Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Holly J. Mitchell, Chair
Senator William W. Monning
Senator Jeff Stone

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Part B

Consultant: Michelle Baass

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4260 DEPARTMENT OF HEALTH CARE SERVICES

5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Continuum of Care Reform: Short-Term Residential Treatment Center Licensing (AB 403, 2015)

Budget Issue. DHCS requests the following resources to implement AB 403 (Stone), Chapter 773, Statutes of 2015:

- One permanent position and expenditure authority of $118,000 for one associate governmental program analyst (AGPA).
- Three-year funding (phased-in) of $251,000 for staffing resources equivalent to one staff services manager I and one AGPA.
- $416,000 ($208,000 General Fund) to reimburse counties for participating in a child and family team and providing assessments for seriously emotionally disturbed children.

Background. AB 403 decreases the usage of group homes and establishes short-term residential treatment centers (STRTCs) as a new type of a community care facility licensed and regulated by the California Department of Social Services (CDSS). The services provided through STRTCs include mental health treatment for children assessed as seriously emotionally disturbed (SED) or that meet the medical necessity criteria for Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

AB 403 requires DHCS or its mental health plans (MHPs) to certify mental health programs for STRTCs. This process includes an on-site review of operations, clinical practice standards, policies and procedures, and treatment modalities. Currently, DHCS is responsible for the certification of rate classification level (RCL) 13 and 14 group homes under the county MHPs. (RCL 13 and 14 group homes can only take seriously emotionally disturbed children.) Under AB 403, the STRTCs will replace the RCL scheme and it is anticipated that a portion of the currently identified 679 RCL group homes will transition to STRTCs. Prior to AB 403, DHCS and MHPs were responsible for certification of 54 RCL 13/14 group homes. Therefore, AB 403 is projected to result in an initial increase in the volume of mental health service centers that must be certified as STRTCs.

In addition to the increased certifications, AB 403 requires DHCS to develop program standards so that intensive mental health treatment services are provided to children housed in STRTCs. Therefore, DHCS will need to promulgate regulations, provide legal consultation and opinion, and develop clear policies and procedures to implement these requirements.

DHCS, or a delegated MHP, certifies the mental health program for RCL 13/14 group homes, pursuant to Welfare and Institutions Code (WIC) Section 11462.01(a). DHCS, or a delegated MHP, uses the criteria for certification to evaluate whether or not the program meets the needs of SED youth. Presently, RCL 13/14 group homes are not required to provide intensive treatment services, as is required for STRTCs. The intensive treatment services that foster children and youth would have access to in STRTCs include, but are not limited to clinical treatment such as psychiatric and psychological services, which could include specialty mental health services; learning disability

assessment and educational services; pre-vocational and vocational counseling; development of independent living, self-help and social skills; and community outreach to develop linkages with other local support and service systems.

DHCS, or a delegated MHP, will continue to conduct annual onsite reviews to ensure compliance with program standards; however, it is anticipated that there will be an increase in the number of onsite reviews. These reviews will continue to include, but are not limited to, a review of client charts, staff in-service training records, program staff resumes, groups/activities, outside resource contracts, program logs and documents, financial records, and policies regarding the operation of the program.

Oversight activities also will continue to include interviews with clients and clinical staff and a review of staff qualifications, as well as any complaint files. When applicable, DHCS will continue to take administrative actions against programs, including the denial, suspension, or revocation of program certifications, or imposition of sanctions and/or plans of correction. DHCS will need to develop a tracking system for initial and annual certifications of STRTCs completed by counties. DHCS will need to coordinate program, fiscal, and health and safety reviews jointly with CDSS' Children and Family Services Division and Community Care Licensing Division.

Previously all of the RCL 13/14 group homes were certified by delegated MHPs. With the new requirements of AB 403, the number of group homes to certify is expected to increase. There are currently 54 RCL 13/14 group homes certified by the MHP delegates, for which DHCS maintains overall responsibility and oversight. Prior to the transition of group homes to STRTCs, DHCS will develop and implement policies and regulations. During the transition and post-transition, DHCS will be responsible for reviewing appeals and waiver requests, providing specialized training to staff, and providing technical assistance to improve the quality and effectiveness of treatment in the STRTCs. This proposal requests resources to address the initial workload anticipated during the transition of RCLs to STRTCs.

Under AB 403, an STRTC becomes a "blended" facility; both a community residential treatment facility, falling under the regulatory authority of CDSS, and an intensive mental health treatment program, under the auspices of DHCS or a delegated MHP. DHCS, or its MHP delegate, currently certifies and oversees all aspects of the residents' mental health treatment program. AB 403 requires DHCS or its MHP delegate and CDSS to conduct joint annual onsite reviews. This approach should improve the oversight and monitoring of the foster care system, since the majority of the youth who will live in these facilities need services delivered by both the mental health and the social service systems.

The Legislative Analyst's Office (LAO). The LAO finds that there is some uncertainty around what certification will require and who will be the certifying entity or entities. The Governor proposes funding for DHCS and MHPs to carry out CCR–related workload, but the augmentation is limited to what is needed to serve STRTCs. Foster Family Agencies (FFAs) facing the same rules as STRTCs do not appear to be accounted for in the Governor's mental health–related budget augmentations. It is unclear whether there may be additional General Fund cost pressures associated with the mental health certification of FFAs. The LAO also notes that more clarity is needed in regard to the role of mental health in CCR.

Subcommittee Staff Comment and Recommendation—Hold Open. The following concerns should be considered when evaluating these proposals:

1. **Short Timeframe to Develop Mental Health Program Approval Standards.** DSS indicates that it plans to have its licensing policies and processes in place for the new STRTCs in July of 2016, so that this placement type can begin on January 1, 2017. DHCS also indicates that it will issue the mental health certification guidelines for STRTCs in July 2016. However, DHCS has just begun meeting with non-county stakeholders this week to discuss mental health issues related to CCR. Consequently, it is unclear how DHCS will be able to issue policies outlining the certification/program approval process and standards for STRTCs by the targeted date of July 2016. Key issues, such as statutory changes; contract amendments; alignment of definitions of assessment, certification, and outcomes; and clarification of "medical necessity" for youth in STRTP placement, still need to be discussed and resolved.

2. **Role of County Mental Health in AB 403 Implementation is Still Unclear.** It is critical for the Administration to clarify the role of county mental health in the implementation of CCR. For example, it is still unknown if the state or county mental health will be conducting the mental health program certification/approval for the STRTCs and FFAs. Similarly, clarity is needed in regard to county mental health's role in child and family teams and the new comprehensive assessment tool (for children entering into the child welfare system).

3. **Budget Estimate Does Not Address FFA.** As noted by the LAO, the Governor's budget does not include funding for the mental health program certification/approval for FFAs. DHCS indicates that it is still working through this issue.

Questions.

1. Please provide an overview of these proposals and the overlap between mental health and CCR.

2. DHCS: Please explain how DHCS will monitor STRTCs and FFAs to ensure that children receive access to specialty mental health services?

3. DHCS: What is the timeline for DHCS to develop the "mental health program" approval standards for STRTCs and FFA? How is DHCS working to meet this timeline?

4. DSS: How does DHCS's timeline to develop standards impact DSS's ability to implement CCR?

5. DHCS: How is DHCS involved in the discussion on reporting CCR outcomes?

Issue 2: Foster Care: Psychotropic Medications (SB 238, 2015)

Budget Issue. The budget includes the following requests:

1. DHCS requests one full-time permanent research program specialist II (RPS II) and $134,000 ($67,000 General Fund) in 2016-17 and $125,000 ($63,000 GF) ongoing, to implement the requirements of SB 238 (Mitchell) Chapter 534, Statutes of 2015.

2. DSS requests resources to meet the requirements of SB 238 and SB 484 (Beall), Chapter 540, Statutes of 2015. Specifically, to meet the requirements of SB 238, DSS is requesting $149,000 ($100,000 General Fund) in contract funding to develop monthly, county-specific reports for children in foster care who are prescribed psychotropic medications through Medi-Cal. To meet the requirements of SB 484, DDS is requesting two-year limited-term funding of $833,000 ($684,000 General Fund) to support approximately five positions (three licensing program analysts (LPA), 0.5 licensing program manager I, 0.5 office assistant, one associate governmental program analyst), effective July 1, 2016.

Background. SB 238 requires data sharing agreements between DHCS and the Department of Social Services (DSS) as well as between DHCS, DSS and county placing agencies regarding children and foster youth taking psychotropic medication. It also requires DSS, in consultation with DHCS and stakeholders, to develop and distribute a monthly report to each county placing agency, and would require this report to include specified information regarding foster youth taking psychotropic medications that have been paid for under Medi-Cal. The monthly report must, at a minimum, include the following information:

- Psychotropic medications that have been authorized for the child.
- Pharmacy data based on paid claims and managed care encounters, including the name of the psychotropic medication, quantity, and dose prescribed for the child.
- Other available data, including, but not limited to, information regarding psychosocial interventions and incidents of polypharmacy.
- One or more indicators that note children for whom additional follow-up may be appropriate. The indicators may include, but need not be limited to, an indicator that identifies each child under five years of age for whom one or more psychotropic medications is prescribed and an indicator that identifies each child of any age for whom three or more psychotropic medications are prescribed.

The federal Child and Family Services Improvement and Innovation Act of 2011 requires states to develop protocols regarding the appropriate use and monitoring of psychotropic medications and how the state will address emotional trauma associated with being a child that is maltreated and removed from their home through placement in foster care.

In October 2012, DHCS and DSS undertook a quality improvement project titled “Improving Psychotropic Medication Use in Children and Youth in Foster Care” in order to explore, identify, and support effective strategies in overseeing and monitoring the use of psychotropic medications of children and youth in the foster care system. This topic and project has received significant interest from, and heightened the awareness of stakeholders, the media, government oversight entities like the Child Welfare Council, as well as the Legislature.

State Agencies Data Sharing Agreements. DHCS currently has an interagency agreement (IA) with DSS, effective April 2015, to share information regarding the oversight and monitoring of psychotropic medication prescribing within the child foster care population. In an effort to address foster youth psychotropic medication prescribing from the provider perspective, the Medical Board of California (MBC) also entered into a data use agreement (DUA) with DHCS in April 2015.

State and County Data Sharing Agreements. Additionally, DHCS has encouraged and signed DUAs with individual counties who want to monitor psychotropic medication use in their specific foster care population. In addition to these currently established DUAs, SB 238 requires more robust data sharing agreements between DHCS and DSS and county placing agencies in a three-way arrangement known as the Global Interagency Agreement (GIA). Under the GIA, DHCS will provide DSS with both medical and pharmacy claims level detail, with which DSS will match with their foster care specific data. This combined, matched data will then be provided to each county's foster care placing agency. Over time, the parameters of the data sharing under the GIA are expected to change as counties develop ways to analyze the data. Such changes will necessitate changes in how the data is pulled and compiled by both DHCS and DSS.

SB 238 creates a mandate for DHCS and DSS to ensure foster care data is shared with all 58 county placing agencies. According to DHCS, this mandate eliminates the existing voluntary nature of the DUAs and will result in increased research and data programming to ensure all 58 counties of California are represented and receiving the required foster care data. See below for information on which counties have DUAs and GIAs.

Individual County DUAs	**Global DUAs (GIA)**
Alameda	Contra Costa
Los Angeles	Santa Clara
Ventura	San Luis Obispo
Riverside	Yuba
	San Francisco
	Butte
	San Mateo
	Madera
	Mendocino
	Modoc
	Placer
	Humboldt
	Kern
	Lake
	Sacramento
	San Diego
	Sonoma
	Yolo

SB 484 mandates additional review and increased standards regarding psychotropic medication usage in group homes, and creates new data collection and notification requirements for the Community Care Licensing Division (CCLD) within DSS in order to identify and mitigate inappropriate levels of psychotropic medication use by children in foster care residing in group homes.

Quality Improvement Project: Improving the Use of Psychotropic Medication among Children and Youth in Foster Care. DHCS and DSS have convened a statewide quality improvement project to design, pilot, and evaluate effective practices to improve psychotropic medication use among children and youth in foster care. In order to meet the goals of the quality improvement project, three workgroups have been created. These include the Clinical Workgroup, the Data and Technology Workgroup, and the Youth, Family, and Education Workgroup.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. DHCS and DSS: Please provide an overview of these proposals.

2. DHCS and DSS: Why don't all counties have DUAs or GIAs? How are DHCS and DSS working with counties to get these established? How are DHCS and DSS meeting the SB 238 mandate to share foster care data with all 58 county placing agencies?

3. DHCS and DSS: Please describe how these reports and data provide oversight at the county level and state level?

4. DHCS and DSS: How will this information be used to reduce the use of psychotropic medications and increase access to mental health, psychosocial, and other support services?

5. DHCS and DSS: Please provide an update on the "Quality Improvement Project: Improving the Use of Psychotropic Medication among Children and Youth in Foster Care."

Issue 3: Oversight: Out-of-County Placements

Oversight Issue. Concerns have been raised regarding a longstanding issue of access to mental health services for foster children and youth placed out of county. When these children are placed out of county, they are at risk of experiencing prolonged delays or denials in accessing mental health services as counties dispute the authorization of, and payment for, services and the responsibility for coordinating these services.

In 2010, the Child Welfare Council approved an action plan to resolve this problem. However, this action plan was not implemented. In early 2015, the Department of Health Care Services (DHCS) and the Department of Social Services (DSS) released a "concept paper" outlining a solution to this longstanding problem. DHCS and DSS indicate that they are close to finalizing guidance to counties on this issue and are awaiting the outcome of AB 1299 (Ridley-Thomas), which was placed on the Senate Appropriations Committee Suspense File in August 2015. This bill would require DHCS to issue policy guidance that establishes conditions for the presumptive transfer of responsibility for providing mental health services to foster youth, from the county of original jurisdiction to the county of residence.

Background. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is an entitlement under federal law for all Medi-Cal-eligible children including children placed into foster care. Specialty mental health is a covered EPSDT benefit for children who meet "medical necessity" criteria for such care.

County mental health plans are the responsible entity that ensures Medi-Cal specialty mental health services are provided. Each county mental health plan contracts with local private mental health service providers or uses county mental health staff to deliver services.

It is estimated that 20 percent of foster children and youth are placed out of county. They are placed out of county for various reasons, such as placement with a relative that may live in another county or placement in a short-term residential placement. In these situations, counties can (1) keep the child enrolled in Medi-Cal in the home county or (2) transfer the child's Medi-Cal case to the host county. There is no statewide policy regarding this choice as each child's situation may be different (and each county may have a different policy).

Staff Comment & Recommendation—Hold Open. Very little progress (since last year's subcommittee hearing on this topic) has been made by the state in providing formal guidance to counties on this topic. While the departments cite AB 1299 as the reason it has not taken any action on this issue, the status of negotiations on AB 1299 remain unclear. DHCS and DSS should determine at what point it will decide to issue its formal guidance and resolve this longstanding issue.

Questions.

1. Please provide an overview of this issue. How are access to care problems that are caused by this uncertainty resolved now?

2. Please provide a brief overview of the policies contained in the draft guidance the state is preparing to release.

3. Given the status of AB 1299, at what point, will the departments determine that it should release its guidance?

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Community Mental Health Overview

Background. California has a decentralized public mental health system with most direct services provided through the county mental health system. Counties (i.e., county mental health plans) have the primary funding and programmatic responsibility for the majority of local mental health programs. See table below for a summary of county community mental health funding.

Table: Estimated Community Mental Health Funding Summary

Fund Source	**2014-15**	**2015-16**	**2016-17**
	Total	**Total**	**Total**
1991 Realignment			
Mental Health Subaccount (base and growth)*	$82,721,000	$122,920,000	$172,928,000
2011 Realignment			
Mental Subaccount Health Account (base and growth)*	$1,121,940,000	$1,132,600,000	$1,121,880,000
Behavioral Health Subaccount (base)**	$1,051,400,000	$1,168,400,000	$1,288,200,000
Behavioral Health Growth Account	$117,000,000	$119,800,000	$128,000,000
Realignment Total	**$2,373,061,000**	**$2,543,720,000**	**$2,711,008,000**
Medi-Cal Specialty Mental Health Federal Funds	**$2,153,244,000**	**$2,279,073,000**	**$2,252,897,000**
Medi-Cal Specialty Mental Health General Fund	**$117,209,000**	**$151,199,000**	**$139,760,000**
Mental Health Services Act Local Expenditures	**$1,730,050,000**	**$1,340,000,000**	**$1,340,000,000**
Total Funds	**$6,373,564,000**	**$6,313,992,000**	**$6,443,665,000**

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

Medi-Cal Mental Health. As of January 1, 2014, there are three systems that provide mental health services to Medi-Cal beneficiaries:

1. **County Mental Health Plans (MHPs) -** California provides Medi-Cal “specialty” mental health services under a waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children’s specialty mental health services are provided under the federal requirements of the Early and Periodic Screening, Diagnosis, and Treatment

(EPSDT) benefit for persons under age 21. County mental health plans are the responsible entity that ensures specialty mental health services are provided. Medi-Cal enrollees must obtain their specialty mental health services through the county.

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

2. **Managed Care Plans (MCPs) -** Effective January 1, 2014, SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session expanded the scope of Medi-Cal mental health benefits and required these services to be provided by the Medi-Cal Managed Care Plans (MCP) excluding those benefits provided by county mental health plans under the SMHS Waiver. Generally these are mental health services to those with mild to moderate levels of impairment. The mental health services provided by the MCPs include:
    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

3. **Fee-For-Service Provider System (FFS system) -** Effective January 1, 2014 the mental health services listed below are also available through the Fee-For-Service/Medi-Cal provider system:
    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

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

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

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

- **Community Services and Supports for Adult and Children's Systems of Care.** This component funds the existing adult and children's systems of care established by the Bronzan-McCorquodale Act (1991). County mental health departments are to establish, through its

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

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

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

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

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

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

Mental Health Services Act Projected Revenue Summary

MHSA Revenues (in millions)							
	actuals	actuals					
	2012-13	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2018-19**
Distribution to counties*	$1,590	$1,236	$1,730	TBD	TBD	TBD	TBD
State Administration**	32	39	79	134	83	105	106
Total MHSA Revenues	**$1,684**	**$1,281**	**$1,851**	**$2,028**	**$2,051**	**$2,093**	**$2,123**

*Source: State Controller's Office Year-to-Date Reports for Monthly Mental Health Services Fund distributions for 2012-13 through 2014-15. For remaining fiscal years, 2016-17 Governor's Budget estimates.
**Source: Department of Finance MHSA Admin Chart.

Subcommittee Staff Comments—Informational Item.

Questions.

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

Issue 2: 2011 Realignment Behavioral Health Subaccount

Oversight Issue. The budget projects $117 million in the Behavioral Health Subaccount Growth for 2014-15, $119.8 million for 2015-16, and $128 million in 2016-17.

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

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

Consistent with practices established in 1991 Realignment, up to 10 percent of the amount deposited in the fund from the immediately preceding fiscal year can be shifted between subaccounts in the Support Services Account with notice to the Board of Supervisors, pursuant to Government Code Section 30025(f). This shift can be done on a one-time basis and does not change base funding. In addition, there is no restriction for the shifting of funds within a subaccount, but any elimination of a program, or reduction of 10 percent in one year or 25 percent over three years, must be duly noticed in an open session as an action item by the Board of Supervisors, pursuant to Government Code Section 30026.5(f). Government Code Section 30026.5(e) also requires 2011 Realignment funds to be used in a manner to maintain eligibility for federal matching funds.

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

For the 2012-13, DHCS gave first priority to Behavioral Health Growth Account funding to reimburse counties for the two entitlement programs, Medi-Cal Specialty Mental Health EPSDT and Drug Medi-Cal. Specifically, this allocation provided additional funding to counties in which the approved claims for EPSDT and Drug Medi-Cal services in each fiscal year were greater than the funding they received in the respective fiscal year from the Behavioral Health Subaccount. The remaining balance of this growth account was then distributed using the same percentage schedule used to distribute the funds allocated to the Behavioral Health Subaccount.

For 2013-14, DHCS gave first priority to Behavioral Health Growth Account funding to reimburse counties for the two entitlement programs, Medi-Cal Specialty Mental Health EPSDT and Drug Medi-Cal, and then distributed the remaining funds based on Medi-Cal enrollment (per county).

The Administration indicates that it anticipates using the same allocation formula for the $117 million in 2014-15 Behavioral Health Growth Account funds that it used in 2013-14.

Base. Revenues deposited into the Behavioral Health Subaccount are distributed based on a schedule created by the Department of Finance in consultation with state agencies and the California State Association of Counties. The Administration and counties are working to develop a formula to distribute the base allocation from the Behavioral Health Subaccount and are targeting to set the base for 2016-17.

Subcommittee Staff Comment and Recommendation—Hold Open. Concerns have been raised by stakeholders that the state should develop mechanisms to distribute the growth funding upfront to incentivize counties to address unmet needs.

Questions.

1. Please provide an overview of this issue.

2. When does DHCS plan to distribute the $117 million in 2014-15 growth funds?

3. What is DHCS's view on how this growth account funding could be used to incentivize counties to increase utilization of specialty mental health and Drug Medi-Cal services?

4. Have counties fully utilized their Behavioral Health Subaccount funds? What happens if counties do not fully utilize these funds in a fiscal year?

Issue 3: Specialty Mental Health Services Oversight and Monitoring

Budget Issue. DHCS requests 13 full-time, permanent positions and expenditure authority of $1,925,000 ($866,000 General Fund) for 2016-17 and $2,128,000 ($972,000 General Fund) on-going. The permanent resources requested, included $400,000 for contracted clinicians, who will work to meet the Special Terms and Conditions (STCs) required by the Centers for Medicare and Medicaid Services (CMS). CMS placed this as a condition of the renewal of DHCS Medi-Cal Specialty Mental Health Services (SMHS) Waiver authorized under Section 1915(b) of the Social Security Act.

The following positions are requested:

Classification	Effective Date
1.0 Nurse Consultant II	7/1/16
2.0 Health Program Spec II 2.0 Health Program Spec I	9/1/16
1.0 Office Technician	1/1/17
1.0 Nurse Consultant II 1.0 Health Program Spec II 1.0 AGPA	7/1/16
1.0 Health Program Spec II 2.0 AGPA 1.0 Staff Services Manager I	1/1/17

Background. On June 24, 2015, CMS issued an approval of the five-year SMHS Waiver and indicated their concerns continue to be program integrity monitoring and compliance of this waiver. This renewal is effective July 1, 2015 through June 30, 2020**.** The STCs will require a substantial increase in workload. As in prior years, ongoing non-compliance issues and chart review disallowances by the County MHPs remain; these issues have recently triggered an audit by the Office of the Inspector General (OIG), which is currently underway. In the renewal, CMS set out specific conditions in order for DHCS to attain compliance with federal and state regulatory requirements as well as the MHP contract requirements, including requiring a process for levying fines, sanctions, and penalties on MHPs that have continued, significant non-compliance issues. While meeting the STCs involves current functions and workload for which resources are needed, it also involves completely new functions and a substantial increase in workload that requires additional resources.

One new function is development and ongoing reporting on a mental health dashboard, using data from External Quality Review Organization (EQRO) and other relevant sources. This is an entirely new function for MHSD, and requires additional resources to design, develop, and post the first mental health dashboard and regular updates. The first dashboard is due by September 1, 2016. During this time, DHCS will also be working with CMS each month to discuss the identified action plans and milestones to ensure they meet CMS' expectations prior to implementation.

According to DHCS, it performs a number of different reviews to determine compliance with state and federal policies, regulations and statutes, as well as the MHP contract. These reviews include, but are not limited to the following:

- Triennial system reviews of MHPs to determine whether they are operating in accordance with all applicable policies, regulations, and statutes.

- Medi-Cal provider certifications and re-certifications for SMHS.

- Triennial outpatient medical record reviews to ensure compliance with medical necessity criteria (per Sections 1830.205 and 1830.210 of Title 9 of the California Code of Regulations (CCR)).

- Triennial inpatient medical record reviews to ensure compliance with medical necessity criteria for hospital days (per Section 1820.205 of Title 9 of the CCR), or, where applicable, for administrative day services (per Section 1820.230 of Title 9 of the CCR).

- Targeted reviews (on a single MHP or a single Medi-Cal provider) as needed, when indicated by a pattern of improper claiming or violations of regulations or statutes.

These reviews have reflected elevated rates of disallowance and/or non-compliance:

- The average non-compliance rate for system reviews of MHPs for 2011-2012, 2012-2013, and 2013-2014 was 17 percent.

- The average disallowance rate for outpatient medical record reviews for 2011-2012, 2012-2013, and 2013-2014 was 38 percent.

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

Generally, CMS finds that a disallowance rate above three to five percent is noteworthy.

Based on a review of the triennial monitoring reports, CMS has identified three major concerns with DHCS' ability to assure that MHPs comply with the waiver requirements. First, DHCS currently only requires MHPs to repay funds back to the state for compliance issues associated with a beneficiary's clinical chart. Thus, MHPs do not face fiscal repercussions for other types of violations that may significantly impede beneficiaries' access to care, such as the required statewide, toll-free 24/7 telephone access line, available in all languages spoken by beneficiaries of the county. Though there is a history of high rates of non-compliance with this regulatory requirement, there are no sanctions, fines, or penalties for these or other violations not associated with beneficiary clinical carts.

Second, in cases where DHCS recoups the reimbursement from MHPs for claims associated with a beneficiary's clinical chart, many of the same compliance issues repeat throughout the triennial reviews. The department's approach (i.e. recoupment for chart disallowances) has not adequately addressed the consistently high error and disallowance rates. While there is existing authority for sanctions, there is not enough analytical and clinical staff to develop and implement sanctions.

Third, the error rates found in chart reviews are not currently extrapolated to the MHPs entire population, in contravention to general auditing principles. DHCS does not extrapolate error rates to the Specialty Mental Health population for the county, and thus MHPs are only required to recompense the state for compliance issues that are identified for specific charts included in the audit sample during triennial reviews.

CMS is concerned about the continued and long-standing MHP noncompliance issues and the consistently elevated rates of disallowance resulting from inpatient and outpatient medical record

reviews. As such, CMS will be carefully analyzing the state's monitoring activities and corrective action plans to ensure all necessary actions are implemented and improvement occurs. Furthermore, these error rates triggered CMS to notify the Office of the Inspector General (OIG), which has begun a review.

Expected outcomes of the approval of these positions would include the following:

- Retention of a five-year Medi-Cal SMHS Waiver by providing the staff resources needed to meet the STCs and implement program improvements required by CMS.
- Increased intensity of primary oversight functions, including more frequent MHP system reviews and outpatient medical record reviews.
- Reduction in the average non-compliance rate for system reviews of MHPs and decreased number of MHPs with low compliance levels.
- Reduction in the average disallowance rate for outpatient medical record reviews and the 18 Short-Doyle/Medi-Cal acute psychiatric inpatient hospitals resulting from inpatient medical record reviews.
- Improved tracking, monitoring and improvement of timeliness of care, access to care, and MHP and subcontractor grievances and appeals.
- Improved transparency of communication with CMS and stakeholders through availability of dashboard MHP performance and subcontractor information.
- Establishment of a system for the levying of sanctions, fines, and penalties for identified levels of continued non-compliance.

Caseload. See table below for projected specialty mental health unduplicated caseload.

Specialty Mental Health Unduplicated Caseload Growth

Year	Unduplicated Adults*	Percent Growth	Unduplicated Children	Percent Growth
2012-13	232,973	0.54%	245215	7.57%
2013-14	234,770	0.77%	261,401	6.60%
2014-15	236,608	0.78%	266,717	2.91%
2015-16	238,000	0.59%	280,569	4.36%
2016-17	239,393	0.59%	292,284	4.18%

*Excludes adults eligible for Medi-Cal as a result of federal health care reform optional Medi-Cal expansion.

Timely Access to Specialty Mental Health Services. At the DHCS Behavioral Health Forum on April 6, 2015, DHCS discussed establishing statewide timely access standards for mental health services provided by county mental health plans. DHCS indicates that discussions with the counties have continued on this topic and that it is close to releasing an information notice regarding these standards. It should be noted that on the physical health care side, managed care plans are required to

meet Knox-Keene statewide standards for timely access to services, for example, for non-urgent and primary care appointments within 10 days of the request.

Medi-Cal Mental Health Ombudsman. The table below summarizes call volume at the Medi-Cal Mental Health Ombudsman Office. This ombudsman is to serve as a bridge between the county mental health plan system and individuals, family members and friends of individuals, in need of mental health services by providing information and assistance in navigating through the system

Table: Summary of Office of the Mental Health Ombudsman Calls (2010 - 2015)

Month	Total	SMHS	Unknown/ Other[i]	Non-MH[ii]	SUD[iii]	LPS[iv]	MCP-MH[v]
2010	4869	1927	N/A	N/A	N/A	N/A	N/A
2011	2121	1011	N/A	N/A	N/A	N/A	N/A
2012	586	366	N/A	N/A	N/A	N/A	N/A
2013	1806	1278	N/A	N/A	N/A	N/A	N/A
2014	5481	3035	N/A	N/A	N/A	N/A	N/A
2015	7509	1213	1182	3020	937	N/A	1157

[i] Unknown/Other category = calls that do not fit within other categories.
[ii] Non-MH = all inquiries regarding non-mental health services (e.g., Medi-Cal enrollment and removing holds).
[iii] SUD = Substance Use Disorders. MHSD began tracking this in 2015 once calls were re-routed to MHSD.
[iv] LPS = Lanterman-Petris-Short (LPS) facilities- calls from conserved individuals or callers seeking information on conservatorships.
[v] MCP-MH = calls related to mental health services delivered by Medi-Cal Managed Care Plans.
Note: This table includes information regarding the number and types of calls received by the Mental Health Ombudsman. This information is based on calls received by the ombudsman. In addition, this information is not reflective of actual call volume as this information has not been consistently tracked due to the factors listed below. As a result, DHCS does not have the ability to provide a true comparison of types of calls for this time period.

- The 2010 and 2011 data is inclusive of inquiries for California State Hospitals. In 2011 – 2012 the Department of State Hospitals became its own entity which resulted in the mental health Ombudsman no longer capturing this information.
- From August 2011 to June 2013, the database was only sporadically used as the former Department of Mental Health was transitioned to the Department of Health Care Services. The data during this period is not reflective of actual call volume.
- 2013-14 numbers are reflective of the Healthy Families transition, and the Affordable Care Act implementation.
- In 2015 the Ombudsman began capturing Substance Use Disorder calls

Subcommittee Staff Comment and Recommendation—Hold Open. The following concerns should be noted:

1. **Broader Engagement of Stakeholder Community is Critical.** Concerns have been raised that DHCS has primarily been working with counties on implementation of the STCs and efforts to improve oversight of county mental health plans. While counties are key partners and deliver specialty mental health services on behalf of the state, other stakeholders, including consumer advocates and providers, have a meaningful perspective in regard to how counties implement and deliver these services.

2. **Limited Caseload Growth.** As noted in the table above, the count of unduplicated adults receiving specialty mental health services is expected to grow less than one percent from the current year to the budget year. This less than one percent growth has occurred or is expected to occur for the last few years. DHCS not been able to provide information explaining this, what appears to be low, growth rate. This same population in Medi-Cal grew an average of six percent for the same time period. The inability of DHCS to understand these caseload numbers

is concerning. A comprehensive understanding of caseload, service utilization, and expenditures is critical in maintaining oversight of county mental health plans and the requirement that individuals have access to these services.

3. **Information Requested by Subcommittee Still Outstanding.** In January, subcommittee staff requested information related to the waiver STCs, such as the recommended indicators for quality and access due to CMS on January 31, 2016, the annual grievance and appeal report due to CMS on January 31, 2016, and the External Quality Review Organization's mental health plan timeliness self-assessment findings presented on December 3, 2015. This information has not been received.

Questions.

1. Please provide an overview of this proposal.

2. How is DHCS working with stakeholders on implementation of the STCs? Who is DHCS working with?

3. As required by the STCs, when does DHCS anticipate posting county mental health plans' plan of corrective action and quality improvement plan as a result of the state compliance reviews?

4. How is DHCS working with stakeholders on the development of dashboard required by the STCs? Will the dashboard be a tool to identify disparities in treatment, access and outcomes?

5. What is DHCS's assessment of the slow rate of growth of unduplicated adults receiving specialty mental health? How does DHCS monitor this?

6. How does DHCS monitor if a county mental health plan fails to authorize all medically-necessary services requested to meet the needs of children?

7. How does DHCS monitor referrals and whether there is a follow-up by the county mental health plan or a provider?

8. What is DHCS's timeline for releasing the information notice regarding timely access standards for mental health services provided by county mental health plans? Do these standards include standards for follow-up appointments?

9. How does DHCS monitor and assess trends in Mental Health Ombudsman call data? What actions has DHCS taken as a result of this assessment? How is DHCS managing resources for this office given the growth in call volume?

10. When will DHCS provide the subcommittee the requested information regarding the STCs?

Issue 4: Performance Outcomes System for Medi-Cal Specialty Mental Health Services

Budget Issue. The budget includes $23.7 million ($11.9 million General Fund) for implementation of the performance outcomes system (POS) for Medi-Cal specialty mental health services as required by SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012 and AB 82 (Committee on Budget), Chapter 34, Statutes of 2013.

These funds would be used to fund county personnel costs and for training for county clinicians on how to use the tools for data collection. County mental health plans will collect, manage, use, and report additional functional assessment data as part of the POS.

Background. SB 1009 requires DHCS to develop a Performance Outcomes System for Medi-Cal Specialty Mental Health Services for children and youth. Consistent with statute, DHCS has produced a Performance Outcomes System Implementation Plan. DHCS released the Performance Outcomes System Implementation Plan with the 2014-15 Governor's budget, and a budget change proposal with initial resources (four staff) to begin to implement and operate this system.

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

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

Through implementation of the POS, California will have a coordinated method for data collection, be able to evaluate specific measures of mental health services, and establish an ongoing process for quality improvement. According to DHCS, in order to meet the POS project milestones, a Quality Assurance/Improvement team will be needed at the county level to collect, manage, use, and report information obtained from the additional functional assessment data. This require modifying existing data systems and increasing staff time or enhancing current staffing levels to implement the plan.

The responsibility for specialty mental health was realigned to the counties in 2011 (2011 Realignment). Pursuant to Proposition 30 (of 2012), legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Local agencies are not obligated to provide programs or

levels of service required by legislation, above the level for which funding has been provided. Therefore, funding for the remaining non-federal costs for counties is 100 percent General Fund.

The last POS report can be found at:
http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/20160111POSStatewide-Final.pdf

Table: Performance Outcomes System Timeline, April 2016

Milestones	Date
System Implementation Plan	
Draft System Implementation Plan	November 2013
Obtain input on the final draft Implementation Plan from the Performance Outcomes System Stakeholder Advisory Committee	December 2013
Deliverable: System Implementation Plan	**January 2014**
Establish Performance Outcomes System Methodology	
Facilitate stakeholder input on a performance outcomes system evaluation methodology (including standardized data sources and data collection tools used for the system, frequency of administration, etc.)	December 2014
Obtain Input on the Performance Outcomes System methodology protocol from the Performance Outcomes System Stakeholder Advisory Committee	February 2015
Deliverable: Performance Outcomes System Protocol	**January 2017**
Initial Performance Outcomes Reporting: Existing DHCS Databases	
Identify performance outcomes data elements in existing DHCS databases	May 2014
Assess data integrity	July 2014
Develop county data quality improvement reports	December 2014
Counties remedy data quality issues	Ongoing
Develop performance outcomes report templates	December 2014
Obtain input on the report templates from the Performance Outcomes System Stakeholder Advisory Committee	February 2015
Deliverable: Statewide and County Reports on Initial Performance Outcomes Using Data from Existing DHCS Databases	**State Reports: Starting February 2015 County Reports: Starting May 2016**
Continuum of Care: Screenings and Referrals	
Convene Performance Outcomes System Stakeholder Advisory Committee to discuss Continuum of Care	December 2013
Obtain input on screening and referral information needed for the Performance Outcomes System from the Stakeholder Advisory Committee	April 2014
Deliverable: Performance Outcomes System Plan Update	**January 2015**
Deliverable: Performance Outcomes System Implementation Plan Update	**On Hold**[1]

1 There have been no changes to the Implementation Plan, so DHCS has focused resources on implementing the other deliverables in the timeline.

Milestones	Date
Comprehensive Performance Outcomes Reporting: Expanded Data Collection	
The activities associated with this task are dependent on the number and scope of additional data elements adopted as part of the Performance Outcomes System methodology.	2014-15
Obtain input on the report templates from the Performance Outcomes System Stakeholder Advisory Committee	Fall 2015
Deliverable: Statewide and County Reports on Comprehensive Performance Outcomes Using Existing and Expanded Data	**2016-2017**
Continuous Quality Improvement Using Performance Outcomes Reports	
Develop trainings to support interpretation of the performance outcomes reports (initial and comprehensive)	Ongoing Beginning in June 2016
Develop quality improvement plan process	Ongoing Beginning in March 2016
Obtain input on the quality improvement plan process from the Performance Outcomes System Stakeholder Advisory Committee	Spring 2016
Deliverable: Quality Improvement Plan Process	**Summer 2016**
Support and monitoring of quality improvement	Ongoing

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

2. When will county specific data be reported? (It was previously reported to this committee that these reports would be posted in February 2016.)

3. When does DHCS plan to delineate foster care information in these reports?

4. What are some findings from the September 2015 report that DHCS has taken action on?

5. Why was development of the implementation plan update related to screenings and referrals put on hold?

6. When does DHCS plan to incorporate Medi-Cal managed care plan mental health screenings and referrals into the POS?

Issue 5: Mental Health Services Act (Proposition 63) Reappropriation

Budget Issue. Through a Spring Finance Letter, DHCS requests reappropriation of $1.9 million in unexpended Mental Health Services Act (MHSA) funding from 2013-14, 2014-15, and 2015-16. The reappropriated funds will support costs to procure contracts for 1) MHSA data quality assurance, 2) MHSA data collection, and 3) MHSD Web re-design. Currently, the department indicates it is unable to provide timely and accurate information for data queries from stakeholders or legislative staff. This proposal requests the following budget bill language to reappropriate unexpended prior year funding:

> **4260-490—Reappropriation, Department of Health Care Services. The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for in those appropriations and shall be available for encumbrance or expenditure until June 30, 2018:**
> **3085—Mental Health Services Fund**
> **(1) Item 4260-001-3085, Budget Act of 2013 (Chs. 20 and 354, Stats. of 2013),**
> **(2) Item 4260-001-3085, Budget Act of 2014 (Ch. 25, Stats. of 2014),**
> **(3) Item 4260-001-3085, Budget Act of 2015 (Ch. 10, Stats. of 2015)**

Of the $1.9 million in funds to be reappropriated, $250,000 per year for 2013-14, 2014-15, and 2015-16 is from unused contract funds and the remaining unexpended funds are due to salary savings in 2013-14, 2014/-5, and 2015-16.

Background. Senate Bill 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012, transferred functions from the former Department of Mental Health (DMH), including functions related to administration of the MHSA program, to DHCS. As part of this transfer, a number of information technology (IT) systems, including the Data Collection and Reporting (DCR) system, were migrated from the former DMH to DHCS. DHCS planned to migrate these systems in two phases. Phase 1 was the transfer of the IT systems from DMH to DHCS. Phase 2 involves a business process reengineering effort to capture system and process efficiencies. Phase I was successfully completed on July 2013.

According to DHCS, by reappropriating the unexpended funds for these contract services, DHCS will be able to:

- Rewrite the DCR system to meet current security and architecture standards.
- Align the DCR system with DHCS' architectural and programming standards in order to more efficiently maintain and adapt the system to changing needs. Currently, the department is not able to modify the system to capture additional data elements without updating the architectural and programming standards.
- Streamline the process of publishing information in an accessible format through a contract for Web re-design.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal and how these reappropriated funds would be used.
2. What was the original intended use of these funds? Why were the contract funds not used?

Issue 6: Drug Medi-Cal

Oversight and Budget Issue. Through a Spring Finance Letter, the Administration requests eight permanent full-time positions to support fiscal oversight and programmatic monitoring requirements 1115 Demonstration Waiver Amendment for the Drug Medi-Cal Organized Delivery System (DMC-ODS).

These resources would be phased in over two years, five positions in 2016-17, for a cost of $624,000 ($312,000 General Fund), and three more positions in 2017-18 for a cost of $322,000 ($161,000 General Fund) given the uncertainty related to how many counties will be ready to file implementation plans and how many will be approved by the federal Centers for Medicare and Medicaid Services (CMS).

Background. The Drug Medi-Cal (DMC) program provides medically necessary substance use disorder treatment services for eligible Medi-Cal beneficiaries. See table below for Drug Medi-Cal funding summary.

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

	2015-16				2016-17			
Service Description	**GF**	**County Funds**	**FF**	**TF**	**GF**	**County Funds**	**FF**	**TF**
Narcotic Treatment Program	$0	$76,438	$93,397	$169,835	$421	$78,896	$96,209	$175,526
Residential Substance Use Services*	$0	$5,088	$5,162	$10,250	$0	$5,650	$5,745	$11,395
Residential Treatment Expansion	$5,096	$0	$9,464	$14,561	$32,494	$0	$58,398	$90,892
Outpatient Drug Free Treatment Services	$0	$13,228	$14,495	$27,723	$121	$10,648	$14,496	$25,265
Intensive Outpatient Services**	$12,293	$1,708	$20,339	$34,340	$12,644	$2,094	$16,550	$31,288
County Administration	$1,287	$9,339	$14,564	$25,190	$1,864	$10,376	$16,710	$28,950

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

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

2011 and for individuals eligible for DMC under 2011 Medi-Cal eligibility rules (pre-health care reform). Additionally, the enactment of 2012-13 and 2013-14 state budgets transferred the responsibility for the SUD programs including DMC, from the former DADP to DHCS.

Drug Medi-Cal Organized Delivery System. At the beginning of 2014, DHCS began a stakeholder engagement process to solicit input to improve the DMC system and purse a DMC-ODS federal waiver to provide an organized delivery system of substance use disorder services and demonstrate how this organized system of care would increase successful outcomes for DMC beneficiaries. The DMC-ODS waiver, an amendment to DHCS' Bridge to Reform Waiver, was approved by CMS on August 13, 2015 for five and a half years.

According to DHCS, the continuum of care model enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance use disorder treatment, and coordinates with other systems of health care.

The implementation of the DMC-ODS is occurring in regional phases modeled after the California Behavioral Health Director's Association boundaries for each region. Additionally, this approach gives DHCS and counties the opportunity to learn from each implementation phase and improve their submission for the next. See charts below for more information on the proposed implementation timeline and participating counties.

Proposed Counties and Implementation Phase Timeline

Description	Phase One (21.3% of population)	Phase Two (60.8% of population)	Phase Three (13.8% of population)	Phase Four (2.7% of population)	Phase Five
Counties completed an Expression of Interest Survey regarding their interest to opt-in to the four phases of implementation. County participation in the Waiver is voluntary. Fifty-three counties expressed interest in participating in the Waiver.	Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma	Kern, Los Angeles, Ventura, San Diego, Imperial, San Luis Obispo, Orange, Santa Barbara, Riverside, San Bernardino	Calaveras, El Dorado, Fresno, Inyo, Kings, Madera, Merced, Mono, Placer, Sacramento, Stanislaus, Yolo, San Joaquin, Sutter, Tuolumne, Yuba	Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Siskiyou, Tehama, Trinity	Tribal Partners
Proposed Timeline for Implementation	July 2016	January 2017	July 2017	January 2018	2018

As of March 2016, seven counties have submitted their implementation plans (IPs) for DHCS and CMS review and approval, see table below. On April 8, 2016, San Mateo's implementation plan was approved. DHCS anticipates the experience gained from the initial IP reviews will improve subsequent phase implementations.

Counties Who Have Submitted Their Implementation Plans

County	Date Submitted Implementation Plan to DHCS	Date Implementation Plan Approved
San Francisco	11/20/2015	
San Mateo	11/21/2015	4/8/2016
Riverside	12/07/2015	
Santa Cruz	12/09/2015	
Santa Clara	02/03/2016	
Marin	02/05/2016	
Los Angeles	02/11/2016	

Counties must submit to DHCS a plan on their implementation of the DMC-ODS. DHCS and CMS are reviewing IPs concurrently with a target of 60 days to approve or send back for adjustments. County IPs will ensure providers are appropriately certified for the contracted services, implementing

at least two evidenced-based practices, trained in ASAM criteria, and participating in efforts to promote culturally competent service delivery.

Simultaneously or after plan review, counties must submit proposed interim rates to DHCS for review and approval. DHCS has been providing technical assistance to counties regarding rate development. DHCS is awaiting approval from CMS regarding the certified public expenditure (CPE) protocol. The CPE protocol is the process by which counties certify they have paid providers for services when submitting claims to the state for reimbursement. The state then makes interim payments to counties based on submitted expenditures. CMS must approve the CPE protocol before any DMC claims will be reimbursed for the federal financial participation. DHCS expects approval of the CPE protocol in the next month.

Upon receipt of rate approval, counties submit their state/county contact to their Board of Supervisors. After approvals are received from the Board of Supervisors, CMS will give the final approval of the DMC-ODS plan. In addition, before providing services, counties must ensure that all providers are trained in the ASAM criteria. DHCS estimates that as long as a county has passed through the CMS, DHCS and county approval processes, it may begin providing DMC services under the waiver in summer 2016.

Counties are not eligible for reimbursement of services without approval of the implementation plan, state contract, and reimbursement rates by CMS and DHCS. Currently for non-waiver counties, the standard statewide DMC service rates are developed by DHCS in accordance with the Welfare and Institutions Code, Sections 14021.51, 14021.6 and 14021.9. Once established, the statewide DMC reimbursement rates are coded into the DMC billing and payment systems (Short-Doyle and SMART) so that services provided to beneficiaries in all counties are reimbursed at the same rate. However, participating waiver counties will propose their own county-specific rates, with subsequent DHCS and CMS approval.

The waiver's STCs include many quality assurance, monitoring, and reporting requirements for participating providers, counties and the state. These activities are to ensure accountability to CMS, as well as, continued program integrity monitoring efforts to prevent waste, abuse and fraud within the DMC services. Quality assurance activities are modeled after Specialty Mental Health requirements and ensure the federal and state provisions of the waiver are properly implemented and oversight is maintained by DHCS. For example, it will remain the state's responsibility to monitor DMC treatment providers and county adherence to the state-county contract through fiscal and cost reporting, collecting beneficiary treatment data, and on-site compliance reviews and licensure renewal.

Existing staff at DHCS have initiated the following activities in preparation for the waiver implementation:

- Participating in weekly workgroups related to new and expanded waiver services, rate setting, IT requirements, cost report requirements, and provider database requirements;
- Conducting preliminary research and work with the Office of Legal Services on waiver contract requirements and developing draft contract documents;
- Identifying global claim adjudication rules which need to be established for the development into the Short Doyle Medi-Cal (SDMC) system to clearly identify waiver claims and differentiate from current regular DMC claims;
- Identifying system changes needed to capture the requirement that every county participating in the waiver will be reimbursed at individually-approved interim rates;
- Developing preliminary modalities, program codes, and service codes for cost reporting purposes;

- Analyzing and developing the different processes needed for cost settlement of waiver counties using an interim rate methodology as opposed to the established methodology of settling at the lower of the provider's allowable cost of rendering the services, the provider's usual and customary charge to the general public for similar services, or the state maximum allowance for the services provided;
- Developing policy documents for new waiver services and additional treatment modalities;
- Developing county monitoring instrument for waiver contracts and annual review protocols;
- Developing program integrity training for county personnel; and
- Reviewing protocols for quality assurance reports from counties and EQRO reports.

According to DHCS, many additional tasks must be accomplished prior to implementation of waiver services and then there will be ongoing functions required to maintain the waiver program and services, separate from non-waiver program activities.

Subcommittee Staff Comment and Recommendation—Hold Open. DHCS indicates that there is backlog in licensing Drug Medi-Cal providers, residential treatment providers in particular. Subcommittee staff has requested information on this backlog. It is unclear how this backlog will impact implementation of DMC-ODS.

Questions.

1. Please provide an overview of this proposal and the status of the waiver implementation.

2. How is DHCS addressing the backlog of residential treatment providers requesting a license? Will this backlog impact timely implementation of DMC-ODS?

3. Please provide an update on how DHCS is meeting the waiver requirement to integrate SUD and primary care services. Has DHCS completed its integration approach due April 1, 2016? How is DHCS working with stakeholders to develop this model?

4. How does DHCS monitor utilization of Drug Medi-Cal services? Why are caseloads and spending for intensive outpatient treatment services and outpatient drug free treatment services going down?

Issue 7: Substance Use Disorders Health Care Reform Implementation

Budget Issue. DHCS requests $1,456,000 ($729,000 General Fund) to convert ten limited-term positions to permanent full-time positions and add one new permanent legal position. The ten two-year limited-term positions are set to expire on June 30, 2016. According to DHCS, the conversion of the positions to permanent full-time positions is necessary to continue to support the requirements set forth in the Affordable Care Act (ACA) and enacted in SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013, which enhanced Medi-Cal substance use disorder services. The additional legal position will address litigation workload associated with both SB 1 X1 and AB 848 (Stone), Chapter 744, Statutes of 2015, discussed later in this agenda. The legal position will be phased-in effective January 1, 2017.

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

To comply with ACA, substance use disorder services under the Drug Medi-Cal (DMC) program were expanded and made available to additional beneficiaries. Treatment planning was added as a component to narcotic treatment, naltrexone treatment, and outpatient drug free treatment services. Intensive outpatient treatment services (previously available only to those who are pregnant, postpartum, or youth eligible for Early and Periodic Screening, Diagnosis and Treatment) was made available to all beneficiaries who meet the requirement for medical necessity. Counseling time limits in narcotic treatment settings were eliminated.

The requirement to expand substance use disorder services and include additional beneficiaries has led to an increase in new providers as well as existing providers expanding their available services. This in turn has increased the baseline workload at DHCS, necessitating additional permanent positions to meet the ongoing demands of updating and maintaining certified provider information databases, processing claims and payments, conducting onsite provider post-service, post-payment reviews, developing and monitoring county and direct provider contracts, and analyzing and settling county and provider cost reports.

According to DHCS, these positions have accomplished the following and are still needed due to the ongoing nature of this workload:

- Participated in the strike teams led by Audits & Investigations (A&I) Division to rid the DMC program of fraudulent providers, as well as, efforts to address the California State Auditor's (CSA) program-related recommendations. Further, these staff assisted with strengthening Title 22 regulations, improved internal controls and program procedures, and conducted DMC trainings to providers to ensure compliance. Additionally, A&I staff conducted a limited-scope review of the DMC program identifying 32 recommendations to improve program integrity. The requested staff would prioritize and implement these recommendations.

- Developed business rules for cost reports, including aid code sources for more than 50 new funding lines and fund combinations resulting from new eligibility aid codes required for the ACA.

- Worked on the electronic funds transfer (EFT) project to enable counties and direct contract providers to receive EFT payment rather than paper warrants.

- Developed new DMC claim reconciliation reports for counties.

- Assisted in the development and implementation of expanded populations into the related DMC billing and payment systems for proper adjudication and payment and provided technical assistance on the necessary changes to ensure there was no break in DMC billing and claims payment.

- Researched all recoupments identified by the CSA and A&I limited scope to recover over $200,000 FFP in DMC funds owed to the state.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

Issue 8: Residential Treatment Facilities (AB 848, 2015)

Budget Issue. DHCS requests four permanent positons and expenditure authority of $478,000, from the Residential and Outpatient Program Licensing Fund (ROLF), to implement AB 848 (Stone), Chapter 744, Statutes of 2015. Of the four positions, one nurse consultant II position will be phased-in effective January 1, 2017, while the rest will be effective July 1, 2016.

Background. Prior to July 1, 2013, the Department of Alcohol and Drug Programs (DADP) was responsible for oversight of residential treatment facilities (RTFs). Effective with the passage of the 2013-2014 budget and associated legislation, all DADP programs and staff, except the Office of Problem Gambling, transferred to the DHCS. Under Health and Safety Code (HSC) Section 11834.01, DHCS has sole authority in state government to license adult alcoholism or drug abuse recovery or treatment facilities. Prior to the enactment of AB 848, HSC Section 11834.02 defined residential alcohol and other drug facilities as any premises, place or building that provides 24-hour residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, that includes at least one of the following: recovery services, treatment services or detoxification services, but prohibited incidental medical services from being provided onsite.

AB 848 permits medical care in a residential treatment facility, and requires specific oversight activities. AB 848 is a direct result of concerns raised, in the September 12, 2012 report by the California Senate Office of Oversight and Outcomes, regarding state oversight of drug and alcohol homes and the potential benefits of limited onsite medical care.

AB 848 amends the HSC to add Section 11834.026 to allow a licensed alcoholism or drug abuse recovery or treatment facility to provide incidental medical services to a resident at the facility premises through or under the supervision of one or more physicians or surgeons licensed by the Medical Board of California or the Osteopathic Medical Board who are knowledgeable about addiction medicine. Incidental medical services at RTFs may also be provided by one or more other health care practitioners acting within the scope of practice of his or her license and under the direction of a physician or surgeon, and who are also knowledgeable about addiction medicine, when specified legislative requirements are met.

According to DHCS, the enactment of AB 848 requires DHCS to assume an additional workload. The bill requires DHCS to develop, adopt and implement regulations on or before July 1, 2018. In addition, staff will establish in-house policies and procedures related to the enforcement of regulations and will provide oversight of RTFs providing incidental medical services in accordance with the regulations. DHCS is also required to review applications from facilities requesting to amend their licenses to include incidental medical services, and establish and collect an additional fee from participating facilities, in an amount sufficient to cover the department's reasonable costs of regulating the provision of those services. As required by statute, any fee that is established is required to be discussed and vetted with stakeholders before being determined. The Legislature must also review and approve the fee.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

4260 Department of Health Care Services (DHCS)

4560 Mental Health Services Oversight & Accountability Commission (OAC)

Issue 1: Oversight of Mental Health Services Act Funds and Outcome Evaluation

Oversight Issue. Numerous concerns have been raised that the state maintains limited oversight of the approximately $2 billion in Mental Health Services Act (MHSA) (Proposition 63) funds distributed to counties. Fundamental questions about county spending on the components of MHSA and outcomes from these expenditures are not easily available or publically reported.

State Positions for MHSA Oversight. According to the January 2016 Mental Health Services Act Expenditure Report, 19 positions at DHCS are funded with MHSA State Administrative Cap funding to provide fiscal and program oversight of the MHSA. According to the report, these positions are used "to develop the county performance contracts, review the current allocation methodology for monthly distribution of MHSA funds, develop annual revenue and expenditure report (RER) forms and review county RER submissions, conduct fiscal audits of county MHSA funds, review issues submitted through the issue resolution process, and review and amend MHSA regulations."

At the OAC, 30 positions support the OAC's statutory oversight and accountability for the MHSA. The primary roles of these functions include "ensuring MHSA funds are expended in the most cost-effective manner and services are provided in accordance with recommended best practices, providing oversight, review, training and technical assistance, for accountability and evaluation of local and statewide projects supported by MHSA funds, ensuring adequate research and evaluation regarding the effectiveness of services being provided and achievement of outcome measures, approving county innovation plans, receiving and reviewing county three-year program and expenditure plan, annual updates and annual revenue and expenditure reports, and implementing and managing the SB 82 Triage Program."

Revenue and Expenditure Reports. Counties are required to submit to DHCS an annual RER. These reports contain information regarding county expenditures for each component of the MHSA. Generally, a fiscal year's information is compiled and posted approximately three years later. For example, in March 2016, the 2012-13 county expenditure report was made available by DHCS. The delay in compiling and posting this information, according to DHCS, is for a number of reasons, including counties not submitting their data timely. Counties note that the template to submit this information is flawed and that it is awaiting revisions to the template.

Performance Contracts. As required by state law, counties must enter into performance contracts with DHCS in order to receive MHSA funds. As part of this agreement, counties must provide all application data and information required by the state to receive this funding, including the RER. Pursuant to this contract, DHCS can withhold payments to counties from the MHS fund.

Reversion and Pending MHSA Related Regulations. DHCS is in the process of developing regulations related the reversion of MHSA funds (unspent funds have not reverted since 2008), regulations for the Local Mental Health Services Fund, investment income, local prudent reserve, and the Annual MHSA Revenue and Expenditure Report. DHCS expects to complete the initial draft of the regulations by mid-April 2016. DHCS indicates it will solicit input from the OAC and County

Behavioral Health Directors Association of California (CBHDA) after the draft regulations have been approved by its Office of Legal Services. DHCS will begin the formal rulemaking process after consulting with MHSOAC and CBHDA. The final regulations package is expected to be sent to the Office of Administrative Law in February 2018.

According to DHCS, the absence of regulations is the reason that DHCS has not reverted any MHSA funds. The former Department of Mental Health determined reversion according to whether a county requested all funds available from a particular fiscal year, within a three year period. The former DMH reverted funds that had not been requested within three years and redistributed those funds. The State Controller's Office distributed to counties all funds that had not been distributed in 2011-12 pursuant to AB 100 (Committee on Budget), Chapter 5, Statutes of 2011. The State Controller now distributes all unreserved funds to counties on a monthly basis. As a result, DHCS is not able to revert funds that have not been requested within a three year period. DHCS is considering prior information notices and stakeholder input as it develops the process for calculating and collecting reversion. While statute is clear that MHSA funds are subject to reversion (see W&I Code Section 5892(h)), according to DHCS, the process for calculating and collecting reversion is not well defined. As such, DHCS indicates that without regulations it would be very difficult for the department to collect any funds from counties.

Fiscal Transparency and Data Efforts. The OAC has entered into contracts with a vendor to improve the fiscal transparency of local MHSA funds. As part of these contracts, a publically-accessible tool is being developed to allow public reporting of Innovation funding (a component of MHSA funding), expenditures, and balances statewide and by county over time. This tool would be dependent on data collected by the RERs.

Additionally, DHCS and OAC have entered into a contract with a vendor to provide a secure environment for viewing confidential health information and analytic software to access data and conduct research and evaluations.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

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

2. DHCS: Please provide an update on counties reporting Proposition 63 revenues and expenditures for 2013-14. When was this information due? How many counties have reported this information? How does DHCS work with counties that have not submitted this information? What is the status of discussions on the template to report this information?

3. DHCS: Why does it take close to three years for Proposition 63 revenues and expenditures to be reported publically?

4. DHCS: Please describe how DHCS enforces the provisions of the MHSA performance contract.

5. DHCS: Please provide an update on the MHSA financial regulation package. Has it been submitted to DHCS's Office of Legal Services?

6. DHCS: Annually, how many issues are raised through the Issue Resolution Process? Please explain what types of issues are raised through this process?

7. OAC: Please explain OAC's activities related to oversight and monitoring of the Proposition 63 funds distributed to counties.

Issue 2: Children's Crisis Services Capacity Development Grant Program

As noted in the table below, approximately $52 million in MHSA State Administrative Cap is available (unspent) in 2016-17. The Legislature may want to consider using this available funding to establish a one-time grant program to build capacity for the continuum of children's crisis services. This continuum of services includes, but is not limited to, crisis residential programs, crisis stabilization services, mobile crisis support teams, family support services, and training.

Table: 2016-17 Governor's Budget and March Annual Accrual Adjustment Mental Health Services Fund Administrative Cap (dollars in thousands)

Fiscal Year	Monthly Cash Transfers	Accruals	Interest	Total Revenue	Admin Cap	Expenditures/ Approps**	Available Cap	Comments
	A	B	C	D	E	F	G	
				(A+B+C)	(D[.035 or .05])		(E-F)	
2012-13*	$1,204,000	$480,000	$721	$1,684,721	$58,965	$31,572	$27,393	Item 4265-001-3085 ($15m appropriated without regard to fiscal year in 2012 Budget Act). Item 6440-001-3085 ($12.3m appropriated in 2014 Budget Act).
2013-14	$1,187,000	$94,000	$548	$1,281,548	$64,077	$39,474	$24,603	Item 4265-001-3085 ($15m appropriated without regard to fiscal year in 2013 Budget Act).
2014-15 /e	$1,367,000	$484,000	$844	$1,851,844	$92,592	$78,989	$13,603	2014 Budget Act appropriations: Item 4265-001-3085 ($15m appropriated without regard to fiscal year), and Items 4560-491 and 6440-001-3085 (subject to available funds through June 30, 2017).
2015-16 /e	$1,462,000	$566,000	$844	$2,028,844	$101,442	$134,406	($32,964)	2015 Governor's Budget: Item 4265-001-3085 ($15m appropriated without regard to fiscal year). The expenditures Include $45m for the California Reducing Disparities Project (DPH).
2016-17/e	$1,515,000	$536,000	$844	$2,051,844	$102,592	$83,286	$19,306	2016 Governor's Budget: Reflects $15 million appropriated without regard to fiscal for the California Reducing Disparities Project (DPH).
TOTALS:					$419,669	$367,727	**$51,942**	

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

**Expenditures in 2014-15, 2015-16, and 2016-17 are displayed in the 2016 Governor's Budget.

e/ = estimate

Departments Funded in 2016-17: Judicial Branch (0250), State Treasurer-California Health Facilities Financing Authority (0977), Office of Statewide Health Planning & Development (4140), Department of Health Care Services (4260), Department of Public Health (4265), Department of Developmental Services (4300), Mental Health Oversight and Accountability Commission (4560), Department of Education (6110), University of California (6440), Financial Information Systems for California (8880), Department of the Military (8940), Department of Veterans Affairs (8955) and Statewide General Administrative Expenses (9900).

As noted in the chart above, about $52 million in State Administrative Cap funding is available.

Background. Reports have called to attention a continuing problem of inappropriate and unnecessary utilization of hospital emergency rooms in California due to limited mental health services for individuals, children in particular, in psychological distress and acute psychiatric crisis. Nearly 40,000 California children ages 5-19 (or five of every 1,000) were hospitalized for mental health issues in 2014.

In 2015, the Mental Health Services Oversight and Accountability Commission initiated a project to understand the state of children's mental health crisis services, document challenges, identify effective

service delivery models, and advance specific policy, funding, and regulatory changes to improve service quality and outcomes. According to draft OAC report, “no county has successfully built out the full continuum of services required to fully meet the needs of children and families in crisis.” The OAC has issued draft recommendations to “support the continued buildout” of a comprehensive continuum of crisis services and ensure access for all children and youth.

Research indicates that crisis residential and stabilization programs reduce unnecessary stays in psychiatric hospitals, reduce the number and expense of emergency room visits, and divert inappropriate incarcerations while producing the same or superior outcomes to those of institutional care. Furthermore, these types of services, according to a California Mental Health Planning Council report, exemplify “the spirit, intent, and guidelines of the Mental Health Services Act” in that it “is a recovery-oriented, client-driven system that modifies to the needs of the client for optimal outcomes.”

The continuum of children’s crisis services includes:

- Crisis Residential – Crisis residential programs are a community-based treatment option in home-like settings that offer safe, trauma informed alternatives to psychiatric emergency units or other locked facilities.
- Crisis Stabilization – Crisis stabilization services are those lasting less than 24 hours for individuals who are in psychiatric crisis. The goal of crisis stabilization is to avoid the need for inpatient services. These services must be provided on a site at licensed 24-hour health care facility.
- Mobile Crisis Support Teams – Mobile crisis support teams can provide crisis intervention and family support.
- Family Support Services – Family support services help families participate in the planning process, access services, and navigate programs.

Subcommittee Staff Comment and Recommendations—Hold Open. It is recommended to hold this item open as discussions continue on this topic, feedback is received from stakeholders, and MHSA State Administrative Cap updates are provided in the May Revision.

Additionally, it should be noted that AB 741 (Williams) proposes to expand the definition of “social rehabilitation facility” to include residential facilities that provide social rehabilitation services in a group setting to children and adolescents recovering from mental illness or in a mental health crisis. Current law only defines these facilities for adults. Creating this licensure category for children’s crisis residential programs would be necessary in order to be eligible for federal Medicaid funding for these crisis services.

Questions.

1. OAC: Please provide an overview of this issue proposed by the Subcommittee.

2. OAC: Please provide an overview of the OAC’s project on children’s mental health crisis services.

3. OAC and DHCS: Do you have any feedback or comments on this proposal?

Issue 3: Suicide Hotlines

Oversight Issue. The Supplemental Report of the 2015 Budget Act requires DHCS to provide to the fiscal and policy committees of the Legislature and to the Legislative Analyst's Office a report on the status of suicide hotlines in the state of California no later than January 10, 2016. The report shall include: (a) a comprehensive assessment of the accessibility of suicide hotlines throughout the state, (b) a cost estimate of ensuring access to suicide hotlines in all parts of the state, (c) a description of how suicide hotlines have been funded over the time period beginning January 1, 2005, and ending January 1, 2016, (d) an explanation of the role of national suicide hotlines in terms of what value is added, and needed, by having separate, state-based suicide hotlines, and (e) an analysis and description of funding strategies to fund suicide hotlines in the future. In developing the report, the department shall confer with the Mental Health Services Oversight and Accountability Commission, the California Mental Health Services Authority, the Office of Emergency Services, County Behavioral Health Directors Association of California, and other key stakeholders.

This report has not yet been received. The Legislature requested this report last year given community mental health advocates requests that the Legislature identify a long-term stable funding source for suicide hotlines as an agreement to use county MHSA funds for this purpose was expiring.

Subcommittee Staff Comment and Recommendation—Hold Open. DHCS indicates that it is in the finalize stages of review for this report; however, it is unknown when it will be released. Community mental health advocates indicate that they are continuing to work with counties and the state to identify a long-term solution.

Questions.

1. Please provide an overview of this issue and findings DHCS has learned in the process of completing this report. What recommendations does DHCS have on this topic?

2. Does anything preclude counties from using MHSA funds to continue to fund suicide hotlines?

4560 Mental Health Services Oversight and Accountability Commission

Issue 1: Overview

Mental Health Services Act (Proposition 63, Statutes of 2004). The Mental Health Services Act (MHSA) imposes a one percent income tax on personal income in excess of $1 million. The purpose of the MHSA is to expand mental health services to children, youth, adults, and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources).

Mental Health Services Oversight and Accountability Commission. The Mental Health Services Oversight and Accountability Commission (OAC) was established in 2005 and is composed of 16 voting members. Among other things, the role of the MHSOAC is to:

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

Subcommittee Staff Comment—Informational Item.

Questions.

1. Please provide a brief overview of the OAC.

2. Please explain how the OAC ensures that services provided, pursuant to the MHSA, are cost effective and consistent with the MHSA. Does it make the findings from these reviews public?

Issue 2: Investment in Mental Health Wellness Act of 2013 – Triage Personnel Grants

Budget Issue. The commission requests reappropriation of $3.8 million in funds from 2013-14 ($2.2 million), 2014-15 ($939,276), and 2015-16 ($585,214), to support triage personnel grants until 2017-18, allowing counties to spend the Triage Grant funding until the end of the current grant cycle.

According to the commission, allowing counties to continue to use the funds awarded to them for the triage personnel grant programs for an additional year would provide more complete information to evaluate the program's effectiveness and further assist thousands of high-need individuals in accessing crisis services including; mental health care, medical care, alcohol and drug treatment, social services, and educational services, as well as reduce unnecessary hospitalizations and inpatient days. Positions funded with these grants are mobile and able to travel to respond to mental health crises, including crisis involving law enforcement. These personnel cab be located in hospitals, emergency rooms, jails, shelters, high schools, crisis stabilization and wellness centers, and other community locations where they can engage with persons needing crisis services. Providing crisis intervention services reduces recidivism and mitigates unnecessary expenditures for local law enforcement. Additionally, the commission will better understand the outcomes of these services now that programs are in place and triage staff has been hired. The required evaluation reports over the next few years will assist the commission with the next cycle of grants by using lessons learned from the current triage personnel grants.

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

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

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

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

These grants cover four fiscal years, with grant funds allocated annually for 2013-14 (for five months), 2014-15, 2015-16, and 2016-17. See table below for award details.

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

Mental Health Wellness Act of 2013
Approved Triage Grants FY 2013-2017

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17		
Amount Allocated	**$32,000,000**	**$32,000,000**	**$32,000,000**	**$32,000,000**		
	Approved	**Approved**	**Approved**	**Approved**	**County Anticipated FTE's**	**FTE's as of 3/30/16**
Southern Region	**$10,848,000**	**$10,848,000**	**$10,848,000**	**$10,848,000**		
Ventura	$840,259	$2,126,827	$2,242,542	$2,364,043	23.0	20.5
Riverside	$488,257	$2,134,233	$2,307,808	$2,510,844	32.3	23.0
Santa Barbara	$933,135	$2,352,536	$2,468,608	$2,594,250	23.5	20.0
Orange	$1,250,000	$3,000,000	$3,000,000	$3,000,000	28.0	8.0
San Bernardino*	$7,174,512	$938,985	$0	$0	25.0	19.0
Region Total	**$10,686,163**	**$10,552,581**	**$10,018,958**	**$10,469,137**	**131.8**	**90.5**
Los Angeles	**$9,152,000**	**$9,152,000**	**$9,152,000**	**$9,152,000**		
Los Angeles	$3,802,000	$9,125,000	$9,125,000	$9,125,000	183.0	97.0
Region Total	**$3,802,000**	**$9,125,000**	**$9,125,000**	**$9,125,000**	**183.0**	**97.0**
Central	**$4,576,000**	**$4,576,000**	**$4,576,000**	**$4,576,000**		
Yolo	$221,736	$505,786	$496,247	$504,465	8.3	6.8
Calaveras	$41,982	$73,568	$73,568	$73,568	1.0	1.0
Tuolumne	$74,886	$132,705	$135,394	$135,518	3.0	3.0
Sacramento	$545,721	$1,309,729	$1,309,729	$1,309,729	20.8	16.0
Mariposa	$88,972	$196,336	$203,327	$210,793	4.3	4.3
Placer	$402,798	$750,304	$667,827	$688,417	13.6	12.8
Madera	$163,951	$389,823	$410,792	$396,030	4.2	4.2
Fresno*	$2,953,099	$120,001	$0	$0	11.5	9.3
Merced	$359,066	$868,427	$882,550	$893,026	8.0	3.0
Region Total	**$4,852,211**	**$4,346,679**	**$4,179,434**	**$4,211,546**	**74.7**	**60.4**
Bay Area	**$6,208,000**	**$6,208,000**	**$6,208,000**	**$6,208,000**		
Sonoma	$351,672	$871,522	$897,281	$923,888	8.0	8.0
Napa	$126,102	$411,555	$403,665	$382,313	6.0	6.0
San Francisco	$1,751,827	$4,204,394	$4,204,394	$4,204,394	61.5	40.2
Marin	$137,065	$315,738	$320,373	$326,746	3.0	3.0
Alameda	$311,220	$765,811	$785,074	$804,692	11.6	12.0
Region Total	**$2,677,886**	**$6,569,020**	**$6,610,787**	**$6,642,033**	**90.1**	**69.2**
Superior	**$1,216,000**	**$1,216,000**	**$1,216,000**	**$1,216,000**		
Butte	$358,519	$514,079	$199,195	$3,277	18.0	14.0
Lake	$26,394	$52,800	$52,800	$52,800	1.0	1.0
Trinity	$60,697	$145,672	$145,672	$145,672	2.5	3.0
Nevada	$289,260	$694,169	$728,878	$765,321	11.8	11.8
Region Total	**$734,870**	**$1,406,720**	**$1,126,545**	**$967,070**	**33.3**	**29.8**
Suicide Prevention	**$7,000,000**					
Golden Gate Nets**	**$7,000,000**					
Project Total	**$7,000,000**					
Total All Regions	**$29,753,130**	**$32,000,000**	**$31,060,724**	**$31,414,786**	**512.9**	**346.9**
Total Vacant Positions						**166.0**
Unencumbered Funds	**$2,246,870**	**$0.00**	**$939,276**	**$585,214**	**Total**	**$3,771,360**

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this item.

2. How does the OAC monitor the progress of and outcomes from these grants? Why are 166 of the 346.9 positions established with these funds vacant?

3. How many individuals have been served with these funds?

Issue 3: Innovation Plan Reviews

Budget Issue. The OAC requests three permanent, full-time positions, for $396,000 from the Mental Health Services Fund (MHSF), to support administration of regulatory authority to perform a review of innovation plans under AB 82 (Committee on Budget), Chapter 23, Statutes of 2013.

Background. In June of 2013, the Governor signed AB 82, a budget trailer bill that modified the Mental Health Services Act and directed the OAC to issue regulations for prevention and early intervention (PEI) programs and innovation programs that were initially authorized under Proposition 63. Innovation is a strategic component of the MHSA, which includes specific goals for reducing homelessness, incarceration, suicide, unemployment and related challenges.

In the summer of 2015, the OAC adopted regulations governing county implementation of prevention and early intervention programs and innovation programs. For this first phase of regulatory work, the OAC redirected administrative, program and legal staff for the development, review and adoption of regulations. The OAC absorbed this workload by delaying other work, reducing its short-term commitments in some areas, such as plan review, contract monitoring and recruitment.

For the second phase of its obligations under AB 82, the OAC is directed to monitor implementation of the regulations and to provide technical assistance to counties under both prevention and early intervention programs and innovation programs. The OAC is proposing to deploy two existing positions for this work – a consulting psychologist and a staff mental health specialist – and is requesting three additional positions – two health program specialist I/II positions, and one research program specialist I/II position. The OAC indicates it also will dedicate, on a temporary basis, a second staff mental health specialist to support initial implementation of PEI regulations.

In 2014-15, the OAC approved 27 innovation plans totaling $129 million in spending. During the first two months of 2015-16, the OAC has reviewed and approved five innovation plans, totaling $24 million in spending. The OAC anticipates an increase in requests for innovation spending, in part because the OAC is working to improve awareness of the availability of innovation funding through the use of an "Innovation Balance Calculator" on its website, which will allow the public, policymakers and mental health advocates to determine the availability of unallocated innovation funds. In 2016-17, it is projected that Innovation component of the MHSA will be $67 million.

Successful innovations in one county can inform and guide investments across all counties. To capture the benefits of innovation, California must improve its ability to recognize and learn from the lessons of innovation, both successes and setbacks. There currently are no efforts to disseminate information on best practices developed and evaluated through an innovation agenda. The OAC, because of its regulatory oversight and the current approval process, finds that it is the appropriate entity to gather and report information on innovations and lessons learned. The OAC believes that this proposal will better equip the OAC to pursue that opportunity.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

Issue 4: Advocacy Contracts

Budget Issue. Through a Spring Finance Letter, the OAC requests $200,000 Mental Health Services Fund (MHSF) ongoing funds beginning in 2016-17 to support mental health advocacy for lesbian, gay, bisexual, transgender, questioning (LGBT) populations, and $1 million MHSF ongoing to support advocacy contracts for youth, veterans, and racial and ethnic minorities.

Background. The Mental Health Services Oversight and Accountability Commission oversees the activities of statewide stakeholder advocacy contracts funded under Welfare and Institution Code Section 5892(d). These contracts, currently held by NAMI California, United Advocates for Children and Families (UACF), California Youth Empowerment Network (CAYEN), and California Association of Mental Health Peer Run Organizations (CAMHPRO) are focused on supporting the mental health needs of clients, consumers, children and youth, and transition aged youth and their families through education, advocacy, and outreach efforts.

These contracts, originally awarded on a sole source basis, were transferred to the OAC after the dissolution of the Department of Mental Health in 2011. Historically, the amount allocated for stakeholder contracts has been a total of $1,954,000 per year, distributed between the following four populations; clients/consumers, children and youth, transition aged youth, and families of clients/consumers.

The Budget Act of 2015 included an additional $1 million MHSF, subject to availability of funds within the five percent administrative cap, to support mental health advocacy on behalf of youth, veterans, and racial and ethnic minorities to be awarded through a competitive process. On January 28, 2016, the OAC adopted language for an additional contract to support mental health advocacy on behalf of LGBTQ. The OAC is requesting an additional $200,000 per year ongoing funds to support this effort.

Advocacy contracts increase participation by underserved populations in discussions to address the mental health needs of consumers and their families through education, advocacy, and outreach efforts. The OAC will release a request for proposal in July 2016 with a focus on supporting the mental health needs of the LGBTQ communities, as well as youth, veterans, and racial and ethnic minorities through education, advocacy, and outreach efforts.

Proposed Allocations for Contracts*	**2016-17**
Clients/Consumers	**$548,000**
Families of Clients/Consumers	**$669,000**
Children and Youth and their Parents/Caregivers	**$437,000**
Transition Age Youth (TAY)	**$500,000**
Veterans	**$400,000**
Racial/Ethnic Minorities	**$400,000**
Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)*	**$200,000**
Total	**$3,154,000**

*Includes funding requested via Spring Finance Letter.

Subcommittee Staff Comment and Recommendation—Hold Open. The Subcommittee is in receipt of a request from Mental Health America of California for an additional $1.536 million augmentation to bring all consumer advocacy contracts to roughly same level as the families of clients/consumers contract (the request is for $670,000 for all contracts).

Questions.

1. Please provide an overview of this proposal.

2. When does the OAC plan to issue the RFP for these contracts? What will be the terms of these contracts?

3. How is the OAC encouraging and requiring these advocates to work at the local level and with boards of supervisors on mental health policy decisions given that most MHSA funds and realigned specialty mental health funds are allocated directly to counties?

Issue 5: Reappropriation of Mental Health Services Fund

Budget Issue. Through a Spring Finance Letter, the OAC requests a reappropriation of $2.5 million Mental Health Services Fund (MHSF) from 2015-16 to continue support of the Evaluation Master Plan and $315,000 MHSF from 2013-14 to permit the completion of consensus guidelines and best practices for involuntary commitment care and provide applicable training. In addition, the Administration proposes amending the budget bill, as specified below:

> "4560-491—Reappropriation, Mental Health Services Oversight and Accountability Commission. The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for in those appropriations and shall be available for encumbrance or expenditure until June 30, 2018:
> 3085—Mental Health Services Fund
> (1) Item 4560-001-3085, Budget Act of 2013 (Chs. 20 and 354, Stats. 2013), as reappropriated by Item 4560-491, Budget Act of 2014 (Ch. 25, Stats. 2014)
> (2) Item 4560-001-3085, Budget Act of 2014 (Ch. 25, Stats. 2014)
> (3) Item 4560-001-3085, Budget Act of 2015 (Ch. 10, Stats. 2015)
> ~~Provisions:~~
> ~~1. T~~
> ~~he funds reappropriated in this item are available to continue funding triage personnel grants approved by the Mental Health Services Oversight and Accountability Commission.~~"

Background. The Budget Act of 2013 included an additional $400,000 one-time MHSF to develop consensus guidelines and best practices for involuntary commitment care and to provide applicable training. The budget further directed that the funds be provided to a statewide and technical assistance entity as contained in Welfare and Institutions Code Section 4061(a)(5). Consistent with that provision, the OAC contracted with the California Institute for Behavioral Health Solutions (CIBHS) to develop the guidelines and implement appropriate training. According to the OAC, unforeseen circumstances have delayed completion of that contract.

State law specifies that, subject to the availability of funds, the OAC shall engage in evaluation activities to help the counties and the Department of Health Care Services ensure that county-level systems of care are serving their target populations; that timely performance data related to client outcome and cost avoidance are being collected, analyzed, and reported; that system of care components are implemented as intended; and to provide information documenting needs for future planning. In recognition of these goals the 2013-14 budget included approval of additional resources for the OAC to implement a broad strategy of ongoing research and evaluation (the Evaluation Master Plan). These resources included ongoing approval for additional permanent staff positions to conduct evaluation activities and monitor contracts. The Evaluation Master Plan identified an initial, five-year strategy to utilize new staffing and contracting resources to improve the state's technical capacity to evaluate mental health program outcomes and to support statewide and county-level goals to assess and improve mental health program performance.

The Budget Act of 2015 included $2.7 million to support new research and evaluation activities, primarily through contracts with external entities. During the past year, the OAC has experienced significant turnover in key staff leadership positions, which has delayed development and

implementation of new research and evaluation contracts. Consequently, the OAC is requesting reappropriation of $2.5 million MHSF to continue implementation of the goals of the Evaluation Master Plan. This reappropriation authority would provide the OAC with additional time to meet the 2015-16 goals of the Evaluation Master Plan in consultation with state and local agencies and mental health providers.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

2. What implementation goals of the Evaluation Master Plan will be continued with these funds?

3. What are the “unforeseen circumstances” that have delayed the contract regarding the development of consensus guidelines and best practices for involuntary commitment care?

0977 California Health Facilities Financing Authority (CHFFA)

Issue 1: Investment in Mental Health Wellness Act of 2013

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

- Crisis Residential Treatment Beds – $125 million one-time General Fund to provide grants to expand existing capacity by at least 2,000 crisis residential treatment beds over two years. These funds are to be used to leverage other private and public funds.
- Mobile Crisis Teams - $2.5 million one-time ($2 million General Fund and $500,000 Mental Health Services Act Fund State Administration) to purchase vehicles to be used for mobile crisis teams and $6.8 million ongoing ($4 million Mental Health Services Act Fund State Administration and $2.8 million federal funds) to support mobile crisis support team personnel.
- Crisis Stabilization Units - $15 million one-time General Fund to provide grants to increase the number of crisis stabilization units.
- $500,000 in one-time General Fund for CHFFA to develop the above-specified grant programs.

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

Implementation Status. To date, CHFFA completed and approved four funding rounds; resulting in 38 grants for the benefit of 35 counties totaling $114,777,577.51. These grants are expected to add 61 mobile crisis vehicles, 58.25 mobile crisis staff, and 1,053 crisis residential treatment and crisis stabilization beds.

All projects are in various stages of completion. As of April 2016, approximately $25.2 million has been disbursed.

As of February 2016, for mobile crisis support teams, counties have purchased 60 of 61 approved vehicles and hired 50.35 of the 58.25 approved mobile crisis staff. For crisis residential treatment programs, Alameda (16) and Santa Barbara (8) counties have completed their projects adding 24 new beds. As for crisis stabilization programs, Fresno (16), Santa Barbara (8) and Nevada (4) counties have completed their projects adding 28 new beds, eight of which are dedicated to children. Sonoma County is expected to open its Crisis Stabilization at the end of February 2016 to add 18 new beds.

See table below for summary of awards and disbursements.

County	Program	Approved Amounts	Disbursements
Alameda	Crisis Residential	$ 6,536,507.37	$ 4,458,330.74
Alameda	Crisis Stabilization	$ 2,183,118.00	$ -
Butte	Crisis Residential	$ 867,425.00	$ 417,050.59
Contra Costa	Mobile Crisis Support	$ 551,511.24	$ 500,086.96
Fresno	Crisis Stabilization	$ 794,795.45	$ 794,795.45
Fresno	Crisis Residential	$ 3,100,714.60	$ -
Kings	Crisis Residential	$ 995,903.84	$ -
Kern	Crisis Stabilization	$ 1,701,924.00	$ -
Lake	Mobile Crisis Support	$ 256,263.09	$ 108,458.88
Los Angeles	Crisis Residential	$ 35,000,000.00	$ -
Los Angeles	Crisis Stabilization	$ 4,210,526.31	$ -
Los Angeles	Mobile Crisis Support	$ 1,817,174.18	$ 627,623.63
Marin	Mobile Crisis Support	$ 439,368.05	$ 77,048.00
Mendocino[1]	Mobile Crisis Support	$ 40,713.18	$ 81,426.36
Mendocino	Crisis Residential	$ 500,000.00	$ -
Merced	Crisis Residential	$ 3,546,999.00	$ 1,536,372.00
Monterey	Mobile Crisis Support	$ 193,615.80	$ 193,615.80
Napa	Crisis Stabilization	$ 1,998,183.38	$ -
Nevada	Crisis Stabilization	$ 500,000.00	$ -
Riverside	Crisis Residential	$ 3,778,935.00	$ -
Riverside	Crisis Stabilization	$ 2,102,065.00	$ -
Riverside	Mobile Crisis Support	$ 775,415.22	$ 492,303.94
Sacramento	Mobile Crisis Support	$ 266,287.01	$ 251,517.03
Sacramento	Crisis Residential	$ 6,945,303.00	$ 755,851.34
San Bernardino	Crisis Residential	$ 11,886,185.00	$ 3,945,906.00
San Bernardino	Crisis Stabilization	$ 2,700,000.00	$ -
San Diego	Crisis Residential	$ 3,688,468.00	$ 2,926,512.00
San Joaquin	Crisis Stabilization	$ 1,836,783.50	$ 137,454.97
San Joaquin	Mobile Crisis Support	$ 696,574.18	$ 270,828.28
San Luis Obispo	Crisis Stabilization	$ 971,070.00	$ -
San Luis Obispo	Mobile Crisis Support	$ 67,377.00	$ 67,377.00
Santa Barbara	Crisis Residential	$ 450,000.00	$ -
Santa Barbara	Crisis Stabilization	$ 1,500,000.00	$ -
Santa Barbara[1]	Mobile Crisis Support	$ 713,525.96	$ 1,375,488.09
Santa Clara	Crisis Residential	$ 3,963,106.00	$ 3,258,666.00
Santa Clara	Crisis Stabilization	$ 736,842.11	$ 418,846.11
Solano	Crisis Residential	$ 2,000,000.00	$ -
Sonoma	Crisis Residential	$ 870,343.00	$ -
Sonoma	Crisis Stabilization	$ 2,000,000.00	$ 2,000,000.00
Ventura	Crisis Stabilization	$ 1,134,777.11	$ 109,875.29
Ventura	Mobile Crisis Support	$ 282,277.93	$ 244,905.36
Yolo	Mobile Crisis Support	$ 177,500.00	$ 160,854.42
	Totals	**$ 114,777,577.51**	**$ 25,211,194.24**

Program	Approved Amount	Disbursement
Crisis Residential	$ 84,129,889.81	$ 17,298,688.67
Crisis Stabilization	$ 24,370,084.86	$ 3,460,971.82
Mobile Crisis Support	$ 6,277,602.84	$ 4,451,533.75
Total	**$ 114,777,577.51**	**$ 25,211,194.24**

1 - Includes a 2nd year of personnel funding allocation disbursement.

[1] - Includes a second year of personnel funding allocation disbursement.

Fifth and Final Funding Round. On March 8th, the application period for the final round of funding closed. CHFFA received 20 applications totaling approximately $27.5 million; approximately $31.7 million is available to be awarded. The Peer Respite program was the only program that was oversubscribed, it received six applications totaling over $4.5 million (maximum award amount, by statute, is $3 million). CHFFA indicates it plans to bring forward funding recommendations to the board at the May 26 meeting. See table below for summary of 5th funding round grant applications.

SB 82 Grant Application - 5th Funding Round

County	Crisis Residential Treatment	Crisis Stabilization	Mobile Crisis Support Teams	Peer Respite Care
Alameda	X	X		X
Imperial		X	X	
Kern			X	
Marin		X		
Mendocino				X
Merced		X		X
Napa	X			
Orange		X		
Sacramento				X
San Bernardino	X	X	X	
San Diego		X		
San Mateo	X			
Santa Barbara	X			
Santa Cruz		X	X	X
Shasta		X		
Sonoma				X
Trinity				X
Program Amounts Requested				
Crisis Residential Treatment	$ 8,965,362			
Crisis Stabilization	$ 13,187,659			
Mobile Crisis Support	$ 750,357			
Peer Respite Care	$ 4,581,538			
Total	**$ 27,484,916**			

CHFFA also notes that it is seeing funds awarded from earlier funding rounds go unclaimed and returned. The most common reason for this seems to be vehicles purchased for mobile crisis programs are less expensive than originally estimated in the grant application.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

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

2. Are counties experiencing difficulties in getting their crisis residential and crisis stabilization programs implemented? Why? Are regulatory or legislative changes needed to address these difficulties?

3. Given that only $27.5 million in funding was requested and $31.7 million is available, what does CHFFA plan to do with this balance? Will these funds revert to the General Fund in 2016-17?

4. How much from earlier funding rounds is expected to go unclaimed and returned to CHFFA? What does CHFFA plan to do with this money?