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

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator William W. Monning
Senator Jeff Stone

Thursday, April 12, 2018
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

PART B

Consultant: Scott Ogus

PUBLIC COMMENT

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4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Community Mental Health - Overview

Community Mental Health – *Three Year Funding Summary*			
Fund Source	**2016-17**	**2017-18**	**2018-19**
1991 Realignment (base and growth):			
Mental Health Subaccount	$129,099,000	$129,099,000	$129,099,000
2011 Realignment (base and growth):			
Mental Health Subaccount	$1,130,387,000	$1,130,982,000	$1,130,648,000
Behavioral Health Subaccount	$1,235,358,000	$1,333,722,000	$1,438,034,000
Realignment Total	**$ 2,494,844,000**	**$2,593,803,000**	**$2,697,781,000**
Medi-Cal SMHS Federal Funds	**$2,319,625,000**	**$2,998,853,000**	**$2,809,387,000**
Medi-Cal SMHS General Fund	**$ 150,849,000**	**$181,861,000**	**$199,565,000**
MHSA Local Expenditures	**$1,827,038,000**	**$1,827,038,000**	**$1,827,038,000**
Total Funds	**$ 6,792,356,000**	**$7,601,555,000**	**$7,533,771,000**

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

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

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

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

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

Affordable Care Act Expansion of Mental Health Benefits. The federal Affordable Care Act expanded certain mental health benefits available to Medi-Cal beneficiaries. SBX1 1 (Hernandez), Chapter 4, Statutes of 2013, implemented these new benefit requirements. These benefits are provided to individuals with mild to moderate levels of impairment by Medi-Cal managed care plans, rather than community mental health plans.

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

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

2. **Managed care plans –** SBX1 1 expanded the scope of Medi-Cal mental health benefits, pursuant to the federal Affordable Care Act, and required these services to be provided by Medi-Cal managed care plans excluding those benefits provided by county mental health plans under the SMHS waiver. Generally these are mental health services for those with mild to moderate levels of impairment. The mental health services provided by managed care plans include:
    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy

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

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

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

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

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

1. **Community Services and Supports for Adult and Children's Systems of Care.** This component funds the existing adult and children's systems of care established by the Bronzan-McCorquodale Act (1991). County mental health departments establish, through a stakeholder process, a listing of programs for which these funds will be used. Of total annual revenues, 80 percent is allocated to this component.

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

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

4. **Workforce Education and Training.** This component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of $460.8 million provided to counties and the Office of Statewide Health Planning and Development (OSHPD). Counties and OSHPD have until June 30, 2018, to spend these funds.

5. **Capital Facilities and Technological Needs.** This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports, and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs.

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

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

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

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

Issue 2: Mental Health Services Division Policy Implementation

Budget Issue. DHCS requests 10 positions and expenditure authority of $1.3 million ($665,000 General Fund and $664,000 federal funds) in 2018-19 and $1.3 million ($638,000 General Fund and $637,000 federal funds) in 2019-20 and annually thereafter. If approved, these resources would allow DHCS to provide additional monitoring, oversight and external review of county mental health programs and short-term residential therapeutic programs.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$665,000	$638,000
0890 – Federal Trust Fund	$664,000	$637,000
3085 – Mental Health Services Fund**	[$500,000]	[$500,000]
Total Funding Request:	**$1,329,000**	**$1,275,000**
Total Positions Requested:	**10.0**	**10.0**

* Positions and Resources are ongoing after 2019-20.

** Mental Health Services Fund resources are non-add, as resources, but not positions, were previously approved.

Background. DHCS is responsible for the oversight and administration of California's community mental health system, including ensuring county mental health plans comply with state and federal laws and regulations, as well as performance and other requirements of contracts with the state for the provision of specialty mental health services. As part of its oversight responsibilities, DHCS monitors county mental health plan compliance with the provisions of the Mental Health Services Act (MHSA), which provides funding from a one percent tax on incomes over $1 million for the provision of specialty mental health services.

MHSA and subsequent amendments require DHCS to monitor annual revenue and expenditure reporting, compliance with performance contracts, critical performance issues referred by the Mental Health Services Oversight and Accountability Commission (MHSOAC), and withholding of funds or imposition of corrective action plans on county mental health plans found to be out of compliance. DHCS is also responsible for providing regulations and guidance to county mental health plans for compliance with state and federal law and regulations governing provision of Medi-Cal eligible services, accounting for MHSA expenditures, compliance with mental health and substance use parity requirements, and other state and federal requirements.

DHCS is also required by federal rules to contract with an external quality review organization (EQRO) to analyze information related to quality, timeliness, and access to specialty mental health services for Medi-Cal beneficiaries. The EQRO publishes individual reports on county mental health plans, an annual statewide summary of county-specific reviews, and quarterly reports on performance improvement projects. AB 1291 (Beall), Chapter 844, Statutes of 2016, requires annual monitoring of each county mental health plan, expands the review to include minor and non-minor dependents in foster care, and requires corrective action plans for deficiencies identified by the EQRO.

DHCS also is responsible for the approval process for certain short-term residential therapeutic programs (STRTPs), a new category of residential facility providing specialized intensive care and

supervision services and supports, treatment, and short-term, 24-hour care and supervision to children. These responsibilities were implemented under the provisions of AB 501 (Ridley-Thomas), Chapter 704, Statutes of 2017. AB 501 permits STRTPs to operate as a Children's Crisis Residential Program (CCRP), which serves children experiencing a mental health crisis as an alternative to psychiatric hospitalization. The Department of Social Services (DSS) is responsible for the licensing of STRTPs to become CCRPs. DHCS or a county mental health plan must approve a CCRP to begin providing services to Medi-Cal beneficiaries.

DHCS requests 10 positions and expenditure authority of $1.3 million ($665,000 General Fund and $664,000 federal funds) in 2018-19 and $1.3 million ($638,000 General Fund and $637,000 federal funds) in 2019-20 and annually thereafter for the following activities related to its various oversight and administration responsibilities for the community mental health system.

MHSA Program Monitoring, Oversight, and Program Policies

- **Two Health Program Specialist I positions** and **two Associate Governmental Program Analysts (AGPAs)** will perform monitoring of county mental health plans for compliance with MHSA. These staff will conduct program reviews of county mental health plans including compliance with requirements for operation of a local stakeholder process, serving MHSA target populations, community collaboration, cultural competence, and full service partnership program requirements such as appropriate staffing levels, 24/7 coverage, and personal service coordination. According to DHCS, it expects to conduct reviews of approximately 20 county mental health plans annually, consistent with its triennial review cycle.

  According to its response to a recent state audit, DHCS hired these positions in January 2018 with funding previously appropriated from the Mental Health Services Fund. DHCS reports these staff are complying with audit findings related to monitoring and performance review of county mental health plans. In this request, DHCS seeks permanent position authority for the staff previously hired for this purpose.

Mental Health Fiscal Policy Development

- **Two Health Program Specialist II positions** will analyze changes in state and federal law and support the development and implementation of regulations governing the various requirements of the community mental health program.

External Quality Review Organization Reporting.

- **Permanent expenditure authority of $443,000 ($222,000 General Fund and $221,000 federal funds)** for new workload for the EQRO contractor to meet the expanded evaluation requirements of AB 1291. According to DHCS, the new workload includes additional site reviews, data analysis, and administrative support, administrative oversight, insurance costs, and supply costs. DHCS also indicates that workload related to other requirements of AB 1291, such as publication of county mental health plans' corrective action plans, will be absorbed by DHCS within existing resources.

Short-Term Residential Treatment Facility Programs.

- **Three AGPAs** and **one Attorney III** to manage the approval process for CCRPs, including tracking the approval process, coordinating reviews with DSS and county mental health plans,

coordinating and providing assistance to facility providers, and managing complaint investigations and reviews. The Attorney III will provide in-house counsel support on legal questions related to the CCRP approval process, and provide other legal advice and research. DHCS expects 54 foster care group homes will convert to STRTPs in 2017-18 and 30 will be approved as CCRPs in 2017-18. Ultimately, DHCS expects all 56 county mental health plans will have contracts with one or more CCRPs.

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

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

1. Please provide a brief overview of this proposal.

2. Please identify the source of the original Mental Health Services Fund appropriation that funds the four requested positions hired in January 2018 for MHSA Program Monitoring, Oversight, and Program Policies.

Issue 3: Drug Medi-Cal and Specialty Mental Health: FQHCs and RHCs (SB 323)

Budget Issue. DHCS requests five positions and expenditure authority of $891,000 ($446,000 General Fund and $445,000 federal funds) in 2018-19, and $3 million ($1.5 million General Fund and $1.5 million federal funds) in 2019-20, $3.2 million ($1.6 million General Fund and $1.6 million federal funds) in 2020-21, $1.2 million ($581,000 General Fund and $580,000 federal funds) in 2021-22, and $595,000 ($298,000 General Fund and $297,000 federal funds) in 2022-23 and annually thereafter. If approved, these resources would allow DHCS to provide oversight, implement system changes, and audit reimbursement rate changes for federally qualified health centers and rural health clinics to provide specialty mental health or Drug Medi-Cal services to eligible beneficiaries pursuant to SB 323 (Mitchell), Chapter 540, Statutes of 2017.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$446,000	$1,509,000
0890 – Federal Trust Fund	$445,000	$1,509,000
Total Funding Request:	**$891,000**	**$3,018,000**
Total Positions Requested:**	**5.0**	**5.0**

* Additional fiscal year resources requested: 2020-21: $3,233,000; 2021-22: $1,161,000; 2022-23 (ongoing): $595,000
** Limited-term expenditure authority equivalent to: 2018-20: 2.0 positions; 2019-21: 16.0 positions; 2020-22: 3.0 positions

Background. The Medi-Cal program reimburses federally qualified health centers (FQHCs) and rural health clinics (RHCs) using an all-inclusive per-visit rate, known as the Prospective Payment System (PPS), for the provision of health care services, including primary care, dental services, pharmacy, psychology/psychiatry, drug counseling, and occupational/physical therapy. A clinic's per-visit rate is calculated by determining its annual total allowable costs for services provided and dividing those costs by the number of eligible visits. Clinics submit cost reports and an accounting of annual visits to the department, which audits the reports and calculates the per-visit rate. Once this rate is set, it grows annually by the Medicare Economic Index, a measure of medical practice cost inflation used by the federal government, unless the rate is recalculated due to a change in the scope of services offered by the clinic.

A clinic may only receive a single per-visit reimbursement on any one day, as the rate is meant to be inclusive of all of the services provided by the clinic. A beneficiary may receive one or more services offered by a clinic on a single day, such as primary care and mental health services, but will only be reimbursed for one visit. If a clinic schedules additional services on a different day, it may receive reimbursement for a second visit at the per-visit rate. However, clinics report that the beneficiary return rate for subsequent referrals is a challenge, particularly for mental health referrals and in rural areas. Under certain circumstances, such as the provision of dental services, clinics may elect to receive reimbursement in Medi-Cal's fee-for-service delivery system, even if the clinic has already received a per-visit rate reimbursement for other services that day.

SB 323 allows FQHCs and RHCs to be reimbursed directly from DHCS or a county for providing Drug Medi-Cal services or specialty mental health services (SMHS). Drug Medi-Cal services may be provided under contract with a county pursuant to the terms of the Drug Medi-Cal Organized Delivery System Waiver (DMC-ODS), if the county is participating, or under direct contract with the county or

DHCS if the county is not participating in the DMC-ODS Waiver. Specialty mental health services may be provided under contract with a county mental health plan that provides services to Medi-Cal beneficiaries pursuant to a contract with DHCS. Reimbursement for Drug Medi-Cal or specialty mental health services must be provided separately from the clinic's PPS rate and any clinic seeking to be reimbursed separately must apply to DHCS for a change in scope of service request. According to DHCS, some clinics' PPS rates include provision of these realigned services because their rates were calculated prior to the 2011 realignment of Drug Medi-Cal and certain specialty mental health services to the counties and have not been updated to reflect current allowable costs.

According to DHCS, an uncertain number of FQHCs and RHCs currently offer substance use disorders treatment services that could be claimed under a separate billing structure for Drug Medi-Cal. Because these services are offered within the clinics' PPS reimbursement rate structure, they are not enrolled as Drug Medi-Cal providers and are not regulated by DHCS for the provision of these services. Clinics that elect to begin providing Drug Medi-Cal services separately would be required to enroll and become certified as Drug Medi-Cal providers through the department's Provider Enrollment Division.

FQHCs and RHCs may also provide mild-to-moderate mental health services, which are reimbursed under a clinic's PPS rate structure by Medi-Cal managed care plans and DHCS, which provides a wrap payment for the portion of the PPS rate not covered by the managed care plan's contracted reimbursement rate. According to DHCS, specific services reimbursed by a Medi-Cal managed care plan as mild-to-moderate may be the same as services that could be provided to a Medi-Cal beneficiary receiving care from a county mental health plan under specialty mental health because the distinction between the two modes of treatment are determined by whether a patient meets medical necessity criteria for specialty mental health services. Medi-Cal managed care plans may deny claims for services if the beneficiary receiving services meets medical necessity criteria for specialty mental health. SB 323 clarifies the process by which clinics may elect to become contracted specialty mental health services providers.

Resources for Provider Enrollment and CSOSR Audits. DHCS requests five positions and expenditure authority of $891,000 ($446,000 General Fund and $445,000 federal funds) in 2018-19, and $3 million ($1.5 million General Fund and $1.5 million federal funds) in 2019-20, $3.2 million ($1.6 million General Fund and $1.6 million federal funds) in 2020-21, $1.2 million ($581,000 General Fund and $580,000 federal funds) in 2021-22, and $595,000 ($298,000 General Fund and $297,000 federal funds) in 2022-23 and annually thereafter. The additional expenditure authority is equivalent to an additional 21 limited-term positions allocated for two-year periods between July 2018 and June 2022. The requested resources are as follows:

1. Substance Use Disorder Program, Policy, and Fiscal Division (SUD-PPFD)
    a. **Two permanent Associate Governmental Program Analysts (AGPAs)** to provide technical assistance and process enrollment and certification applications for FQHCs and RHCs to become Drug Medi-Cal providers. These positions will also provide ongoing support for monitoring and claims payments for these providers.
2. Audits and Investigations (A&I) Unit
    a. **Limited-Term resources equivalent to 15 Health Program Auditor III positions** to perform audits of cost reports from FQHCs and RHCs associated with a change in scope of service request. The department estimates 180 (15 percent) of the 1,200 clinics

statewide will choose to separately bill for Drug Medi-Cal and/or specialty mental health services and will submit a change in scope of service request under SB 323.

3. Office of Legal Services (OLS) and Office of Administrative Hearings and Appeals (OAHA)
   a. **Limited-Term resources equivalent to one Attorney IV, one Attorney I, one Health Program Auditor IV, and one Administrative Law Judge III** to manage and adjudicate appeals and hearings of rate determinations made during the audit and PPS rate determination process required by clinics submitting a change in scope of service request under SB 323.
4. Mental Health Services Division (MHSD)
   a. **Three permanent AGPAs** to perform oversight and monitoring of FQHCs and RHCs that choose to become billable providers of specialty mental health services.
   b. **Limited-term resources equivalent to two AGPAs** for initial provider enrollment and validation activities for FQHCs and RHCs that choose to become billable providers of specialty mental health services.

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

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

1. Please provide a brief overview of this proposal.

Issue 4: Drug Medi-Cal Estimate - Overview

Budget Issue. The budget includes $251.8 million ($6.1 million General Fund, $178.1 million federal funds, and $67.5 million county funds) in 2016-17 and $984.6 million ($147.3 million General Fund, $684.2 million federal funds, and $153.1 million county funds) in 2017-18 for Drug Medi-Cal.

2017-18 Drug Medi-Cal Program Funding Summary (dollars in thousands)					
Service Description	**2017-18**				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**	**Case-load**
Narcotic Treatment Program	$220,546	$5,966	$166,313	$48,267	49,067
Outpatient Drug Free Treatment Services	$29,548	$841	$24,501	$4,206	35,976
Intensive Outpatient Treatment Services	$9,847	$1,404	$8,293	$150	6,252
Residential Treatment Services	$1,830	$39	$1,277	$514	361
Organized Delivery System Waiver	$426,342	$76,172	$296,693	$53,477	-
Drug Medi-Cal Cost Settlement	$3,000	$100	$2,900	$-	-
Drug Medi-Cal County Administration	$6,496	$-	$3,248	$3,248	-
County Util. Review/Quality Assurance	$9,131	$-	$6,278	$2,853	-
TOTAL	**$706,740**	**$84,522**	**$509,503**	**$112,715**	**91,656**
Regular Total	$678,509	$84,272	$490,884	$103,353	90,313
Perinatal Total	$9,604	$150	$6,193	$3,261	1,343
Other Total	$18,627	$100	$12,426	$6,101	-

2018-19 Drug Medi-Cal Program Funding Summary (dollars in thousands)					
Service Description	**2018-19**				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**	**Case-load**
Narcotic Treatment Program	$230,979	$8,216	$173,261	$49,502	50,133
Outpatient Drug Free Treatment Services	$31,207	$1,162	$25,686	$4,359	36,784
Intensive Outpatient Treatment Services	$10,029	$1,503	$8,373	$153	6,323
Residential Treatment Services	$1,924	$53	$1,344	$527	370
Organized Delivery System Waiver	$1,199,462	$209,808	$829,760	$159,894	-
Drug Medi-Cal Cost Settlement	$-	$-	$-	$-	-
Drug Medi-Cal County Administration	$6,496	$-	$3,248	$3,248	-
County Util. Review/Quality Assurance	$23,177	$-	$15,934	$7,243	-
TOTAL	**$1,503,274**	**$220,742**	**$1,057,606**	**$224,926**	**93,610**
Regular Total	$1,452,843	$220,405	$1,025,562	$206,876	92,238
Perinatal Total	$20,758	$337	$12,862	$7,559	1,372
Other Total	$29,673	$-	$19,182	$10,491	-

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

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

Both DHCS and counties have specific oversight requirements for Drug Medi-Cal. DHCS is tasked with administrative and fiscal oversight, monitoring, auditing and utilization review. Counties can contract for Drug Medi-Cal services directly, or contract with DHCS, which then directly contracts with providers to deliver Drug Medi-Cal services. Counties that elect to contract with DHCS to provide services are required to maintain a system of fiscal disbursement and controls, monitor to ensure that billing is within established rates, and process claims for reimbursement. DHCS is also implementing a new Drug Medi-Cal Organized Delivery System Waiver, a pilot project to test organized delivery of an expanded benefit package for substance use disorder services. (See Issue 5: Drug Medi-Cal – Organized Delivery System Waiver)

Drug Medi-Cal is delivered through four base modalities:

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

  The budget includes $220.5 million ($6 million General Fund, $166.3 million federal funds, and $48.3 million county funds) in 2017-18 and $231 million ($8.2 million General Fund, $173.3 million federal funds, and $49.5 million county funds) in 2018-19 for NTP services. In 2017-18, NTP caseload is expected to be 49,067, a decrease of 602 (1.2 percent) compared to the 2017 Budget Act. In 2018-19, NTP caseload is expected to be 50,133, an increase of 1,066 (2.2 percent) compared to the revised 2017-18 caseload estimate.

- **Outpatient Drug Free (ODF) Treatment Services** – Outpatient services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with a substance abuse diagnosis in an outpatient setting. Participants receive at least two group, face-to-face counseling sessions per month. Additional counseling and rehabilitation services include admission physical

examinations, intake, medical necessity establishment, medication services, treatment and discharge planning, crisis intervention, collateral services, and individual and group counseling. The budget includes $29.5 million ($841,000 General Fund, $24.5 million federal funds, and $4.2 million county funds) in 2017-18 and $31.2 million ($1.2 million General Fund, $25.7 million federal funds, and $4.4 million county funds) in 2018-19 for ODF services. In 2017-18, ODF caseload is expected to be 35,976, a decrease of 1,227 (3.3 percent) compared to the 2017 Budget Act. In 2018-19, ODF caseload is expected to be 36,784, an increase of 808 (2.2 percent) compared to the revised 2017-18 caseload estimate.

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

  The budget includes $9.8 million ($1.4 million General Fund, $8.3 million federal funds, and $150,000 county funds) in 2017-18 and $10 million ($1.5 million General Fund, $8.4 million federal funds, and $153,000 county funds) in 2018-19 for IOT services. In 2017-18, IOT caseload is expected to be 6,252, an increase of 278 (4.7 percent) compared to the 2017 Budget Act. In 2018-19, IOT caseload is expected to be 6,323, an increase of 71 (1.1 percent) compared to the revised 2017-18 caseload estimate.

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

  The budget includes $1.8 million ($39,000 General Fund, $1.3 million federal funds, and $514,000 county funds) in 2017-18 and $1.9 million ($53,000 General Fund, $1.3 million federal funds, and $527,000 county funds) in 2018-19 for RTS. In 2017-18, RTS caseload is expected to be 361, a decrease of 82 (18.5 percent) compared to the 2017 Budget Act. In 2018-19, RTS caseload is expected to be 370, an increase of 9 (2.5 percent) compared to the revised 2017-18 caseload estimate.

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

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

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

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

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

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

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

Issue 5: Drug Medi-Cal – Organized Delivery System Waiver

Budget Issue. The budget includes $426.3 million ($76.2 million General Fund, $296.7 million federal funds, and $53.5 million county funds) in 2017-18 and $1.2 billion ($209.8 million General Fund, $829.8 million federal funds, and $159.9 million county funds) in 2018-19 for the implementation of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver. The Waiver authorizes a pilot project to test organized delivery of an expanded benefit package for substance use disorder services.

2017-18 DMC-ODS Waiver Program Funding Summary (dollars in thousands)				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**
Organized Delivery System Waiver Total	**$426,342**	**$76,172**	**$296,693**	**$53,477**
Regular Total	$420,163	$76,104	$292,987	$51,072
Perinatal Total	$6,179	$68	$3,706	$2,405

2018-19 DMC-ODS Waiver Program Funding Summary (dollars in thousands)				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**
Organized Delivery System Waiver Total	**$1,199,462**	**$209,808**	**$829,760**	**$159,894**
Regular Total	$1,182,260	$209,582	$819,477	$153,201
Perinatal Total	$17,202	$226	$10,283	$6,693

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

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

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

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

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

1. Existing Drug Medi-Cal Services

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

2. Expanded Services Available in ODS Waiver

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

According to DHCS, five counties began providing services under the DMC-ODS Waiver in 2016-17: San Mateo, Riverside, Santa Clara, Marin, and Contra Costa. 15 counties are expected to begin providing services in 2017-18 and 20 counties are expected to being providing services in 2018-19. The department reports a total of 40 counties are participating or planning to participate in the DMC-ODS Waiver. 18 counties are not expected to participate.

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

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

1. Please provide an update on the implementation of the DMC-ODS Waiver.

Issue 6: Additional Proposals for Investment

Children Exposed to Community Violence. The Los Angeles City Attorney requests up to $2 million for a pilot project to fund service providers with the support of the local police department and governmental agencies to provide therapeutic services to children exposed to community violence and suffering from trauma. Service providers would focus on areas with economic and racial disparity where access to trauma therapy is either not known, difficult to access or not utilized because of lack of education on the issue of trauma. The intervention team would include the service provider including trauma-focused therapists, police trained to identify children suffering from trauma, community advocates/interventionists, local community based prosecution teams, and others whose goal is to intervene and respond to children exposed to violence so these children do not end up in the criminal justice system due to unresolved trauma. The pilot would identify 5-10 target areas with an allocation of $200,000 per year for three years for each project.

Drug and Alcohol Counselors in Emergency Departments. The California chapter of the American College of Emergency Physicians (CalACEP) requests $20 million total funds to create a statewide pilot program that places a certified drug and alcohol counselor in each of the roughly 400 emergency departments (EDs) throughout California. Data would be gathered during the pilot to measure the efficacy of treatment and the cost savings to the Medi-Cal program and other payers.

According to CalACEP, a variety of studies have shown direct referrals to treatment have enrollment rates as high as 50 percent. In New Jersey, the newly established Opioid Overdose Recovery Program provides ED intervention for patients who experience an opioid overdose. In the first six months of implementation, over 80 percent of patients accepted bedside intervention, while 40 percent of those patients accepted recovery support services, and 45 percent accepted detox, substance use disorder treatment and/or recovery. Over 60 percent of the overdose patients were Medicaid beneficiaries.

The University of California, Davis Medical Center ED applied for a grant through the Office of the President over a year ago to employ a certified drug and alcohol counselor to provide interventions in their ED and has also shown impressive results. Over a 12 month period, the Medi-Cal patients who received a brief intervention and referral to treatment experienced a 60 percent decline in ED utilization.

Screening, Brief Intervention, Referral, and Treatment (SBIRT) Expansion. The County Behavioral Health Directors Association requests $8.4 million ($2.6 million General Fund and $5.8 million federal funds) to expand the Medi-Cal benefit for alcohol misuse, screening and counseling to include screening for overuse of opioids and other illicit drugs such as heroine and methamphetamine. The program for screening, brief intervention, referral, and treatment (SBIRT) has traditionally focused on alcohol misuse and has been shown to reduce hazardous drinking across diverse populations when implemented according to established best practices. This request seeks to expand screening to detect use of opioids and other drugs as an important step to combatting the current crisis and save lives.

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

Questions. The subcommittee has requested advocates to present these proposals and respond to questions from subcommittee members.

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

Issue 1: Mental Health Services Act Fiscal Reversion and Program Administration

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

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

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

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

MHSA also required counties to spend a portion of their revenues on two additional components to build the infrastructure to support mental health programs:

4. *Workforce Education and Training:* This component aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental illness. Counties may use funds to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of $460.8 million provided to counties and the Office of Statewide Health Planning and Development (OSHPD). Counties and OSHPD have until June 30, 2018, to spend these funds.

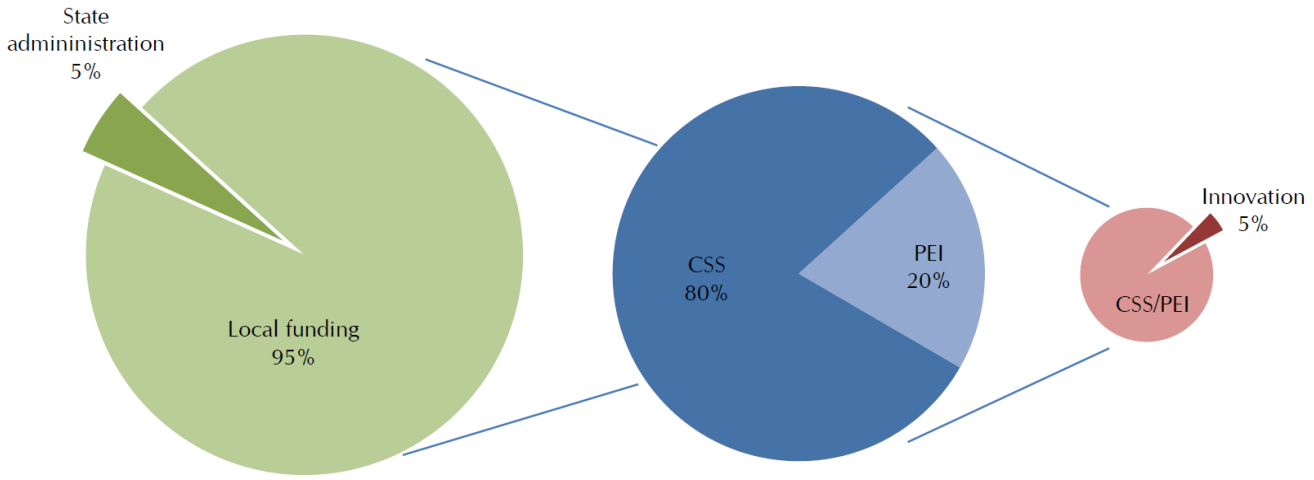
5. *Capital Facilities and Technological Needs:* This component finances necessary capital and infrastructure to support implementation of other MHSA programs. It includes funding to improve or replace technology systems and other capital projects.

MHSA funds are allocated to counties through a formula that weighs each county's need for mental health services, the size of its population most likely to apply for services, and the prevalence of mental

illness in the county. Adjustments are made for the cost-of-living and other available funding resources. The formula also provides a minimum allocation to rural counties for the CSS and PEI components.

State Administration Funds. MHSA authorizes the use of up to five percent of annual revenues for state administration and specifies that these funds are to be used by state agencies to "implement all duties pursuant to the [MHSA] programs." This includes ensuring adequate research and evaluation regarding the effectiveness and outcomes of MHSA services and programs.

Apportionment of Mental Health Services Act Funds.



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

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

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

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

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

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

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

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

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

AB 114 provided clarity regarding counties' treatment of funds previously subject to reversion, provided timelines for DHCS to report annually to counties and the public regarding MHSA funds subject to reversion, and ensured MHSA funds allocated to each of the expenditure components required by the act (CSS, PEI, and Innovation) remain allocated to those components after reversion to other counties.

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

DHCS Findings

1. DHCS has not developed a process to recover unspent MHSA funds subject to reversion, with counties accumulating a total of $231 million unspent funds as of 2015-16.
   Auditor Recommendation: DHCS should develop an MHSA fiscal reversion process.
2. DHCS has not provided guidance to counties regarding proper expenditures of interest earned on MHSA funds on deposit, with counties accumulating a total of $81 million in unspent interest as of 2015-16.
   Auditor Recommendation: DHCS should clarify that interest on MHSA funds is subject to the same reversion requirements as the MHSA funds counties receive.
3. DHCS has not established a formal process to govern how much of a county's MHSA funds may be held in reserve, with counties holding a total of $535 million in reserve, or 47 percent of total prior-year CSS funds, as of 2015-16.
   Auditor Recommendation: DHCS should establish and enforce an MHSA reserve level that allows county programs to maintain sufficient funds for providing mental health services during times of economic hardship, but does not result in holding reserves that are excessive. Under a conservative approach, the level could be set at 33 percent of prior year CSS expenditures, which is equal to the highest one-year decline in CSS allocations since 2007-08.

4. DHCS has not analyzed or accounted for a $225 million fund balance that existed in the Mental Health Services Fund when it was transferred from the former Department of Mental Health in 2012.
   Auditor Recommendation: DHCS should complete its analysis of the $225 million fund balance by May 1, 2018, and allocate unspent funds to counties accordingly. DHCS should also regularly scrutinize the fund to determine reasons for any excess fund balances.
5. DHCS has made minimal efforts to ensure county mental health programs submit their required annual reports on time, hampering DHCS' ability to calculate MHSA reversion amounts and properly oversee MHSA spending.
   Auditor Recommendation: DHCS should publish its proposed fiscal regulations, which will include provisions governing the annual report process, by June 2018 and subsequently implement a process that will enable it to withhold MHSA funds from counties that fail to submit reports on time.
6. DHCS has been slow to implement oversight of counties' MHSA spending and programs. Although DHCS developed an MHSA fiscal audit process in 2014, it has limited the audits' usefulness because it focused its reviews on data and processes contained in its Short-Doyle Medi-Cal cost reports, which are at least seven years old.
   Auditor Recommendation: DHCS should publish its proposed fiscal regulations, which will include provisions governing the fiscal audit process, by June 2018 and subsequently develop and implement an MHSA fiscal audit process, independent of Short-Doyle Medi-Cal reviews, to review revenues and expenditures for the most recent fiscal year.
7. DHCS has not developed regulations to establish an appeals process for county mental health programs to challenge findings. DHCS has also not implemented a program review process to evaluate the effectiveness of counties' MHSA projects.
   Auditor Recommendation: DHCS should establish a process for conducting comprehensive program reviews and begin conducting those reviews by July 2018.

MHSOAC Findings

8. MHSOAC has not provided clear guidance to counties regarding the Innovation plan approval process, which may have contributed to local mental health agencies holding unspent Innovation funds of $146 million as of 2015-16.
   Auditor Recommendation: MHSOAC should continue its efforts to help county mental health programs understand the types of Innovation projects that commissioners believe are appropriate. These efforts should include engagement and dialogue with county mental health programs through events and forums about the types of innovative approaches that would meet the requirements of the MHSA. MHSOAC should use meetings of its Innovation subcommittee or a similar mechanism to evaluate progress of its efforts to reduce unspent Innovation funds and the need for continued engagement and dialogue with county mental health programs.
9. MHSOAC has required county mental health programs to submit annual reports for PEI programs beginning December 2017, as required by legislation approved in 2013, but has not completed an internal process for reviewing and analyzing these reports to ensure submission of timely and reliable data.
   Auditor Recommendation: MHSOAC should finalize its review processes for reviewing and analyzing PEI program status reports no later than July 2018. MHSOAC should also continue its efforts to launch data tools to track county mental health programs' funding, services, and outcomes.

10. MHSOAC has not developed metrics to evaluate the outcome of triage grants approved by the Legislature and designed to expand the number of mental health personnel available at emergency rooms, jails, homeless shelters, and clinics.
    Auditor Recommendation: MHSOAC should require county mental health programs to uniformly report data on their use of triage grants and establish statewide metrics to evaluate the impact of triage grants by July 2018.

DHCS Response to Audit Findings and Recommendations. DHCS indicates that it agrees with most of the findings and recommendations contained in the audit. According to DHCS, in response to the provisions of AB 114, it released Mental Health/Substance Use Disorders (MHSUDS) Information Notice 17-059, which provides guidance to county mental health programs regarding the treatment of funds subject to reversion prior to July 1, 2017. This guidance includes information regarding how it will determine funds subject to reversion for each MHSA component including the disposition of earned interest, consequences for failure to submit timely annual reports, the appeals process for determinations of funds subject to reversion by fiscal year, and requirements for counties to prepare plans to spend these funds. DHCS also reports it is in the process of submitting fiscal regulations for the prospective oversight of MHSA funds subject to reversion after July 1, 2017, which will contain provisions substantially similar to the requirements contained in MHSUDS Information Notice 17-059. These regulations are expected to be submitted for public comment by January 2019. DHCS also reports it has completed development of a process with the State Controller's Office to withhold funds from county mental health programs that fail to submit timely annual reports.

DHCS indicates its MHSUDS Information Notice 17-059, its forthcoming fiscal regulations, and its withholding process with the Controller address the following recommendations:
Recommendation #1: Develop a fiscal reversion process
Recommendation #2: Clarify the treatment of earned interest
Recommendation #3: Establish an appropriate reserve level
Recommendation #5: Process for withholding MHSA funds for failure to submit timely reports

While DHCS agreed with the need to establish an appropriate reserve level (Recommendation #3), DHCS disagreed with the Auditor's recommended reserve level of no more than 33 percent. DHCS reports it contracted with a fiscal consultant who recommended a prudent reserve level of between 64 and 82 percent. DHCS believes this reserve level properly takes into account changes in expenditures over time and inflation.

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

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

In response to Recommendation #7 (Establish process for comprehensive program reviews), DHCS indicates it has hired four staff to begin conducting onsite program reviews beginning September 2018. DHCS is requesting permanent position authority for these staff in its budget change proposal, *Mental Health Services Division Policy Implementation*, heard earlier by the subcommittee.

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

In response to Recommendation #9 (Develop review process for PEI services), MHSOAC indicates it is providing support to a statewide learning community, which was scheduled to begin meeting on March 1, 2018, and will focus on policies, procedures, and strategies for counties to gather, report, and evaluate data collected to meet the PEI annual reporting requirements.

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

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

In addition to concerns about these additional fund balances, the timeliness of DHCS' oversight of the broader community mental health system also raises questions. In particular, DHCS indicates that auditing of Short-Doyle Medi-Cal cost reports are often several years in arrears. For this reason, according to DHCS, auditing of more recent MHSA expenditures is not possible. DHCS also indicates that, in addition to certain counties failing to submit required annual reports for MHSA expenditures, some have failed to submit Short-Doyle Medi-Cal cost reports in a timely manner, as well. While DHCS indicates that adjustments resulting from cost report auditing is exempt from federal claiming time limits, and therefore no federal funding is at risk from the lack of timely cost report submission, the Legislature may wish to consider whether this extended reconciliation period is permissive of robust fiscal oversight of both MHSA funding and the broader community mental health system.

Statewide Evaluation of MHSA Funded Programs. The California Behavioral Health Directors Association (CBHDA) notes there has never been a comprehensive, statewide evaluation of MHSA funded programs. In response, CBHDA proposes to require DHCS to contract with a non-profit educational institution to develop a methodology to implement a rigorous, statewide evaluation of all MHSA expenditures. CBHDA proposes that all non-mandated MHSA State Administration expenditures be frozen until the evaluation methodology has been implemented.

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

Panel Discussion. The subcommittee has requested the following panelists to comment on the findings and recommendations of the state audit:

- **John Baier**, Audit Principal, and **Rick Weisberg**, Legal Counsel, California State Auditor
- **Jennifer Kent,** Director, Department of Health Care Services
- **Toby Ewing,** Exec. Director, Mental Health Services Oversight and Accountability Commission
- **Kirsten Barlow,** Executive Director, County Behavioral Health Directors Association

Questions. The subcommittee has requested the Auditor's Office, DHCS, MHSOAC, and CBHDA to respond to the following:

1. Auditor: Please briefly present the findings and recommendations of the recent state audit: "*Mental Health Services Act: The State Could Better Ensure the Effective Use of Mental Health Services Act Funding"*

2. DHCS: Please briefly present the department's response to the findings and recommendations of the audit related to DHCS.

3. DHCS: Please describe in detail the status of development of the process for fiscal reversion, both for funds subject to reversion prior to July 1, 2017, and funds subject to reversion prospectively. Specifically:

    a. How will the department and counties calculate amounts subject to reversion?
    b. What opportunities will counties have to appeal determinations of amounts owed or other adverse findings?
    c. How will the department operationalize the reversion process to receive amounts owed?
    d. What is the status of development of a process to withhold funds from counties that fail to provide timely annual reporting?
    e. What steps would occur between a county's missed deadline and withholding of funds?
    f. How much of a county's allocation would be withheld and for how long?

4. DHCS: What is the status of the $225 million fund balance identified by the audit in the Mental Health Services Fund? Are there unexpended funds available for distribution to counties?

5. DHCS: Please describe the department's view of the appropriate level of prudent reserves for counties' MHSA funds. How does the department's recommended prudent reserve level account for funds counties retain during a significant portion of the three year period prior to reversion?

6. DHCS: Please describe how the department provides fiscal oversight of MHSA expenditures in the context of its fiscal audit process for Short-Doyle Medi-Cal. Given the long time-frame for reconciliation of these cost reports, how can the department manage effective fiscal oversight of expenditures that may have occurred several years in the past?

7. Auditor: Please describe any concerns that remain regarding DHCS' response to the audit's findings and recommendations. Does the Auditor's office have any follow-up recommendations in light of DHCS' responses to the audit?

8. MHSOAC: Please briefly present the commission's response to the findings and recommendations of the audit related to MHSOAC.

9. MHSOAC: Please describe the status of review of prevention and early intervention programs and the results, if any, of the commission's March 1, 2018 learning community meeting on this topic.

10. MHSOAC: Please describe the details of the $10 million contract to develop a statewide evaluation of the effectiveness of triage grants.

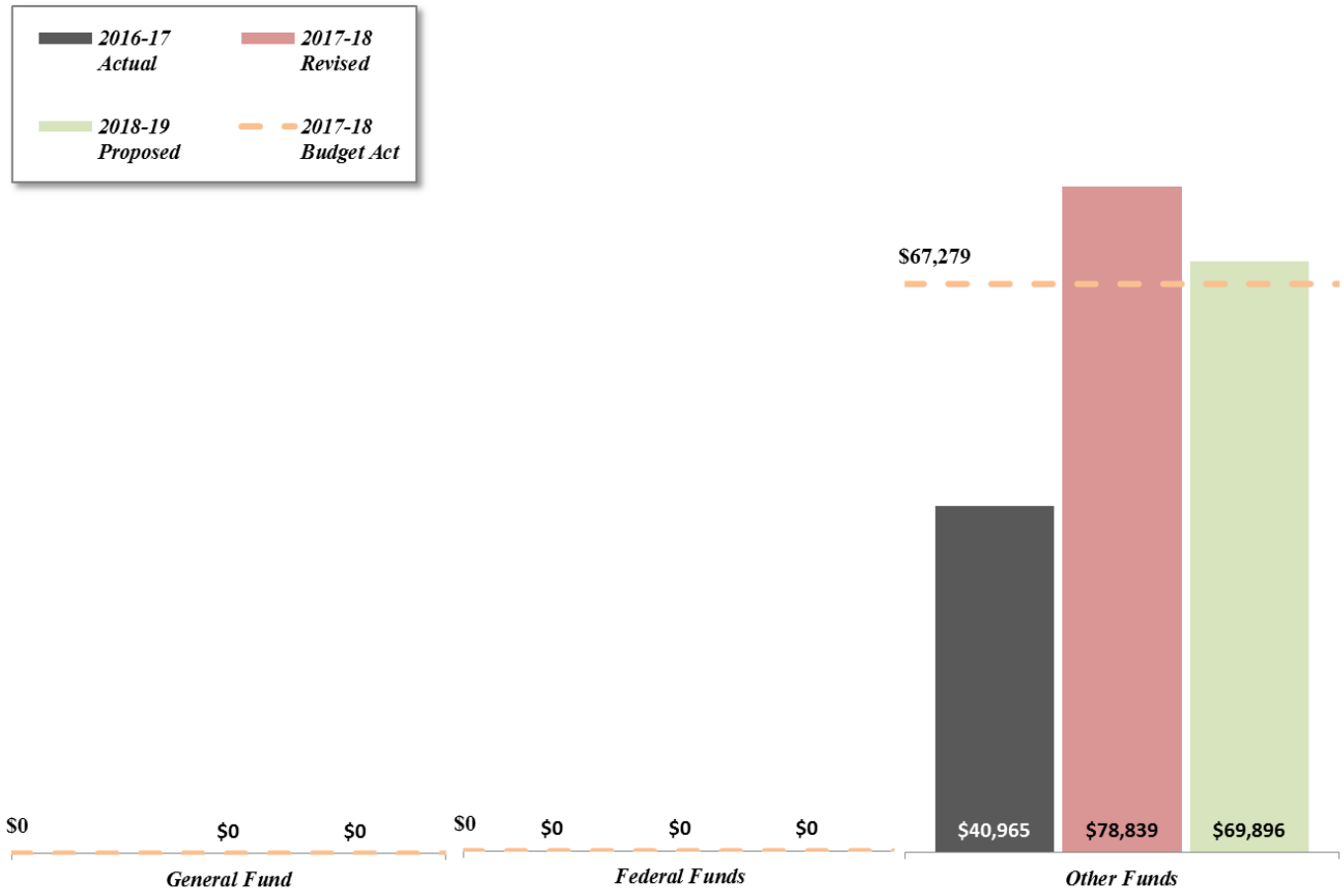
11. CBHDA: Please respond to the findings and recommendations of the audit related to the specific counties reviewed, as well as impacts on county mental health programs of the findings of the audit related to both DHCS and MHSOAC.

12. CBHDA: Do county mental health programs have any concerns about DHCS' actions to date regarding fiscal reversion? What challenges exist for counties in providing timely annual reports of MHSA revenues and expenditures?

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Overview

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



Mental Health Svcs Oversight & Accountability Commission - *Department Funding Summary*			
Fund Source	***2017-18 Budget Act***	***2017-18 Revised***	***2018-19 Proposed***
General Fund	$0	$0	$0
Federal Funds	$0	$0	$0
Other Funds	$67,279,000	$78,839,000	$69,896,000
Total Department Funding:	**$67,279,000**	**$78,839,000**	**$69,896,000**
Total Authorized Positions:	**29.0**	**26.6**	**26.6**
Other Funds Detail:			
Reimbursements (0995)	*$22,000,000*	*$22,000,000*	*$22,000,000*
Mental Health Services Fund (3085)	*$45,279,000*	*$56,839,000*	*$47,896,000*

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

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

Elected Officials:

- Attorney General
- Superintendent of Public Instruction
- Senator selected by the President pro Tem
- Assemblymember selected by the Speaker

12 members appointed by the Governor:

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

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

MHSOAC's responsibilities are as follows:

Review of MHSA Programs

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

Evaluations

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

Research

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

Triage

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

Stakeholder Contracts

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

Commission Projects

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

Technical Assistance & Training

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

Stakeholder Advocacy Contracts for Mental Health Issues Among Immigrants and Refugees. The California Pan-Ethnic Health Network (CPEHN) and the California Immigrant Policy Center (CIPC) request $1.3 million from the Mental Health Services Fund for MHSOAC to develop stakeholder advocacy contracts to support the mental health and engagement of immigrants and refugees. According to CPEHN and CIPC, the Trump Administration's continued scapegoating and attacking of immigrants has created a hostile atmosphere for many in our communities. The state has taken legislative action to limit the reach of the federal government and invested additional resources in support of immigrant legal services. Immigrants and refugees continue to show their strength and resiliency in weathering these attacks, but the cumulative impact takes a toll on the health and well-being of communities. As part of the MHSA, MHSOAC can support key partnerships, programs, and planning to meet the mental health needs of Californians and their families. In addition, pursuant to Welfare and Institutions Code Section 5892(d), the Mental Health Services administrative fund must include funds to promote stakeholder engagement in decisions concerning the public mental health system. The 2015 Budget Act included funds to increase stakeholder engagement among diverse racial and ethnic communities and among veterans, and the 2016 Budget Act included funds to increase stakeholder engagement among LGBTQ communities. CPEHN and CIPC request funding for stakeholder contracts to include mental health issues among immigrant and refugee communities.

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

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

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

2. Please briefly comment on the proposal for stakeholder advocacy contracts for mental health issues among immigrants and refugees.

Issue 2: County Mental Health Innovation Planning

Budget Issue. MHSOAC requests expenditure authority from the Mental Health Services Fund of $2.5 million in 2018-19 and 2019-20. If approved, these resources would allow MHSOAC to contract with a private entity to provide support to counties in developing plans for innovative programs under the Mental Health Services Act, specifically to address community mental health diversion efforts for individuals found incompetent to stand trial.

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2018-19**	**2019-20**
3085 – Mental Health Services Fund	$2,500,000	$2,500,000
Total Funding Request:	**$2,500,000**	**$2,500,000**

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

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

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

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

The Innovation component of MHSA expenditures provide county mental health programs the opportunity to develop and test new, unproven approaches to service delivery, or to adapt existing strategies to improve mental health services. This component includes specific goals for improving delivery of services under the CSS and PEI components of the MHSA by: increasing access to underserved groups, increasing the quality of services, promoting interagency collaboration, and increasing access to services including permanent supportive housing. One of the primary goals of the MHSA PEI component is reducing negative outcomes from mental illness including incarceration.

MHSOAC is responsible for approving county expenditure plans for Innovation funding. Prior to submitting an Innovation plan for consideration, counties must provide a 30 day public review, conduct a local mental health board hearing, and either have approval or a calendared appearance date for approval by the county board of supervisors. After these steps have been completed, counties submit a

final Innovation plan, including a budget, to the MHSOAC, which reviews the proposal and provides technical assistance to make any necessary modifications to address questions or concerns. Finally, counties present the Innovation plan to the MHSOAC, which approves or rejects the proposal.

Incompetent to Stand Trial Community Mental Health Diversion. Mental Health Diversion – In the Governor's January budget, the Administration proposed a mental health diversion package of $117.3 million ($114.8 million General Fund and $2.5 million Mental Health Services Fund) to increase the state-county partnership to address the growing number of people in the criminal justice system found incompetent to stand trial due to mental health impairments. Specifically, the proposal includes:

- $100 million General Fund spent over three years for community alternatives to increase diversion from the criminal justice system for people who are mentally ill.
- $14.8 million General Fund for a partnership between the Department of State Hospitals and Los Angeles County to provide treatment in the community for up to 150 people who have been found incompetent to stand trial.
- $2.5 million from the Mental Health Services Fund for MHSOAC to provide two years of consulting services to assist counties in developing diversion programs.

This request for resources from MHSOAC is a component of the Administration's package of IST diversion proposals.

Challenges for County Implementation of Innovative Programs. While MHSA provided significant new funding to counties for mental health programs, the funds are required to be expended within three years. Funds not expended within three years are subject to reversion to the state for redistribution to other counties. According to a recent state audit, $230.8 million of MHSA funds were subject to reversion as of June 2016. Of that figure, $145.6 million (63.1 percent) were funds allocated for Innovation.

According to MHSOAC, 52 counties (88 percent) have presented an Innovation plan since 2013. The details of Innovation plan submissions by fiscal year are as follows:

Fiscal Year:	# of Counties	# of Projects	Total INN Dollars	Total INN Extensions
2013-14	8	14	$7,867,712	$-
2014-15	16	26	$127,742,348	$1,111,054
2015-16	15	17	$46,920,919	$5,587,378
2016-17	18	27	$66,347,688	$2,008,608
2017-18	10	21	$88,557,465	$5,172,606

Technical Assistance for Innovation Plans for IST Diversion. MHSOAC requests expenditure authority from the Mental Health Services Fund of $2.5 million in 2018-19 and 2019-20 to contract with a private consultant to provide technical assistance to counties in developing innovation plans, with a particular focus on IST diversion. According to MHSOAC, the consultant will bring together experts from health care, technology, communications, and translational science and management sectors to improve utilization of Innovation funds. Counties would not be required to participate or use the services provided by the contractor. However, those counties that do participate will benefit from a collaborative process with the contractor and MHSOAC in developing successful Innovation plans

focused on diversion programs to reduce the number of individuals referred to state hospitals as incompetent to stand trial.

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

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

1. Please provide a brief overview of this proposal.

2. Please provide examples of what types of programs for community mental health diversion for the IST population or other justice-involved populations could be funded by existing or future MHSA Innovation funds.

3. If Innovation funds are part of a county's proposal to DSH for an IST diversion grant, how would MHSOAC collaborate with DSH to ensure timely approval of both the Innovation component and the IST diversion component? What would be the expected timeframe for approval?

4440 DEPARTMENT OF STATE HOSPITALS
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Incompetent to Stand Trial (IST) Population – Overview

Background. The Department of State Hospitals (DSH) admits individuals found incompetent to stand trial (IST) under Section 1370 of the Penal Code, typically for felony offenses, and provides clinical and medical services to restore these individuals to competency. Because of capacity constraints within the state hospital system, 840 individuals in the IST population are housed in county jails because they are awaiting placement into a state hospital bed or jail-based competency program. This backlog, which has grown 40 percent in the last year, places operational and fiscal stress on county jails and may violate the rights of individuals in custody for longer than a reasonable time to evaluate their potential for restoration to competency.

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

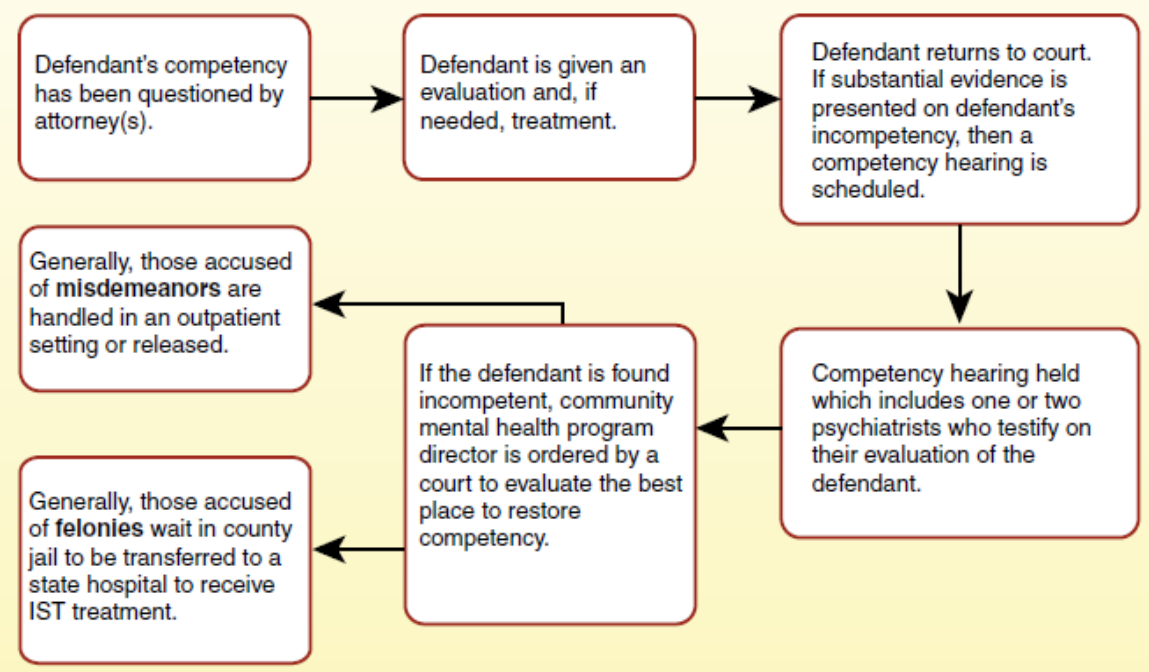


Figure 1: Incompetent to Stand Trial Commitment Process
Source: "*An Alternative Approach:Treating the Incompetent to Stand Trial", Legislative Analyst's Office, Jan 2012*

Long-Standing Issues with IST Backlog. Since the 2007-08 fiscal year, the backlog of IST referrals awaiting treatment in state hospitals has grown from between 200 and 300 to 840 as of December 2017. In 1972, the United States Supreme Court found in *Jackson v. Indiana* that a person committed on account of his or her incapacity to proceed to trial cannot be held for longer than the reasonable period of time necessary to determine whether the individual is likely to attain capacity. California law requires state hospital or outpatient facility staff to report to the court within 90 days on the status of the defendant's restoration to competency. Based on this 90 day requirement, several court rulings have recommended that a "reasonable" time to transfer IST patients for treatment is no more than 30 to 35 days. Many IST patients remain in county custody for longer, which may violate these patients' due process rights. In addition, the housing of IST patients in county jails while they await availability of treatment beds in state hospitals places stress on county jail systems.

Administration Proposals to Increase IST Capacity in State Hospitals. Over recent years, the Administration has proposed a series of projects to expand capacity in State Hospitals for the treatment of IST patients. These proposals were in response to the growing backlog of IST patients in county jails over the last ten years. In addition to a $117.5 million package to promote community-based diversion of those at risk for being referred as IST, the budget includes several proposals that implement previously approved capacity expansions at State Hospitals.

Metropolitan State Hospital Secured Bed Capacity Increase. DSH requests 346.1 positions and General Fund expenditure authority of $53.1 million in 2018-19 and 473.4 positions and General Fund expenditure authority of $69 million in 2019-20 and annually thereafter to activate newly secured units at Metropolitan State Hospital to provide increased capacity for the treatment of IST patients. The 2016 Budget Act included capital outlay construction funding to securely enclose existing patient buildings

that currently house civilly committed patients under the Lanterman-Petris-Short (LPS) Act. Once secured, the LPS patients currently housed in these units will be transferred to non-secured buildings elsewhere on the Metropolitan campus and allow for additional secured capacity for the treatment of IST patients currently in county jails awaiting state hospital treatment. This request activates and provides staff for approximately 236 forensic beds over the course of 2018-19 to treat IST patients.

Metropolitan State Hospital Per Patient Operating Equipment and Expenses. DSH requests General Fund expenditure authority of $3.7 million annually to fund the operating equipment and expenses associated with the activation of the additional 236 beds for the treatment of IST patients at Metropolitan State Hospital.

Jail-Based Competency Treatment Program Activation. DSH requests General Fund expenditure authority of $516,000 in 2017-18, $8.1 million in 2018-19, and $8.3 million in 2019-20 and annually thereafter to activate jail-based competency treatment (JBCT) beds for the treatment of IST patients in county jails, pursuant to approval of program expansions in previous budget requests. DSH contracts with county jail facilities to provide restoration of competency services in jails, treating IST patients with lower acuity and that are likely to be quickly restored to competency. The current system-wide census of IST patients receiving JBCT services is 173 as of June 30, 2017. This request nets savings from delayed implementation of existing JBCT contracts in Mendocino, Sacramento, and Stanislaus counties with additional costs for the activation of five JBCT beds in Riverside and 50 beds in San Bernardino.

Coalinga State Hospital MDO Bed Activation. DSH requests 81.2 positions and General Fund expenditure authority of $11.5 million in 2018-19 and 96.9 positions and General Fund expenditure authority of $13.7 million in 2019-20 to increase capacity for the treatment of mentally disordered offenders (MDOs) at Coalinga State Hospital. This increased capacity is intended to allow transfer of MDOs from other State Hospitals to create additional capacity in those State Hospitals for the treatment of IST patients. Coalinga has already increased its MDO capacity by 25 beds. This request will allow for a two-phase activation of an additional 80 beds during 2018-19.

Kern Admission, Evaluation, and Stabilization Center. DSH reports a reduction in General Fund expenditures in 2017-18 of $1.7 million related to delays in negotiation and execution of a contact with Kern County to establish an Admission, Evaluation, and Stabilization (AES) Center at the Lerdo Pre-Trial Facility located in Bakersfield. The Kern AES Center is expected to receive and treat IST patients committed to State Hospitals directly from nearby catchment counties.

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

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

1. Please provide a brief overview of treatment of the IST population in State Hospitals.

2. Please detail implementation of capacity expansions related to treatment of IST patients contained in the 2018-19 Estimate.

3. Please provide historical background for the backlog of individuals referred as IST housed in county jails and efforts to increase capacity for this population.

4. What, if any, evidence exists that may suggest a cause for the continued increase in this population over the last several years?

Issue 2: IST Diversion Proposals – County Mental Health Treatment Partnerships

Budget Issue and Trailer Bill Language. DSH requests two positions and expenditure authority of $117.3 million ($114.8 million General Fund and $2.5 million Mental Health Services Fund) in 2018-19 to contract with counties to develop new or expand existing diversion programs for individuals with serious mental illness with potential to be found incompetent to stand trial (IST) on felony charges.

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$114,800,000	$376,000
3085 – Mental Health Services Fund*	$2,500,000	$2,500,000
Total Funding Request:	**$117,300,000**	**$2,876,000**
Total Positions Requested:**	**2.0**	**2.0**

* Mental Health Services Fund is also separately reflected in the MHSOAC budget request.
** Positions are limited-term and would be authorized through 2020-21.

Background. DSH admits individuals found incompetent to stand trial (IST), typically for felony offenses, and provides clinical and medical services to restore these individuals to competency. Because of capacity constraints within the state hospital system, 840 individuals in the IST population are housed in county jails because they are awaiting placement into a state hospital bed or jail-based competency program. This backlog, which has grown 40 percent in the last year, places operational and fiscal stress on county jails and may violate the rights of individuals in custody for longer than a reasonable time to evaluate their potential for restoration to competency. The budget includes the latest in a series of Administration proposals over recent years to address the IST backlog. While previous Administration IST proposals have focused primarily on increasing capacity within State Hospitals and jail-based competency treatment (JBCT) programs, these proposals focus primarily on community-based treatment and diversion of IST patients or individuals with serious mental illness at risk of future referral for IST treatment due to potential involvement with the criminal justice system.

State-County Partnerships for Diversion of Potential IST Offenders. DSH requests trailer bill language and General Fund expenditure authority of $100 million to contract with counties to develop new or expand existing diversion programs for individuals with severe mental illnesses. These programs would be primarily focused on individuals diagnosed with schizophrenia, shizoaffective disorder, or bipolar disorder with the potential to be found IST on felony charges. Programs components would include:

- Evidence-based community mental health treatment and wrap around services, such as forensic assertive community treatment teams, crisis intervention teams, forensic alternative centers, intensive case management, criminal justice coordination, peer support, supportive housing, and vocational support.
- Targeting of individuals with serious mental illnesses where a nexus exists between the illness and the alleged criminal activity, there is significant evidence of mental illness at the time of the alleged crime, the crime is driven by conditions of homelessness, and the individual does not pose a significant safety risk if treated in the community.

Counties would be required to contribute matching funds of 20 percent of the program costs and provide outcomes data on the success of the program towards the goal of reducing IST referrals by 30 percent. In addition to funding for county diversion contracts, DSH requests one Chief Psychologist and one Health Program Specialist I position on a three-year, limited-term basis to provide diversion and risk assessment expertise and to review and provide technical assistance for county diversion proposals.

Los Angeles County Community Mental Health Treatment of IST Offenders. DSH requests General Fund expenditure authority of $14.8 million to contract with Los Angeles County for 150 beds to treat IST patients in community settings, based on the county's experience in treating misdemeanor IST patients in similar settings. The contract, currently under negotiation to begin July 2018, would provide a coordinated continuum of mental health placements including five beds in a locked acute psychiatric hospital, 45 beds in a locked Institute for Mental Disease or mental health rehabilitation center, and 100 beds in residential facilities with clinical and supportive services. Los Angeles County has approximately 185 IST offenders awaiting state hospital placement. The contract will also include $2.5 million of funding for Los Angeles County staffing resources for 10-12 positions, including a clinical team of six to eight staff members, which would provide patient support by stabilizing patients on medications and preparing them for community placement, and a navigation team of two to three staff members to support connections to social services and other needs.

	Locked Inpatient	Locked IMD type IMD Type	Unlocked, secured, Clinically Enhanced Type
Proposed # of Beds	5	45	100
Facility Type	General Acute Care Hospital or Acute Psychiatric Hosptial -- likely Olive View Medical Center	Low acuity hospital, and/or Nursing facility; licenses as an Institute for Mental Disease facility or a Mental Health Rehabilitation Center	Residential site with clinical and supportive services on-site
Facility Bed Capacity	18 total beds with 5 set aside for this project	2 different facilities: 1st up to 15 beds in San Fernando Valley part of LA County; 2nd with up to 35 beds in southern LAC or San Diego County	3-5 sites across LA County with 20-40 beds each
Security	Locked unit	Locked facilities	Open, but gated and with staff and security cameras monitoring entrance/exit
Staffing	24/7 nursing and MD staff, full-time clinical SW and support staff	24/7 nursing staff, M-F and on call MD staff, full-time clinical SW and support staff	24/7 case management and security staff, full-time clinical social work and nursing staff; potentially nurse practitioner on call
Treatment	Stabilization of Acute Mental Health or Medical symptoms	Sub-acute stablization of patients who do not require acute care, but who are not clinically ready for outpatient care and restoration of competency treatment.	Outpatient treatment, maintenance of stabilization, on-site psychiatric care, medication support and monitoring, group and individual therapy and restoration of competency treatment.

Figure 1: Los Angeles County IST Restoration in Community Mental Health Treatment Placements
Source: *2018-19 Department of State Hospitals Governor's Budget Proposals and Estimate*

MHSOAC Funding for Coordination of Innovative Programs for Diversion. MHSOAC requests $2.5 million from the state administration account of the Mental Health Services Fund for a consultant to evaluate existing county plans and innovative strategies to address local mental health needs, coordinate with the state and counties to utilize existing resources and programs to support mental health treatment, and assist counties with coordination of programs to support IST diversion efforts. This issue will be heard separately by the subcommittee (see also MHSOAC *Issue 2: County Mental Health Innovation Planning*).

Stakeholder Proposal – Community Mental Health Diversion for IST and State Prisoners. Stanford Law School's Three Strikes Project requests trailer bill language to expand upon the Administration's IST diversion proposal to address unmet mental health needs among both State Hospital patients and individuals incarcerated in state prisons. Modeled on similar incentive-based funding programs, such as SB 81 (Committee on Budget and Fiscal Review), Chapter 175, Statutes of 2007, and SB 678 (Leno), Chapter 608, Statutes of 2009, this proposal requires the Department of Finance, in consultation with other law enforcement agencies and entities, to calculate the state costs of incarceration in state prisons or restoration of competency treatment in State Hospitals and share 35 percent of those costs with counties for every individual with mental illness diverted to community-based treatment below a certain baseline threshold.

According to the Three Strikes Project, more than 30 percent of California prisoners currently receive treatment for a serious mental disorder, which represents a 150 percent increase since 2000. In addition, the severity of psychiatric symptoms of state prisoners has risen dramatically over the last five years. Defendants with mental illness receive longer prison sentences, on average, and some counties send a disproportionate number of defendants with mental illness to state prison.

While the Administration's proposed investment in community mental health diversion programs is a necessary component of addressing unmet mental health needs in the community that may lead to involvement in the justice system, the solitary focus on IST referrals ignores the equally challenging public health problem and fiscal impacts of individuals with severe mental illness sentenced to state prisons. The Three Strikes Project proposal, which is also contained in SB 142 (Beall) and would be combined with the Administration's current IST community mental health diversion proposal, incorporates financial incentives for counties to divert more at-risk individuals for community treatment and provides an ongoing funding source for diversion programs.

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

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

1. Please provide a brief overview of the three proposals to address diversion and treatment of IST patients or individuals at risk of referral as IST.

2. The Legislature previously approved $68 million of funding for infrastructure grants, administered by the California Health Facilities Financing Authority (CHFFA), to support community mental health diversion programs. How is DSH working with CHFFA to

coordinate its current infrastructure funding efforts with the programs envisioned by DSH as eligible for funding under its community-based mental health diversion proposal?

3. The community-based diversion proposal provides $100 million for three years for these state-county partnerships. Are county programs expected to utilize these funds for one-time expenditures, or for an ongoing program? How would counties be expected to sustain programs without ongoing funding?

4. Counties would be expected to provide outcomes data for funded diversion programs. How would DSH hold counties accountable for meeting the objectives of these programs, particularly the goal of diverting 30 percent of current IST referrals for treatment in the community?

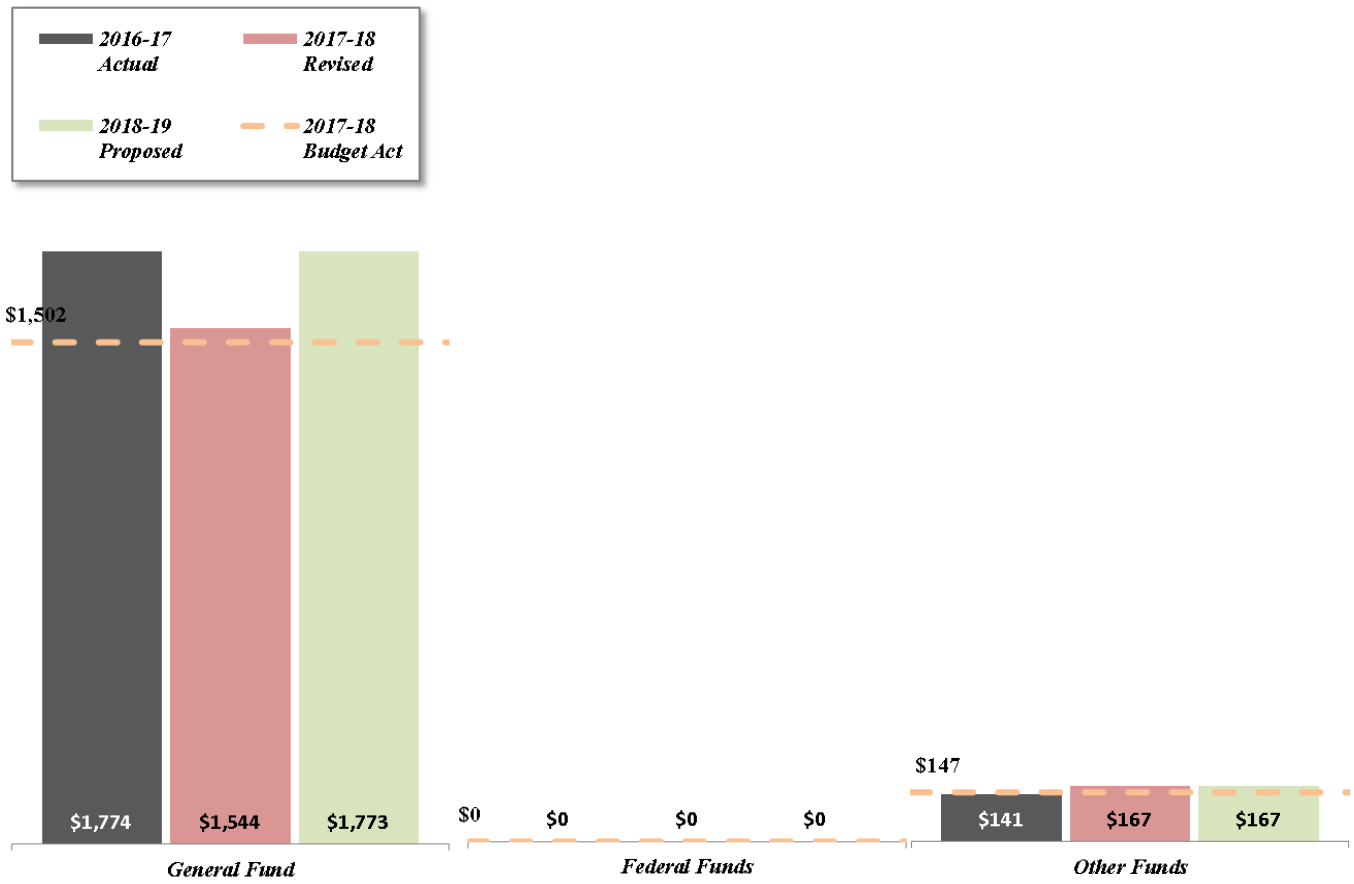
5. Does DSH or the Administration generally expect these community mental health diversion programs for individuals at risk of justice involvement to have the additional benefit of diverting individuals from incarceration in county jails or state prisons, as well as reducing felony IST referrals to State Hospitals?

6. DSH provides hospital-based and jail-based treatment and restoration of competency for individuals referred from counties as IST. What expertise does DSH possess that will allow it to effectively identify best practices for community-based diversion programs at the county level?

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: Overview

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



Department of State Hospitals - *Department Funding Summary*			
Fund Source	***2017-18 Budget Act***	***2017-18 Revised***	***2018-19 Proposed***
General Fund	$1,501,897,000	$1,544,175,000	$1,772,657,000
Federal Funds	$0	$0	$0
Other Funds	$147,165,000	$167,295,000	$167,295,000
Total Department Funding:	**$1,649,062,000**	**$1,711,470,000**	**$1,939,952,000**
Total Authorized Positions:	**8569.6**	**9809.5**	**10344.1**
Other Funds Detail:			
CA State Lottery Education Fund (0814)	*$21,000*	*$32,000*	*$32,000*
Reimbursements (0995)	*$147,144,000*	*$167,263,000*	*$167,263,000*

Background. DSH oversees five state hospitals which comprise the largest inpatient forensic mental health hospital system in the nation. In addition to forensic admissions, which comprise 91 percent of its population, the five state hospitals admit individuals civilly committed under the Lanterman-Petris-Short (LPS) Act because they require physically secure 24-hour care and meet legal criteria that they represent a danger to themselves or others. The categories of individuals admitted to state hospitals for treatment are:

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

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

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

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

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

- ***Coleman*** **Class Patients (Mentally Ill Prisoners)** – *Coleman* patients are referred by the California Department of Corrections and Rehabilitation (CDCR) when they are found to be mentally ill while in prison. *Coleman* patients return to CDCR custody when they have received the maximum benefit from treatment. If these individuals are still mentally ill at the end of their prison term, they may be committed to DSH as MDO.

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

	2017-18	2018-19
Population by Hospital		
Atascadero	1,247	1,175
Coalinga	1,318	1,393
Metropolitan	807	1,043
Napa	1,269	1,269
Patton	1,509	1,492
Population Total	**6,150**	**6,372**
Population by Commitment Type		
Incomptent to Stand Trial (IST)	1,523	1,774
Not Guilty by Reason of Insanity (NGI)	1,407	1,404
Mentally Disordered Offender (MDO)	1,328	1,296
Sexually Violent Predator (SVP)	920	920
Lanterman-Petris-Short Civil Commitments (LPS)	628	634
Coleman Referrals	336	336
Dept. of Juvenile Justice (DJJ)	8	8
Jail-Based Competency Treatment (JBCT) Programs		
Riverside JBCT	25	25
San Bernardino JBCT	126	146
Sacramento JBCT (Male and Female)	44	44
San Diego JBCT	30	30
Sonoma JBCT	10	10
Kern Admission, Evaluation, and Stabilization (AES) Center	60	60
Mendocino JBCT	TBD	TBD
Stansislaus JBCT	12	12
Proposed Expansion of JBCT	--	54
Total JBCT Programs	**307**	**381**

Figure 1: State Hospital Population by Hospital, Commitment Type and JBCT Programs
Source: *2018-19 Governor's Budget Proposals and Estimates, Department of State Hospitals, January 2018*

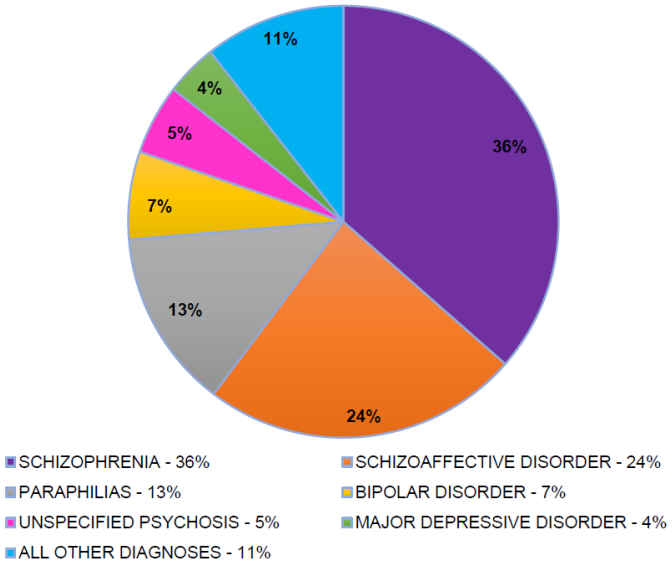


Figure 2: State Hospital Population By Major Diagnosis, as of July 1, 2017
Source: *Report on Measures of Patient Outcomes, Department of State Hospitals, January 2018*

The five state hospitals operated by DSH are:

- **Atascadero State Hospital –** Located on the Central Coast in San Luis Obispo County, Atascadero is a self-contained psychiatric hospital with an all-male population primarily composed of MDO, *Coleman*, IST, and NGI patients. Atascadero has a licensed bed capacity of 1,275 and an operational bed capacity of 1,185.

- **Coalinga State Hospital** – Located in the Central Valley in Fresno County, Coalinga is a self-contained psychiatric hospital with an all-male population primarily composed of MDO, *Coleman*, and SVP patients. Coalinga has a licensed bed capacity of 1,500 and an operational bed capacity of 1,310.

- **Metropolitan State Hospital** – Located in Norwalk in Los Angeles County, Metropolitan is an "open" style campus within a security perimeter. Due to community concerns, a formal agreement with the City of Norwalk and the county sheriff prohibits Metropolitan from accepting patients charged with murder or a sex crime, or at high risk for escape. Metropolitan primarily serves LPS, IST, MDO, and NGI patients and has a licensed bed capacity of 1,106 and an operational bed capacity of 826.

- **Napa State Hospital** – Located in Napa County, Napa has an "open" style campus within a security perimeter. Napa primarily treats IST, NGI and LPS patients and has a licensed bed capacity of 1,418 and an operational bed capacity of 1,270.

- **Patton State Hospital** – Located in the town of Highland in San Bernardino County, Patton is an "open" style campus within a security perimeter operated by correctional officers from CDCR due to concerns from the surrounding community. Patton primarily serves LPS, IST, MDO, and NGI patients, has a licensed bed capacity of 1,287, and an operational bed capacity of 1,527.

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

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

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

Issue 2: Unified Hospital Communications Public Address System – Phase 2

Budget Issue. DSH requests two positions and General Fund expenditure authority of $359,000 in 2018-19, $4.6 million in 2019-20, $7.7 million in 2020-21, and $3.7 million in 2021-22 and annually thereafter. If approved, these positions and resources would allow DSH to support an increase in maintenance costs for Phase 1, and implementation of Phase 2, of its Unified Hospital Communications Public Address System Project.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$359,000	$4,629,000
Total Funding Request:	**$359,000**	**$4,629,000**
Total Positions Requested:**	**2.0**	

* Additional fiscal year resources requested: 2020-21: $7,725,000; 2021-22: $3,721,000; 2022-23 (ongoing): $3,651,000
** Positions are ongoing after 2019-20.

Background. The 2015 Budget Act approved resources to fund Phase 1 of the implementation of a new public address system for the State Hospitals. The new Unified Hospital Communications Public Address (UHCPA) System is intended to improve communication and dissemination of information quickly and intelligibly throughout each hospital campus. According to DSH, once it is implemented, the UHCPA system will allow for two-way communications between public speakers in key areas and dispatch, allow for targeted announcements to specific hospital areas to prevent disruption in non-affected areas, provide clear and intelligible announcements, and allow message prioritization to prevent concurrent message delivery.

Phase 1 of implementation provided for the installation of the PA systems and associated local area networks (LAN) at Coalinga and Patton State Hospitals. Network-based PA systems can be integrated with a hospital's emergency system through a single interface, which can then broadcast appropriate warnings over the speakers on every floor in the event of an emergency or natural disaster. The UHCPA systems also provide complementary alert capability to the Personal Duress Alarm Systems (PDAS) implemented in recent years to provide alerts to nearby hospital police and other staff regarding incidents of physical aggression. According to DSH, the PDAS cannot inform staff when a response to an alert is no longer necessary. The UHCPA system can provide situational details to staff to respond appropriately to incidents of aggression and other emergencies.

Phase 2 of the UHCPA system project would provide for the installation of the system at Metropolitan, Atascadero, and Napa State Hospitals. DSH requests two Senior Information Systems Analysts, to be shared among the three hospital locations, to provide support for management of vendor contracts and performance, and to assist in integrating the new systems related to the PA system at the three hospitals. Implementation of Phase 2 would begin in October 2018 and proceed in three waves, concluding in January 2024. The DSH request includes contract resources of $1.7 million in 2019-20, $5.3 million in 2020-21, and $1.3 million in 2021-22 and annually thereafter for maintenance and operations of the system, as well as non-capital asset equipment purchases of $2.6 million in 2019-20, $2.1 million in 2020-21 and 2021-22, and $2 million in 2022-23 and annually thereafter.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Ongoing Costs for Personal Duress Alarm System

Budget Issue. DSH requests ongoing General Fund expenditure authority of $2.7 million. If approved, these resources would allow DSH to support ongoing maintenance and service for its Personal Duress Alarm System Project.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$2,700,000	$2,700,000
Total Funding Request:	**$2,700,000**	**$2,700,000**

* Resources are ongoing after 2019-20.

Background. The 2013 Budget Act approved resources to implement a Personal Duress Alarm System (PDAS) within the State Hospital system. PDAS units are used to alert hospital police and other nearby employees when a duress incident occurs. The system was approved in response to significant numbers of violent incidents within State Hospitals. According to 2013 data, patients committed 2,586 physically aggressive acts against staff and 3,344 physically aggressive acts against other patients.

According to DSH, when the PDAS project was initially approved and funded, the budget did not include sufficient funding to cover upgrades to new models or versions of equipment necessary for ongoing maintenance of the system. Vendors frequently introduce new models and versions of equipment and phase-out support of older models and versions. DSH requests General Fund resources of $2.7 million annually to refresh hardware components of the PDAS system as they reach the end of their useful life and are no longer supported by the manufacturer. According to the manufacturer, the refresh periods for the major PDAS components are as follows:

Replacement Item	Replacement Unit Cost	Refresh Cycle in Years
Personal Duress Alarm		
Ekahau tag	106.92	2
Ekahau charger	10.80	5
Access Point - Indoor	638.60	4
Access Point - Outdoor	3,087.14	4
Catalyst and Core Switches		
Cisco core switches	82,770.66	5
Cisco Catalyst 32 Port MDF switches	43,235.53	5
Cisco Catalyst 24 Port MDF switches	27,378.32	5
Cisco Catalyst 16 Port MDF swithces	20,778.44	5
Cisco Catalyst 3750/3850 IDF - 24 Port	6,872.69	5
Cisco Catalyst 3750/3850 IDF - 48 Port	11,071.73	5
Cisco Catalyst 4xxx IDF switches	25,646.22	5
Cisco Controllers and Servers		
Cisco Wireless LAN Controller	128,875.54	6
Cisco Nexus UCS	53,462.38	6
Cisco UCS server	40,550.03	6
EMC VNX Storage Area Network	69,784.20	6

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

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

1. Please provide a brief overview of this proposal.

Issue 4: Information Security Program Expansion

Budget Issue. DSH requests two positions and General Fund expenditure authority of $3.1 million in 2018-19 and $1.7 million in 2019-20 and annually thereafter. If approved, these positions and resources would allow DSH to provide adequate staffing to protect information assets and remediate findings identified in a recent security assessment by the California Military Department.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$3,080,000	$1,678,000
Total Funding Request:	**$3,080,000**	**$1,678,000**
Total Positions Requested*:	**2.0**	

* Positions and resources are ongoing after 2019-20.

Background. AB 670 (Irwin), Chapter 518, Statutes of 2015, authorizes the California Department of Technology (CDT) to conduct independent security assessments of state departments and agencies, requiring no fewer than 35 assessments be conducted annually. AB 670 requires CDT to prioritize for assessment state departments or agencies that are at higher risk due to handling of personally identifiable information or health information protected by law, handling of confidential financial data, or levels of compliance with certain information security and management practices. Independent security assessments are conducted by the Cyber Network Defense (CND) Team at the California Military Department.

Because DSH systems contain confidential and sensitive information, including Social Security Numbers and protected health information, DSH underwent a CND security assessment in October 2017. In January 2018, DSH also initiated a security review pursuant to the requirements of State Administrative Manual Section 5300 and HIPAA Security Rules. Both of these assessments identified similar findings:

1. Existing asset tracking practices do not include a comprehensive inventory of all information system components, nor permit full life cycle management of information assets.
2. Continuous monitoring of systems and alerting on security incidents has not been possible due to lack of personnel in security operations positions.
3. Detection of rogue devices connected to the DSH network is not possible using existing tools and personnel.
4. Insufficient funds exist for training of staff on modern, industry-standard secure coding techniques.
5. Scanning of systems for vulnerabilities is completed by security staff, but system hardening and remediation of vulnerabilities is difficult or impossible with existing tools.

DSH Requests Resources to Remediate Findings of the Security Assessment. In order to remediate the findings of the CND and internal security assessments, DSH requests two permanent positions and General Fund expenditure authority of $3.1 million in 2018-19 and $1.7 million in 2019-20 and annually thereafter. Specifically, DSH requests:

1. **One Systems Software Specialist II** to lead technical staff managing and maintaining the system which inventories all assets and tracks them through their lifecyle.

2. **One Systems Software Specialist II** to serve as lead technical staff managing and maintaining the system which monitors the threats to the Department's information technology resources from external and internal sources.
3. **Security System Solutions** including inventory and asset management, security information and event management, patching solutions for non-Microsoft applications, secure code review solutions and training, and on-premise rogue device detection paired with mobile and cloud security solutions.

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

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

1. Please provide a brief overview of this proposal.

Issue 5: Electronic Health Records Planning

Budget Issue. DSH requests four positions and General Fund expenditure authority of $1.3 million in 2018-19 and $713,000 in 2019-20. If approved, these positions and resources would allow DSH to complete Stages 3 and 4 of the Project Approval Lifecycle process for implementation of an integrated electronic health record for State Hospital inpatients.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$1,267,000	$713,000
Total Funding Request:	**$1,267,000**	**$713,000**
Total Positions Requested*:	**4.0**	

* Positions are ongoing after 2019-20.

Background. DSH manages the nation's largest inpatient forensic mental health hospital system. The five State Hospitals managed by DSH employ nearly 11,000 staff and served 13,403 patients with an average daily census of 7,087 in 2016-17. The department's jail-based competency programs served a total of 729 patients with a capacity of 178 and its conditional release program (CONREP) maintains an average daily census of approximately 636.

According to DSH, the size of the State Hospital system and its affiliated programs result in complex problems maintaining continuity of patient care and the accurate flow of information and patient data within and among hospitals and external care providers. Intra-hospital patient transfers occur frequently to accommodate changes in levels of care, commitment codes, safety, proximity to family and social supports, and other individualized needs. DSH reports it uses approximately 27 separate systems related to admissions, registration, pharmacy, billing, and primary medical care functions.

DSH also reports that it is out of compliance with the federal Health Information Technology for Economic and Clinical Health (HITECH) Act, which provides assistance and support for organizations to become meaningful users of electronic health records (EHR). DSH also reports it is out of compliance with federal and state recommendations that it adopt an inventory system to safeguard pharmaceutical drugs. As a result, DSH is seeking to implement an EHR system, and is collaborating with Cerner, a supplier of Health Information Technology solutions, as one possible alternative solution.

DSH seeks to replace certain key functions currently managed by other systems with implementation of an EHR system. Specifically, DSH seeks to replace admissions registration, pharmacy services, billing, and certain primary care business functions currently managed through other processes or through no process at all. DSH is seeking to achieve improvement in the following metrics:

1. Admission Registration
    a. Decrease the number of returning DSH patients incorrectly matched with previous records.
    b. Assign 100 percent of patients a single patient identifier across all electronic systems.
2. Pharmacy Services
    a. Provide access to active medication list for patients (Goal: 80 percent of patients within the first 90 days).

   b. Provide data exchange between pharmacy and billing systems, which does not currently exist.
3. Billing
   a. Reduce the number of Medicare claims returned with errors to less than 25 percent.
   b. Provide accurate patient cost of care accounts to reduce reconciliation time and labor.
   c. Eliminate instances of double billing.
4. Primary Care
   a. Provide exchange of data between primary care and other systems, which does not currently exist.
   b. Provide functionality to complete 100 percent of documents electronically.

DSH intends its proposed EHR system to meet confidentiality, security, and privacy requirements for protected health information (PHI) and personally identifiable information (PII) and other state and federal requirements. DSH also indicates it intends the EHR to be interoperable with external EHR systems to allow for continuity of care and data exchange for State Hospital patients discharged into the community.

Resources Requested to Complete Project Approval Lifecycle. DSH has begun the Project Approval Lifecycle process required by the California Department of Technology. The Stage 1 Business Analysis is complete and DSH is finalizing its Stage 2 Alternatives Analysis. According to DSH, the Stage 2 Alternatives Analysis is evaluating lower cost options to implement an EHR system, as its initial special project report indicates the cost is over $386 million.

DSH requests the following positions and resources to complete Stages 3 and 4 of the Project Approval Lifecycle:

1. **One Data Processing Manager IV** to serve as project manager to track and manage all EHR project readiness and governance efforts.
2. **One Data Processing Manager II** to serve as contract manager to coordinate among control agencies, DSH legal EHR experts, and project planning team members to ensure the solicitation development, selection, and award is properly planned and executed.
3. **One Health Program Specialist I** to implement organizational readiness activities to ensure the billing functions are integrated effectively with the clinical goals of the project.
4. **One Attorney III** to serve as a legal expert to ensure all HIPAA, privacy, and contractual considerations and requirements are addressed.
5. **Contract Resources** of $500,000 one-time to hire EHR implementation consultants. These consultants will focus on organizational readiness, provide guidance based on market research and contract preparation, and serve as subject matter experts, soliciting and incorporating input from DSH clinicians.

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

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

1. Please provide a brief overview of this proposal.