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

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator Melissa Hurtado
Senator Jeff Stone

Thursday, April 4, 2019
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

PART B

Consultant: Scott Ogus

PUBLIC COMMENT

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4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Community Mental Health - Overview

Community Mental Health – *Three Year Funding Summary*			
Fund Source	**2017-18**	**2018-19**	**2019-20**
1991 Realignment (base and growth):			
Mental Health Subaccount	$129,296,000	$129,415,000	$213,846,000
2011 Realignment (base and growth):			
Mental Health Subaccount	$1,129,234,000	$1,133,218,000	$1,132,142,000
Behavioral Health Subaccount	$1,415,447,000	$1,542,119,000	$1,658,031,000
Realignment Total	**$ 2,673,977,000**	**$2,804,752,000**	**$3,004,019,000**
Medi-Cal SMHS Federal Funds	**$2,954,125,000**	**$2,960,284,000**	**$3,149,401,000**
Medi-Cal SMHS General Fund	**$ 167,177,000**	**$263,550,000**	**$285,941,000**
MHSA Local Expenditures	**$2,009,301,000**	**$2,009,301,000**	**$2,009,301,000**
Total Funds	**$7,804,580,000**	**$8,037,887,000**	**$8,448,662,000**

Background. 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 Office of Statewide Health Planning and Development (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.

Subcommittee Staff Comments and Recommendation—Hold Open. Subcommittee staff recommends holding this item open as updated estimates of caseload and expenditures will be provided at the May Revision.

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

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

Issue 2: Unusual Occurrences-Complaint Investigations and Disaster Response

Budget Issue. DHCS requests eight positions and expenditure authority of $1.6 million ($858,000 General Fund and $719,000 federal funds) in 2019-20, $1.5 million ($809,000 General Fund and $678,000 federal funds) in 2020-21, and $1.1 million ($595,000 General Fund and $464,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to manage investigations of violations and unusual occurrences in licensed facilities, as well as supporting behavioral health resources during natural disasters or other emergencies.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$858,000	$809,000
0890 – Federal Trust Fund	$719,000	$678,000
Total Funding Request:	**$1,577,000**	**$1,487,000**
Total Requested Positions:	**8.0**	**8.0**

* Additional resources requested – 2021-22 and ongoing: $1,059,000 ($595,000 General Fund and $464,000 federal funds).

Background. The DHCS Mental Health Services Division (MHSD), Licensing and Certification Branch (LCB) is responsible for the licensing, certification and oversight of 285 residential mental health programs ranging from acute care to long-term programs. LCB is responsible for implementing and maintaining a system for compliance with licensing and certification requirements. DHCS is currently the sole licensing authority for 55 facilities, including 30 psychiatric health facilities (PHFs) and 25 mental health rehabilitation centers (MHRCs). In addition, DHCS certifies 230 mental health programs within facilities that are licensed by either the Department of Public Health or the Department of Social Services.

DHCS is currently responsible for the investigation of unusual occurrences reported by facilities and complaints filed by the public, as well as the implementation of civil and monetary sanctions for violations. Unusual occurrences is defined by California regulations as any condition or event which has jeopardized or could jeopardize the health, safety, security or well-being of any patient, employee or any other person while in the facility. Unusual occurrences include epidemic outbreaks of disease, poisonings, fires, physical injury, death, non-consenting sexual acts, physical assaults, patient abuse, or actual or threatened walkout or other curtailment or interruption of services. Unusual occurrence reports (UORs) are required to be reported to DHCS within 24 hours of occurrence.

According to DHCS, the number of UORs and complaints reported to LCB has increased by 68.3 percent between 2016 and 2017. The primary driver of the increase in workload was a sharp increase in UORs from community treatment facilities, which rose from 486 in 2016 to 1,134 in 2017. DHCS reports that a rise in acuity levels for individuals in DHCS licensed and certified facilities has contributed to more active reporting of unusual occurrences. As a result, as of June 2018, DHCS reported a total UOR and complaint investigation backlog of 1,303.

DHCS also supports state-level response activities under the State of California Emergency Plan related to behavioral health needs. During natural disasters or other emergencies, DHCS provides support to counties including providing resource materials, collecting status updates of impacted mental health

facilities, and developing application for federal funding. According to DHCS, it does not have any staff dedicated solely to supporting disaster behavioral health response and must redirect existing staff and re-prioritize workload to respond.

DHCS requests eight positions and expenditure authority of $1.6 million ($858,000 General Fund and $719,000 federal funds) in 2019-20, $1.5 million ($809,000 General Fund and $678,000 federal funds) in 2020-21, and $1.1 million ($595,000 General Fund and $464,000 federal funds) annually thereafter. If approved, these positions and resources would support the following additional staff:

- **One Staff Services Manager I** position and **six Associate Governmental Program Analysts** would be responsible for conducting desk and field investigations of complaints and reportable unusual occurrences, as well as receiving, logging, and tracking progress and resolution.

- Limited-term resources equivalent to **two Attorney III** positions for two years would support the investigative workload at all stages, including providing legal advice, determining specific violations and whether they are supported by evidence, assisting with drafting sanctions documents, and providing legal support for sanctions appeals. DHCS indicates the legal workload may be higher than projected in this request and, if it is higher, may request additional resources in the future.

- **One Associate Governmental Program Analyst** would support workload needed to respond to behavioral health needs during a disaster, unusual event, or emergency. This workload would include serving as a subject matter expert on behavioral health during state- or local-level disaster response, serving as a subject matter expert during emergency preparedness and planning activities, and preparing applications and overseeing implementation of the federally funded Crisis Counseling Assistance and Training Program.

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: Drug Medi-Cal Estimate

Budget Issue. The budget includes $593.4 million ($59.7 million General Fund, $403.2 million federal funds, and $130.5 million county funds) in 2018-19 and $687.1 million ($70.3 million General Fund, $489.9 million federal funds, and $126.9 million county funds) in 2019-20 for Drug Medi-Cal.

2018-19 Drug Medi-Cal Program Funding Summary (dollars in thousands)					
Service Description	**Total Funds**	**General Fund**	**Federal Funds**	**County Funds**	**Case-load**
Narcotic Treatment Program	$174,360	$5,334	$122,889	$46,137	9,164
Outpatient Drug Free Treatment Services	$18,712	$711	$14,309	$3,692	3,186
Intensive Outpatient Treatment Services	$7,176	$1,961	$4,814	$401	412
Residential Treatment Services	$2,882	$35	$1,638	$1,209	26
Organized Delivery System Waiver	$308,297	$50,627	$216,330	$41,340	-
Drug Medi-Cal Cost Settlement	($818)	($105)	($713)	$0	-
Drug Medi-Cal Annual Rate Adjustment	$5,781	$166	$4,009	$1,606	-
Drug Medi-Cal County Administration	$69,592	$992	$34,796	$33,804	-
County Util. Review/Quality Assurance	$7,417	$0	$5,099	$2,318	-
TOTAL	**$593,399**	**$59,721**	**$403,171**	**$130,507**	**12,788**
Regular Total	$508,445	$59,388	$358,916	$90,141	12,666
Perinatal Total	$8,763	$107	$5,073	$3,583	122
Other Total	$76,191	$226	$39,182	$36,783	-

2019-20 Drug Medi-Cal Program Funding Summary (dollars in thousands)					
Service Description	**Total Funds**	**General Fund**	**Federal Funds**	**County Funds**	**Case-load**
Narcotic Treatment Program	$174,676	$5,364	$123,246	$46,066	9,144
Outpatient Drug Free Treatment Services	$19,165	$731	$14,633	$3,801	3,266
Intensive Outpatient Treatment Services	$7,377	$2,089	$4,872	$416	427
Residential Treatment Services	$1,467	$20	$831	$616	28
Organized Delivery System Waiver	$425,215	$60,840	$314,022	$50,353	-
Drug Medi-Cal Cost Settlement	$0	$0	$0	$0	-
Drug Medi-Cal Annual Rate Adjustment	$7,229	$431	$4,932	$1,866	-
Drug Medi-Cal County Administration	$44,908	$858	$22,454	$21,596	-
County Util. Review/Quality Assurance	$7,104	$0	$4,884	$2,220	-
TOTAL	**$687,141**	**$70,333**	**$489,874**	**$126,934**	**12,865**
Regular Total	$629,385	$69,383	$459,184	$100,818	12,752
Perinatal Total	$5,744	$92	$3,352	$2,300	113
Other Total	$52,012	$858	$27,338	$23,816	-

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

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

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

Drug Medi-Cal is delivered through four base modalities:

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

  The budget includes $174.4 million ($5.3 million General Fund, $122.9 million federal funds, and $46.1 million county funds) in 2018-19 and $174.7 million ($5.4 million General Fund, $123.2 million federal funds, and $46.1 million county funds) in 2019-20 for NTP services. In 2018-19, NTP caseload is expected to be 9,164 a decrease of 39,736 (81.3 percent) compared to the 2018 Budget Act. In 2019-20, NTP caseload is expected to be 9,144, a decrease of 20 (0.2 percent) compared to the revised 2018-19 caseload estimate.

- **Outpatient Drug Free (ODF) Treatment Services** – Outpatient services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with a substance abuse diagnosis in an outpatient setting. Participants receive at least two group, face-to-face counseling sessions per month. Additional counseling and rehabilitation services include admission physical examinations, intake, medical necessity establishment, medication services, treatment and discharge planning, crisis intervention, collateral services, and individual and group counseling.

The budget includes $18.7 million ($711,000 General Fund, $14.3 million federal funds, and $3.7 million county funds) in 2018-19 and $19.2 million ($731,000 General Fund, $14.6 million federal funds, and $3.8 million county funds) in 2019-20 for ODF services. In 2018-19, ODF caseload is expected to be 3,186, a decrease of 33,873 (91.4 percent) compared to the 2018 Budget Act. In 2019-20, ODF caseload is expected to be 3,266, an increase of 80 (2.5 percent) compared to the revised 2018-19 caseload estimate.

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

  The budget includes $7.2 million ($2 million General Fund, $4.8 million federal funds, and $401,000 county funds) in 2018-19 and $7.4 million ($2.1 million General Fund, $4.9 million federal funds, and $416,000 county funds) in 2019-20 for IOT services. In 2018-19, IOT caseload is expected to be 412, a decrease of 5,279 (92.8 percent) compared to the 2018 Budget Act. In 2019-20, IOT caseload is expected to be 427, an increase of 15 (3.6 percent) compared to the revised 2018-19 caseload estimate.

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

  The budget includes $2.9 million ($35,000 General Fund, $1.6 million federal funds, and $1.2 million county funds) in 2018-19 and $1.5 million ($20,000 General Fund, $831,000 federal funds, and $616,000 county funds) in 2019-20 for RTS. In 2018-19, RTS caseload is expected to be 26, a decrease of 375 (93.5 percent) compared to the 2018 Budget Act. In 2019-20, RTS caseload is expected to be 28, an increase of 2 (7.7 percent) compared to the revised 2018-19 caseload estimate.

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open as updated estimates of caseload and expenditures will be provided at the May Revision.

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

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

Issue 4: Drug Medi-Cal – Organized Delivery System Waiver

Budget Issue. The budget includes $308.3 million ($50.6 million General Fund, $215.1 million federal funds, and $41.3 million county funds) in 2018-19 and $425.2 million ($60.8 million General Fund, $312.5 million federal funds, and $50.4 million county funds) in 2019-20 for the implementation of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver. The Waiver authorizes a pilot project to test organized delivery of an expanded benefit package for substance use disorder services.

2018-19 DMC-ODS Waiver Program Funding Summary (dollars in thousands)				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**
Organized Delivery System Waiver Total	**$308,297**	**$50,627**	**$215,057**	**$41,340**
Regular Total	$304,400	$51,233	$212,764	$39,172
Perinatal Total	$3,897	$55	$2,293	$1,507
Claims Error*	$-	($661)	$-	$661

***** Payments for new required and optional services in the ACA expansion population were erroneously paid using General Fund for the non-federal share.

2019-20 DMC-ODS Waiver Program Funding Summary (dollars in thousands)				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**
Organized Delivery System Waiver Total	**$425,215**	**$60,840**	**$312,452**	**$50,353**
Regular Total	$426,120	$60,787	$311,145	$49,618
Perinatal Total	$2,095	$53	$1,307	$735

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

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

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

The standard Drug Medi-Cal program covers outpatient services, intensive outpatient services, limited perinatal residential services, and narcotic treatment program services. Optional participation in the

DMC-ODS Waiver allows counties to cover an expanded array of SUD services for Medi-Cal beneficiaries. The benefits offered under the DMC-ODS Waiver are as follows:

1. Existing Drug Medi-Cal Services

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

2. Expanded Services Available in ODS Waiver

    - Additional MAT (non-NTP providers)
    - Partial Hospitalization
    - Withdrawal Management
        - ASAM Criteria Level 3.7 – Medically monitored inpatient
        - ASAM Criteria Level 4.0 – Medically managed intensive inpatient

According to DHCS, four counties began providing services under the DMC-ODS Waiver in 2016-17, and seven counties began providing services in 2017-18. In 2018-19, 28 additional counties are expected to begin providing services, with phased-in implementation expected to occur through April 2019. The department reports a total of 39 counties are participating or planning to participate in the DMC-ODS Waiver. 19 counties have elected not to participate.

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 an update on the implementation of the DMC-ODS Waiver.

Issue 5: Drug Medi-Cal Chaptered Legislation (SB 823, SB 1228, AB 2861)

Budget Issue. DHCS requests 16 positions and expenditure authority of $1.9 million ($1.7 million General Fund and $135,000 federal funds) in 2019-20 and $2.2 million ($2 million General Fund and $135,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to implement new requirements for substance use disorder treatment programs regarding clinical assessment and treatment planning, patient brokering, and telehealth. These requirements were implemented pursuant to SB 823 (Hill), Chapter 781, Statutes of 2018, SB 1228 (Lara), Chapter 792, Statutes of 2018, and AB 2861 (Salas), Chapter 500, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$1,723,000	$2,041,000
0890 – Federal Trust Fund	$135,000	$135,000
Total Funding Request:	**$1,858,000**	**$2,176,000**
Total Requested Positions:	**16.0**	**16.0**

* Positions and Resources ongoing after 2020-21.

Background. Established in 1980, the Drug Medi-Cal program provides medically necessary substance use disorder (SUD) treatment services to eligible Medi-Cal beneficiaries through four primary modalities: 1) the Narcotic Treatment Program (NTP), Outpatient Drug Free (ODF) treatment services, Intensive Outpatient Treatment (IOT) services, and Residential Treatment Services (RTS). Both DHCS and counties have specific oversight requirements for Drug Medi-Cal. DHCS is tasked with administrative and fiscal oversight, monitoring, auditing and utilization review. Counties can contract for Drug Medi-Cal services directly, or contract with DHCS, which then directly contracts with providers to deliver Drug Medi-Cal services. Counties that elect to contract with DHCS to provide services are required to maintain a system of fiscal disbursement and controls, monitor to ensure that billing is within established rates, and process claims for reimbursement. DHCS is also implementing a new Drug Medi-Cal Organized Delivery System Waiver, a pilot project to test organized delivery of an expanded benefit package for substance use disorder services.

SB 823 Requires Adoption of ASAM Criteria for Licensure of Treatment Facilities. In addition to its responsibilities under Drug Medi-Cal, DHCS is responsible for licensing, certification, and monitoring of alcohol and other drug (AOD) residential treatment programs. DHCS reviews initial facility applications and conducts on-site reviews, oversees licensing and certification renewals, conducts on-site monitoring compliance reviews, and investigates complaints of facilities and counselors. SB 823 (Hill), Chapter 781, Statutes of 2018, requires DHCS to adopt the American Society of Addiction Medicine (ASAM) treatment criteria, or an equivalent evidence-based standard, as the minimum standard of care for licensed facilities.

According to DHCS, the ASAM criteria is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results-based care in the treatment of addiction. The ASAM criteria utilizes a multi-dimensional patient assessment that is based on the degree of direct medical management provided; the structure, safety and security provided; and the intensity of treatment services provided. Through this strength-based multi-dimensional assessment, the

ASAM criteria addresses the patient's needs, obstacles and liabilities, as well as the patient's strengths, assets, resources and support structure, and provides an evidence-based common standard for assessing a patient's needs by identifying their placement within a full continuum of care.

The ASAM criteria's multi-dimensional assessment is structured around six unique dimensions which represent different life areas that together impact the assessment, service planning, and level of care placement decisions. These dimensions are utilized to provide a common language of holistic, biopsychosocial assessment and treatment across addiction treatment, physical health, and mental health services. The dimensions are:

- Dimension 1: Acute Intoxication and or Withdrawal Potential
- Dimension 2: Biomedical Conditions and Complications
- Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
- Dimension 4: Readiness to Change
- Dimension 5: Relapse, Continued Use, or Continued Problem Potential
- Dimension 6: Recovery Environment

The ASAM criteria provides setting, staffing, support systems, therapies, assessments, documentation and treatment plan reviews to ensure the clinical needs of the patient are met. Clinical information pertaining specifically to adults and separate ones for youth are clearly identified. Specialized treatment needs for individuals with complex needs, such as co-occurring disorders, are also contained within ASAM.

Programs operating under the Drug Medi-Cal Organized Delivery System (DMC-ODS) provide a continuum of care modeled on the ASAM criteria for substance use disorder treatment services, which allows these programs to offer a consistent standard of care. DHCS developed a designation program to certify that all DMC-ODS providers of adult and adolescent Level 3.1 through 3.5 residential and inpatient services are capable of delivering care consistent with ASAM criteria. DHCS conducts a review of facility self-reported information and conducts a conference call with each program to determine whether the residential treatment facility is provisionally able to support ASAM Levels 3.1 (Clinically Managed Low-Intensity Residential Services for adolescents and adults), 3.3 (Clinically Managed Population-Specific High-Intensity Residential Services for adults only) or 3.5 (Clinically Managed Medium-Intensity Residential Services for adolescents and Clinically Managed High-Intensity Residential Services for adults).

DHCS is requesting **one Staff Services Manager I** position to manage **six Associate Governmental Program Analysts** in its Substance Use Disorder Compliance Division to implement the requirements of SB 823. According to DHCS, prior to the passage of SB 823, clinical assessments of treatment plans have not been a required aspect of residential licensure. DHCS would be required to promulgate regulations, formulate policies and procedures, draft information notices, and make recommendations on administrative and program-related problems. Each analyst would be responsible for managing a caseload of approximately 90 facilities applying for new ASAM designations. Analysts would review specifications related to treatment planning, educational scheduling, client file documentation, licensing requirements, coordination of care policies, quality monitoring, and data reporting.

SB 1228 Limits Patient Brokering in Recovery and Treatment Facilities. According to DHCS, the nationwide rise in the opioid epidemic highlights the need for treatment services, but has also fueled a surge in patient brokering and patient trafficking. Patient brokering occurs in California's SUD facilities and among the SUD workforce, but DHCS did not have the authority to take action against the facility or the workforce, resulting in insurance fraud and overbilling for inappropriate treatment services. Within the last three years, DHCS has started to receive complaints with allegations specific to issues of the illegal practice of patient brokering and trafficking. Complaints include individuals with or without a SUD being paid to enter certain SUD facilities, counselors or staff receiving kick-backs via money, gifts or services for making referrals to particular facilities, telling individuals they will enter one facility and placing them at a different facility in order to make money, facilities purchasing individual referrals from a referral service, and providing illicit drugs to individuals in order to refer them or retain them in the facility.

SB 1228 (Lara), Chapter 792, Statutes of 2018, prohibits the following persons, programs, or entities from giving or receiving compensation for referral to alcohol or drug treatment services:

1) A licensed alcoholism or drug abuse recovery and treatment facility,
2) A person with an interest of more than 10 percent in a licensed alcoholism or drug abuse recovery and treatment facility,
3) An employee of a licensed alcoholism or drug abuse recovery and treatment facility,
4) A certified alcohol or other drug program,
5) A person with an interest of more than 10 percent in a certified alcohol or other drug program, or
6) An employee of a certified alcohol or other drug program.

SB 1228 authorizes DHCS to assess penalties, suspend or revoke licensure, certification, or registration of a facility, program or counselor for a violation of the prohibition on receiving compensation for patient referrals.

DHCS requests **one Staff Services Manager I** position and **five Associate Governmental Program Analysts** in its Substance Use Disorder Compliance Division. Each analyst would be responsible for initial analysis, oversight, and monitoring of patient brokering and trafficking activities. Analysts would conduct monitoring visits, unannounced visits, conduct complaint investigations, and develop and complete provider trainings and outreach on program requirements.

DHCS also requests **one Attorney I** position in its Office of Legal Services. The attorney would provide legal support to program staff for on-site facility visits including evidence training, legal advice on evidence gathering and interviewing, analysis of evidence, legal theories and legal actions, and advice on follow up work to support legal actions. The attorney would also assist with informal conferences, regulatory development and ongoing legal support.

AB 2861 Allows Drug Medi-Cal Counseling Services Through Telehealth. AB 2861 (Salas), Chapter 500, Statutes of 2018, allows a Drug Medi-Cal certified provider to receive reimbursement for individual counseling services provided through telehealth by a licensed practitioner of the healing arts or a registered or certified alcohol or other drug counselor, when medically necessary and in accordance with the Medicaid state plan. AB 2861 also requires DHCS to promulgate regulations to implement the new policy by July 1, 2022.

DHCS requests **one Associate Governmental Program Analyst** in its Substance Use Disorder Program Policy and Fiscal Division to promulgate regulations, bulletins, and information notices related to implementation of telehealth reimbursement for Drug Medi-Cal providers.

DHCS also requests **one Attorney I** position in the Office of Legal Services to develop the required state plan amendment, develop information notices, and develop regulations. The position would also support contract development, legal research, consultation, written legal advice, and advice regarding the legal questions surrounding telehealth's application in the SUD context.

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 6: SAPT Block Grant Compliance and Audit Enhancement

Budget Issue. DHCS requests 14 positions and federal fund expenditure authority of $1.9 million in 2019-20 and $2.1 million ongoing thereafter. If approved, these resources would allow DHCS to correct audit findings and comply with a corrective action plan related to deficiencies in administration of the federal Substance Abuse Prevention and Treatment Block Grant.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0890 – Federal Trust Fund	$1,9165,000	$2,078,000
Total Funding Request:	**$1,916,000**	**$2,078,000**
Total Requested Positions:	**14.0**	**14.0**

* Positions and Resources ongoing after 2020-21.

Background. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) administers the Substance Abuse Prevention and Treatment (SAPT) Block Grant program, which provides funds to states to help plan, implement, and evaluate activities that prevent and treat substance abuse. The SAPT Block Grant program sets aside funds to target specific populations and services including pregnant women and women with dependent children, intravenous drug users, tuberculosis services, persons living with HIV/AIDS, and primary prevention. According to SAMHSA, California received $254.7 million from the SAPT Block Grant in the federal fiscal year ending September 2018.

DHCS is the designated single state agency that administers the SAPT Block Grant in California. Recent audits by the California State Auditor and SAMHSA have found insufficient oversight and reporting of SAPT Block Grant programs, resulting in a mandatory corrective action plan imposed by SAMHSA. The audit and corrective action plan require enhancement of fiscal oversight, programmatic processes, and monitoring and auditing of grant recipients, as well as substance use disorder facilities providing services funded by the SAPT Block Grant.

As a requirement of the SAPT Block Grant, DHCS is required to collect outcomes data and other information in three systems. The California Treatment Outcomes Measurement System – Treatment (CalOMS-Tx) collects outcome data from counties and providers to identify successful interventions to facilitate the improvement of service delivery. The Drug and Alcohol Treatment Access Report (DATAR) is the DHCS system that collects data on substance use disorder treatment capacity and waiting list, which is used to determine the capacity of the overall system to meet the demand for services. The Behavioral Health Services Information System (BHSIS) collects information on the facilities and services available for behavioral health treatment and on the characteristics of clients admitted to such facilities. BHSIS consists of four national datasets: 1) Treatment Episode Data Set, 2) Inventory of Behavioral Health Services, 3) National Survey of Substance Treatment Services, and 4) the Behavioral Health Treatment Services Locator.

In addition to its data collection responsibilities, DHCS is also responsible for fiscal management and auditing of county programs funded by the SAPT Block Grant. DHCS reviews annual county budgets, quarterly reporting, expenses and payments for compliance with program requirements. DHCS also conducts program audits of county programs receiving SAPT Block Grant funding. The California State

Auditor found that DHCS was not conducting an appropriate number of audits to meet the SAPT Block Grant requirements. As a result, DHCS intends to conduct 19 county audits each year, auditing each of the 58 counties over a three year period.

DHCS requests 14 positions and federal fund expenditure authority of $1.9 million in 2019-20 and $2.1 million ongoing thereafter to comply with the audit findings and corrective action plan related to deficiencies in administration of the federal Substance Abuse Prevention and Treatment Block Grant. Specifically, DHCS requests the following positions:

Substance Use Disorder Program, Policy and Fiscal Division (SUD-PPFD) – Three positions

- **One Staff Services Manager I** and **two Associate Governmental Program Analysts** would manage the increased volume of database administration for the CalOMS-Tx, DATAR, and BHSIS systems. These systems were previously managed by the Enterprise Innovation and Technology Services (EITS) Division and will now shift to SUD-PPFD. These positions would be responsible for maintenance of information within the data systems.

SUD-PPFD, Fiscal Management and Accountability Section (FMAS) – One position

- **One Associate Governmental Program Analyst** would manage the fiscal processes of the annual SAPT Block Grant award. This workload includes review and analysis of 57 county budgets, 228 quarterly reports, quarterly accounting of SAPT Block Grant expenses, quarterly payments, and annual determination of redirections by award.

Audits and Investigations, Financial Audits Branch-Drug Medi-Cal Audit Section – Six positions

- **One Health Program Audit Manager I** would manage a team of **one Health Program Auditor IV** position, **three Health Program Auditor III** positions, and **one Office Technician** to manage the additional auditing workload recommended by the California State Auditor and consistent with the corrective action plan.

Office of Legal Services – Two positions

- **One Attorney I** position would perform legal research, provide legal advice, and draft legal opinions to ensure the SAPT Block Grant data reporting meets all state and federal requirements. The attorney would also review investigations and audits of counties and providers, as well as provide legal support for any necessary changes to current processes, documentation requirements, contract management, or oversight.
- **One Attorney IV** position would support and defend SAPT Block Grant appeals of audit findings and adjustments at the Office of Administrative Hearings and Appeals, engage with opposing counsel to assess settlement opportunities, and assist the Attorney General with defense of DHCS if providers challenge final appeal decisions.

Office of Administrative Hearings and Appeals (OAHA) – Two positions

- **One Administrative Law Judge II** position and **one Senior Legal Analyst** would handle increased workload related to appeal of audit findings. DHCS expects an additional 19 informal appeal requests annually, of which 15 will result in formal hearings. This represents 100 percent of annual county audits requesting informal appeals.

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 7: Proposals for Investment

Stakeholder Proposals for Investment. The subcommittee has received the following proposals for investment.

Substance Use Counselors in Emergency Departments. The California Chapter of the American College of Emergency Physicians (CalACEP) requests General Fund expenditure authority of $30 million to support the hiring of trained substance use disorder peer navigators and behavioral health peer navigators in emergency departments of acute care hospitals. According to CalACEP, brief interventions are successful in a variety of settings, but there is a unique opportunity to provide this intervention in the emergency department (ED). Patients presenting to the ED are more likely to be having a mental health crisis or have a substance use disorder than those presenting to primary care. For patients coming into the ED with a substance use disorder, the visit offers the opportunity for a "teachable moment" due to the crisis that precipitated the ED visit.

The University of California (UC) Davis Medical Center ED applied for a grant through the UC Office of the President over a year ago to employ a certified drug and alcohol counselor to provide interventions in their ED. Over a 12 month period, the Medi-Cal insured patients who received a brief intervention and referral to treatment experienced a 60 percent decline in ED utilization after the intervention. Based on an average cost to Medi-Cal of $861.50 per visit, this one program resulted in savings to the Medi-Cal program of more than $350,000. There are also likely savings associated with reduced hospital admissions, as studies have shown persons who needed substance abuse treatment and did not get it were 81 percent more likely to be admitted to the hospital during their current ED visit and 46 percent more likely to have reported making at least one ED visit in the previous 12 months.

Expansion of SBIRT to Opioids and Other Drugs. The California Behavioral Health Directors Association requests expenditure authority of $8.4 million ($2.6 million General Fund and $5.8 million federal funds) to expand the Medi-Cal benefit for screening, brief intervention, referral and treatment (SBIRT) to include screening for overuse of opioids and other illicit drugs such as heroin and methamphetamine. The U.S. Department of Health and Human Services describes expanding SBIRT for drug use as a promising practice and the U.S. Preventive Services Task Force is re-visiting its recommendations on this topic. A comprehensive, national SBIRT grant program recently reported a 75 percent reduction in illicit drug use, consistent with other evidence linking SBIRT to reduction in the use of cocaine, amphetamine-type stimulants and opioids. Expanding screening to detect use of opioids and other drugs would be an important step in combatting the current crisis and saving lives.

Youth Mental Health First Aid Training for Teachers and Schools. The California Council of Community Behavioral Health Agencies, the California Behavioral Health Directors Association, and the Born This Way Foundation request expenditure authority to pilot Youth Mental Health First Aid training for teachers and school personnel in districts with high rates of suicide or with high populations of at-risk youth. According to the proponents, 30 percent of high school students report experiencing depression symptoms - feeling sad or hopeless almost every day for two or more weeks in a row, so much so that they stopped doing some usual activities. 18 percent of high school students have seriously considered attempting suicide, and eight percent attempted suicide one or more times. Suicide is the second leading cause of death for youth 15 to 24 years old and the third leading cause of death among

youth aged 10 to 14. In addition, marginalized populations, particularly LGBTQ youth, are at even greater risk. Youth Mental Health First Aid USA is an eight hour in-person course that teaches educators, parents, and other adults how to identify, understand, and respond to signs of mental illnesses and substance use disorders in youth. This preventative training teaches the skills needed to reach out and provide initial help and support to someone who may be experiencing a crisis or developing a mental health or substance use issue.

County Suicide Prevention Strategic Plans. The Steinberg Institute requests resources to require all California counties to develop a suicide prevention strategic plan with an emphasis on adolescents. Over a ten year period, California has experienced a constant rise in deaths by suicide. Youth suicide and self-inflicted injury is on the rise and is the second leading cause of death among youth age 15 to 24 nationwide. Studies show prevention and early intervention efforts can help avoid a suicidal crisis. Local governments play a key role in convening stakeholders from diverse sectors like school districts, health care, youth justice, media campaigns, and community education and organizing. When counties implement strategic suicide prevention plans, they result in fewer suicide deaths in their county.

Friday Night Live Partnership at the Tulare County Office of Education. The Friday Night Live Partnership and the California Behavioral Health Directors Association (CBHDA) request General Fund expenditure authority of $6 million annually to provide supplemental funding for the California Friday Night Live Partnership at the Tulare County Office of Education. According to CBHDA, the Friday Night Live program is a key element of the prevention services provided in 50 or more counties. Cumulatively it represents the highest level of prevention activities in the statewide data collection system managed by DHCS. The Friday Night Live program works well in concert with all our efforts to improve the mental health, school connectedness, and health and safety of youth.

Children's Crisis Residential Programs Trailer Bill Proposal. The California Alliance of Child and Family Services requests trailer bill language to explicitly define Children's Crisis Residential Programs (CCRPs) as Psychiatric Residential Treatment Facilities (PRTFs) and funded accordingly. According to the Alliance, AB 501 (Ridley-Thomas), Chapter 704, Statutes of 2017, created a licensing category for children's mental health crisis residential programs, which is a mental health facility designed to treat youth who are not at imminent danger to themselves or others, but are unsafe to remain in the community due to their mental health needs. The model used in the development of AB 501, as well as models throughout the country utilize the Medicaid mental health program category of Psychiatric Residential Treatment Facility (PRTF), an all-inclusive program for Medicaid beneficiaries. Since AB 501 did not explicitly identify the facility as PRTFs, DHCS refuses to recognize CCRPs as PRTFs, and has designed a funding structure that covers only specific specialty mental health services, not the entire cost of providing 24-hour care and treatment.

Funding for Public Administrators, Public Guardians, and Public Conservators. The California Association of Public Administrators, Public Guardians, and Public Conservators (CAPAPGPC), the California State Association of Counties (CSAC), CBHDA, and the Service Employees International Union of California (SEIU CA) request General Fund expenditure authority of $68 million for DHCS to augment county spending for Public Administrator, Public Guardian, and Public Conservator (PA/PG/PC) programs at the county level. According to the proponents, PA/PG/PC programs are the only statewide California safety net programs that do not receive any dedicated state or federal funding even though the majority of the individuals served by these programs qualify for Med-Cal. In total,

California counties are spending approximately $194 million annually to provide critical PA/PG/PC services to California's most defenseless dependent adults and decedent estates. On average county PA/PG/PC programs are understaffed by 20 percent. State funding to annually augment, not supplant, county spending for these programs by 35 percent, or $68 million, would increase direct services to the vulnerable dependent adult population whom PA/PG/PC programs serve.

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 stakeholders to present these proposals for investment.

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

Issue 1: Mental Health Services Act Oversight and Policy Development

Budget Issue. DHCS requests 13 positions and Mental Health Services Fund expenditure authority of $1.9 million in 2019-20 and $1.8 million annually thereafter. If approved, these resources would allow DHCS to provide oversight and monitoring of the use of Mental Health Services Act funds, in response to a series of audits by the California State Auditor and hearings by the Little Hoover Commission.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3085 – Mental Health Services Fund	$1,919,000	$1,802,000
Total Funding Request:	**$1,919,000**	**$1,802,000**
Total Requested Positions:	**13.0**	**13.0**

* Positions and Resources ongoing after 2020-21.

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

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

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

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

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

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

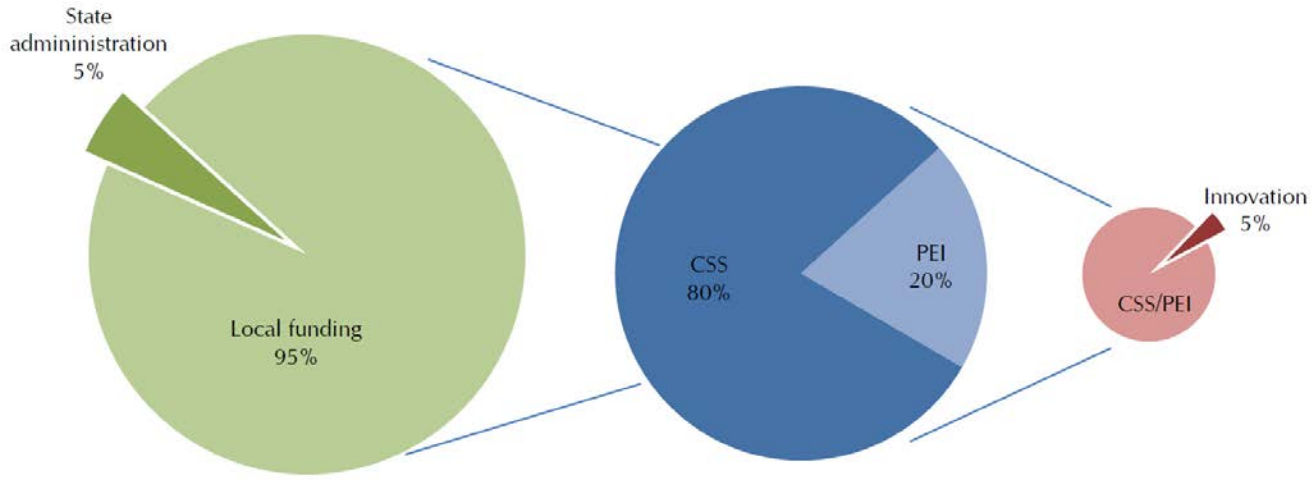
mental health system and increase the cultural competency of staff and workforce development programs.

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

MHSA funds are allocated to counties 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.

Apportionment of Mental Health Services Act Funds.



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

Reversion Requirements for Unspent County Funds. MHSA requires the reversion of unspent county funds to the state. According to Welfare and Institutions Code section 5892 (h), "any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years". However, DHCS has not reverted unspent county funds since 2008. In recent years, mental health advocates expressed concerns that counties were retaining MHSA funds that could be reverted and reallocated to the provision of additional mental health services. However, counties reported various challenges with accurate reporting of funds subject to reversion, including limitations on reporting forms from DHCS, inadequate identification of funds owed, and unclear policies for reversion.

2017 Budget Act Implemented Transparency Requirements for MHSA Reversion. In an effort to address the concerns from stakeholders and counties regarding the MHSA reversion process, the Legislature adopted several reforms in trailer bill language as part of the 2017 Budget Act. AB 114 (Committee on Budget), Chapter 38, Statutes of 2017, implemented the following changes:

1. Holds counties harmless for reversion prior to 2017-18, with funds reallocated to the counties of origin for the originally allocated purposes (e.g. prevention and early intervention, or innovative programs).

2. By July 1, 2018, requires DHCS and counties to report on the amounts owed prior to 2017-18 and requires counties to submit a plan to spend these funds by July 1, 2020.

3. Extends reversion period from three to five years for small counties (population under 200,000).

4. Requires DHCS to annually post by each October 1, the amount of each county's funds subject to reversion and when the funds will revert.

5. After July 1, 2017, requires reverted funds be reallocated to other counties for the purposes originally allocated (e.g. prevention and early intervention, or innovative programs).

6. Upon approval of an innovation plan by the Mental Health Services Oversight and Accountability Commission, allows funds allocated for innovative programs to re-start the three year period, after which the funds would be subject to reversion (five year period for small counties).

AB 114 provided clarity regarding counties' treatment of funds previously subject to reversion, provided timelines for DHCS to report annually to counties and the public regarding MHSA funds subject to reversion, and ensured MHSA funds allocated to each of the expenditure components required by the act (CSS, PEI, and Innovation) remain allocated to those components after reversion to other counties. In its October 2018 report on funds subject to reversion as of July 1, 2017, DHCS identified a total of $391 million subject to reversion that was deemed reverted and reallocated to the expenditure components to which it was first allocated. Of this amount, $5.1 million was allocated for CSS, $128.2 million for PEI, $187.5 million for Innovation, $27 million for Workforce Education and Training, and $43.2 million for Capital Facilities and Technological Needs.

State Audit of MHSA Oversight by DHCS and MHSOAC. In response to similar concerns that prompted the Legislature to adopt the reforms contained in AB 114, the Joint Legislative Audit Committee requested the State Auditor to review the funding and oversight of the MHSA by DHCS and MHSOAC. After review of both entities and a sample of three county mental health programs (Alameda, Riverside, and San Diego), the Auditor released Report 2017-117: "*Mental Health Services Act: The State Could Better Ensure the Effective Use of Mental Health Services Act Funding"*, which made the following findings and recommendations:

DHCS Findings

1. DHCS has not developed a process to recover unspent MHSA funds subject to reversion, with counties accumulating a total of $231 million unspent funds as of 2015-16.

   Auditor Recommendation: DHCS should develop a MHSA fiscal reversion process.

2. DHCS has not provided guidance to counties regarding proper expenditures of interest earned on MHSA funds on deposit, with counties accumulating a total of $81 million in unspent interest as of 2015-16.

   Auditor Recommendation: DHCS should clarify that interest on MHSA funds is subject to the same reversion requirements as the MHSA funds counties receive.

3. DHCS has not established a formal process to govern how much of a county's MHSA funds may be held in reserve, with counties holding a total of $535 million in reserve, or 47 percent of total prior-year CSS funds, as of 2015-16.

   Auditor Recommendation: DHCS should establish and enforce an MHSA reserve level that allows county programs to maintain sufficient funds for providing mental health services during times of economic hardship, but does not result in holding reserves that are excessive. Under a conservative approach, the level could be set at 33 percent of prior year CSS expenditures, which is equal to the highest one-year decline in CSS allocations since 2007-08.

4. DHCS has not analyzed or accounted for a $225 million fund balance that existed in the Mental Health Services Fund when it was transferred from the former Department of Mental Health in 2012.

   Auditor Recommendation: DHCS should complete its analysis of the $225 million fund balance by May 1, 2018, and allocate unspent funds to counties accordingly. DHCS should also regularly scrutinize the fund to determine reasons for any excess fund balances.

5. DHCS has made minimal efforts to ensure county mental health programs submit their required annual reports on time, hampering DHCS' ability to calculate MHSA reversion amounts and properly oversee MHSA spending.

   Auditor Recommendation: DHCS should publish its proposed fiscal regulations, which will include provisions governing the annual report process, by June 2018 and subsequently implement a process that will enable it to withhold MHSA funds from counties that fail to submit reports on time.

6. DHCS has been slow to implement oversight of counties' MHSA spending and programs. Although DHCS developed an MHSA fiscal audit process in 2014, it has limited the audits' usefulness because it focused its reviews on data and processes contained in its Short-Doyle Medi-Cal cost reports, which are at least seven years old.

Auditor Recommendation: DHCS should publish its proposed fiscal regulations, which will include provisions governing the fiscal audit process, by June 2018 and subsequently develop and implement an MHSA fiscal audit process, independent of Short-Doyle Medi-Cal reviews, to review revenues and expenditures for the most recent fiscal year.

7. DHCS has not developed regulations to establish an appeals process for county mental health programs to challenge findings. DHCS has also not implemented a program review process to evaluate the effectiveness of counties' MHSA projects.

   Auditor Recommendation: DHCS should establish a process for conducting comprehensive program reviews and begin conducting those reviews by July 2018.

MHSOAC Findings

8. MHSOAC has not provided clear guidance to counties regarding the Innovation plan approval process, which may have contributed to local mental health agencies holding unspent Innovation funds of $146 million as of 2015-16.

   Auditor Recommendation: MHSOAC should continue its efforts to help county mental health programs understand the types of Innovation projects that commissioners believe are appropriate. These efforts should include engagement and dialogue with county mental health programs through events and forums about the types of innovative approaches that would meet the requirements of the MHSA. MHSOAC should use meetings of its Innovation subcommittee or a similar mechanism to evaluate progress of its efforts to reduce unspent Innovation funds and the need for continued engagement and dialogue with county mental health programs.

9. MHSOAC has required county mental health programs to submit annual reports for PEI programs beginning December 2017, as required by legislation approved in 2013, but has not completed an internal process for reviewing and analyzing these reports to ensure submission of timely and reliable data.

   Auditor Recommendation: MHSOAC should finalize its review processes for reviewing and analyzing PEI program status reports no later than July 2018. MHSOAC should also continue its efforts to launch data tools to track county mental health programs' funding, services, and outcomes.

10. MHSOAC has not developed metrics to evaluate the outcome of triage grants approved by the Legislature and designed to expand the number of mental health personnel available at emergency rooms, jails, homeless shelters, and clinics.

    Auditor Recommendation: MHSOAC should require county mental health programs to uniformly report data on their use of triage grants and establish statewide metrics to evaluate the impact of triage grants by July 2018.

DHCS Response to Audit Findings and Recommendations. DHCS indicated that it agreed with most of the findings and recommendations contained in the audit. According to DHCS, in response to the provisions of AB 114, it released Mental Health/Substance Use Disorders (MHSUDS) Information Notice 17-059, which provides guidance to county mental health programs regarding the treatment of funds subject to reversion prior to July 1, 2017. This guidance includes information regarding how it would determine funds subject to reversion for each MHSA component including the disposition of earned interest, consequences for failure to submit timely annual reports, the appeals process for determinations of funds subject to reversion by fiscal year, and requirements for counties to prepare plans to spend these funds.

On March 22, 2019, DHCS released a notice of proposed rulemaking DHCS-16-009, promulgating fiscal regulations for the prospective oversight of MHSA funds subject to reversion after July 1, 2018. According to DHCS, the purpose of the regulations is to provide a clear framework for MHSA recipients to allocate, transfer, expend, and report the use of MHSA funds, and to establish rules and processes for reversion of funds. The regulations provide definitions of key fiscal terminology, address allocation and expenditure requirements of MHSA funds including investment gains, transfer of MHSA funds from the CSS account, funding and transfers from the prudent reserve, maintenance of records for such transactions, reversion of unspent MHSA funds, and an appeals process. The 45 day comment period for the regulations will expire in May 2019.

DHCS indicates its MHSUDS Information Notice 17-059, its pending fiscal regulations, and its withholding process with the Controller address the following recommendations:

Recommendation 1: Develop a fiscal reversion process
Recommendation 2: Clarify the treatment of earned interest
Recommendation 3: Establish an appropriate reserve level
Recommendation 5: Process for withholding MHSA funds for failure to submit timely reports

While DHCS agreed with the need to establish an appropriate reserve level (Recommendation 3), DHCS disagreed with the Auditor's recommended reserve level of no more than 33 percent. However, SB 192 (Beall), Chapter 328, Statutes of 2018, approved by the Governor in September 2018, sets the prudent reserve level at no more than 33 percent.

In response to Recommendation 4 (Analyze $225 million Mental Health Services Fund balance), DHCS reports it has identified the $225 million 2004 Mental Health Services Fund balance as an appropriation amount, rather than unexpended MHSA revenues, and no funds are available to distribute to counties.

DHCS disagrees with Recommendation 6 (Develop MHSA fiscal audit process independent of Short-Doyle Medi-Cal reviews). DHCS believes it cannot conduct a separate audit of MHSA expenditures without Short-Doyle cost report audits because, if the amount of available federal financial participation is unknown, the amount of non-federal expenditures for which MHSA funds would be required would also be unknown. However, DHCS indicates it is updating its fiscal audit and program oversight activities through regulations that are expected to be submitted in 2019.

In response to Recommendation 7 (Establish process for comprehensive program reviews), the 2018 Budget Act included four staff to begin conducting onsite program reviews beginning September 2018.

MHSOAC Response to Audit Findings and Recommendations. MHSOAC indicates it agrees with all of the findings and recommendations contained in the audit. In response to Recommendation 8 (Engagement and education to improve counties' Innovation plans), MHSOAC indicates it is committed to an ongoing process of engagement with county agencies and stakeholders to improve awareness of Innovative project proposals, approvals, and evaluation results. The 2018 Budget Act included resources for MHSOAC to hire a private contractor to assist counties in developing Innovation plans, with particular emphasis on diversion programs for individuals referred to a State Hospital as incompetent to stand trial.

In response to Recommendation 9 (Develop review process for PEI services), MHSOAC indicates it is providing support to a statewide learning community, which began meeting in March 2018, and will focus on policies, procedures, and strategies for counties to gather, report, and evaluate data collected to meet the PEI annual reporting requirements.

In response to Recommendation 10 (Statewide evaluation of triage grants), MHSOAC indicates it authorized $10 million in January 2018 to contract with a third party to perform statewide evaluations of the triage grants.

MHSOAC Fiscal Reporting Tool. According to MHSOAC, in 2015 the commission's Financial Oversight Committee requested staff to explore options for providing regular, descriptive information to the public about county MHSA expenditures, revenues, and unspent funds, and authorized staff to negotiate contracts to develop a series of web applications and tools to inventory and display key fiscal information. MHSOAC recently released its Fiscal Reporting Tool, which is based on county annual revenue and expenditure reports (ARER) submitted by the counties to DHCS and publicly reported. However, MHSOAC indicates DHCS has recalculated certain categories of funding certified by counties in ARERs in its estimate of funds subject to reversion, resulting in discrepancies between the fiscal reporting tool and DHCS fiscal reporting.

Questions About Oversight of MHSA Expenditures and Program Outcomes Persist. While DHCS, MHSOAC and county mental health programs are making progress on providing additional transparency regarding MHSA expenditures and programs, there are still areas of concern for the oversight of MHSA expenditures and program outcomes. While the Auditor's recommendations focused primarily on MHSA funds subject to reversion and recommended levels of prudent reserves, the audit highlights that the 59 mental health agencies had a total ending MHSA balance of more than $2.5 billion, which includes amounts subject to reversion, as well as funding that may be retained within the three year reversion period. Many counties may not be spending MHSA revenues until the second or third year after receipt. While the three year reversion period was meant to encourage expenditures of funds within a reasonable timeframe, it is unclear the extent to which counties are utilizing the three year reversion period as an additional source of fund reserves.

In addition to concerns about these additional fund balances, the timeliness of DHCS' oversight of the broader community mental health system also raises questions. In particular, DHCS indicates that auditing of Short-Doyle Medi-Cal cost reports are often several years in arrears. For this reason, according to DHCS, auditing of more recent MHSA expenditures is not possible. DHCS also indicates that, in addition to certain counties failing to submit required annual reports for MHSA expenditures,

some have failed to submit Short-Doyle Medi-Cal cost reports in a timely manner, as well. While DHCS indicates that adjustments resulting from cost report auditing is exempt from federal claiming time limits, and therefore no federal funding is at risk from the lack of timely cost report submission, the Legislature may wish to consider whether this extended reconciliation period is permissive of robust fiscal oversight of both MHSA funding and the broader community mental health system.

DHCS Requests Resources to Manage its MHSA Responsibilities. DHCS requests 13 positions and Mental Health Services Fund expenditure authority of $1.9 million in 2019-20 and $1.8 million annually thereafter to provide oversight and monitoring of the use of Mental Health Services Act funds, in response to a series of audits by the California State Auditor and hearings by the Little Hoover Commission. Funding for these positions would be partially offset by termination of a technical assistance and training contract with the California Institute for Behavioral Health Solutions (CIBHS) funded at $4.1 million annually. According to DHCS, this funding is no longer necessary as counties may use local funding to contract with an entity for training and technical assistance to support local needs.

DHCS has responsibility for a range of fiscal and programmatic oversight activities of MHSA-funded programs, including developing and administering ARERs to identify county revenues and expenditures, implementation and triennial review of performance contracts with county mental health plans, referrals of critical performance issues from MHSOAC, and withholding funds and requirements for corrective action plans for county non-compliance with applicable laws and regulations. The requested resources would fund the following activities:

Fiscal Oversight – Three positions

- **One Health Program Specialist I** position, **one Associate Governmental Program Analyst**, and **one Information Technology Associate** would be responsible for reviewing ARERs to determine compliance with applicable laws and regulations, monitoring county program expenditures, providing technical assistance to counties in preparing ARERs, calculating reversion for each MHSA component, communicating with counties regarding reversion, and developing and maintaining databases and fiscal web pages for stakeholder transparency.

Program Oversight – Four positions

- **Two Health Program Specialist I** positions and **two Associate Governmental Program Analysts** would evaluate Three-Year Program and Expenditure Plan or Annual Updates with ARERs prior to each county site review, develop county findings reports with narrative summary of non-compliance findings from on-site reviews, determine if county correction plans are sufficient, identify and participate in performance improvement projects, and monitor ongoing quality improvement.

Policy Development – Five positions

- **One Staff Services Manager I** position, **two Health Program Specialist I** positions and **two Associate Governmental Program Analysts** would update existing fiscal, program, and evaluation policy for each of the five components of the MHSA, develop policies for new requirements or processes necessary due to changes in statute or regulation, or based on findings identified through program oversight reviews.

DHCS also requests conversion of limited-term resources equivalent to **one Staff Services Manager II** to permanent. This position would oversee and manage the MHSA fiscal and program oversight activities of the requested staff positions.

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 and MHSOAC to respond to the following:

1. DHCS: Please provide a brief overview of the request for positions and resources for MHSA Oversight and Policy Development.

2. DHCS: Please describe the activities performed by CIBHS under the training and technical assistance contract proposed for termination. What funding would DHCS expect counties to provide to contract with their own vendor for this purpose?

3. DHCS: Please provide a brief overview of the fiscal regulations for MHSA funding released on March 22, 2019. How will these regulations improve transparency and accountability for MHSA funds provided to counties?

4. MHSOAC: Please describe the fiscal reporting tool developed by the commission and the challenges posed by the recalculation of ARER amounts by DHCS.

Issue 2: Early Psychosis Research and Treatment

Budget Issue. DHCS requests General Fund expenditure authority of $25 million in 2019-20. If approved, these resources would allow DHCS to provide grants to county mental health plans, nonprofit organizations, behavioral health providers, or academic institutions to identify and support appropriate interventions for California youth experiencing signs of early psychosis.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$25,000,000	$-
Total Funding Request:	**$25,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. According to the National Institute of Mental Health, psychosis describes a condition that affects the mind, where there has been some loss of contact with reality, or a psychotic episode. During a period of psychosis, a person's thoughts and perceptions are disturbed and the individual may have difficulty understanding what is real and what is not. Symptoms of psychosis may include delusions (false beliefs) and hallucinations (seeing or hearing things that others do not see or hear). Other symptoms include incoherent or nonsense speech, and behavior that is inappropriate for the situation. A person in a psychotic episode may also experience depression, anxiety, sleep problems, social withdrawal, lack of motivation, and difficulty functioning overall. Psychosis often begins when a person is in their late teens to mid-twenties. Three out of 100 people will experience psychosis at some time in their lives and about 100,000 adolescents and young adults nationwide experience their first episode of psychosis each year. According to the National Association of Mental Illness, several factors may contribute to psychosis, including genetics, trauma, substance use, physical illness or injury, or mental health conditions such as schizophrenia, schizoaffective disorder, bipolar disorder, or depression.

The average delay between the onset of symptoms and diagnosis and treatment of psychosis is 18.5 months. Clinical research suggests that early intervention at the first signs of psychosis results in better treatment outcomes. According to DHCS, there are emerging evidence-based strategies to identify, diagnose, and treat individuals with early signs of serious mental illness, including psychotic symptoms and behaviors. Some of these interventions include cognitive and behavioral psychotherapy, low doses of antipsychotic medications, family education and support, educational and vocational rehabilitation and coordinated case management.

DHCS requests one-time General Fund expenditure authority of $25 million in 2019-20 to provide grants to support projects that demonstrate innovative approaches to detect and intervene when young people have had, or are at risk of, psychosis. If approved, DHCS would seek competitive applications from entities, including but not limited to, county mental health plans, nonprofit organizations, behavioral health providers, or academic institutions to identify and support appropriate interventions for California youth experiencing the signs of early psychosis. The grants would not be allowed to supplant existing financial or resource commitments by a county or county mental health plan. Successful applicants may be required to provide a matching contribution to access larger grant awards over $1 million. The requested resources include up to $1 million for administrative resources for implementation of the program.

MHSOAC Early Psychosis Intervention Plus Program. AB 1315 (Mullin), Chapter 414, Statutes of 2017, established the Early Psychosis Intervention Plus (EPI Plus) Program at MHSOAC. The bill established an advisory committee to the commission to: 1) provide advice and guidance on approaches to early psychosis and mood disorder detection and intervention programs from an evidence-based perspective, 2) review and make recommendations on funding awards for early psychosis and mood disorder detection and intervention programs, 3) assist and advise on evaluation of the programs, 4) recommend a core set of standardized clinical and outcome measures programs would be required to collect, and 5) inform funded programs about opportunities to participate in clinical research studies. The bill established the Early Psychosis and Mood Disorder Detection and Intervention Fund to collect private or federal funding, but prohibited allocation of General Fund for this purpose. Once $500,000 is deposited in the fund, MHSOAC is authorized to develop a competitive grant program for counties to accomplish the following goals:

- Expanding the provision of high-quality, evidence based early psychosis and mood disorder detection and intervention services in the state.
- Improving access to effective services for transition-aged youth and young adults at high risk for, or experiencing, psychotic symptoms.
- Measuring more comprehensively and effectively, programmatic effectiveness and enrolled client outcomes of programs receiving awards.
- Improving client experience in accessing services and in working toward recovery and wellness.
- Increasing participation in school attendance, social interactions, personal bonding relationships, and active rehabilitation.
- Reducing unnecessary hospitalizations and inpatient days by using community-based services and improving access to timely assistance to early psychosis and mood disorder detection and intervention services.
- Expanding the use of innovative technologies for mental health information feedback, including technologies for treatment and symptom monitoring.
- Providing local communities with increased financial resources to leverage additional public and private funding sources.

The funding requires counties to provide a contribution of local funds and may not supplant existing county funding for these purposes. MHSOAC is also authorized to set aside up to 10 percent of the funding for clinical research studies.

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 and MHSOAC to respond to the following:

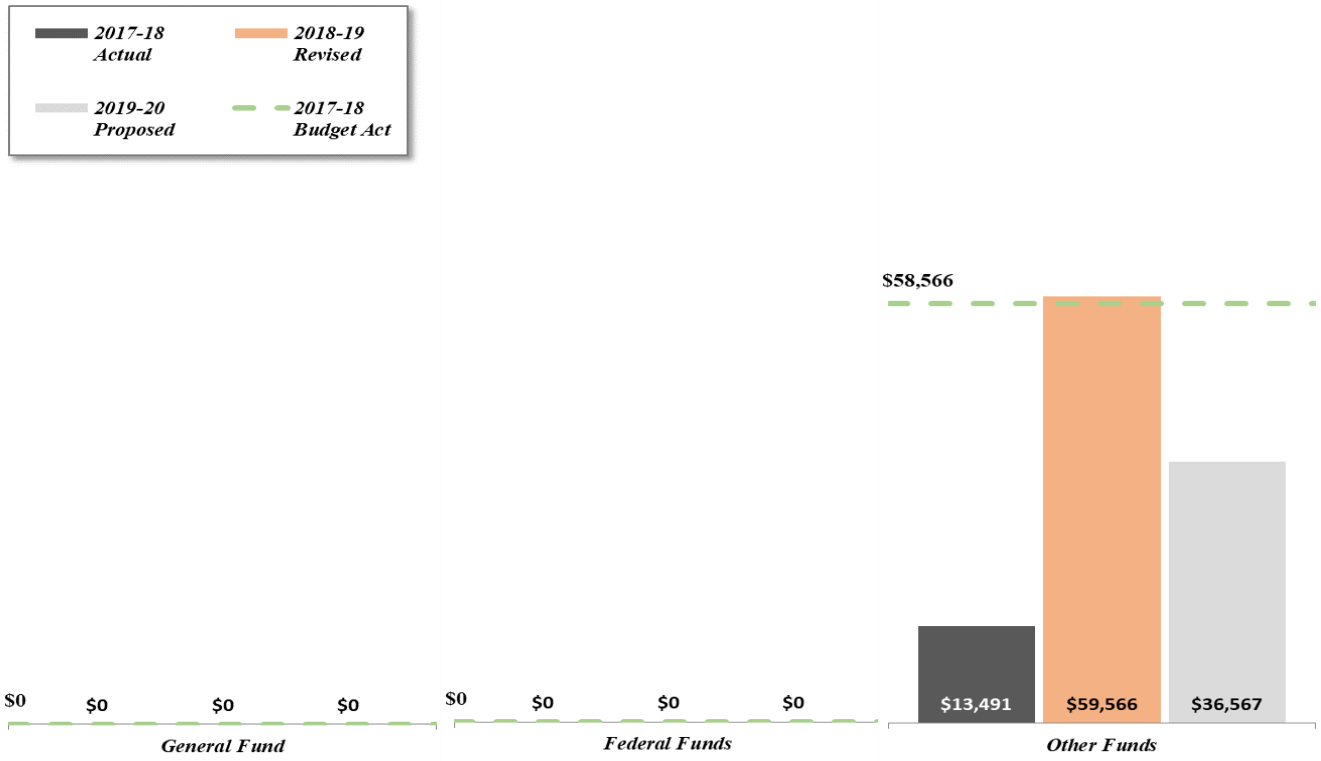
1. DHCS: Please provide a brief overview of this proposal.

2. MHSOAC: Please provide a status update on the EPI Plus program, including establishment of an advisory committee and implementation of a selection process for grant awards upon receipt of sufficient funding.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Overview

Mental Health Services Oversight & Accountability Commission – *Three-Year Funding Summary*
(dollars in thousands)



Mental Health Svcs Oversight & Accountability Commission - *Department Funding Summary*			
Fund Source	***2018-19 Budget Act***	***2018-19 Revised***	***2019-20 Proposed***
General Fund	$0	$0	$0
Federal Funds	$0	$0	$0
Other Funds	$58,566,000	$59,566,000	$69,896,000
Total Department Funding:	**$58,566,000**	**$59,566,000**	**$69,896,000**
Total Authorized Positions:	**26.6**	**26.6**	**27.6**
Other Funds Detail:			
Reimbursements (0995)	*$22,000,000*	*$-*	*$-*
Mental Health Services Fund (3085)	*$36,566,000*	*$59,566,000*	*$36,567,000*

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

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

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

Elected Officials:

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

12 members appointed by the Governor:

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

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

MHSOAC's responsibilities are as follows:

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—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 MHSOAC's mission and programs.

Issue 2: Transition Staff from Temporary to Permanent

Budget Issue. MHSOAC requests one position funded by existing expenditure authority from the Mental Health Services Fund. If approved, this position authority would transition a temporary help position to permanent status.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3085 – Mental Health Services Fund	$-	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**1.0**	**1.0**

* Position ongoing after 2020-21.

Background. According to the Department of Finance, Section 31.00 of the annual Budget Act provides departments the authority to administratively establish and reclassify positions within an existing appropriation, subject to certain criteria. In particular, administratively establishing positions is generally reserved for circumstances that mandate additional, previously unanticipated current year workload. In July 2018, the Department of Finance released Budget Letter 18-16 to provide guidance to departments regarding establishment of position authority for positions funded through the temporary help blanket.

The temporary help blanket provides staffing flexibility to meet operational needs and allows a department to temporarily hire above its total authorized positions. However, frequently workload managed by positions supported by the temporary help blanket initially believed to be temporary becomes permanent. Budget Letter 18-16 instructed departments during the 2019-20 budget development process to work with Department of Finance to analyze the use of blanket positions for permanent workload and submit a net-zero BCP to establish any necessary authorized positions. In addition to providing more transparency, converting blanket positions to authorized positions allows departments to receive accurate funding for employee compensation and retirement adjustments, which is not provided for blanket positions.

According to MHSOAC, its temporary help blanket supports **one Staff Services Analyst** position that provides administrative support to commission members and staff for commission meetings. This employee's current duties include meeting logistics, meeting material preparation, committee meeting support, travel coordination, training coordination, and front desk reception. MHSOAC indicates these duties are ongoing and is requesting to transition this position from temporary to permanent status. MHSOAC would redirect $78,000 from its existing operating expenses and equipment budget to fund the establishment of the requested position.

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.

Issue 3: Investment in Mental Health Wellness Act Triage Grant Funding

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.

Between 2013-14 and 2017-18, counties received the following grant funding for triage personnel:

County	Funding	County	Funding
Alameda	$2,666,797	Orange	$10,250,000
Butte	$1,075,070	Placer	$2,509,346
Calaveras	$262,686	Riverside	$7,441,142
Fresno	$3,073,100	Sacramento	$4,474,908
Lake	$184,794	San Bernardino	$8,113,498
Los Angeles	$31,177,000	San Francisco	$14,365,009
Madera	$1,360,596	Santa Barbara	$8,348,529
Marin	$1,099,922	Sonoma	$3,044,363
Mariposa	$699,428	Trinity	$497,713
Merced	$3,003,070	Tuolumne	$478,503
Napa	$1,323,635	Ventura	$7,573,671
Nevada	$2,477,628	Yolo	$1,728,234

The first round of grants, funded in 2014, resulted in more than 70,000 instances of individuals utilizing services provided through the grants. The program resulted in an increase in access and linkage to services and resources, utilization of peers in crisis intervention, a reduction in psychiatric hospitalizations and in stigma associated with mental illness, and improved consumer well-being and coordination of services.

The 2018 Budget Act reduced the Mental Health Service Fund expenditure authority by $12 million for an annual allocation of $20 million. In 2018, MHSOAC also requested to reappropriate unspent funding from the first round of triage grants, but the request was not included in the 2018 Budget Act. According to MHSOAC, the combined reduction in ongoing funding has resulted in a 29 percent reduction in available funding for triage grants to counties. MHSOAC reports the reduction led counties to scale back programs that were granted under a second round of funding prior to the reduction. MHSOAC worked with grantees to ensure the programs were in alignment with the requirements of the

triage program. However, the reduction in program funding ultimately led to reductions in schools served by triage personnel, reductions in personnel hours for crisis intervention and case management, and reductions in mobile treatment personnel.

Request for Restoration of Triage Personnel Funding. MHSOAC requests additional expenditure authority from the Mental Health Services Fund of $15 million to restore the funding reduction included in the 2018 Budget Act and dedicate these funds and an additional $3 million for partnerships between local educational agencies and county mental health plans.

SB 582 (Beall), currently pending in the Legislature, would require MHSOAC, when making grant funds available on and after July 1, 2021, to allocate at least 50 percent of those funds to local educational agency and county mental health plan partnerships. The bill also would provide annual expenditure authority from the Mental Health Services Fund of $15 million for establishment of these partnerships.

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 the triage grant program, the projects funded to date, and adjustments required by the reduction in funding in the 2018 Budget Act.

2. Please present the proposed restoration of triage grant funding, including the intended use of these restored funds.

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

Issue 1: Overview and Reappropriation of Investment in Mental Health Wellness Funding

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

California Health Facilities Financing Authority Three-Year Funding Summary			
Fund Source	**2017-18**	**2018-19**	**2019-20**
	Actual	***Revised***	***Proposed***
0001 – General Fund	$1,000	$67,499,000	$-
0904 – CHFFA Fund	$14,480,000	$20,897,000	$9,090,000
0995 – Reimbursements	$-	$2,800,000	$-
3085 – Mental Health Services Fund	$4,253,000	$160,453,000	$144,000,000
6046 – Children's Hospital Fund	$526,000	$40,000,000	$40,362,000
6079 – Children's Hosp. Bond Act Fund	$30,689,000	$100,775,000	$75,775,000
6084 – No Place Like Home Fund	$151,000	$149,000	$-
8073 – CHAMP Acct, CHFFA Fund	$-	$5,600,000	$5,600,000
Total Department Funding:	**$50,100,000**	**$398,173,000**	**$274,827,000**
Total Authorized Positions:	**16.4**	**17.5**	**17.5**

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

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

five University of California Children's Hospitals are eligible for $69.2 million each through Proposition 61 and Proposition 3 combined. As of December 2018, the following grants have been approved under Proposition 61 and Proposition 3:

- Children's Hospital and Research Center Oakland
  - Prop. 61: $73.9 million (six completed projects)
  - Prop. 3: $97.4 million (four completed projects)
- Valley Children's Health Care (formerly Children's Hospital Central California)
  - Prop. 61: $73.9 million (six completed projects)
  - Prop. 3: $70 million (seven completed projects; one project in progress; $27.4 million remaining to be disbursed)
- Children's Hospital Los Angeles
  - Prop. 61: $72.2 million (one completed project)
  - Prop. 3: $97.4 million (one completed project)
- Children's Hospital Orange County
  - Prop. 61: $73.9 million (five completed projects)
  - Prop. 3: $97.4 million (one completed project)
- Earl and Loraine Miller Children's Hospital Long Beach
  - Prop. 61: $73.9 million (one completed project)
  - Prop. 3: $34.7 million (one completed project; two projects in progress; $62.7 million remaining to be disbursed)
- Loma Linda University Children's Hospital
  - Prop. 61: $26.1 million (two completed projects; one project in progress; $47.9 million remaining to be disbursed)
  - Prop. 3: $- (one project in progress; $97.4 million remaining to be disbursed)
- Lucile Salter Packard Children's Hospital at Stanford
  - Prop. 61: $73.6 million (one completed project)
  - Prop. 3: $97.4 million (one completed project)
- Rady Children's Hospital San Diego
  - Prop. 61: $73.9 million (three completed projects)
  - Prop. 3: $88.9 million (seven completed projects; one project in progress; $8.5 million remaining to be disbursed)
- Mattel Children's Hospital at UCLA
  - Prop. 61: $29.8 million (one completed project)
  - Prop. 3: $24.9 million (one completed project; one project in progress; $14.1 million remaining to be disbursed)
- UC Davis Children's Hospital
  - Prop. 61: $29.8 million (three completed projects)
  - Prop. 3: $18.7 million (two completed projects; one project in progress; $20.3 million remaining to be disbursed)
- University Children's Hospital at UC Irvine
  - Prop. 61: $29.8 million (one completed project)
  - Prop. 3: $- (two projects in progress; $39 million remaining to be disbursed)
- UC San Diego Children's Hospital
  - Prop. 61: $29.8 million (one completed project)

  - Prop. 3: $39 million (one project in progress)
- UC San Francisco Children's Hospital
  - Prop. 61: $29.8 million (one completed project)
  - Prop. 3: $39 million (one completed project)

According to CHFFA, after each children's hospital received its maximum grant award, there was $8.2 million remaining due to accrued interest and lower than expected administration costs. CHFFA developed regulations allowing a third and fourth round of funding to disburse the remaining funds. In the third round of funding, four University of California Children's Hospitals each received an additional $128,121, while eight non-profit children's hospitals each received an additional $944,551.

New Children's Hospital Bond Act Approved in 2018. In November 2018, voters approved Proposition 4, the Children's Hospital Bond Act of 2018, which authorizes $1.5 billion in general obligation bonds to fund a new round of capital improvements at California children's hospitals. Eight non-profit children's hospitals are eligible for up to $135 million each, five University of California Children's Hospitals are eligible for $54 million each, and an estimated 160 hospitals that provide services in the California Children's Services program are eligible for a total of $150 million, or $8 to $15 million each. CHFFA expects the deadline for first round funding applications for the new program will be in March or April 2020.

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

Clinic Grant Programs. AB 2875 (Cedillo), Chapter 99, Statutes of 2000, established the Cedillo-Alarcon Community Clinic Investment Act of 2000 and allocated $50 million to CHFFA for the purpose of awarding grants to eligible primary care clinics for capital outlay projects. In 2004, as part of the Anthem-Well Point merger, $35 million dollars was allocated to CHFFA for the purpose of awarding grants to eligible health care facilities providing service to underserved communities throughout California. To qualify for funding, the proposed project must be a health facility, operated by a private, non-profit corporation or association, city, city and county, county, or hospital district. Approximately 150 non-profit community clinics received grants for infrastructure improvement.

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

- Receive no more than $30 million in annual gross revenues.

- Located in a rural Medical Service Study Area as defined by the California Workforce Policy Commission.
- A district hospital.

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

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

Clinic Lifeline Grant Program. The 2017 Budget Act established the Clinic Lifeline Grant Program, which authorized the expenditure of $20 million of reserves in the HELP II program to assist small and rural health facilities, including community based clinics, that may be adversely affected financially by a reduction or elimination of federal government assistance and that have little to no access to working capital. Clinics are eligible for up to $250,000 each for core operating expenses and must either have less than $10 million in annual operating expenses, be located in a rural medical service study area, or be operated by a district hospital or health care district. In June 2018, 42 clinics received $8.3 million during the first round of funding awards. Applications for funding are accepted on a rolling basis. According to CHFFA, there is approximately $11.2 million remaining to be disbursed under the Lifeline Grant Program.

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

Investment in Mental Health Wellness Grant Program. SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, provided $142.5 million in one-time General Fund, $4 million in ongoing Mental Health Services Act (MHSA) funding, and $2.8 million in federal matching funds (reimbursements) to provide grants for community-based mental health crisis support. Known as the Investment in Mental Health Wellness Act of 2013, SB 82 authorized CHFFA to disburse funds to California counties or their nonprofit or public agency designees to develop mental health crisis support

programs. The one-time General Fund grants support capital projects to increase capacity for crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and peer respite. The MHSA and federal funds grants support personnel costs associated with operation of mobile crisis support teams. The grants support capital improvement, expansion and limited start-up costs.

CHFFA conducted six funding rounds for competitive grant awards, approving a total of 56 grants for 79 projects (69 capital and 10 personnel) in 41 counties. Approximately $136.5 million of capital funding (General Fund) and $4 million of MHSA funding for mobile crisis support team personnel has been encumbered. As of September 2018, $62.4 million of total funding has been disbursed. Once projects are completed, these grants will add the following mental health crisis support resources:

- 110 mobile crisis vehicles (or equivalent IT equipment)
  - Status (Sept 2018): 110 purchased

- 57.25 mobile crisis personnel
  - Status (Sept 2018): 57.25 individuals hired

- 782 crisis stabilization and crisis residential treatment beds
  - Status (Sept 2018):
    - 152 crisis stabilization beds added; additional 422 have a site secured, are under construction, or awaiting licensing and certification
    - 110 crisis residential treatment beds added; additional 91 have a site secured, are under construction or awaiting licensing and certification

- 12 peer respite beds
  - Status (Sept 2018): eight added; six in the planning stage

CHFFA Proposes Reappropriation to Align Expenditure Authority. The 2016 Budget Act authorized $30 million for children's mental health crisis services, which included $16 million General Fund and $14 million Mental Health Service Fund. The 2017 Budget Act reverted the $16 million General Fund authority and replaced it with $16.4 million from the Mental Health Services Fund. However, the first allocation of $14 million Mental Health Service Fund was made available for encumbrance or expenditure until June 30, 2019, the second allocation of $16.4 million Mental Health Service Fund was made available until June 30, 2020, and the remaining General Fund resources from previous allocations were made available for liquidation of encumbrances until December 31, 2021. CHFFA proposes reappropriation budget bill language to align the encumbrance and expenditure periods for these funds until June 30, 2024, to improve operation of the children's crisis funding under the Investment in Mental Health Wellness program. The language is as follows:

0977-492–Reappropriation, California Health Facilities Financing Authority. Notwithstanding any other provision of law, the balances of the appropriations provided in the following citations are reappropriated to fund crisis residential treatment, crisis stabilization, mobile crisis support teams, and/or family respite care approved by the California Health Facilities Financing Authority and shall be available for encumbrance or expenditure until June 30, 2024:

0001–General Fund

(1) Item 0977-101-0001, Budget Act of 2013 (Chs. 20 and 354, Stats. 2013), as reappropriated by Item 0977-490, Budget Act of 2016 (Ch. 23, Stats. 2016).
(1) 50–Mental Health Wellness Grants

3085–Mental Health Services Fund

(1) $10,815,000 in Item 0977-101-3085, Budget Act of 2016 (Ch. 23, Stats. 2016) appropriated in Program 0890–Mental Health Wellness Grants.

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 CHFFA to respond to the following:

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

2. Please provide a status update on implementation of the Children's Hospital Bond Act of 2018 (Proposition 4).

3. Please provide a status update on implementation and awards for the Clinic Lifeline Grant Program.

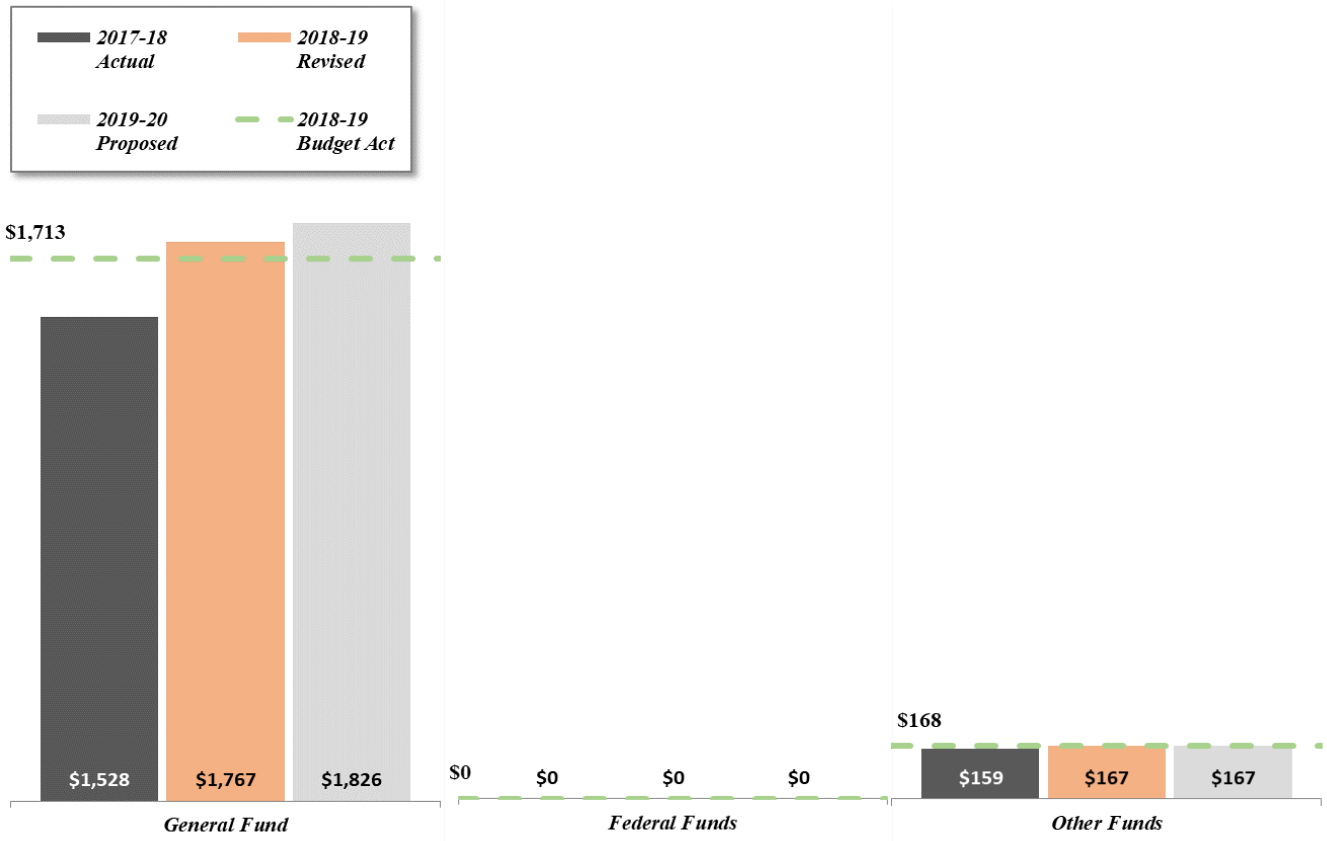
4. Please provide a status update on implementation of the Investment in Mental Health Wellness Grant Program.

5. Please present CHFFA's proposed reappropriation language for the Investment in Mental Health Wellness Grant Program.

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: Overview

Department of State Hospitals – *Three-Year Funding Summary*
(dollars in millions)



Department of State Hospitals - *Department Funding Summary*			
Fund Source	***2018-19 Budget Act***	***2018-19 Revised***	***2019-20 Proposed***
General Fund	$1,713,168,000	$1,766,643,000	$1,825,789,000
Federal Funds	$0	$0	$0
Other Funds	$167,508,000	$167,499,000	$167,346,000
Total Department Funding:	**$1,880,676,000**	**$1,934,142,000**	**$1,993,135,000**
Total Authorized Positions:	**10088.7**	**10088.7**	**11006.4**
Other Funds Detail:			
CA State Lottery Education Fund (0814)	*$32,000*	*$23,000*	*$23,000*
Reimbursements (0995)	*$167,476,000*	*$167,476,000*	*$167,323,000*

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 88.6 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.

- **Mentally Disordered Offenders (MDO)** – MDO patients are parolees who meet the following six criteria for MDO 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. MDO 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 MDO.

- **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.

	2018-19	2019-20
Population by Hospital		
Atascadero	1,093	1,106
Coalinga	1,403	1,403
Metropolitan	906	1,046
Napa	1,278	1,278
Patton	1,484	1,494
Population Total	**6,164**	**6,327**
Population by Commitment Type		
Incomptent to Stand Trial (IST)	1,465	1,613
Not Guilty by Reason of Insanity (NGI)	1,393	1,399
Mentally Disordered Offender (MDO)	1,421	1,427
Sexually Violent Predator (SVP)	953	953
Lanterman-Petris-Short Civil Commitments (LPS)	700	703
Coleman Referrals	230	230
Dept. of Juvenile Justice (DJJ)	2	2
Jail-Based Competency Treatment (JBCT) Programs		
Kern Admission, Evaluation, and Stabilization (AES) Center	60	60
Riverside JBCT	22	22
Sacramento JBCT (Male and Female)	42	42
San Bernardino JBCT	123	143
San Diego JBCT	28	28
Sonoma JBCT	11	11
Stansislaus JBCT	11	11
Monterey JBCT	15	15
San Joaquin JBCT	10	10
Solano JBCT	12	12
Mendocino JBCT	TBD	TBD
Mariposa JBCT	TBD	TBD
Butte JBCT	5	5
Southern CA County A JBCT	5	5
Central CA County B JBCT	0	5
Northern CA County C JBCT	0	6
Northern CA County D JBCT	0	48
Southern CA County E JBCT	0	10
Total JBCT Programs	**344**	**433**

Figure 1: State Hospital Population by Hospital, Commitment Type and JBCT Programs
Source: *2019-20 Governor's Budget Proposals and Estimates, Department of State Hospitals, January 2019*

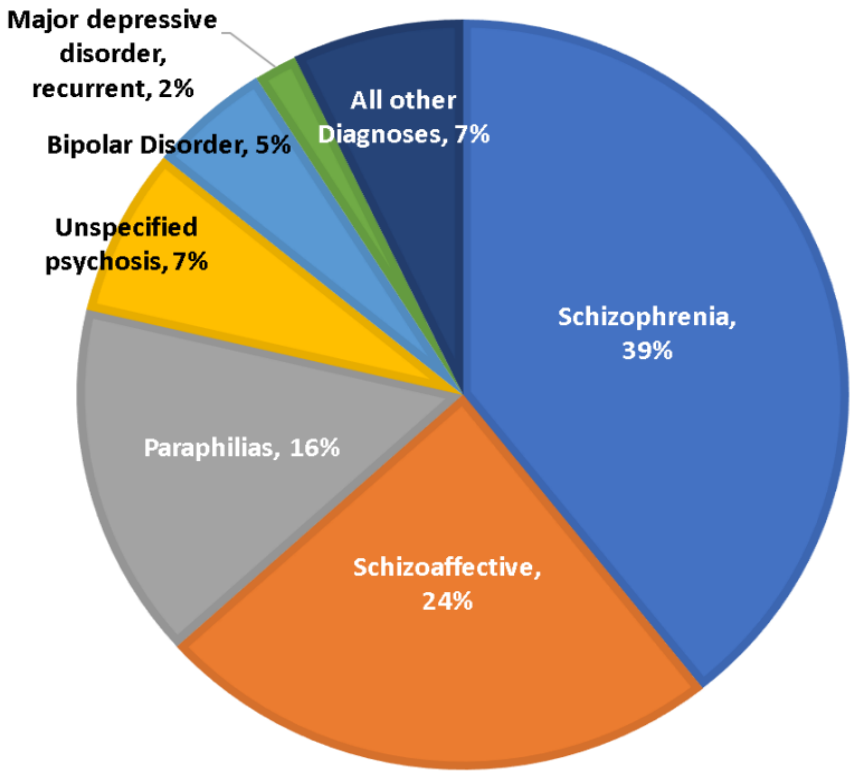


Figure 2: State Hospital Population By Major Diagnosis
Source: *2019-20 Governor's Budget Proposals and Estimates, Department of State Hospitals, January 2019*

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 MDO, *Coleman*, IST, and NGI patients. Atascadero has an operational bed capacity of 1,184.

- **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 MDO, *Coleman*, and SVP patients. Coalinga has an operational bed capacity of 1,286.

- **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, MDO, and NGI patients and has an operational bed capacity of 826.

- **Napa State Hospital** – Located in Napa County, Napa has an "open" style campus within a security perimeter. Napa primarily treats IST, NGI and LPS patients and has an operational bed capacity of 1,255.

- **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, MDO, and NGI patients and has an operational bed capacity of 1,527.

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 the State Hospital system, including major inpatient categories, treatment programs, and significant organizational changes.

Issue 2: State Hospitals Program Updates

Budget Issue. DSH requests resources to support the following program updates in its Governor's Budget Estimate.

Program Update: Metropolitan State Hospital Bed Expansion. DSH requests 119.3 positions and General Fund expenditure authority of $18.6 million in 2019-20 and 130 positions and General Fund expenditure authority of $20.1 million in 2020-21 and annually thereafter to activate 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 currently house 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.

The 2017 Budget Act included 22.2 positions in 2017-18, and 38.5 positions and $12.4 million in 2018-19 to prepare for the expansion by relocating LPS patients and hiring hospital police officers. The 2018 Budget Act included a reduction of 10.1 positions and savings of $1.1 million in 2017-18 due to delays in activations. The 2018 Budget Act also included 162.8 positions and $24.8 million in 2018-19 and 342.2 positions and $50.6 million in 2019-20 for patient movement and activation of four new forensic units. The current budget request activates and provides staff for approximately 236 forensic beds between March and November 2019 to treat IST patients.

Program Update: Jail-Based Competency Treatment (JBCT) Programs. DSH reports net General Fund savings of $253,000 in 2018-19 composed of one-time cost savings of $1.9 million at San Bernardino and San Joaquin JBCT programs, offset by $1.6 million in increased costs at Sacramento, Sonoma, Mariposa, Solano, Mendocino, and Butte JBCT programs. DSH requests General Fund expenditure authority of $1.1 million in 2019-20, and $1.7 million in 2020-21 and annually thereafter to activate jail-based competency treatment beds for the treatment of IST patients in county jails, pursuant to approval of program expansions in previous budget requests. DSH contracts with county jail facilities to provide restoration of competency services in jails, treating IST patients with lower acuity and that are likely to be quickly restored to competency. DSH expects these programs to increase bed capacity by 254 in 2018-19 and 274 in 2019-20.

DSH also requests General Fund expenditure authority of $191,000 in 2018-19, $11 million in 2019-20, and $11.4 million in 2020-21 and annually thereafter for the proposed activation of new JBCT programs. DSH proposes: 1) an April 2019 activation of a five-bed JBCT program in a Southern California county; 2) a July 2019 activation of a five-bed JBCT program in a Central California county, a six-bed JBCT program in a Northern California county, and a 48-bed JBCT program in a Northern California county; and 3) an October 2019 activation of a 10-bed JBCT program in a Southern California County. According to DSH, the cost estimate is based on an expected per diem rate of $420 per patient.

DSH is also requesting General Fund expenditure authority of $259,000 annually to support patients' rights advocates. Existing law requires patients' rights advocates to provide advocacy services for, and conduct investigations of alleged or suspected abuse and neglect of, including deaths of, persons with

mental disabilities residing in state hospitals. According to DSH, these requirements include patients in JBCT programs. If approved, these resources would allow for 6.5 patients' rights advocates based on a 60 patient caseload for each advocate.

Program Update: Patient Driven Operating Expenses and Equipment. In a 2015 report, the Legislative Analyst's Office made recommendations for improvement in the DSH budgeting methodology, including the establishment of a standardized per patient operating expenses and equipment cost estimate and an annual budget adjustment based on patient census. According to DSH, the average operating cost per patient is $19,534 across all five state hospitals, which represents an increase of 18 percent over the last six years. This increase is primarily driven by the costs of pharmaceuticals and outside hospitalization.

Over the past five years, DSH reports its patient population has increased by 547 beds, including expansions of 236 secured beds at Metropolitan State Hospital. However, DSH did not budget for operating expenses and equipment for much of these new beds. The 2018 Budget Act included $3.7 million for the operating expenses and equipment for the 236 secured beds at Metropolitan. Due to delays in unit activations, DSH reports 140 of those beds will not be activated as expected, resulting in $2.2 million General Fund savings in 2018-19.

DSH requests General Fund expenditure authority of $10.5 million annually to support the full cost of operating expenses and equipment for the 547 beds activated since 2012-13 in the five state hospitals.

Program Update: Hospital Police Officer Academy. The DSH Office of Protective Services (OPS) provides safety and security to patients, staff, and the community through competent, professional law enforcement services, while facilitating compassionate treatment of patients. OPS is supported by approximately 657 Hospital Police Officers (HPOs) across all five state hospitals. New HPO cadets are required to attend the DSH Police Academy, a 14 week program to ensure proper training on requirements and standards of the HPO classification.

According to DSH, the Hospital Police Academy historically ran two sessions annually of 32 cadets each. The 2017 Budget Act included $7.8 million in 2017-18 and $12.4 million and three limited-term positions in 2018-19 to expand to three academies of 50 cadets each. The academy expansion was necessary to accommodate the need for additional HPOs for the new secured bed space at Metropolitan State Hospital.

DSH requests conversion of three limited-term positions to permanent and General Fund expenditure authority of $5.8 million annually to continue the specialized expanded academy. DSH reports it has 98.7 HPO vacancies as of September 2018, primarily due to an academy failure rate of 8.2 percent, attrition, and a high proportion of law enforcement staff eligible for retirement.

Program Update: Enhanced Treatment Program (ETP) Staffing. AB 1340 (Achadjian), Chapter 718, Statutes of 2014, authorized DSH to establish an ETP pilot project to expand the range of clinical treatment options for patients determined to be at the highest risk of dangerous behavior or violence against other patients or hospital staff and cannot be safely treated in a standard treatment environment. According to DSH, the risk of violence against other patients or hospital staff imposes both a threat to health and safety, as well as a barrier to the effective treatment of other patients who may fear for their

physical safety in a standard treatment environment with a potentially violent patient. The pilot project period extends approximately five years from the first patient admitted to the ETP and imposes certain requirements on admission and treatment within an ETP.

Patients are evaluated for admission to an ETP based on requirements contained in AB 1340. A patient referred to an ETP by state hospital clinical staff is assessed by a dedicated forensic psychologist within three business days to make an initial determination regarding the appropriateness of the referral. If the referral is appropriate, the patient is further assessed by a panel comprised of a state hospital medical director, psychiatrist, and psychologist to certify admission to the ETP within seven days of the original referral. Upon admission, a forensic needs assessment team psychologist conducts a violence risk assessment and develops a treatment plan in writing and, if possible, with the collaboration of the patient. The treatment plan, which must be reviewed and updated every ten days, must include information about the patient's mental health status and diagnoses, prescribed medications, goals of treatment, planned interventions and methods, documentation of success in meeting objectives, evaluation of the factors contributing to or detracting from the patient's progress, an activity plan, plans for other services needed by the patient, discharge criteria, goals for an aftercare plan in a standard treatment environment upon discharge, and a plan for post-discharge follow up.

In addition to the admission and treatment criteria, each ETP has specified staff-to-patient ratios, housing and facility requirements, and accessibility requirements. Each ETP is also required to maintain an independent patients' rights advocate to provide advocacy services to patients admitted to an ETP.

The 2017 Budget Act authorized 44.7 positions and $8 million in 2017-18 and 115.1 positions and $15.2 million annually thereafter to activate the first two ETP units at Atascadero State Hospital. According to DSH, construction for the first unit began in September 2018 and was completed February 2019, while construction for the second unit was expected to begin February 2019 and be completed June 2019.

The 2018 Budget Act included reversion of General Fund savings of $4.9 million General Fund in 2017-18 and $4.6 million in 2018-19 related to construction delays of the ETP units. For 2019-20, the 2018 Budget Act included 60.3 positions and General Fund expenditure authority of $8.3 million annually thereafter to fund an additional ETP unit at Atascadero, as well as one unit at Patton. According to DSH, construction for the third unit at Atascadero is expected to begin June 2019 and be completed in September 2019, while construction for the unit at Patton is expected to begin September 2019 and be completed in January 2020.

DSH expects General Fund savings in 2019-20 of $1.8 million due to a five month delay for the ETP unit at Patton. The expected construction timelines are as follows:

Units/Hospital	Construction Initiated	Construction Completed
DSH-Atascadero Unit 1	September 24, 2018	February 11, 2019
DSH-Atascadero Unit 2	February 11, 2019	June 3, 2019
DSH-Atascadero Unit 3	June 3, 2019	September 23, 2019
DSH-Patton Unit 1	September 2, 2019	January 27, 2020

Program Update: Lanterman-Petris-Short (LPS) Population and Personal Services Adjustment. 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. Counties reimburse state hospitals for the costs of treatment for LPS patients.

According to DSH, the focus of treatment for the LPS population is on psychiatric stabilization and psychosocial treatments to reduce the risk of danger to themselves or others and develop basic life skills to function optimally in a lower level of care in the community. In 2017-18, DSH had a budgeted LPS capacity of 628. As of July 2018, DSH reported a total LPS census of 690. The 2018 Budget Act included a $20.1 million adjustment in reimbursement authority to account for actual expenditures for LPS patients.

DSH requests additional reimbursement expenditure authority of $606,000 in 2019-20 and annually thereafter. This additional authority would allow DSH to have sufficient authority to accept the expected LPS caseload from county commitments. The amount of this additional authority was calculated based on 2018-19 projected expenditures of $157.4 million, which is $606,000 less than its 2018-19 authority of $156.7 million.

Program 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), Mentally Disordered Offenders (MDO), felony Incompetent to Stand Trial (IST) and Mentally Disordered Sex Offenders. 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 currently contracts for one 17 bed STRP in Los Angeles County. A 16 bed STRP in Fresno County was closed in November 2017.

DSH requests General Fund expenditure authority of $1 million in 2019-20 and annually thereafter to fund its contracted CONREP caseload of 666 clients. Due to rising housing costs, DSH was required to reduce its CONREP caseload to 621 clients to remain within its budgeted authority. If approved, these additional resources will allow DSH to cover the cost increases for each of the housing types in the program.

Program Update: Forensic CONREP – Sexually Violent Predator (SVP) Program. Beginning in 1996, Sexually Violent Predators (SVP) were added to the CONREP population and are conditionally released to their county of domicile by court order with sufficient funding to provide treatment and supervision services. According to DSH, the CONREP-SVP program offers patients direct access to an array of mental health services with a forensic focus, as well as regularly scheduled sex offender risk

assessments, polygraph testing, and review of Global Position System (GPS) data and surveillance. DSH reports there are currently 14 patients residing in a house and two in a motel throughout California within the county of commitment. DSH has established two rate structures for CONREP-SVPs: 1) $310,000 per SVP where a permanent residence has been established, and 2) $653,000 per CONREP-SVP when ordered as a transient release.

DSH requests General Fund expenditure authority of $768,000 in 2018-19 and $2.1 million annually thereafter. If approved, these resources would support an expected caseload increase of four SVPs in 2018-19, including two transient releases, for a total of 21 SVPs conditionally released to the community by June 2019, and an additional two SVPs released by June 2020 for a total caseload of 23.

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 updates referenced in this item.

Issue 3: Incompetent to Stand Trial – Diversion and Community-Based Treatment

Background. The Department of State Hospitals (DSH) admits individuals found 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, DSH expects 815 individuals in the IST population will be housed in county jails in 2018-19 because they are awaiting placement into a state hospital bed or jail-based competency treatment program. This backlog, which has grown significantly in recent years, places operational and fiscal stress on county jails and may violate the 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.

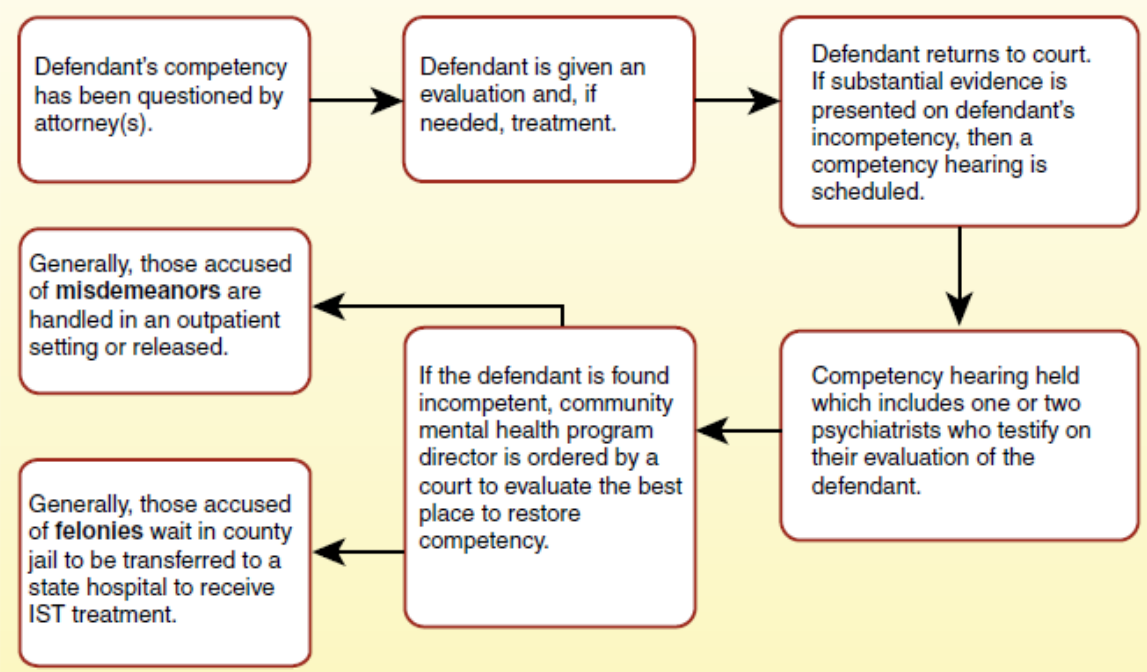


Figure 1: Incompetent to Stand Trial Commitment Process
Source: "*An Alternative Approach:Treating the Incompetent to Stand Trial", Legislative Analyst's Office, Jan 2012*

Long-Standing Issues with IST Backlog. Since the 2007-08 fiscal year, the backlog of IST referrals awaiting treatment in state hospitals has grown from between 200 and 300 to 836 as of July 2018. In 1972, the United States Supreme Court found in *Jackson v. Indiana* that a person committed on account of his or her incapacity to proceed to trial cannot be held for longer than the reasonable period of time necessary to determine whether the individual is likely to attain capacity. California law requires state hospital or outpatient facility staff to report to the court within 90 days on the status of the defendant's restoration to competency. Based on this 90 day requirement, several court rulings have recommended that a "reasonable" time to transfer IST patients for treatment is no more than 30 to 35 days. Many IST patients remain in county custody for longer, which may violate these patients' due process rights. In addition, the housing of IST patients in county jails while they await availability of treatment beds in state hospitals places stress on county jail systems.

Incompetent to Stand Trial Diversion Program. In the 2018 Budget Act, the Legislature approved trailer bill language and General Fund expenditure authority of $100 million over three years to promote community mental health treatment and diversion for individuals determined to be, or at risk of being determined to be, incompetent to stand trial. Specifically, the program included the following components:

- Diversion of Individuals with Mental Disorders – Grants pre-trial diversion to defendants, including postponement of prosecution and referral to mental health treatment, under the following conditions:

    1. The court is satisfied the defendant suffers from a qualifying mental disorder including, but not limited to, schizophrenia, schizoaffective disorder, or posttraumatic stress disorder, but excluding antisocial personality disorder, borderline personality disorder, and pedophilia.

2. The court is satisfied the defendant's mental disorder played a significant role in the commission of the charged offense.
3. A qualified mental health expert determines the defendant would respond to mental health treatment.
4. The defendant consents to diversion, waives his or her right to a speedy trial, and agrees to comply with treatment as a condition of diversion.
5. The court is satisfied the defendant will not pose an unreasonable risk of danger to public safety.
6. The court is satisfied the recommended treatment program will meet the specialized mental health needs of the defendant.
7. The period of diversion shall be no longer than two years.

If the court concludes a defendant has substantially complied with the requirements of diversion, has avoided significant new violations of law, and has a plan in place for long-term mental health care, the court shall dismiss the charges that prompted the initial diversion.

- Community-Based Treatment – Provides $100 million over three years to assist counties in providing diversion for individuals with serious mental illnesses who may otherwise be found incompetent to stand trial. These county programs will provide clinically appropriate or evidence-based mental health treatment and wraparound services across a continuum of care to:

  - Individuals diagnosed with schizophrenia, shizoaffective disorder, or bipolar disorder who could potentially be found incompetent to stand trial.
  - Individuals for which there is a significant relationship between the individual's mental disorder and the charged offense or between the individual's conditions of homelessness and the charged offense.
  - Individuals that do not pose an unreasonable risk of danger to public safety if treated in the community.

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 status update on the community-based treatment diversion program authorized in the 2018 Budget Act, including counties receiving awards, brief descriptions of program services, and county matching requirements.

2. Please describe how DSH intends to evaluate the outcomes for each of the programs funded by the community-based treatment diversion program.

Issue 4: Atascadero – Potable Water Booster Pump System

Capital Outlay Budget Issue. DSH requests General Fund expenditure authority of $113,000 in 2019-20. If approved, these resources would allow DSH to support preliminary plans for a project to install a potable water booster pump system to serve Atascadero State Hospital's main water system.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$113,000	$-
Total Funding Request:	**$113,000**	**$-**

Background. According to DSH, Atascadero State Hospital's water supply is generated from five underground wells located on the northeast part of the campus. Each well station has a pump that sends water from the wells to an adjacent underground reservoir, from which it is pumped to a one million gallon storage tank on top of a hill. The storage tank then supplies water to the hospital by gravity feed. This gravity line supports the hospital's fire sprinkler system, as well as patient showers, kitchens, and bathrooms.

DSH reports when multiple users draw water, the hospital's main water pressure drops considerably. Water pressure during normal operations averages between 40 and 50 pounds per square inch (psi), which is below the necessary 60 psi required for normal facility operations. According to DSH, the reduced pressure could compromise the hospital's fire sprinkler system in the event of a fire.

DSH requests General Fund expenditure authority of $113,000 in 2019-20 to support preliminary plans for a project to install a potable water booster pump system to serve Atascadero State Hospital's main water system. DSH expects the total project will cost $2.1 million, including $113,000 for preliminary plans, $229,000 for working drawings, and $1.8 million for construction. If approved, this request would only support preliminary plans for the project.

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 5: Increased Court Appearances and Public Records Act Requests

Budget Issue. DSH requests 5.5 two-year limited-term positions and General Fund expenditure authority of $767,000 in 2019-20 and 2020-21. If approved, these positions and resources would allow DSH to address increases in court hearings at which DSH attorneys are required to appear, as well as increases in requests pursuant to the Public Records Act.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$767,000	$767,000
Total Funding Request:	**$767,000**	**$767,000**
Total Requested Positions:	**5.5**	**5.5**

Background. Since the 2007-08 fiscal year, the backlog of individuals determined incompetent to stand trial (IST) awaiting treatment in state hospitals has grown from between 200 and 300 to 836 as of July 2018. In 1972, the United States Supreme Court found in Jackson v. Indiana that a person committed on account of his or her incapacity to proceed to trial cannot be held for longer than the reasonable period of time necessary to determine whether the individual is likely to attain capacity. California law requires state hospital or outpatient facility staff to report to the court within 90 days on the status of the defendant's restoration to competency. Based on this 90 day requirement, several court rulings have recommended that a "reasonable" time to transfer IST patients for treatment is no more than 30 to 35 days. Many IST patients remain in county custody for longer, which may violate these patients' due process rights.

According to DSH, the ongoing and growing IST waitlist has resulted in a significant amount of related litigation, including:

- County public defenders filing motions seeking Orders to Show Cause (OSCs) why DSH should not be held in contempt for not timely admitting IST patients, and seeking sanctions.
- County public defenders filing motions under Code of Civil Procedure section 177.5 seeking sanctions against DSH for not complying with superior court orders to admit IST patients by a date specified.
- Superior courts issuing OSCs seeking to sanction DSH for not timely admitting IST patients or violating court orders to admit patients.
- Courts setting status conferences, with mandatory appearances by DSH, to explain why the patients have not been transported, or admitted to its hospitals, or considering whether to hold DSH in contempt.
- County public defenders filing motions seeking standing orders requiring that DSH admit IST patients by a specified time-frame.
- County public defenders filing writs of habeas corpus, writs seeking release of IST patients held in jail awaiting admission to DSH, and writs of mandate requiring DSH to comply with various specified time-frames for admission.
- The ACLU and private law-firms filing state and federal civil-rights cases seeking injunctive relief and damages for alleged violations of IST patients' constitutional rights.

DSH attorneys must respond, object, appear, or serve as staff counsel to represent DSH in each of these types of motions, status conferences, OSCs, standing-order requests, writs, and civil-rights litigation. The courts often provide less than one week notice to appear to defend DSH against an OSC and it is not uncommon for DSH to be provided only 24 or 48 hours of notice for a contempt hearing. DSH attorneys are required to constantly be ready to travel on short notice anywhere from two to four hours away to appear on DSH's behalf in county superior courts to advocate against findings of contempt or sanctions.

In addition to increased legal workload, DSH reports the number of Public Records Act requests it receives annually has increased by 220 percent between 2012 and 2018. The Public Records Act (PRA) requires all entities of the state to disclose governmental records to the public, upon request, unless there is an applicable statutory exemption. DSH legal staff receive PRA requests, reach out to relevant divisions, review and catalog records identified for responsiveness or exemption, and provide the responsive records with any necessary redactions.

DSH requests 5.5 two-year limited-term positions and General Fund expenditure authority of $767,000 in 2019-20 and 2020-21. If approved, these positions and resources would support **three Attorney I** positions to handle the increased volume of OSC appearances and other hearing-related work. This workload includes reviewing hospital and patient documentation, reviewing alienist reports and commitment packets, working with the DSH Patient Management Unit and hospital forensic staff to ascertain a patient's status on the waitlist, communicating with courts and public defenders to seek to have OSCs vacated in the event of an imminent patient placement, and appearing in court to defend DSH at hearings against court orders to transport the patient, OSCs to hold DSH in contempt, and any follow-up status conferences.

These positions and resources would also support **one Legal Secretary** to support the three attorneys by coordinating and calendaring OSC hearings; preparing OSC responses, declarations, and requests for representations; and other legal support.

For the PRA workload, this request would support **one Legal Analyst** and **0.5 Staff Services Analyst** to review PRA requests, gather input from hospital divisions and headquarters, review and redact responsive documents, draft and prepare PRA response letters, consult with DSH attorneys regarding PRA legal issues, and advise DSH staff on PRA-related matters.

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 6: Privacy Protection Program

Budget Issue. DSH requests nine positions and General Fund expenditure authority of $1.3 million annually. If approved, these resources would allow DSH to establish a system-wide Privacy Protection Program in accordance with a recent audit by the California Office of Health Information Integrity.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$1,263,000	$1,254,000
Total Funding Request:	**$1,263,000**	**$1,254,000**
Total Requested Positions:	**9.0**	**9.0**

* Positions and resources ongoing after 2020-21.

Background. According to DSH, federal and state laws and policies, including the Health Insurance Portability and Accountability Act (HIPAA), the Lanterman-Petris-Short Act, the Information Practices Act, the Statewide Health Information Policy Manual, and the State Administrative Manual Chapter 5300, require health care providers to perform privacy and security activities to safeguard health information. The California Office of Health Information Integrity (CalOHII) is responsible for ensuring state departments comply with HIPAA. In May 2018, CalOHII performed an audit of DSH's health information privacy and security activities from both system-wide and hospital-specific perspectives. CalOHII audited four compliance categories related to privacy, security, administration, and patient rights in two hospitals and six system-wide programs. The audit contained 61 findings, of which 34 were high risk, 24 were medium risk, and three were low risk. The most significant finding was that DSH lacks a system-wide privacy program responsible for policies and procedures, training, monitoring and oversight over compliance, incident and breach response, and risk mitigation. CalOHII requires DSH to address all deficiencies by November 2019.

DSH requests nine positions and General Fund expenditure authority of $1.3 million annually to establish a system-wide Privacy Protection Program and a Privacy Office. Specifically, DSH requests the following positions:

- **One Attorney III** would act as a legal subject matter expert on complex privacy issues, draft and review contracts, perform de-identification and data governance, and ensure patient rights are maintined.

- **One Attorney I** would handle the increased volume of privacy and security incidents, act as legal subject matter expert on privacy laws and policies, develop, review and update privacy policies, assist with operationalization and implementation of privacy policies, and develop and present privacy training.

- **Six Associate Governmental Program Analysts,** one located at each of the state hospitals and the state headquarters, would perform investigations, log and track incidents, analyze root causes, coordinate and track corrective action, ensure corrective action has been fully completed, ensure patients have access to health information and can make amendments or corrections, draft and

update hospital-specific procedures to operationalize privacy policies, assist in responding to subpoenas, court orders, and patient requests for the release of their information.

- **One Staff Services Manager I Specialist** would act as a non-attorney subject matter expert in privacy compliance related to HIPAA, the Lanterman-Petris-Short Act, the Information Practices Act, the Public Records Act, the State Administrative Manual, and the Statewide Health Information Policy Manual.

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 7: Contracted Services and Patient Management Support

Budget Issue. DSH requests eight positions and General Fund expenditure authority of $1.1 million annually to manage the development and ongoing support of the expansion of competency restoration programs, an increasing caseload of patients determined incompetent to stand trial (IST), and to provide essential data and analysis for effective and efficient management of DSH patient management programs.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$1,085,000	$1,077,000
Total Funding Request:	**$1,085,000**	**$1,077,000**
Total Requested Positions:	**8.0**	**8.0**

* Positions and resources ongoing after 2020-21.

Background. According to DSH, there continues to be an increase in IST patients referred to DSH by California counties. Since 2016-17, IST referrals have grown by 37.9 percent. Between July 2018 and October 2018, DSH received 1,704 IST referrals and anticipates receiving 5,112 total IST referrals in 2018-19, a 14.6 percent growth from 2017-18. To address the continual increase in IST referrals, DSH has established several jail-based competency treatment (JBCT) programs, the Admission, Evaluation, and Stabilization (AES) Center in Kern, and the Los Angeles Community-Based Restoration program. DSH reports that JBCT and AES capacity has increased by 83 percent since 2016-17.

DSH also reports it has worked to increase efficiency and maximize service to IST patients by reducing the average length of stay and streamlining the referral intake process by way of centralization in DSH under the Patient Management Unit. As a result, 5,813 IST patients were served by DSH in 2017-18, which was a growth of 9.1 percent from 2016-17. With the projected increases in capacity at both state hospitals and JBCT programs, DSH anticipates serving 6,426 IST patients in 2018-19, a 10.5 percent growth from 2017-18.

DSH indicates that, to continue to manage the growth of IST referrals, DSH will need additional staffing resources to manage the referral intake process and the placement of patients at appropriate facilities; to appropriately facilitate and support additional JBCT, AES, and Community Based Restoration (CBR) programs; and to collect, manage, and report on all applicable data related to the new JBCT, AES, and community-based programs.

DSH requests eight positions and General Fund expenditure authority of $1.1 million annually to manage the development and ongoing support of the expansion of competency restoration programs, an increasing caseload of patients determined incompetent to stand trial (IST), and to provide essential data and analysis for effective and efficient management of DSH patient management programs. Specifically, DSH requests the following:

- **One Consulting Psychologist** would assist in monitoring clinical and administrative performance of JBCT and AES programs, conduct site visits, participate in organization and planning of formal program reviews and development and update of policies and procedures, serve as liaison between

the programs and DSH staff and the courts, and gather and use data to support findings of program deficiencies.

- **One Health Program Specialist I** position would serve as the primary contract manager, analyze administrative problems related to the program, recommend actions, review special incident reports, serve as liaison between DSH and program staff, perform independent analysis of fiscal and programmatic data, serve as lead for Public Records Act and media requests, perform quarterly on-site liaison program reviews, and assist in performing formal program reviews.

- **One Research Data Specialist I** position would reconcile data for weekly reporting on patient movement to and from the JBCT waitlist, coordinate with state hospital staff to ensure precision of the weekly Pending Placement Report, collaborate in discussions relating to all DSH IST referrals and waitlist management, develop and produce full annual program reports, develop and produce semiannual program analyses for executive staff and other stakeholders, develop and produce annual reports for the Los Angeles Community-Based Restoration Program, develop and produce semiannual analyses of the Los Angeles Community-Based Restoration program for executive staff and other stakeholders, provide support in litigation and legislation requests, and conduct regular data auditing to ensure data management standards.

- **Four Associate Governmental Program Analysts** would receive and document receipt of referrals for IST patients, review referral packets for completeness, enter referral information into a statewide management database, request any missing information or documentation, communicate the referral to clinical staff for evaluation of appropriate placement, determine the proper placement of the patient and update the database for proper tracking, transfer the records to the appropriate hospital or JBCT, address any JBCT denials, and monitor the JBCT census.

- **One Office Technician** would provide clerical support including scheduling meetings, preparing travel arrangements, assisting with travel claims, time keeping, mail distribution, supply ordering, filing, answering phones, responding to emails, preparing documents, making arrangements for new employees, and data entry.

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 8: Deferred Maintenance

Budget Issue. DSH requests General Fund expenditure authority of $35 million in 2019-20. If approved, these resources would allow DSH to address deferred maintenance projects that represent critical infrastructure deficiencies. These resources would be available for encumbrance or expenditure until June 30, 2022.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$35,000,000	$-
Total Funding Request:	**$35,000,000**	**$-**

Background. According to DSH, state hospital facilities require routine maintenance and repair to keep them in acceptable condition and to preserve and extend their useful lives. The state hospitals were established in 1875 (Napa), 1893 (Patton), 1915 (Metropolitan), 1954 (Atascadero), and 2005 (Coalinga). The majority of the hospitals' buildings were built prior to 1960 and are in constant need of repair.

California Code of Regulations, Title 22, Section 71641(a)(b) states that each "hospital shall be clean, sanitary, and in good repair at all times" and "hospital buildings and grounds shall be maintained free of such environmental pollutants and such nuisances as may adversely affect the health or welfare of patients." Over time, the number of deferred maintenance projects for each state hospital has grown, making it more challenging to make the necessary repairs.

DSH requests General Fund expenditure authority of $35 million in 2019-20 available for encumbrance or expenditure until June 30, 2022. If approved, these resources would allow DSH to address deferred maintenance, primarily road repairs and roof replacement, at its five state hospitals. These projects are as follows:

Deferred Maintenance Projects		
Hospital	Project	Cost
Atascadero	Road Repairs	$ 300,000
Coalinga	Road Repairs	$ 300,000
Metropolitan	Road Repairs	$ 300,000
Metropolitan	Roof and Air Handler Replacement	$ 10,000,000
Napa	Road Repairs	$ 300,000
Napa	Building 168 Roof Replacement	$ 10,000,000
Napa	Building 196 Roof Replacement	$ 4,000,000
Napa	Building 261 Roof Replacement	$ 1,500,000
Patton	Road Repairs	$ 300,000
Patton	G Building Roof Replacement	$ 5,000,000
Patton	T Building Roof Replacement	$ 1,000,000
Patton	Ligature Retrofits	$ 2,000,000

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.