organizations; providers of services; law enforcement agencies; education; social services agencies; veterans; representatives from veterans organizations; providers of alcohol and drug services; health care organizations; and other important interests. The stakeholders must also include individuals representing youth from historically marginalized communities, representatives from organizations specializing in working with underserved racially and ethnically diverse communities, and representatives from LGBTQ+ communities.

Draft three-year plans must be prepared and circulated for review for at least 30 days to stakeholders. In addition, the local mental health board must conduct a public hearing on the plan after the 30 day stakeholder comment period to make recommendations to the local mental health agency on any revisions.

The Behavioral Health Services Act – Reforming the MHSA. SB 326 (Eggman), Chapter 790, Statutes of 2023, and AB 531 (Irwin), Chapter 789, Statutes of 2023, made significant changes to the MHSA, with many provisions appearing on the ballot as Proposition 1, approved by voters in March 2024. These changes recast the Mental Health Services Act as the Behavioral Health Services Act (BHSA), revising categories of expenditures for county behavioral health systems with a focus on housing interventions, expanding access to substance use disorder services, increasing transparency in county behavioral health planning, increasing evaluation and reporting on outcomes in the behavioral health system, and realigning oversight responsibilities between state departments and entities. In addition, Proposition 1 authorized $6.4 billion in bonds to construct, acquire, and rehabilitate more than 10,000 new treatment beds and supportive housing units, as well as sites to help serve more than 100,000 people annually.

BHSA – Impacts on County Behavioral Health Departments. As the vast majority of California's behavioral health system is realigned to counties, the most significant changes implemented by BHSA are to the operation and funding of county behavioral health departments. Currently, county behavioral health systems support their programs through a combination of funding streams, including 1991 and 2011 state-local realignment funds, state General Fund, federal Medicaid matching funds, federal grant funds for mental health and substance use disorders, and MHSA revenue.

BHSA Revises Previous MHSA Funding Allocations for Counties. The existing county allocations of MHSA revenue allow counties to spend 76 percent on community services and supports, 19 percent on prevention and early intervention, and 5 percent on innovative programs, with special allocations within those categories for capital needs, workforce development, and maintenance of a prudent reserve. Beginning July, 2026, BHSA revises these allocations as follows:

1) 30 percent of funds are required to be allocated for housing interventions. 50 percent of these funds are required to be used for housing interventions for individuals who are chronically homeless with a focus on encampments, with 25 percent to be used for capital development projects.

2) 35 percent of funds are required to be used for full-service partnerships, which provide the full spectrum of community services including mental health services (e.g. treatment, peer support, supportive services, etc.), non-mental health services (e.g. food, clothing, housing, health care treatment, etc.), and wrap around services for children. BHSA provides that FSP expenditures for housing would be covered by the housing intervention funding category, rather than the FSP category.

3) 35 percent of funds are required to be used for behavioral health services and supports (BHSS) for children and youth and adults or older adults, early intervention, outreach and engagement, workforce education and training, capital facilities and technological needs, and innovative programs.

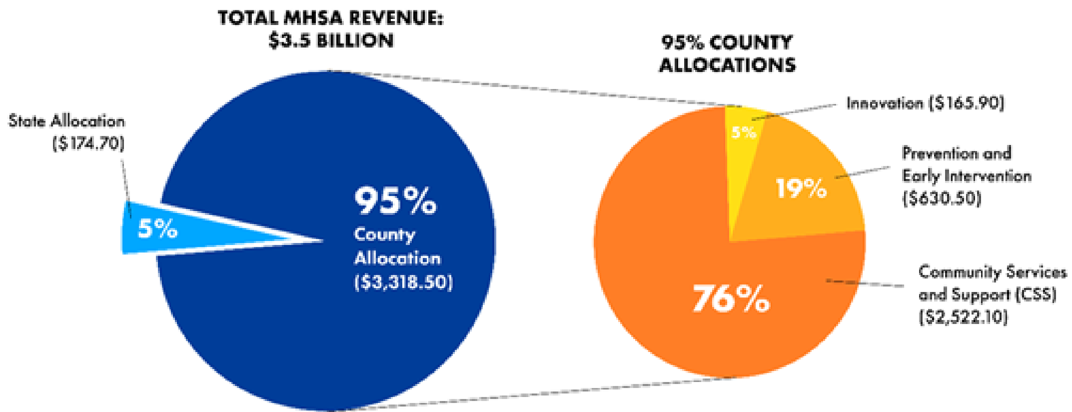
Counties may also set aside funding for prudent reserves to ensure programs are able to continue operating despite fluctuations in BHSA revenue allocations. Previously, counties were authorized to set aside prudent reserves of up to 30 percent of the average CSS allocations received in the preceding five years.

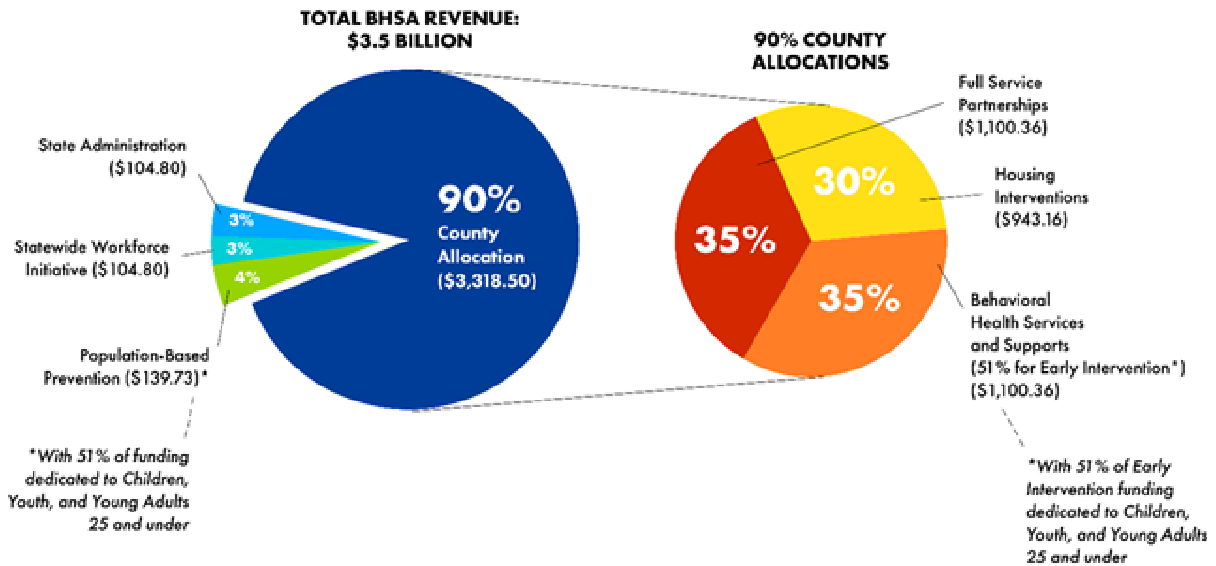
BHSA, when fully implemented will allow counties to set aside 25 percent of the allocation to its local behavioral health services fund.

Comparison of Existing MHSA Allocations and BHSA Allocations (effective July 1, 2026)

Source: *California Health and Human Services Agency. BHSA Fact Sheet. September 2023.*

(Dollars in Millions)





BHSA provisions allow counties, with the approval of DHCS, to transfer up to 14 percent of the total funds between the housing intervention, FSP, or BHSS allocations, as long as no single allocation is decreased by more than 7 percent. In addition, BHSA allows small counties (less than 200,000 population) to apply for an exemption from the housing intervention requirement beginning in 2026, with other counties allowed to seek an exemption beginning in 2032. BHSA allows all counties to seek an exemption from the FSP requirement beginning in 2032.

Transitions County Three-Year Plans to Integrated Plan for Behavioral Health Services and Outcomes. Pursuant to the Bronzon-McCorquodale Act, counties currently convene a mental health board consisting of 10 to 15 members to serve in an advisory role to the county board of supervisors, review and evaluate the local public mental health system, and advise the county board of supervisors on the delivery of mental health services in the county. MHSA also requires each county mental health program to prepare and submit to DHCS and MHSOAC a three-year program and expenditure plan, with annual updates, adopted by the county's board of supervisors, and in consultation with local stakeholders. The plan must include: 1) a program for prevention and early intervention; 2) a program for services to children; 3) a program for services to adults and seniors; 4) a program for innovations; 5) a program for technological needs and capital facilities; 6) identification of shortages in personnel to provide services and additional assistance needed from education and training programs; 7) establishment and maintenance of a prudent reserve to ensure stability of program funding; 8) certification by the county behavioral health director and county auditor-controller that the county has complied with MHSA requirements and other fiscal accountability requirements.

BHSA revises the requirements for three-year plans to instead require an Integrated Plan for Behavioral Health Services and Outcomes (Integrated Plan). The Integrated Plan is required to include the following sections:

1) Community mental health services provided
2) Programs and services funded from BHSA revenue
3) Programs and services funded by the Projects for Assistance in Transition from Homelessness (PATH) provided by DHCS
4) Programs and services funded by the federal Community Mental Health Services Block Grant
5) Programs and services funded by the federal Substance Abuse Block Grant
6) Programs and services provided by Medi-Cal managed care plans for mild and moderate conditions
7) Programs and services provided under Drug Medi-Cal or a Drug Medi-Cal Organized Delivery System (DMC-ODS)
8) Programs and services funded by distributions from the Opioid Settlements Fund
9) Services provided through other federal grants or other mental health and substance use disorder programs

The Integrated Plan must also include a budget that includes county planned expenditures and reserves for BHSA distributions, as well as any other funds; a description of how county planned expenditures align with statewide and local behavioral health goals and outcome measures (e.g. reducing homelessness or justice involvement); a description of efforts to reduce identified disparities in behavioral health outcomes; a description of data sources considered to identify disparities and unmet needs for certain populations; and a description of the county's workforce strategy. The Integrated Plan must also be

developed with an expanded list of local stakeholders, similar to the previous three-year plan, but with an additional focus on those experienced with substance use disorder treatment services.

In addition to planning around county behavioral health services, BHSA requires a county to participate in the development of its local health jurisdiction's community health improvement plan, required under the Future of Public Health infrastructure investment adopted in the 2022 Budget Act. BHSA also requires a county to work with each Medi-Cal managed care plan operating in the county to develop the plans' population needs assessment developed under the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

County Behavioral Health Outcomes, Accountability, and Transparency Report. BHSA requires counties and Medi-Cal behavioral health delivery systems, including DMC-ODS, to annually submit to DHCS a County Behavioral Health Outcomes, Accountability, and Transparency (BHOAT) Report. The report must include:

1) The county's annual allocation of state and federal behavioral health funds, by category
2) The county's annual expenditure of state and federal behavioral health funds, by category
3) The amounts of annual and cumulative unspent state and federal behavioral health funds, including funds in a reserve account, by category
4) The county's annual expenditure of county general funds and other funds, by category, on mental health or substance use disorder treatment services.
5) The sources and amounts spent annually as the nonfederal share for Medi-Cal specialty mental health services and Medi-Cal substance use disorder treatment services, by category.
6) All administrative costs, by category
7) All contracted services, and the cost of those contracted services, by category
8) Information on behavioral health services provided to persons not covered by Medi-Cal, including those who are uninsured, covered by Medicare, or covered by commercial insurance, by category
9) Other data and information including spending on children and youth, service utilization data, performance outcome measures, data regarding populations with identified disparities in behavioral health outcomes, data to identify racial, ethnic, age, gender, and other demographic disparities and inform disparity reduction efforts, and information on eligible adults and older adults who are incarcerated, experiencing homelessness, and the number of eligible children and youth who access evidence-based early psychosis and mood disorder detection and intervention programs.
10) Data and information on workforce measures and metrics.

Annually, the County BHOAT Report must be approved by the county's board of supervisors and posted on the DHCS website.

Changes to State Administration Allocations. Prior to allocation of funding to county CSS, PEI, and innovation programs, MHSA authorizes 5 percent of total revenue to be allocated for state administrative purposes. State Administration allocations may be used to support the Mental Health Services Oversight and Accountability Commission's operations and programs, as well as other critical statewide priorities, as allocated by the Legislature in the annual Budget Act. MHSA State Administration funding has been used to support behavioral health workforce programs, the Mental Health Student Services Act, Mental Health Wellness programs, and the California Reducing Disparities Project.

Effective July 1, 2026, BHSA revises the allocation for state administration purposes as follows:

1) Increases the total allocation for state administration purposes from five percent to ten percent.
2) The ten percent allocation for state administration is further subdivided into the following allocations:

    a. State Directed Purposes – Three percent is allocated for state directed purposes consistent with the BHSA, for CalHHS, DHCS, the California Behavioral Health Planning Council, HCAI, BHSOAC, CDPH and any other state agency. According to the Administration, this allocation is likely to be approximately $105 million annually.

    b. HCAI Behavioral Health Workforce Initiative – Three percent is allocated to HCAI to develop and implement a behavioral health workforce initiative. The initiative must be developed in consultation with stakeholders and focus on efforts to build and support the workforce to meet the need to provide holistic and quality services; and support the development and implementation of strategies for training, supporting, and retaining the county behavioral health workforce and non-county contracted behavioral health workforce, including efforts to increase racial, ethnic, and linguistic diversity of behavioral health providers and increase access in geographically underserved areas. A portion of the initiative may focus on providing technical assistance to county and contracted providers to support the stabilization and retention of the behavioral health workforce, as well as maximizing the use of peer support specialists. According to the Administration, this allocation is likely to be approximately $105 million annually.

    c. CDPH Population-Based Mental Health and Substance Use Disorder Prevention – Four percent is allocated to CDPH to provide population-based mental health and substance use disorder prevention programs, with at least 51 percent of these funds for serving populations who are 25 years of age or younger. These population based prevention programs are intended to reduce the prevalence of mental health and substance use disorders and resulting conditions, and must incorporate evidence-based promising or community-defined evidence practices to: 1) reduce the risk of individuals developing a mental health or substance use disorder; 2) target populations at elevated risk for a mental health, substance misuse, or substance use disorder; 3) reduce stigma associated with seeking help for mental health challenges and substance use disorders; 4) target populations disproportionately impacted by systemic racism and discrimination; and 4) prevent suicide, self-harm, or overdose. The prevention programs must also be provided in school or off campus settings, and may include school-based health centers, student wellness centers, student well-being centers, group coaching and consultation, stigma reduction, mental health first aid programs to identify and prevent suicide or overdose. According to the Administration, this allocation is likely to be approximately $140 million annually.

MHSOAC to Become BHSOAC – Changes to Commission Structure, Funding, and Responsibilities. Effective January 1, 2025, BHSA recasts the Mental Health Services Oversight and Accountability Commission (MHSOAC) as the Behavioral Health Services Oversight and Accountability Commission (BHSOAC) and revises the structure and responsibilities of the commission as follows:

1) Expands the membership of the new BHSOAC from 16 members to 27 members. The members of the BHSOAC will include:

a. The Attorney General (or designee)
b. The Superintendent of Public Instruction (or designee)
c. A Senator selected by the President Pro Tempore of the Senate (or designee)
d. An Assemblymember selected by the Speaker of the Assembly (or designee)
e. The following 23 members appointed by the Governor:
   i. Two persons who have or have had a mental health disorder
   ii. Two persons who have or have had a substance use disorder*
   iii. A family member of an adult or older adult who has or has had a mental health disorder
   iv. One person who is 25 years of age or younger and has or has had a mental health disorder, substance use disorder, or co-occurring disorder*
   v. A family member of an adult or older adult who has or has had a substance use disorder*
   vi. A family member of a child or youth who has or has had a mental health disorder
   vii. A family member of a child or youth who has or has had a substance use disorder*
   viii. A current or former county behavioral health director*
   ix. A physician specializing in substance use disorder treatment
   x. A mental health professional
   xi. A professional with expertise in housing and homelessness*
   xii. A county sheriff
   xiii. A superintendent of a school district
   xiv. A representative of a labor organization
   xv. A representative of an employer with less than 500 employees
   xvi. A representative of an employer with more than 500 employees
   xvii. A representative of a health care service plan or insurer
   xviii. A representative of an aging or disability organization*
   xix. A person with knowledge and experience in community-defined evidence practices and reducing behavioral health disparities*
   xx. A representative of a children and youth organization*
   xxi. A veteran or a representative of a veterans organization*

** New positions under BHSA*

2) Transfers responsibility over prevention and early intervention to DHCS, to establish priorities for the use of early intervention program funds.

3) Eliminates responsibility for approving county innovation plans, as this category of county funding is eliminated in BHSA.

4) Requires collaboration with DHCS on establishing early intervention program priorities, establishing a biennial list of evidence-based practices and community-defined evidence practices, establishing FSP standards of care and criteria for step-down, and metrics to measure and evaluate programs and services.

5) Requires collaboration with CDPH to develop population-based prevention programs and develop best practices to overcome stigma and discrimination.

6) Requires BHSOAC to submit a report by January 1, 2030, and every three years thereafter, with recommendations for improving and standardizing promising practices across the state.

7) Authorizes BHSOAC to administer the BHSA Innovation Partnership Fund, to award grants to private, public, and nonprofit partners to promote development of innovative mental health and substance use disorder programs and practices, as well as improving BHSA programs and practices for underserved populations, low-income populations, communities impacted by other behavioral health disparities, and other populations determined by the commission. The fund will receive $20 million annually between 2026-27 and 2030-31, with subsequent allocations provided by the Legislature in the annual Budget Act.

8) Requires BHSOAC to submit a report by January 1, 2030, and every three years thereafter, on the key accomplishments of the Innovation Partnership Fund.

DHCS Retains and Expands Role of Oversight and Guidance for BHSA Programs. Under MHSA, DHCS was the primary oversight authority for county expenditures of MHSA funding, the county three-year planning process, reversion of unspent county MHSA funds, and general county compliance with the provisions of the MHSA. Under BHSA, DHCS retains this role and expands its responsibilities to cover oversight and guidance for the early intervention program. In its primary oversight and guidance role, DHCS is also responsible for making determinations regarding how counties will comply with the new categorical funding requirements of the BHSA and fulfill their expanded responsibilities under the new three-year Integrated Plan process. DHCS is also the recipient of new reporting requirements from counties, including the annual County BHOAT Report.

Panel Discussion. The subcommittee has requested the following panelists to discuss the fiscal and programmatic implications of the Behavioral Health Services Act:

- **Department of Health Care Services (DHCS)**
- **California Department of Public Health (CDPH)**
- **Mental Health Services Oversight and Accountability Commission (MHSOAC)**
- **County Behavioral Health Directors Association of California (CBHDA)**

Subcommittee Staff Comment. This is an informational item.

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

<u>DHCS:</u>

1. Please provide an overview of the fiscal and programmatic changes implemented by the Behavioral Health Services Act (BHSA), as reflected in SB 326 (Eggman) and voter approval of Proposition 1, including the following:

    a. Changes to the distributions of BHSA funding categories, relative to current MHSA distributions, beginning July 1, 2026.

b. Changes to DHCS oversight of three-year county planning, including expected timelines for DHCS to establish guidance for counties regarding compliance with new requirements for development and submission of the new integrated plan and annual updates.
c. Changes to DHCS oversight of reversion and redistribution of unspent BHSA funds, including any expected changes to the methodology for calculating funds subject to reversion or the methodology for redistribution of funds to counties.
d. New DHCS responsibilities for specifying required elements of the County Behavioral Health Outcomes, Accountability, and Transparency Report, including expected timelines for DHCS to establish guidance to counties for data and submission requirements for the report, as well as DHCS responsibilities to establish metrics to measure and evaluate the quality and efficacy of behavioral health services and programs.

2. Please provide an overview of how DHCS will oversee county compliance with the new housing intervention program requirements implemented by the BHSA (WIC Section 5830), effective July 1, 2026. Please include a discussion of the following:

    a. Expected timelines for DHCS to establish guidelines for compliance with these new requirements.
    b. How DHCS will make determinations regarding which housing interventions are eligible uses for the housing intervention category of BHSA funding.
    c. How DHCS will determine what constitutes a "reasonable timeframe" for units to be available and how DHCS will determine the cost-per-unit threshold for housing interventions.
    d. What coordination, if any, DHCS will require counties to engage in between their housing intervention programs and the housing interventions and community supports offered through the California Advancing and Innovating Medi-Cal (CalAIM) and other initiatives (e.g. Behavioral Health Bridge Housing, BH Continuum Infrastructure Program, transitional rent, housing transition/navigation, housing deposits, tenancy/sustaining services, etc..)

3. Please provide an overview of how DHCS will oversee county compliance with the 35 percent allocation requirement for full-service partnerships (FSPs), including the following:

    a. Changes to the required services offered as part of FSP service delivery compared to existing MHSA requirements.
    b. How DHCS currently calculates county compliance with the existing MHSA FSP requirement and any changes to that calculation expected when the new BHSA requirements are implemented July 1, 2026. Please include a description of how federal Medicaid matching funds are treated in this calculation.
    c. What level of expenditures counties are currently utilizing for housing interventions related to FSPs that would qualify as eligible uses of housing intervention funding under the new BHSA allocations.
    d. How DHCS will disentangle FSP expenditures that are eligible uses of housing intervention funding and those that are only eligible uses of FSP funding under the new BHSA allocations, including expected timelines of guidance to counties on how these determinations will be made by DHCS.

4. Please provide an overview of services that are eligible uses of BHSA funding under the definition of "substance use disorder treatment services" included in the Act, including the following:

   a. How BHSA funding for substance use disorder treatment services interacts with county administration of Drug Medi-Cal or Drug Medi-Cal Organized Delivery System programs.
   b. What services, if any, are eligible uses of BHSA funding that are not Medi-Cal covered benefits.

5. Please provide an overview of how DHCS will establish priorities for the use of early intervention funds, beginning July 1, 2026, including expected timeline for guidance to counties regarding eligible uses of this funding.

6. Please provide an overview of changes to counties' ability to manage a prudent reserve of BHSA funding, including changes, if any, to county requirements that must be met before accessing prudent reserve balances.

7. Please provide an overview of DHCS planning for expenditure of resources from voter-approved bonds for the Behavioral Health Continuum Infrastructure Program, including an expected timeline of grant rounds and eligible uses of bond funding.

<u>CDPH</u>:

1. Please provide a brief overview of CDPH's responsibilities to implement population-based mental health and substance use disorder prevention programs, beginning July 1, 2026.

2. How will CDPH engage with the Legislature, stakeholders, and other partners to determine the programs that will be funded with this allocation of BHSA funds?

3. What types of interventions qualify as population-based prevention in the context of mental health and substance-use disorders?

4. How will CDPH use this funding to ensure programs that are implemented address the diversity of the state's residents' and communities' experience with, and viewpoints regarding, prevention and treatment of behavioral health conditions?

5. How will this program integrate with, and benefit from the experience of, the California Reducing Disparities Project?

<u>MHSOAC</u>:

1. Please provide a brief overview of the changes to the Commission structure and responsibilities implemented by BHSA, including the following:

   a. Changes to the Commission membership, including number of commissioners and required appointees

   b. Changes to oversight of county expenditures on prevention and early intervention and innovation programs, including how the Commission plans to help counties transition these expenditures from existing programs to programs allowable under BHSA.
   c. Changes to the Commission's role conducting oversight, analysis, and evaluation of the state's behavioral health system, including access to behavioral health system data and other necessary information.

2. Please provide a brief overview of the process the Commission envisions for implementation of the BHSA Innovation Partnership Fund grant program, including the types of programs that might be funded with the relatively small allocation of BHSA resources dedicated for this purpose, as well as how these programs would be similar or dissimilar to programs counties are implementing now utilizing MHSA innovation funding.

3. How will the Commission utilize its recent experience overseeing Prevention and Early Intervention programs to help inform the priorities for use of early intervention program funding as implemented by BHSA?

<u>CBHDA:</u>

1. Please provide an overview of the fiscal and programmatic changes to county behavioral health systems implemented by the Behavioral Health Services Act (BHSA), as reflected in SB 326 (Eggman) and voter approval of Proposition 1, including the following:

   a. Changes to the distributions of BHSA funding categories, relative to current MHSA distributions, beginning July 1, 2026.
   b. How the changes to distributions of funding categories will impact current county behavioral health programs and services. Please include a comparison of existing expenditures for each current MHSA category to expected expenditures for the future implementation of BHSA categories.
   c. Changes to procedures for three-year county planning, including new responsibilities related to the integrated plan and annual updates.
   d. Changes to counties' ability to maintain prudent reserves, and any expected changes to counties' approach to managing revenue volatility.

2. Please provide an overview of how counties will likely approach the new housing intervention program requirements implemented by the BHSA (WIC Section 5830), effective July 1, 2026. Please include a discussion of the following:

   a. Current expenditures on housing interventions by counties within existing programs that may qualify as housing interventions in this category of BHSA expenditures.
   b. How counties will prioritize the types of housing interventions that will be funded.
   c. How counties will coordinate these housing interventions with other housing intervention programs, such as CalAIM, Behavioral Health Bridge Housing, and the Behavioral Health Continuum Infrastructure Program.

3. How do counties expect their responsibilities to administer full service partnerships to change, if at all, after implementation of the BHSA changes to funding categories?

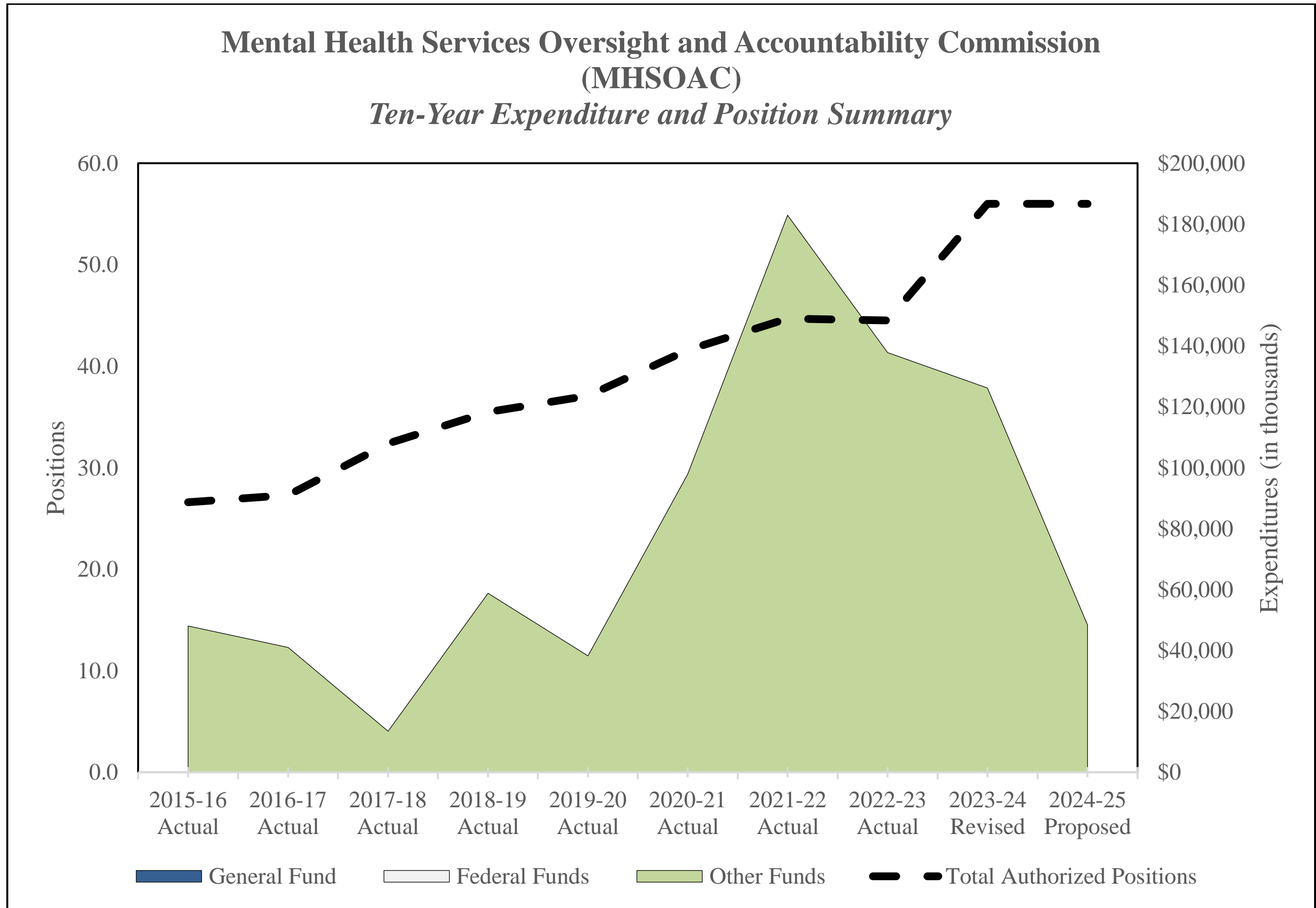
4. Please provide an overview of how counties would likely approach the expansion of eligible BHSA expenditures to substance use disorder services, including:

    a. How BHSA funding for substance use disorder treatment services would interact with existing county administration of Drug Medi-Cal or Drug Medi-Cal Organized Delivery System programs.
    b. Services that are not Drug Medi-Cal eligible that might be covered by the expansion of eligible uses for BHSA funding.

5. How will counties use funding provided by the BHSA, either through ongoing BHSA revenue, or one-time BHSA bond funds, to address workforce shortages in behavioral health professions?

4560 Mental Health Services Oversight and Accountability Commission

Issue 1: Overview



Mental Health Services Oversight and Accountability Commission - *Department Funding Summary* *(dollars in thousands)*

Fund Source	*2022-23 Actual*	*2023-24 Budget Act*	*2023-24 Revised*	*2024-25 Proposed*
General Fund	$0	$0	$0	$0
Federal Funds	$0	$0	$0	$0
Other Funds	$137,808	$63,169	$126,182	$48,304
Total Department Funding:	**$137,808**	**$63,169**	**$126,182**	**$48,304**
Total Authorized Positions:	**44.5**	**56.0**	**56.0**	**56.0**
Other Funds Detail:				
Reimbursements (0995)	*$0*	*$15,000*	*$15,000*	*$0*
Mental Health Services Fund (3085)	*$137,808*	*$48,169*	*$111,182*	*$48,304*

Mental Health Services Act (Proposition 63; 2004). Proposition 63, the Mental Health Services Act (MHSA), an initiative approved by voters in 2004, imposes a one percent income tax on personal income in excess of $1 million 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). The MHSA authorized the creation of the Mental Health Services Oversight and Accountability Commission to drive transformational change across the state's health system.

Mental Health Services Oversight and Accountability Commission. The Mental Health Services Oversight and Accountability Commission (MHSOAC) was established in 2005 and is composed of 16 voting members. These members include:

<u>Elected Officials:</u>

- Attorney General
- Superintendent of Public Instruction
- Senator selected by the President pro Tempore of the Senate
- Assemblymember selected by the Speaker of the Assembly

<u>12 members appointed by the Governor:</u>

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

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

MHSOAC's responsibilities are as follows:

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

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

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

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

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

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

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

Mental Health Student Services Act (MHSSA). The 2019 Budget Act included expenditure authority from the Mental Health Services Fund of $50 million in 2019-20 and $10 million annually thereafter for the Mental Health Student Services Act (MHSSA), a competitive grant program to establish mental health partnerships between county mental health or behavioral health departments and school districts, charter schools, and county offices of education. These partnerships support: (1) services provided on school campuses; (2) suicide prevention; (3) drop-out prevention; (4) outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ), and youth who have been expelled or suspended from school; (5) placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services; and (6) other prevention, early intervention, and direct services, including, but not limited to, hiring qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth.

Prior to the MHSSA, SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, known as the Investment in Mental Health Wellness Act, included expenditure authority from the Mental Health Services Fund of $32 million annually for MHSOAC to support counties to increase capacity for client assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. In 2018-19 the expenditure authority was reduced to $20 million annually. According to MHSOAC, since 2017-18, 50 percent of the funding has been allocated to programs dedicated to children and youth aged 21 and under, and approximately $20 million was allocated for four School-County Collaboration Triage grants to: 1) provide school-based crisis intervention services for children experiencing or at risk of experiencing a mental health crisis and their families or caregivers; and 2) supporting the development of partnerships between behavioral health departments and educational entities. Humboldt County, Placer County, Tulare

County Office of Education, and a joint powers authority in San Bernardino County were awarded $5.3 million annually over four years in this program. MHSOAC also awarded grants for school-based triage programs in Berkeley, Humboldt, Riverside, Sacramento, and San Luis Obispo.

Building on the partnership model in the triage grant program, MHSSA supports partnerships between county behavioral health programs and educational entities. Combining the $50 million allocation in 2019-20 with the annual $10 million allocations for the subsequent three fiscal years, MHSOAC allocated a total of $75 million over four years for funding of the MHSSA Partnership Grant Program. The funding was made available in two categories: 1) $45 million for counties with existing school mental health partnerships, and 2) $30 million for counties developing new or emerging partnerships. Within each category, funding was made available based on the population size of a county with a total of six grants at $2.5 million each made available to small counties (less than or equal to 200,000 population), six grants at $4 million each made available to medium counties (between 200,000 and 750,000 population), and six grants at $6 million each made available to large counties (greater than 750,000 population).

According to MHSOAC, 38 counties submitted applications for funding. 20 counties with existing partnerships submitted applications and 10 received awards. 18 counties developing new or emerging partnerships submitted applications and eight received awards. However, 20 counties that submitted applications did not receive funding.

Children and Youth Behavioral Health Initiative – Expansion of MHSSA. The 2021 Budget Act included $205 million ($100 million CFRF and $105 million Mental Health Services Fund) in 2021-22 for MHSOAC for the Mental Health Student Services Act program, as part of the Administration's Children and Youth Behavioral Health Initiative. The 2021 Budget Act augmentation of the MHSSA was intended to rapidly provide funding to the 20 counties that applied, but did not receive partnership grant awards during the initial round of MHSSA funding. The potential impacts of the COVID-19 pandemic on the behavioral health needs of students made rapid deployment of resources to school campuses a high priority for the Legislature. According to MHSOAC, the initial 2019 Budget Act funding, as well as the 2021 Budget Act augmentation of MHSSA funding supported $207 million for 58 partnership grant awards.

MHSOAC to Become BHSOAC – Changes to Commission Structure, Funding, and Responsibilities. Effective January 1, 2025, the Behavioral Health Services Act, approved by voters in March 2024, recasts the Mental Health Services Oversight and Accountability Commission (MHSOAC) as the Behavioral Health Services Oversight and Accountability Commission (BHSOAC) and revises the structure and responsibilities of the commission as follows:

1) Expands the membership of the new BHSOAC from 16 members to 27 members. The members of the BHSOAC will include:

    a. The Attorney General (or designee)
    b. The Superintendent of Public Instruction (or designee)
    c. A Senator selected by the President Pro Tempore of the Senate (or designee)
    d. An Assemblymember selected by the Speaker of the Assembly (or designee)
    e. The following 23 members appointed by the Governor:
        i. Two persons who have or have had a mental health disorder

ii. Two persons who have or have had a substance use disorder*
iii. A family member of an adult or older adult who has or has had a mental health disorder
iv. One person who is 25 years of age or younger and has or has had a mental health disorder, substance use disorder, or co-occurring disorder*
v. A family member of an adult or older adult who has or has had a substance use disorder*
vi. A family member of a child or youth who has or has had a mental health disorder
vii. A family member of a child or youth who has or has had a substance use disorder*
viii. A current or former county behavioral health director*
ix. A physician specializing in substance use disorder treatment
x. A mental health professional
xi. A professional with expertise in housing and homelessness*
xii. A county sheriff
xiii. A superintendent of a school district
xiv. A representative of a labor organization
xv. A representative of an employer with less than 500 employees
xvi. A representative of an employer with more than 500 employees
xvii. A representative of a health care service plan or insurer
xviii. A representative of an aging or disability organization*
xix. A person with knowledge and experience in community-defined evidence practices and reducing behavioral health disparities*
xx. A representative of a children and youth organization*
xxi. A veteran or a representative of a veterans organization*

** New positions under BHSA*

2) Transfers responsibility over prevention and early intervention to DHCS, to establish priorities for the use of early intervention program funds.

3) Eliminates responsibility for approving county innovation plans, as this category of county funding is eliminated in BHSA.

4) Requires collaboration with DHCS on establishing early intervention program priorities, establishing a biennial list of evidence-based practices and community-defined evidence practices, establishing FSP standards of care and criteria for step-down, and metrics to measure and evaluate programs and services.

5) Requires collaboration with CDPH to develop population-based prevention programs and develop best practices to overcome stigma and discrimination.

6) Requires BHSOAC to submit a report by January 1, 2030, and every three years thereafter, with recommendations for improving and standardizing promising practices across the state.

7) Authorizes BHSOAC to administer the BHSA Innovation Partnership Fund, to award grants to private, public, and nonprofit partners to promote development of innovative mental health and substance use disorder programs and practices, as well as improving BHSA programs and practices for underserved

populations, low-income populations, communities impacted by other behavioral health disparities, and other populations determined by the commission. The fund will receive $20 million annually between 2026-27 and 2030-31, with subsequent allocations provided by the Legislature in the annual Budget Act.

8) Requires BHSOAC to submit a report by January 1, 2030, and every three years thereafter, on the key accomplishments of the Innovation Partnership Fund.

Subcommittee Staff Comment. This is an informational item.

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

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

Issue 2: Mental Health Wellness Program Reappropriation

Budget Bill Language – Governor's Budget. MHSOAC requests reappropriation of up to $1 million of expenditure authority from the Mental Health Services Fund, previously authorized in the 2021 Budget Act, until June 30, 2026, to support the Mental Health Wellness Program.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
3085 – Mental Health Services Fund	$-	[$1,000,000]
Total Funding Request:	**$-**	**[$1,000,000]**
Total Requested Positions:	**0.0**	**0.0**

* Non-add, reappropriation of resources previously approved in the 2021 Budget Act.

Background. The Investment in Mental Health Wellness Act of 2013 authorized Mental Health Service Fund expenditure authority of $32 million annually to add 600 triage personnel in select rural, urban, and suburban regions. The 2016 Budget Act included an additional $3 million to provide a complete continuum of crisis intervention services and supports for children age 21 and under and their families and caregivers. Triage personnel provide intensive case management and linkage to services for individuals with mental health disorders at various points of access. Targeted case management services may be provided face to face, by telephone, or by telehealth with the individual in need of assistance or his or her significant support person, and may be provided anywhere in the community. These service activities may include, but are not limited to: 1) communication, coordination, and referral; 2) monitoring service delivery to ensure the individual accesses and receives services; 3) monitoring the individual's progress; 4) providing placement service assistance and service plan development. The 2018 Budget Act reduced the annual triage program allocation to $20 million annually. According to MHSOAC, the triage program, now referred to as the Mental Health Wellness Program, received additional program flexibility in SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, due to delays related to the COVID-19 pandemic. MHSOAC requests reappropriation of up to $1 million, previously authorized in the 2021 Budget Act, due to program grantees unable to spend the granted funds. If approved, these reappropriated funds would be redistributed to one or more grantees that did not receive funding in previous grant rounds.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

0530 California Health and Human Services Agency

Issue 1: Office of Youth and Community Restoration – SYTF Data

Background: DJJ Closure and Realignment. The 2020-21 Budget Act included a plan to permanently close the Division of Juvenile Justice (DJJ) at the California Department of Corrections and Rehabilitation (CDCR). While most youth were already housed or supervised locally, prior to July 1, 2021, counties could choose to send youths who had committed violent, serious, or sex offenses to state facilities operated by DJJ. There were typically about 650 youth statewide in DJJ facilities. DJJ permanently closed on June 30, 2023, and the last youths were transferred to counties, completing the realignment of the juvenile justice system to the county level. The plans for DJJ closure and realignment are outlined in SB 823 (Committee on Budget and Fiscal Review), Chapter 337, Statutes of 2020 and SB 92 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2021.

As a result of realignment, counties are responsible for caring for youth with more serious needs and who have committed more serious offenses. The realignment plan outlined a process for counties to establish Secure Youth Treatment Facilities (SYTFs) for high-level offenders who would have previously been housed at DJJ. To assist counties with their increased responsibility, the state provides block grant funding to counties for each realigned youth, and one-time funding for planning and juvenile facility infrastructure needs. As of September 2023, there were 2,878 youth housed in juvenile facilities statewide

OYCR. To support counties in this transition, the realignment plan included the creation of the OYCR to provide statewide assistance, coordination, and oversight. OYCR is under the Health and Human Services Agency (HHS) rather than under CDCR or the Board of State and Community Corrections (BSCC), reflecting the intended shift away from corrections and toward services and treatment. The mission of the Office, as defined in statute, is "[T]o promote trauma responsive, culturally informed services for youth involved in the juvenile justice system that support the youths' successful transition into adulthood and help them become responsible, thriving, and engaged members of their communities."

Mandates of the OYCR include:

- Identify policy recommendations for improved outcomes for court-involved youth.
- Identify and disseminate best practices to inform rehabilitative and restorative youth practices.
- Provide technical assistance to develop and expand local youth diversion opportunities.
- Evaluate the efficacy of local programs being utilized for realigned youth and report to the Governor and Legislature by July 1, 2025.
- Develop a report on youth outcomes in the juvenile justice system based on the updated JCPSS (Department of Justice) System.
- Provide an ombudsperson to investigate complaints and resolve where possible and report regularly to the Legislature.

- Concur with the BSCC on any juvenile grants.

- Assume administration of juvenile grants no later than January 1, 2025.

- Concur with the BSCC on new standards for secure youth treatment facilities.

Welfare and Institutions Code 2200 requires that all juvenile justice grant administration functions at the BSCC move to OYCR by January 1, 2025.

OYCR Funding. The 2021 Budget Act included $27.6 million in 2021-22 and $7 million ongoing for OYCR. The 2021-22 funding included $20 million for technical assistance, disseminating best practices, and grants. The 2022 Budget Act included an additional $10 million ongoing for the Office, and language detailing the duties and responsibilities of the Ombudsperson within OYCR. The 2023 Budget Act continued the $10 million appropriation for OYCR for technical assistance, disseminating best practices, and issuing grants to counties and probation departments for the purposes of transforming the juvenile justice system to improve outcomes for justice involved youth.

Juvenile Justice Data Collection. In addition to the $10 million budget for OYCR, the 2023 Budget Act included $3.54 million to facilitate the collection of specific juvenile justice data related to realignment. These 2023 Budget Act made these funds available to county probation departments to provide OYCR with the following data for the 2021-22 and 2022-23 fiscal years, disaggregated by gender, age, and race or ethnicity:

1. Number of youth and their commitment offense or offenses, if known, who are under the county's supervision that are committed to a secure youth treatment facility, including youth committed to secure youth treatment facilities in another county.

2. The number of individual youth in the county who were adjudicated for an offense under subdivision (b) of Section 707 of the Welfare and Institutions Code or Section 290.008 of the Penal Code.

3. Number of youth, including their commitment offense or offenses, if known, transferred from a secure youth treatment facility to a less restrictive placement.

4. Number of youth for whom a hearing to transfer jurisdiction to an adult criminal court was held, and number of youth whose jurisdiction was transferred to adult criminal court.

The 2023 Budget Act requires the data listed above to be submitted to OYCR by December 30, 2023 for the 2021-22 and 2022-23 fiscal years, and by December 30, 2024 for the 2023-24 fiscal year. A summary of the statewide data is below and was presented to the Subcommittee on February 29, 2024 – the final report, including county-level data, is anticipated from OYCR shortly.

AB 102 Data Updates

	FY 2021-2022	FY 2022-2023
A. Number of youth committed to SYTF	237	427
B1. Number of youth adjudicated of a 707(b) offense	1,459	1,730
B2. Number of youth adjudicated of a PC 290.008 offense (not counted in B1)	98	74
C. Number of youth transferred from SYTF to LRP	*	100
D1. Number of youth for whom a fitness hearing was ordered	197	221
D2a. Number of youth transferred to adult criminal court	43	33
D2b. Number of youth NOT transferred to adult criminal court	80	94

Note: The data displayed reflect a statewide count.
Note: For FY 21-22, nine counties had no youth to report. (n=48)
For FY 22-23, eight counties had no youth to report. (n=49)
One county was excluded from analysis due to data accessibility challenges.
* Data not displayed for privacy – less than 11 youth

Subcommittee Staff Comment and Recommendation—Informational item. No action is needed.

Questions. The subcommittee requests OYCR respond to the following:

1. Please present an overview the county-specific juvenile justice data counties were required to submit to OYCR pursuant to the 2023 Budget Act.

2. What do these data tell us about how realignment is implementing across the state? In what areas does the data show progress in meeting the goals of realignment and in what areas does the data indicate cause for concern? Are there particular counties in which the data shows notable progress or problems?

3. How will this data inform OYCR's work moving forward, including the development of grants and policy recommendations?

4. What would be the effect of not having this data reported regularly from year to year? What could be improved or expanded for future data collection purposes in order for OYCR to carry out its mission?

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Community Behavioral Health Programs Overview

Funding for Community Mental Health Programs – *Multi-Year Funding Summary*			
Fund Source	**2022-23**	**2023-24**	**2024-25**
1991 Realignment (base and growth):			
Mental Health Subaccount	$500,130,000	$585,263,000	$603,375,000
2011 Realignment (base and growth):			
Mental Health Subaccount	$1,129,400,000	$1,128,100,000	$1,127,000,000
Behavioral Health Subaccount	$2,220,800,000	$2,299,500,000	$2,363,800,000
Realignment Total	**$3,850,330,000**	**$4,012,863,000**	**$4,094,175,000**
Medi-Cal SMHS Federal Funds	**$3,133,174,000**	**$3,089,329,000**	**$3,069,890,000**
Medi-Cal SMHS General Fund	**$368,862,000**	**$510,129,000**	**$321,513,000**
MHSA Local Expenditures	**$2,849,480,000**	**$2,259,662,000**	**$2,397,563,000**
Total Funds	**$10,201,846,000**	**$9,871,983,000**	**$9,883,141,000**

Community Mental Health - Overview. California's system of community mental health treatment was first established in 1957 after passage of the Short-Doyle Act. Prior to Short-Doyle, the state was primarily responsible for the care and treatment of Californians with mental illness or developmental disabilities in fourteen regional psychiatric hospitals throughout the state. Short-Doyle was enacted to allow individuals with mental illness to be treated in a community-based setting nearer to friends and family to support more successful treatment outcomes, and resulted in a significant shift of the locus of treatment out of the state's psychiatric hospitals and into the community. Covered Short-Doyle benefits included treatment and rehabilitation services in primarily outpatient settings, as well as community education and training for professionals and staff in public entities to address mental health problems early.

Mental Health Services in Medi-Cal. Medi-Cal, California's state Medicaid program, was established in 1966 and covered specific mental health-related benefits including psychiatric inpatient hospital services, nursing facility care, and professional services provided by psychiatrists and psychologists. In 1971, many of the benefits provided by local Short-Doyle community mental health programs were also included in the scope of benefits provided to Medi-Cal beneficiaries. During this period, beneficiaries could access mental health services through Short-Doyle Medi-Cal (SD/MC) or through direct fee-for-service Medi-Cal providers (FFS/MC).

State-Local Realignment Funding for Community Mental Health. In 1991, in response to a state General Fund deficit, many state programs and funding streams were realigned to local governments

including community mental health programs. The Bronzan-McCorquodale Act (1991 Realignment) provided that county mental health departments would be responsible for community mental health services for Medi-Cal beneficiaries, for payments to state hospitals for treatment of individuals civilly committed under the Lanterman-Petris-Short Act (LPS), and for Institutions for Mental Disease (IMDs) that provide short-term nursing level care to individuals with serious mental illness. Funding for these programs is provided by redirection of sales tax and vehicle license fee revenues to counties.

In 2011, additional mental health responsibilities were realigned to counties in a package primarily focused on major public safety programs (2011 Realignment). Additional sales tax and vehicle license fee revenue was allocated to counties to fund these programs, which included responsibility for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children in Medi-Cal. Funding for the 1991 Mental Health Subaccount, up to $1.12 billion, was redirected to fund maintenance of effort requirements for the California Work Opportunities and Responsibility for Kids (CalWORKs) program. This redirection of funding was replaced by $1.12 billion of 2011 Realignment revenue deposited in the 2011 Realignment Mental Health Subaccount for community mental health programs. Consequently, realignment funding for community mental health services is derived primarily from 2011 Realignment funding allocations.

Affordable Care Act Expansion of Mental Health Benefits. The federal Affordable Care Act expanded certain mental health benefits available to Medi-Cal beneficiaries. SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013, First Extraordinary Session, implemented these new benefit requirements. These benefits are provided to individuals with mild to moderate levels of impairment by Medi-Cal managed care plans, rather than community mental health plans.

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

1. **County Mental Health Plans (MHPs) -** California provides Medi-Cal specialty mental health services (SMHS) under a federal 1915(b) waiver that includes outpatient SMHS, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's SMHS is provided under the federal requirements of the EPSDT benefit for persons under age 21. County mental health plans are responsible for the provision of SMHS and Medi-Cal enrollees must obtain SMHS through the county. SMHS is a Medi-Cal entitlement for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria.

2. **Managed care plans –** SB 1 X1 expanded the scope of Medi-Cal mental health benefits, pursuant to the federal Affordable Care Act, and required these services to be provided by Medi-Cal managed care plans excluding those benefits provided by county mental health plans under the SMHS waiver. Generally these are mental health services for those with mild to moderate levels of impairment. The mental health services provided by managed care plans include:

   - Individual and group mental health evaluation and treatment (psychotherapy)
   - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
   - Outpatient services for the purposes of monitoring drug therapy

- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation

3. **Fee-For-Service Provider System -** Effective January 1, 2014 the mental health services listed below are also available through the fee-for-service provider system:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation

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

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

Most MHSA funding is to be expended by county mental health departments for mental health services consistent with local Three-Year Plans with Annual Updates approved by DHCS and the required five components, as required by MHSA. The following is a brief description of the five components:

1. **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 establish, through a stakeholder process, a listing of programs for which these funds will be used. Of total annual revenues, 80 percent is allocated to this component.

2. **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.

3. **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.

4. **Workforce Education and Training.** This component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a

total of $460.8 million provided to counties and the Department of Health Care Access and Information (HCAI, formerly OSHPD).

5. **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.

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

Drug Medi-Cal - Overview. The Drug Medi-Cal program covers substance use disorder services by certified providers under contract with the counties or with DHCS. Drug Medi-Cal services are offered by counties either through the State Plan or through the Drug Medi-Cal Organized Delivery System (DMC-ODS), an expanded service delivery model offered under an 1115 Waiver authorized by the federal Centers for Medicare and Medicaid Services (CMS). Drug Medi-Cal provides State Plan services under four primary modalities:

- Narcotic Treatment Program – The Narcotic Treatment Program (NTP) provides outpatient methadone maintenance services directed at stabilization and rehabilitation of persons with opioid dependency and substance use disorder diagnoses. The program includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions.
- Outpatient Drug Free – Outpatient Drug Free (ODF) counseling treatment services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with substance use disorder diagnosis in an outpatient setting. This includes services under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Each ODF participant receives at least two group counseling sessions per month. Counseling and rehabilitation services include: 1) admission physical examinations, 2) intake, 3) medical necessity establishment, 4) medication services, 5) treatment and discharge planning, 6) crisis intervention, 7) collateral services, and 8) individual and group counseling.
- Intensive Outpatient Treatment – Intensive Outpatient Treatment (IOT) services are provided to beneficiaries with substance use disorder diagnoses. These outpatient counseling and rehabilitation services are provided at least three hours per day, three days per week. Services include: 1) admission physical examinations, 2) intake, 3) medication services, 4) treatment planning, 5) crisis intervention, 6) collateral services, 7) individual and group counseling, and 8) parenting education.
- Residential Treatment Services – Residential Treatment Services (RTS) provides rehabilitation services to perinatal beneficiaries with substance use disorder diagnosis in a non-institutional, non-medical, residential setting. Each beneficiary lives on the premises and is supported in an effort to restore, maintain, and apply interpersonal and independent living skills and access community support systems.

DMC-ODS counties, in addition to the four primary modalities, are required to offer the following services: 1) non-perinatal RTS, 2) withdrawal management (levels 1.0, 2.0, and 3.2), 3) recovery services, 4) case management, 5) physician consultation, and 6) expanded medication assisted treatment (buprenorphine, naloxone, and disulfiram). DMC-ODS counties may also offer: 1) additional medication

assisted treatment (through non-NTP providers), 2) partial hospitalization, and 3) withdrawal management (levels 3.7 and 4.0).

Behavioral Health Continuum Infrastructure Program. The 2021 Budget Act included expenditure authority of $755.7 million ($445.7 million General Fund and $310 million Coronavirus Fiscal Recovery Fund or CFRF) in 2021-22, $1.4 billion ($1.2 billion General Fund and $220 million CFRF) in 2022-23 and $2.1 million General Fund in 2023-24 for competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. Of this amount, $150 million was made available to support mobile crisis infrastructure, along with $55 million in federal grant funds from the Substance Abuse and Mental Health Services Administration (SAMHSA), for a total investment of $205 million. DHCS announced the BHCIP funding would be released in six rounds, as follows:

- Round 1: Mobile Crisis - $205 million
- Round 2: County and Tribal Planning Grants - $16 million
- Round 3: Launch Ready - $518.5 million
- Round 4: Children and Youth - $480.5 million
- Round 5: Behavioral Health Needs Assessment Phase One - $480 million
- Round 6: Behavioral Health Needs Assessment Phase Two - $480 million

The following facility types may be considered for project funding through BHCIP:

- Community wellness centers
- Hospital-based outpatient treatment (e.g. outpatient detox or withdrawal management)
- Intensive outpatient treatment
- Narcotic Treatment Programs (NTPs)
- NTP medication units
- Office-based outpatient treatment
- Sobering centers
- Acute inpatient hospitals – medical detox or withdrawal management
- Acute psychiatric inpatient facilities
- Adolescent residential treatment facilities for substance use disorders (SUD)
- Adult residential treatment facilities for SUD
- Chemical dependency recovery hospitals
- Children's crisis residential programs (CCRPs)
- Community treatment facilities (CTFs)
- Crisis stabilization units (CSUs)
- General acute care hospitals (GACHs) and acute care hospitals (ACHs)
- Mental health rehabilitation centers (MHRCs)
- Psychiatric health facilities (PHFs)
- Short-term residential therapeutic programs (STRTPs)
- Skilled nursing facilities with special treatment programs (SNFs/STPs)
- Social rehabilitation facilities (SRF)
- Peer respite

- Recovery residence/sober living homes

Funding may also be used for mobile crisis infrastructure.

Due to the General Fund shortfall, the Governor's January budget proposes to delay Round 6 of BHCIP funding from 2024-25 until 2025-26.

Qualifying Community-Based Mobile Crisis Services. Section 9813 of the federal American Rescue Plan Act of 2021 authorizes state Medicaid programs to provide qualifying community-based mobile crisis intervention services for a period of up to five years, beginning April 1, 2022, and ending March 31, 2027. States that implement the mobile crisis intervention benefit receive an 85 percent federal match for reimbursement of these services for the first three years of the five year period.

Mobile crisis intervention services are intended to provide rapid response, individual assessment, and crisis resolution by trained mental health and substance use treatment professionals and paraprofessionals in situations that involve individuals with behavioral health conditions. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) describes three core components of a robust crisis system: 1) a 24 hour clinically staffed call center that can serve as a the hub of an integrated mental health crisis system, 2) mobile crisis response teams that can respond rather than law enforcement, and 3) crisis receiving and stabilization facilities that provide short-term services and can be accessed readily rather than relying on emergency departments or hospital environments.

The 2022 Budget Act authorized the addition of qualifying community-based mobile crisis intervention services, beginning January 1, 2023, for a five year period as a mandatory Medi-Cal benefit available to eligible Medi-Cal beneficiaries 24 hours a day, seven days a week. The benefit will implemented through the county behavioral health delivery systems by multidisciplinary mobile crisis teams in the community. The services cover both mental health and substance use disorder crises, using the specialty mental health benefit and adding crisis intervention as an outpatient service eligible under the Drug Medi-Cal benefit. According to DHCS, the benefit is provided outside a hospital or other facility setting and includes screening and assessment, stabilization and de-escalation, and coordination with and referrals to health, social, and other services and supports.

Behavioral Health Bridge Housing. The 2022 Budget Act included General Fund expenditure authority of $1 billion in 2022-23 and $500 million in 2023-24 to support bridge housing projects to address the immediate housing and treatment needs of people experiencing unsheltered homelessness with serious behavioral health conditions. Funding will be administered through the BHCIP process and used to purchase and install tiny homes with time-limited operational supports, as well as other bridge housing settings, such as assisted living. DHCS expects county behavioral health departments and Medi-Cal managed care plans to improve coordination to serve people with acute behavioral health challenges and those needing housing, treatment, and services, including medication, peer and family supports.

Due to the General Fund shortfall, the Governor's January budget proposes to delay $265 million of Behavioral Health Bridge Housing funding from 2023-24 until 2024-25 and $235 million from 2024-25 until 2025-26.

Subcommittee Staff Comment—This is an informational item.

Questions. The subcommittee requests DHCS respond to the following:

1. Please provide a brief overview of the significant program changes related to specialty mental health or Drug Medi-Cal services for the 2023-24 and 2024-25 fiscal years.

Issue 2: Narcotic Treatment Program Licensing Trust Fund

Budget Change Proposal – Governor's Budget. DHCS requests expenditure authority from the Narcotic Treatment Program Licensing Trust Fund of $500,000 annually. If approved, these resources would allow the DHCS Licensing and Certification Division to utilize licensure fee revenue from this fund to support program oversight.

Multi-Year Funding Request Summary		
Fund Source	**2024-25**	**2025-26***
0243 – Narcotic Treatment Program Licensing Trust Fund	$500,000	$500,000
Total Funding Request:	**$500,000**	**$500,000**

* Resources ongoing after 2025-26.

Background. The DHCS Licensing and Certification Division is responsible for licensing the establishment of all public and private narcotic treatment programs in the state and ensuring compliance with relevant statutory and regulatory requirements to ensure the safety and well-being of patients, the community, and the public. Narcotic treatment programs provide opioid medication assisted treatment to persons addicted to opiates, and provide detoxification or maintenance treatment services such as medical evaluations and rehabilitative services to help patients become or remain productive members of society.

The Licensing and Certification Division is authorized to charge and collect licensure fees on narcotic treatment programs to support licensure and inspection costs, not to exceed the actual costs of the program. According to DHCS, the narcotic treatment program licensing fees for 2023-24 are $4,052 for initial application for licensure, $1,126 for the base annual license fee, $35 patient slot fee, and a $1,437 program relocation fee. The fund receives approximately $2.1 million annually in fee revenue to support the program, and maintains a fund balance of between $4.6 million and $5.1 million over recent years.

Resource Request. DHCS requests expenditure authority from the Narcotic Treatment Program Licensing Trust Fund of $500,000 annually to allow the DHCS Licensing and Certification Division to utilize licensure fee revenue from this fund to support program oversight. According to DHCS, during 2021-22 and 2022-23, the cash balance in the fund has exceeded its appropriation. However, DHCS reports that in recent years, expenses have increased for the division, resulting in expenditures exceeding the fund's expenditure authority. When the division exceeded its expenditure authority, it has sought to supplement its budget with General Fund, although the licensing fund had sufficient cash reserves to support the expenditures. DHCS believes the addition of $500,000 of expenditure authority from the fund would be sufficient to prevent any additional need for General Fund supplemental support in future years.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 3: Behavioral Health Bridge Housing Program Funding Shift

Local Assistance – Governor's Budget. DHCS requests to delay expenditure authority from the Mental Health Services Fund of $265 million, originally approved in the 2023 Budget Act, from 2023-24 until 2023-24, for support of the Behavioral Health Bridge Housing program. In addition, DHCS also requests to shift the delayed expenditure authority from the Mental Health Services Fund to the General Fund, due to a shortfall in the availability of Mental Health Services Fund resources. DHCS also requests to delay General Fund expenditure authority of $235 million for the Behavioral Health Bridge Housing program, also approved in the 2023 Budget Act, from 2024-25 until 2025-26.

Multi-Year Funding Request Summary			
Fund Source	**2023-24**	**2024-25***	**2025-26**
0001 – General Fund	$-	$30,000,000	$235,000,000
3085 – Mental Health Services Fund	($265,000,000)	$-	$-
Total Funding Request:	**($265,000,000)**	**$30,000,000**	**$235,000,000**

* General Fund resources are net result of $265 million increased expenditures from 2023-24 delay and fund shift, and $235 million decreased expenditures from 2024-25 delayed until 2025-26.

Background. The 2022 Budget Act included General Fund expenditure authority of $1 billion in 2022-23 and $500 million in 2023-24 to support bridge housing projects to address the immediate housing and treatment needs of people experiencing unsheltered homelessness with serious behavioral health conditions. Funding will be administered through the Behavioral Health Continuum Infrastructure Program process and used to purchase and install tiny homes with time-limited operational supports, as well as other bridge housing settings, such as assisted living. DHCS expects county behavioral health departments and Medi-Cal managed care plans to improve coordination to serve people with acute behavioral health challenges and those needing housing, treatment, and services, including medication, peer and family supports.

The 2023 Budget Act included expenditure authority from the Mental Health Services Fund of $265 million, and a concomitant reduction of General Fund expenditure authority of $265 million, to support the Behavioral Health Bridge Housing program in 2023-24, and authorized delay of the final $250 million of the $1.5 billion allocated for the program, from 2023-24 until 2024-25. The resources from the Mental Health Services Fund were allocated from the State Administration Account of the fund. These resources were meant to offset General Fund expenditures of $265 million expected to be spent in 2023-24.

Local Assistance Request. DHCS requests to delay expenditure authority from the Mental Health Services Fund of $265 million, originally approved in the 2023 Budget Act, from 2023-24 until 2023-24, for support of the Behavioral Health Bridge Housing program. In addition, DHCS also requests to shift the delayed expenditure authority from the Mental Health Services Fund to the General Fund, due to a shortfall in the availability of Mental Health Services Fund resources. DHCS also requests to delay General Fund expenditure authority of $235 million for the Behavioral Health Bridge Housing program, also approved in the 2023 Budget Act, from 2024-25 until 2025-26.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal

Issue 4: Children and Youth Behavioral Health Initiative Fee Schedule – Trailer Bill Language

Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to authorize a contract with a third party administrator to administer the school-linked statewide behavioral health provider network and fee schedule authorized by the Children and Youth Behavioral Health Initiative. The language would also authorize the imposition of a fee on health care service plans, insurers, and Medi-Cal managed care plans to support the contract with the third party administrator.

Background. As part of the Children and Youth Behavioral Health Initiative, the Legislature approved trailer bill language to require DHCS to develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to a student 25 years of age or younger at a school site. A health care service plan, including a Medi-Cal managed care plan, or an insurer will, commencing January 1, 2024, be required to reimburse school-based services provided to one of its members according to the fee schedule, regardless of whether the provider is within the plan's or insurer's contracted provider network.

According to DHCS, there are significant operational complexities around provider management and claims submission for school-based or school-linked providers, as well as credentialing and provider oversight. Many school-based providers have no experience with billing commercial or self-insured plans for services provided to students. To address these concerns, the 2023 Budget Act included expenditure authority from the Mental Health Services Fund of $10 million in 2023-24 to create statewide infrastructure for provider management and to manage billing for behavioral health services furnished to students under the Children and Youth Behavioral Health Initiative statewide fee schedule. These resources support development and implementation of the infrastructure for provider, billing, and claiming management for the behavioral health services provided to students as part of the Children and Youth Behavioral Health Initiative.

General Fund Budget Solution and Trailer Bill Language. DHCS proposes trailer bill language to authorize a contract with a third party administrator to administer the school-linked statewide behavioral health provider network and fee schedule authorized by the Children and Youth Behavioral Health Initiative. The language would also authorize the imposition of a fee on health care service plans, insurers, and Medi-Cal managed care plans to support the contract with the third party administrator. Specifically, the proposed language would:

1) Authorize DHCS to contract with an entity to administer the school-linked statewide behavioral health provider network, including enrollment, credentialing, and reimbursement of providers.

2) Requires participating providers to comply with enrollment and credentialing requirements and submit all claims for reimbursement under the school-linked statewide fee schedule to the third party administrator.

3) Requires health care service plans, insurers, and Medi-Cal managed care plans to comply with requirements set forth by the third party administrator to cover and reimburse behavioral health services included in the school-linked statewide behavioral health services fee schedule.

4) Authorizes DHCS to establish and charge a fee to health care service plans, insurers, and Medi-Cal managed care plans to cover the cost of administering the school-linked statewide behavioral health provider network, including the contract with the third party administrator.

5) Requires that the fee shall be set in an amount sufficient to cover all costs incurred by the state associated with implementing the fee schedule, allows DHCS to periodically update and the amount and structure of the fee based on costs, and notify the Legislature of any proposed fee increases through submission of the semiannual Medi-Cal Local Assistance Estimate.

6) Establishes the Behavioral Health Schoolsite Fee Schedule Administration Fund to collect fee revenue to be used, upon appropriation by the Legislature, to support state costs for administering the school-linked statewide behavioral health provider network and fee schedule, including the third party administrator contract.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

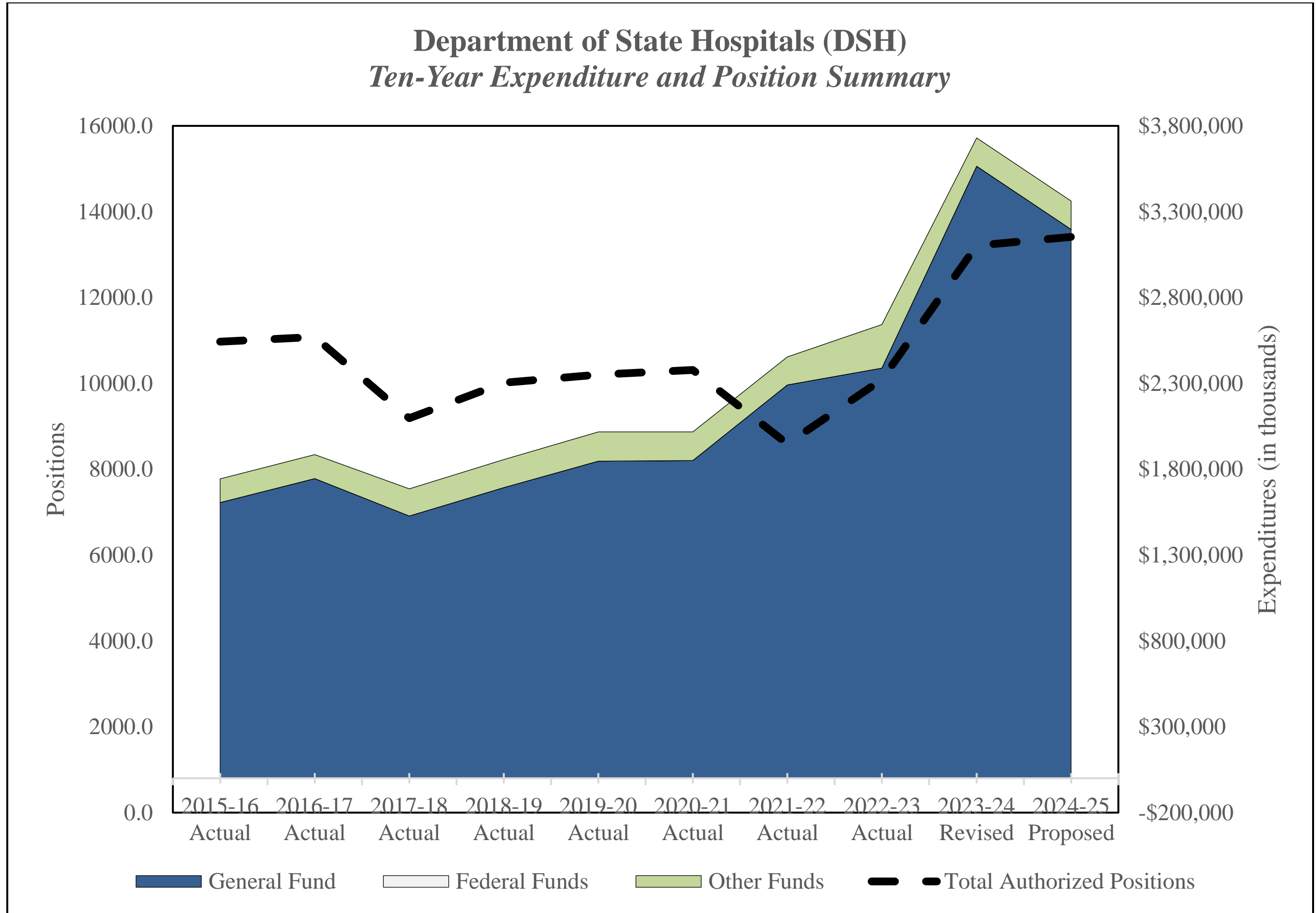
Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

2. Does the department have any preliminary estimates of the amount or structure of the proposed fee on health care service plans, insurers, and Medi-Cal managed care plans?

4440 Department State Hospitals

Issue 1: Overview



Department of State Hospitals - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	***2022-23 Actual***	***2023-24 Budget Act***	***2023-24 Revised***	***2024-25 Proposed***
General Fund	$2,388,626	$3,258,712	$3,564,325	$3,197,195
Federal Funds	$0	$100	$100	$100
Other Funds	$254,704	$165,346	$165,346	$165,346
Total Department Funding:	**$2,643,330**	**$3,424,158**	**$3,729,771**	**$3,362,641**
Total Authorized Positions:	**10090.8**	**13352.2**	**13210**	**13412**
Other Funds Detail:				
CA State Lottery Education Fund (0814)	*$59*	*$21*	*$21*	*$21*

Reimbursements (0995)	*$192,784*	*$165,325*	*$165,325*	*$165,325*
CA Emergency Relief Fund (3398)	*$61,861*	*$0*	*$0*	*$0*

Background. DSH oversees five state hospitals which comprise the largest inpatient forensic mental health hospital system in the nation. In addition to forensic admissions, which comprise 87.2 percent of its population, the five state hospitals admit individuals civilly committed under the Lanterman-Petris-Short (LPS) Act because they require physically secure 24-hour care and meet legal criteria that they represent a danger to themselves or others. The categories of individuals admitted to state hospitals for treatment are:

- **Incompetent to Stand Trial (IST)** – IST patients are referred to DSH under Section 1370 of the Penal Code if a court has determined they are unable to understand the nature of criminal proceedings or assist counsel in their defense. IST patients receive competency-based treatment and are returned to court once able to participate in court proceedings. Most IST patients are charged with felonies, with some misdemeanors.

- **Not Guilty by Reason of Insanity (NGI)** – NGI patients are individuals found guilty of an offense, but are admitted to DSH if a court determines the individual was "insane" at the time the crime was committed. NGI patients are committed for a term equal to the maximum sentence which could have been imposed, though may be recommitted for an additional two years if the individual represents a substantial danger of physical harm.

- **Offenders with a Mental Health Disorder (OMD)** – OMD patients are parolees who meet the following six criteria for OMD classification: (1) presence of a severe mental disorder, (2) the mental disorder is not in remission or requires treatment to be kept in remission, (3) the mental disorder was a factor in the commitment offense, (4) the prisoner has been in treatment at least 90 days in the year prior to release, (5) the commitment offense involved force or violence or serious bodily injury, (6) the prisoner continues to be dangerous due to the severe mental disorder. OMD commitments under Section 2962 of the Penal Code span the length of the parole term, but may be extended for up to one year if the patient represents a danger of physical harm to others.

- **Sexually Violent Predators (SVP)** – SVP commitments are civil commitments of prisoners released from prison who meet certain criteria under the Sexually Violent Predator Act, including being convicted of certain sex offenses and diagnosed with a mental disorder that increases the likelihood of engaging in sexually violent criminal behavior. SVP patients undergo an annual review process to evaluate the patient's suitability for release into the community, either conditionally or without supervision.

- **Lanterman-Petris-Short (LPS)** – LPS patients are individuals that require physically secure 24-hour care and are committed through civil court proceedings that determine the individual is a danger to themselves or others or suffers from a grave disability. LPS patients are discharged when their county of residence places them in a different facility, in independent living, or with family, or if a court removes the conservatorship.

- ***Coleman* Class Patients (Mentally Ill Prisoners)** – *Coleman* patients are referred by the California Department of Corrections and Rehabilitation (CDCR) when they are found to be

mentally ill while in prison. *Coleman* patients return to CDCR custody when they have received the maximum benefit from treatment. If these individuals are still mentally ill at the end of their prison term, they may be committed to DSH as an OMD.

- **Conditional Release Program (CONREP)** – CONREP provides outpatient treatment to individuals ordered by a court to be released if their symptoms have been stabilized and they no longer represent a danger to society. After one year, a court hearing determines if the patient will continue in the program, be sent back to DSH, or be released.

	2023-24	2024-25
Population by Hospital		
Atascadero	1,067	1,067
Coalinga	1,341	1,341
Metropolitan	902	902
Napa	1,103	1,103
Patton	1,426	1,426
State Hospitals Population Total	**5,839**	**5,839**
Population by Commitment Type		
Incomptent to Stand Trial (IST)	1,912	1,912
Not Guilty by Reason of Insanity (NGI)	1,225	1,225
Offender with a Mental Health Disorder (OMD)	1,051	1,051
Sexually Violent Predator (SVP)	954	954
Lanterman-Petris-Short Civil Commitments (LPS)	585	585
Coleman Referrals	112	112
Contracted Programs		
Jail-Based Competency Treatment (JBCT) Programs	522	567
Community-Based Restoration	948	1,706
Community Inpatient Facilities	183	223
Contracted Programs Population Total	**1,653**	**2,496**
CONREP Programs		
CONREP SVP	27	31
CONREP Non-SVP	674	674
CONREP FACT Program	90	90
CONREP Step Down Facilities	184	184
Total CONREP Programs	**975**	**979**
Total State Hospitals, Contracted, and CONREP Programs	**8,467**	**9,314S**

Figure 1: State Hospital Projected Census by Hospital, Commitment Type and Contracted Programs
Source: *2024-25 Governor's Budget Estimate, Department of State Hospitals, January 2024*

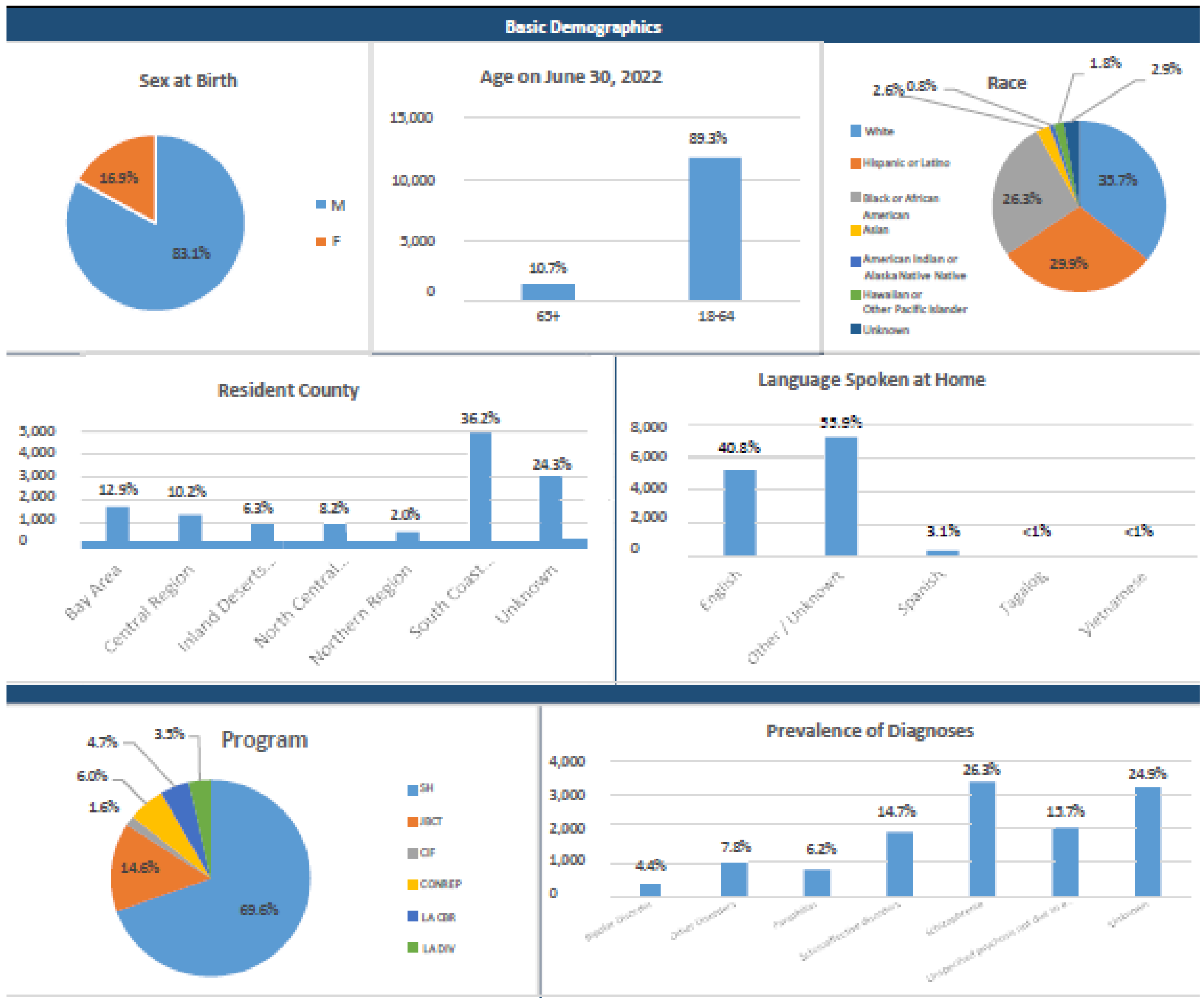


Figure 2: State Hospital Demographic Snapshot: All Commitment Types
Source: *2024-25 Governor's Budget Estimate, Department of State Hospitals, January 2024*

The five state hospitals operated by DSH are:

- **Atascadero State Hospital** – Located on the Central Coast in San Luis Obispo County, Atascadero is a self-contained psychiatric hospital with an all-male population primarily composed of OMD, *Coleman*, IST, LPS, and NGI patients. Atascadero has a licensed bed capacity of 1,275 beds, employs approximately 2,280 staff, and served 1,067 patients in 2022-23.

- **Coalinga State Hospital** – Located in the Central Valley in Fresno County, Coalinga is a self-contained psychiatric hospital with an all-male population primarily composed of LPS, OMD, *Coleman*, NGI, and SVP patients. Coalinga has a licensed bed capacity of 1,500 beds, employs approximately 2,490 staff, and served 1,341 patients in 2022-23.

- **Metropolitan State Hospital** – Located in Norwalk in Los Angeles County, Metropolitan is an "open" style campus within a security perimeter. Due to community concerns, a formal agreement with the City of Norwalk and the county sheriff prohibits Metropolitan from accepting patients charged with murder or a sex crime, or at high risk for escape. Metropolitan primarily serves LPS, IST, OMD, and NGI patients and has a licensed bed capacity of 1,106 beds, employs approximately 2,270 staff, and served 762 patients in 2022-23.

- **Napa State Hospital** – Located in Napa County, Napa has an "open" style campus within a security perimeter. Napa primarily treats IST, LPS, OMD, and NGI patients and has a licensed bed capacity of 1,418 beds, but is currently able to operate only 1,374 beds. Napa employs approximately 2,670 staff, and served 1,103 patients in 2022-23.

- **Patton State Hospital** – Located in the town of Highland in San Bernardino County, Patton is an "open" style campus within a security perimeter operated by correctional officers from CDCR due to concerns from the surrounding community. Patton primarily serves LPS, IST, OMD, *Coleman* and NGI patients and has a licensed bed capacity of 1,287 beds, employs approximately 2,570 staff, and served 1,416 patients in 2022-23.

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide a brief overview of the State Hospital system, including major inpatient categories, treatment programs, and significant organizational changes.

Issue 2: Program and Caseload Updates

Program and Caseload Updates – Governor's Budget. DSH requests resources to support the following program and caseload updates in its 2024-25 Governor's Budget Estimate.

Program Update – Metropolitan: Increased Secure Bed Capacity. DSH estimates General Fund savings of $9.6 million in 2023-24 due to delays in the activation of newly secured units at Metropolitan State Hospital to provide increased capacity for the treatment of IST patients. The 2016 Budget Act included capital outlay construction funding to securely enclose existing patient buildings that previously housed civilly committed patients under the Lanterman-Petris-Short (LPS) Act. Once secured, the LPS patients currently housed in these units will be transferred to non-secured buildings elsewhere on the Metropolitan campus and allow for additional secured capacity for the treatment of IST patients currently in county jails awaiting state hospital treatment.

According to DSH, of the five units under construction, Unit 1 was activated September 23, 2019, Unit 2 was activated on January 29, 2020, and Unit 3 was activated on November 1, 2022. Units 4 and 5 were originally scheduled to be activated in September 2021, but the activation of these units was delayed until due to the following: 1) impacts from the COVID-19 pandemic, 2) use of these units to relocate skilled nursing facility patients due to water damage to the facility, and 3) use of these units as swing space as Metropolitan upgrades its fire alarm system in other housing units in the hospital. The 2023 Budget Act assumed these units would be activated in July 2023. DSH now expects these units to be activated in May 2024, a 10 month delay that will result in a one-time savings of $9.6 million General Fund in 2023-24.

Program Update – Mission Based Review: Direct Care Nursing. DSH estimates General Fund savings of $10.3 million in 2023-24 due to delays in staffing changes to implement methodologies to provide appropriate 24-hour nursing care, administration of medication, and an afterhours nursing supervisory structure. The 2019 Budget Act included a total of 379.5 positions and General Fund expenditure authority of $46 million, phased in over three years, to implement new direct care nursing staffing methodology changes developed in collaboration with the Department of Finance. Due to the pandemic-induced recession, and resulting General Fund deficit, the 2020 Budget Act shifted these resources to be phased in across a longer time frame. DSH reports the following updates to the phase in of positions:

- Medication Pass Psychiatric Technicians – The 2019 Budget Act included 335 positions for medication pass staffing. The 2020 Budget Act adjusted the positions to be phased-in over five years. As of August 31, 2023, all 335 positions had been established and 177 positions had been filled, resulting in a General Fund savings of $10.3 million in 2023-24. According to DSH, recruiting for these positions has proven challenging and the department is contracting with a marketing and outreach consultant to create digital ad campaigns and produce leads for multiple DSH classifications, including psychiatric technicians. DSH is also collaborating with various college programs to increase overall admissions for psychiatric technician programs, and striving to streamline the hiring process with rapid hiring events and same-day contingent offers.

- Afterhours Supervising Registered Nurses – The 2019 Budget Act included 44.5 positions for afterhours nursing supervision. The 2020 Budget Act adjusted these positions to be phased-in over two years. As of August 31, 2023, all 44.5 positions had been established and all 44.5 positions had been filled.

Program Update – Mission Based Review: Treatment Team and Primary Care. DSH estimates General Fund savings of $5.3 million in 2023-24 due to delays in hiring for treatment and primary care teams. In 2020-21, DSH proposed changes to its staffing methodologies for its treatment and primary care teams, including a total of 250.2 positions and General Fund expenditure authority of $64.2 million over a five year period. However, due to the pandemic induced recession and resulting General Fund shortfall, the 2020 Budget Act only included 12.5 positions and General Fund expenditure authority of $5 million in 2020-21 and 30 positions and General Fund expenditure authority of $10 million annually thereafter to support implementation of these staffing changes. The 2021 Budget Act included 213.3 positions and $54.1 million, phased in over five years, to support full implementation of the new staffing methodology. DSH reports the following updates to the phase-in of positions:

- Interdisciplinary Treatment Team –A total of 180.4 positions were allocated to support the Interdisciplinary Treatment Team, which is responsible for the planning and delivery of treatment, discipline-specific other workload, administrative and professional responsibilities, crisis prevention, unit milieu work, and crisis and incident management. As of August 31, 2023, 52.8 of the 180.4 positions had been established.
- Primary Medical Care – A total of 31.9 positions were allocated to support primary medical care including routine preventative care and the treatment of non-life-threatening medical illness. As of August 31, 2023, all 31.9 positions had been established and 10.5 positions had been filled, resulting in a General Fund savings of $4.1 million in 2023-24.
- Trauma-Informed Care –A total of six positions were allocated to support trauma-informed care, a comprehensive approach that includes workforce training, trauma-informed policies and standards, and the provision of evidence-based, trauma-specific screening, assessment, referral, and treatment. As of August 31, 2023, all six of the positions had been established and all six positions had been filled.
- Clinical Executive Structure: Administrative Support –A total of six positions were allocated for administrative support positions for personnel management. As of August 31, 2023, all six of the positions had been established and all six of the positions had been filled.
- Clinical Executive Structure: Executive Leadership – A total of 12 positions were allocated for clinical executive leadership including six Medical Directors, one Assistant Medical Director, and five Chiefs of Primary Care Services for the five state hospitals. As of August 31, 2023, all 12 positions had been established, and seven of the positions had been filled, resulting in a General Fund savings of $1.2 million in 2023-24.
- Discharge Strike Team –A total of six positions were allocated to support the Discharge Strike Team, which focuses on establishing and strengthening relationships with placement communities to improve knowledge of community resources, address barriers to placement and improve communication in efforts to expedite placement. As of August 31, 2023, all six positions had been established, and all six positions had been filled.

Program Update – Patient-Driven Operating Expenses and Equipment. DSH General Fund expenditure authority of $10.8 million in 2023-24 and annually thereafter to support operating expenses and equipment (OE&E) related to the care and treatment of DSH patients. These expenses include funding for outside medical care, pharmaceuticals, patient clothing, food, and costs for patient advocacy. For 2023-24, DSH estimates costs for utilities have risen by $4.6 million, costs for foodstuffs have risen by $2.9 million, and costs for pharmaceuticals have risen by $1.4 million. DSH estimates costs related to

updated census figures for 2023-24 are approximately $2 million. DSH estimates patient census and per patient costs to remain static for 2024-25, resulting in no additional costs for 2024-25 and ongoing. If this adjustment is approved, the total annual costs for OE&E would rise from $135.9 million to $146.7 million.

Program and Caseload Update: Forensic Conditional Release Program (CONREP) – General/Non-Sexually Violent Predator (Non-SVP) Program. The Forensic Conditional Release Program (CONREP) was established in 1986 and provides outpatient treatment to individuals ordered by a court to be released if their symptoms have been stabilized and they no longer represent a danger to society. The CONREP population includes patients committed to state hospitals as Not Guilty by Reason of Insanity (NGI), Offenders with a Mental Health Disorder (OMD), and felony Incompetent to Stand Trial (IST). After one year, a court hearing determines if the patient will continue in the program, be sent back to DSH, or be released.

According to DSH, when a patient is discharged to CONREP, the goal is to provide an independent living environment in the least restrictive setting. However, if the patient has not demonstrated the ability to live in the community without direct staff supervision, the patient is referred to a Statewide Transitional Residential Program (STRP), a resource used by CONREP to provide patients the opportunity to learn and demonstrate appropriate community living skills in a controlled setting with 24 hour supervision.

DSH estimates General Fund savings of $599,000 in 2023-24 due to delays in admissions to its Northern California Statewide Transitional Residential Program (STRP) facility.

- 55 Statewide Transitional Residential Program (STRP) Beds in 2023-24, including:
  - 35 bed activated Southern California STRP
  - 20 bed activated Northern California STRP
- 90 Forensic Assertive Community Treatment (FACT) Beds, including:
  - 30 activated beds in Central California in 2022-23
  - 60 beds activated in Northern California and Southern California in 2021-22
- 132 Institute of Mental Disorder (IMD) Beds in 2023-24, including
  - Southern CA IMD Facility – DSH reports delayed activation of a 78 bed Institute for Mental Disease (IMD) facility in southern California due to delayed external approvals from the federal Centers for Medicare and Medicaid Services (CMS) and the state Department of Public Health, as well as supply chain and labor shortages related to the COVID-19 pandemic. As of November 2023, 33 beds have been activated as part of Phase I with 20 patients transferring from the adjacent Sylmar IMD program. The remaining beds in Phase II scheduled for activation in late December 2023. DSH reports $2.8 million General Fund savings in 2023-24 from delayed program activation would be used to support retrofitting costs for its Sylmar IMD to allow it to transition from a CONREP program to a 24-bed Community Inpatient Facility program dedicated to serving IST patients.
  - Northern CA IMD Facility – DSH established a ten bed IMD facility in northern California, which was activated in July 2020. In July 2021, DSH extended the contract term and expanded the program by an additional ten beds. The 2023 Budget Act expanded services for an additional ten beds, for a total of 30 beds. DSH reports as of November 2023, all 30 beds are filled or reserved for patients ready for placement.

- <u>Northern CA STRP Facility</u> – According to DSH, as of November 2023, eight of the 20 beds in this facility are filled. As a result, DSH reports a one-time General Fund savings of $599,000 in 2023-24.

Program Update – Contracted Patient Services Incompetent to Stand Trial (IST) Solutions. DSH estimates General Fund savings of $58.6 million in 2023-24 due to changes in jail-based competency treatment program (JBCT) programs, community inpatient facility (CIF) programs, and Early Access and Stabilization Services (EASS) programs. According to DSH, the 2023 Budget Act assumed an IST waitlist of 804 due to implementation and expansion of existing IST programs. For 2024-25, DSH estimates the IST waitlist is at 501 as of January 1, 2024.

- <u>Jail-Based Competency Treatment (JBCT) Programs</u> – DSH estimates General Fund savings of $8.6 million in 2023-24, primarily driven by delays in expansions and activations of jail-based competency treatment (JBCT) programs.
- <u>Community Inpatient Facility (CIF)</u> – DSH estimates General Fund savings of $30 million in 2023-24 due to a lengthy negotiation process to secure additional community inpatient facility (CIF) contracts in time for a 2023-24 activation. DSH reports it has activated four CIFs with a total of 159 beds, with 136 of those beds filled as of November 2023.
- <u>Early Access and Stabilization Services (EASS)</u> – The Early Access and Stabilization Services program was established as part of the IST Solutions package approved in the 2022 Budget Act. According to DSH, the program provides treatment at the earliest point possible upon an individual's commitment and promotes stabilization to increase community-based treatment placements. To rapidly establish the EASS programs in county jails, DSH reports it is leveraging existing JBCT programs and starting new programs in counties without JBCT programs. DSH reports the first EASS program was activated in July 2022, and as of November 29, 2023, a total of 44 EASS programs have been activated. The counties that have activated EASS programs include: Kings, Monterey, Ventura, Fresno, Calaveras, Stanislaus, Yuba, Nevada, Sierra, Shasta, Santa Barbara, Merced, San Bernardino, Madera, Lassen, Sonoma, Del Norte, Humboldt, Imperial, Santa Cruz, Napa, Sutter, Riverside, Lake, San Benito, Tuolumne, Amador, Plumas, Solano, El Dorado, Glenn, Mariposa, Colusa, Tulare, Mono, Modoc, San Diego, San Luis Obispo, Sacramento, Inyo, Butte, San Joaquin, Tehama, Yolo, and San Mateo.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of each of the program and caseload updates referenced in this item.

Issue 3: Infectious Disease Prevention

Program Update – Governor's Budget. DSH requests General Fund expenditure authority of $25.9 million in 2024-25 and $7.7 million annually thereafter to support infection control measures to protect the health and safety of employees and patients in compliance with state and federal infectious disease prevention guidance.

Multi-Year Funding Request Summary		
Fund Source	**2024-25**	**2025-26***
0001 – General Fund	$25,900,000	$7,700,000
Total Funding Request:	**$25,900,000**	**$7,700,000**
Total Requested Positions:	**10.0**	**10.0**

* Resources ongoing after 2025-26.

Background. The state's response to the COVID-19 pandemic has required rapid deployment of state and federal resources to support a wide variety of activities designed to mitigate the spread of the virus, while maintaining vital services and protecting the most vulnerable Californians. The 2021 Budget Act included General Fund expenditure authority of $52 million in 2021-22 to support staff costs for cleaning, staffing coverage, environmental projects, custody tasks, screening and isolation, commodity purchases, sanitation supplies, changes in food service, as well as equipment for heating and air, filtration, and information technology solutions. The 2022 Budget Act included General Fund expenditure authority of $64.6 million in 2022-23 to support response activities to the COVID-19 pandemic, primarily for staffing and testing. The 2023 Budget Act included $42.1 million in 2023-24 to support testing, surge capacity resources, public health teams, and commodity goods.

Resource Request. DSH requests General Fund expenditure authority of $25.9 million in 2024-25 and $7.7 million annually thereafter to support infection control measures to protect the health and safety of employees and patients in compliance with state and federal infectious disease prevention guidance. Specifically, DSH requests resources in the following categories:

- Testing – DSH requests General Fund expenditure authority of $10 million in 2024-25 for the costs of testing patients and employees of the state hospitals. DSH reports that its state hospitals will continue to perform diagnostic screening testing for both patients and staff, even though the COVID-19 state of emergency has ended. These testing activities will require both rapid antigen tests and polymerase chain reaction (PCR) test capabilities.

- Surge Capacity Resources – DSH requests General Fund expenditure authority of $8.2 million in 2024-25 to support surge capacity for its hospitals, including:
  - *Hospital Staffing* - $4.7 million in 2024-25 would support contracted short-term staffing support during COVID-19 surges.
  - *Norwalk Alternate Care Site* - $3.5 million in 2024-25 would support an alternate care site in Norwalk, which is administered by the California Department of Corrections and Rehabilitation under an interagency agreement with DSH. The site is part of the Southern Youth Correctional Reception Center and Clinic and is being operated as a satellite facility to Metropolitan State Hospital for use as an isolation or quarantine space. These resources would continue to support the interagency agreement for this facility, currently scheduled to run through December 31, 2024.

- Vaccinations – DSH requests General Fund expenditure authority of $3.8 million in 2024-25 and annually thereafter to support administration of vaccinations for patients and staff. DSH offers comprehensive influenza and COVID-19 vaccination programs, as well as offering vaccinations for Hepatitis B, tetanus/diphtheria/acellular pertussis (Tdap), measles/mumps/rubella (MMR), and varicella zoster virus (VZV). Previously, COVID-19 vaccines were provided at no cost to DSH by CDPH. CDPH no longer provides no cost vaccines, requiring DSH to purchase COVID-19 and other vaccines provided to patient and staff.

- Public Health Nurses – DSH requests 10 positions and General Fund expenditure authority of $1.9 million in 2024-25 and annually thereafter to continue support of ten existing Public Health Nurses that support the department's vaccination and monitoring programs.

- Commodity Goods – DSH requests General Fund expenditure authority of $2 million in 2024-25 and annually thereafter to support personal protective equipment (e.g. gloves, gowns, masks, protective clothing, and face shields), sanitation supplies (e.g. germicidal bleach, hand sanitizer, and hydrogen peroxide wipes), and additional food and food supplies for quarantined and isolated patients unable to eat in the common dining rooms.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 4: Incompetent to Stand Trial (IST) Solutions – Trailer Bill Language

Trailer Bill Language – Governor's Budget. DSH proposes trailer bill language to clarify the statutory authority provided to implement various Incompetent to Stand Trial (IST) solutions authorized by the 2022 Budget Act.

Background. The State Hospitals system admits individuals determined to be incompetent to stand trial (IST) under Section 1370 of the Penal Code, typically for felony offenses, and provides clinical and medical services to restore these individuals to competency. Because of capacity constraints within the state hospital system, as of November 2023, 501 individuals in the IST population are housed in county jails awaiting placement into a state hospital bed or jail-based competency program. This backlog, which had grown significantly in the prior two years due to the COVID-19 pandemic, placed operational and fiscal stress on county jails and, according to recent court rulings, violated the due process rights of individuals in custody for longer than a reasonable time to evaluate their potential for restoration to competency.

Incompetent to Stand Trial Referrals. Under California law "[a] person cannot be tried or adjudged to punishment or have his or her probation, mandatory supervision, post-release community supervision, or parole revoked while that person is mentally incompetent." IST patients are referred to DSH under Section 1370 of the Penal Code if a court has determined they are unable to understand the nature of criminal proceedings or assist counsel in their defense. IST patients receive competency-based treatment and are returned to court once able to participate in court proceedings. If a defendant's attorney raises concerns about his or her competency to stand trial, the judge in the case may order a mental health evaluation by a psychiatrist or clinical psychologist. If the evaluation finds substantial evidence the defendant is incompetent, a competency hearing is scheduled with additional expert testimony and an opportunity for the defendant to respond to or refute the findings of the evaluation. If the court finds a defendant incompetent to stand trial, the local community health director determines whether the defendant is best treated in a local facility, an outpatient facility, or at a state hospital. Misdemeanants are typically treated in an outpatient setting or released, while felonies are typically referred for treatment at a state hospital. If a bed is not available in a state hospital, the defendant remains in the custody of the county until a bed becomes available. Capacity constraints in the state hospital system have resulted in ongoing backlogs of defendants deemed IST in county jails for extended periods awaiting treatment.

***Stiavetti v. Clendenin* Requires Commencement of Treatment for IST Patients Within 28 Days.** In 2015, five family members of IST patients committed to DSH and the Department of Developmental Services (DDS) filed suit against the state challenging statewide delays in transfer of IST patients from county jails to DSH or DDS to begin substantive treatment services as a violation of the patients' due process rights. On April 19, 2019, the Alameda County Superior Court concluded that IST patients have a constitutional right to substantive services within a reasonable period of time and that DSH and DDS had violated the due process rights of IST patients referred to a state hospital or to DDS. The court found that constitutional due process requires that DSH and DDS must commence substantive services to restore an IST patient to competency within 28 days of the transfer of responsibility for an IST patient to DSH. On August 25, 2021, the California Supreme Court denied final review of the court's decision and, upon remand, the Alameda County Superior Court issued the following amended compliance timelines for DSH and DDS:

- No later than August 27, 2022: DSH and DDS must commence substantive services for all IST patients within 60 days from the transfer of responsibility date.
- No later than February 27, 2023: DSH and DDS must commence substantive services for all IST patients within 45 days from the transfer of responsibility date.
- No later than August 27, 2023: DSH and DDS must commence substantive services for all IST patients within 33 days from the transfer of responsibility date.
- No later than February 27, 2024: DSH and DDS must commence substantive services for IST patients within 28 days from the transfer of responsibility date.

Administration Proposals to Increase IST Capacity in State Hospitals. Over recent years, this Administration and the previous Administration have proposed a series of projects to expand capacity in State Hospitals for the treatment of IST patients. These proposals were in response to the growing backlog of IST patients in county jails over the last ten years and the potential for court mandates resulting from the *Stiavetti* case. These proposals include: 1) expansion of secured bed capacity at Metropolitan State Hospital to treat IST patients; 2) expansion of existing jail-based competency treatment programs and implementation of new programs; and 3) activation of OMD bed capacity at Coalinga State Hospital to allow transfer from other secured units to provide treatment space for IST patients in other hospitals.

2018 Budget Act - IST Community-Based Diversion Program. The 2018 Budget Act included General Fund expenditure authority of $100 million to establish an IST Diversion Program, which contracts with counties to serve individuals with serious mental illnesses with potential to be determined to be incompetent to stand trial (IST) on felony charges. The program prioritized $91 million of funding for these programs in the 15 counties with the highest referrals of ISTs to DSH in 2016-17, including Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Santa Barbara, Santa Clara, Solano, Sonoma, and Stanislaus. These counties were not required to submit a competitive application. In May 2020, Stanislaus County chose not to participate due to COVID-19 related economic issues and lack of other county resources to establish the program.

Of the remaining funding, $8.5 million was made available to other counties under a competitive funding process. In June 2019, DSH awarded funding to the following counties: Del Norte, Marin, Placer, San Francisco, San Luis Obispo, Santa Cruz, and Yolo. In November 2019, DSH awarded a second round of funding to Humboldt, San Mateo, Siskiyou, and Ventura counties.

IST Workgroup Established to Recommend Solutions to Reduce Backlog. In response to the court's ruling in *Stiavetti*, the 2021 Budget Act included trailer bill language to require DSH to convene an IST Solutions Workgroup to identify short-term, medium-term, and long-term solutions for alternatives to placement of defendants determined to be IST in a state hospital. The IST Solutions Workgroup met five times between August 2021 and November 2021 to develop solutions to the backlog of IST patients awaiting admission to state hospitals. The workgroup focused on three primary areas: 1) early access to treatment and stabilization for individuals determined to be IST on felony charges; 2) diversion and community-based restoration for individuals determined to be IST on felony charges; and 3) improving the quality of initial county competency evaluations. The workgroup released its findings in a report in November 2021 that included short-, medium-, and long-term recommendations.

IMD and Sub-Acute Bed Capacity Funding Program. In addition to establishment of the IST Workgroup, the 2021 Budget Act included 22 positions and General Fund expenditure authority of $267.1

million to authorize DSH to contract for subacute bed capacity to address the increasing number of IST patient referrals to state hospitals. DSH reports it began engagement with multiple private providers in summer 2021 and continues to work with those providers to develop bed capacity throughout the state. DSH is attempting to partner with providers that can provide a blend of acute and sub-acute bed capacity, which DSH believes will allow more individuals to transition from jail to community settings and promote a broader continuum of care. DSH is engaging counties that currently lack capacity to stabilize IST patients to provide funding to expand the reach of diversion programs. In addition, DSH is engaging with counties that have not been able to fully participate in diversion and community-based restoration programs due to lack of availability of sub-acute beds in their communities. DSH is also attempting to align funding for this program with the proposals contained within its IST Solutions Package.

IST Solutions Program. The 2021 Budget Act included General Fund expenditure authority of $93 million in 2021-22 and $571 million annually thereafter to support implementation of solutions to provide timely treatment for patients determined incompetent to stand trial (IST) on felony charges and to support ongoing efforts to decriminalize mental illness in California. Of these resources, $75 million in 2021-22 and $175 million annually thereafter was allocated for IST solutions, and $18 million in 2021-22 and $46 million annually thereafter was allocated for IST diversion and community-based restoration (CBR), approved in the 2021 Budget Act. The 2022 Budget Act included total additional ongoing funding of $350 million beginning in 2022-23. The IST solutions included the following:

- *Stabilization and Early Access to Treatment.* $24.9 million in 2021-22 and $66.8 million in 2022-23 and annually thereafter to provide access to treatment services for individuals on the IST waitlist. Treatment is facilitated in partnership with county jail mental health providers and includes administration of medications such as long-acting injectable (LAI) medications, increased clinical engagement, and competency education. DSH leverages its existing jail-based competency treatment infrastructure to provide these services.
- *Care Coordination and Waitlist Management*. $1.7 million in 2021-22 and $4.9 million in 2022-23 and annually thereafter to support teams to screen all IST patients to determine eligibility for community-based programs, provide enhanced monitoring of the waitlist, and provide commitment-to-admission case management to coordinate appropriate placements and maximize bed usage.
- *Housing Augmentation for Current Diversion Contracts*. $60 million in 2021-22 to support one-time interim housing investments for IST patients participating in a DSH diversion program. $75,000 per patient supports the cost of appropriate housing to facilitate increased diversion placements of patients determined IST on felony charges. Counties use this funding to provide housing to diversion clients in the most appropriate level-of-care such as IMDs, mental health rehabilitation centers, residential housing with clinically enhanced services, board and care homes, and other appropriate residential facilities.
- *Housing Infrastructure - CBR or Diversion Beds.* $6.4 million in 2021-22 and $233 million in 2022-23 and annually thereafter to support development of residential housing settings for IST patients participating in CBR or diversion programs. $350,000 in start-up funds was provided for approximately 700 housing units to cover down payment, retrofitting, and furnishings to provide approximately 5,000 beds.
- *Community Program Funding for CBR or Diversion Clients*. $266.5 million in 2022-23 and annually thereafter to support creation or expansion of permanent community-based treatment programs for IST patients. These resources support a robust per-patient rate, non-treatment costs of managing

community-based programs, transitional housing support for IST patients released from custody, and technical assistance resources for participating counties.
- *Increased Conditional Release Program (CONREP) Placements*. $433,000 in 2022-23 and annually thereafter to support a pilot for a new independent placement determination panel to increase the number of individuals served in the community through the Conditional Release Program (CONREP).

Trailer Bill Language Request. DSH proposes trailer bill language to clarify the statutory authority provided to implement various Incompetent to Stand Trial (IST) solutions authorized by the 2022 Budget Act. Specifically, the proposed trailer bill language would:

1) Clarify that DSH has the authority to receive medical records for individuals committed to DSH.

2) Require public and private medical facilities to provide medical records to DSH upon request.

3) Provide a mechanism to remove individuals from the IST waitlist if the individual is out of the county sheriff's custody, or is not delivered to a DSH facility after reasonable efforts to coordinate.

4) Clarify statute regarding the circumstances under which an individual restored to competency can remain at DSH for the purpose of maintaining competency.

5) Establish authority for the court to address the issue of involuntary medications for individuals that remain at DSH for the purposes of maintaining competency.

6) Extend DSH authority to bill for individuals restored to competency who remain in state hospital treatment beds after 10 days to other DSH funded IST treatment programs.

7) Change the timeline from quarterly to monthly for DSH contracted diversion programs to report diversion data to DSH.

8) Provide authority in the Vehicle Code for DSH to assist discharging patients with obtaining California identification cards.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposed trailer bill language.

Issue 5: Metropolitan – Central Utility Plant Replacement

Capital Outlay Budget Change Proposal – Governor's Budget. DSH requests General Fund expenditure authority of $50.5 million in 2024-25. If approved, these resources would support the construction phase of the project at Metropolitan State Hospital to replace the Central Utility Plant.

Multi-Year Funding Request Summary		
Fund Source	**2024-25**	**2025-26**
0001 – General Fund	$50,445,000	$-
Total Funding Request:	**$50,445,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The Central Utility Plant at Metropolitan State Hospital was completed in 1988 and provided a net electrical output of 27,800 kilowatts. Originally built and operated by Wheelabrator Norwalk Energy Corporation, Metropolitan assumed control of plant operations after termination of the contract with Wheelabrator. According to DSH, the plant operates the central steam boiler system and chiller plants, underground mechanical, electrical, and steam distribution infrastructure, energy management systems, and provides connection to the site's natural gas, water, and sanitary sewer lines. DSH reports that the old, inefficient design of the plant and the age of the equipment, along with the lack of modern environmental controls, makes future repair and maintenance difficult and extremely costly. In addition, DSH reports the original steam and underground piping distribution system was installed in 1915 and up to 20 percent of steam is lost through leaks. Major repairs to the infrastructure and full replacement of the older heating and cooling systems are necessary to achieve current operating standards for reliability, efficiency, and cost-effectiveness.

Capital Outlay Request – Construction. DSH requests General Fund expenditure authority of $50.5 million in 2024-25 to support the construction phase of the project at Metropolitan State Hospital to replace the Central Utility Plant., which supplies steam for hot water and central heating and chilled water for air conditioning to 32 patient housing and administrative buildings. DSH expects the project to: 1) replace the chillers, boilers, and pumps and replace all steam and condensate piping with hot water piping; 2) remove the steam and condensate piping campus-wide; 3) install hot water lines in the tunnels, crawl spaces, and open trenches with removable steel open grating locations; 4) install temporary steam boilers at several locations; and 5) install new boiler plant in the existing gas compressor room, consisting of three hot water boilers and pumps with room for a fourth boiler and pump if needed in the future. According to DSH, the new boilers would be comprised of commercial duty, low emissions equipment certified by the Southern California Air Quality Management District. The hot water pumps would also utilize variable speed operation to maximize plant efficiency.

According to DSH, total project costs are estimated to be $54.1 million, including the following:

- Preliminary plans - $1,835,000
- Working drawings - $1,863,000
- Construction - $50,445,000

The construction phase costs would include $42.1 million for the construction contract, $3 million for contingency, $3 million for architectural and engineering services, and $2.3 million for other project costs.

According to DSH, preliminary plans will be completed by February 2024, working drawings would begin in February 2024 and be completed in February 2025, and construction would begin in February 2025 and be completed in March 2027.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.