Joint Oversight Hearing

Assembly and Senate Health Committees
Assembly Budget Subcommittee No. 1 on Health and Human Services and Senate Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services

Tuesday, February 21, 2012, Upon Call of the Chairs – Room 4202

Restructuring the Behavioral Health System in California

This joint hearing of the Assembly Health Committee, the Senate Health Committee, the Assembly Budget Subcommittee No. 1 and the Senate Budget Subcommittee No. 3 will examine the implementation of budget and statutory changes related to community-based mental health and drug and alcohol services enacted through budget and health and human services budget trailer bill legislation in 2011, and the Administration's proposed mental health and substance use disorder budget changes for the 2012-13 budget.

Background on Mental Health and Substance Use Prevalence in California
As part of federal approval of California's 2010 "Bridge to Reform" Medicaid waiver, the Centers for Medicare and Medicaid Services (CMS) required California to submit a mental health and substance use needs assessment. This assessment is due to CMS on March 1, 2012, and a draft report was released for public review and comment on January 31, 2012. While the primary purpose of the needs assessment was to review the needs and service utilization of current Medi-Cal recipients and identify opportunities to prepare Medi-Cal for the expansion of enrollees and the increased demand for services resulting from health reform, but the draft report provides estimated prevalence for the entire state population. Findings of the statewide estimated prevalence from the draft report are as follows:

Youth (0-17) with serious emotional disturbance	7.56%
Adults with serious emotional disturbance	4.28%
Adults: broad definition of mental health need	15.85%
Youth (0-17) with substance use needs	2.7%
Adults (18+) with substance use needs	8.76%

In addition to the needs assessment, CMS required California to submit for CMS approval a detailed behavioral health services plan, including how the state will coordinate with the Department of Mental Health (DMH) and Department of Alcohol and Drug Programs (DADP) outlining the steps and infrastructure necessary to meet requirements of a benchmark plan no later than 2014. This plan is due to CMS by October 1, 2012. It is important to note that although substance use disorder (SUD) services were included in the assessment, SUD services were not made part of the 1115 waiver, and so are not being addressed in the "Bridge to Reform" in any direct way.

Background on California's Public Mental Health System
California has a decentralized public mental health system with most direct services provided through the county mental health system. The system of community-based mental health services was initiated through the Short-Doyle Act of 1957, which created a funding structure for the development of community-based mental health services. The purpose of the Short-Doyle Act was to develop a community-based system of services to improve care and encourage deinstitutionalization by providing state matching fund reimbursement for local mental health services. In 1968, the Lanterman-Petris-Short Act established standards for the involuntary treatment of individuals and increased the state funding participation rate for community mental health programs. Beginning with a pilot program in the early 1970s, Short-Doyle mental health program were allowed to draw down federal Medicaid matching funds to match their own funding to provide certain mental health services to Medi-Cal eligible individuals.

In response to state fiscal problems in the 1980s, the state began to reduce its General Fund commitment to mental health services. In 1990-91, the state faced an estimated $14 billion General Fund shortfall, and numerous programs, including mental health, faced reductions. In 1991, the Legislature passed and Governor Wilson signed into law AB 1288 (Bronzan and McCorquodale), Chapter 89, Statutes of 1991, which realigned the fiscal and administrative responsibility for county mental health care. The intent of mental health realignment was generally to provide a more stable funding source for community-based services, to shift program accountability to the local level, establish local advisory boards in each county to provide advice to local mental health directors, make services more client-centered and family-focused, develop performance measures and outcome data, and redefine the role of the state in providing services through the state hospital system and its responsibilities in program oversight and evaluation.

In 1992, realignment funding replaced about $700 million in state General Fund support for community mental health services. Realignment revenues, funded by an increase in the sales tax and in vehicle license fees, are collected by the state and allocated to various accounts and subaccounts in the Local Revenue Fund. The Mental Health Subaccount was the principal fund that contains revenues for the provision of local mental health services. These funds are distributed to the counties on a formula basis as contained in statute.

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA). Proposition 63 enacted a surcharge on incomes over $1 million annually, and dedicated the resulting revenue to expanding community mental health programs. The MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system, with the purpose of promoting recovery for individuals with serious mental illness.

Background on California's Substance Use Disorder Services
California's system for the provision of substance use disorder (SUD) services is primarily run at the county level, overseen by the Department of Alcohol and Drug

Programs (DADP). DADP administers the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, nearly $260 million in 2011-12 with a Maintenance of Effort requirement, and other discretionary grants from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the Parolee Services Network Program, Narcotic Treatment Program, Driving Under the Influence Program, Office of Problem Gambling, and Drug Court Programs. DADP also certifies and licenses SUD providers in the community and, until the transfer approved for 2011-12, administered the Drug Medi-Cal Treatment Program (DMC), which accounted for about a quarter of the functions at the Department.

DADP contracts with counties and direct service providers for the provision of DMC. County participation in DMC is optional, and counties may elect to provide services directly or subcontract with providers for these services. All but approximately 15 California counties currently maintain a program. If a county chooses to not participate in DMC and a certified provider within that county indicates a desire to provide these services, DADP currently executes a service contract directly with the provider.

The five covered services for the DMC program listed in Section 4.19B of California's Medicaid State Plan include:

- Day Care Rehabilitation Treatment - Minimum of three hours per day, three days per week, for EPSDT-eligible beneficiaries and pregnant and postpartum women only.
- Outpatient Drug Free Services – Individual counseling for 50-minute minimum or group counseling for 90-minute session.
- Perinatal Residential Substance Abuse Treatment – 24-hour structured environment, excluding room and board, for pregnant women and mothers.
- Naltrexone Treatment Services – Face-to-face contact per calendar day for counseling and/or medication services.
- Narcotic Treatment Services – Core services (intake assessment, treatment planning, physical evaluation, drug screening, and physician supervision), laboratory work (tuberculin and syphilis tests, monthly drug screening, and pregnancy tests for certain patients), dosing (ingredients and dosing for methadone and other patients).

Medi-Cal Managed Care plans exclude from their contracts all services available under the DMC Program as well as outpatient drug therapies that are listed in the Medi-Cal Provider Manual as alcohol and substance abuse treatment drugs, and reimbursed through the Medi-Cal fee-for-service program.

In 2000, California voters approved the Substance Abuse and Crime Prevention Act, or Proposition 36, which changed state law so that certain adult offenders who use or possess illegal drugs are sentenced to participate in drug treatment and supervision in the community rather than being sentenced to prison or jail, supervised on probation, or going without treatment. From 2001-02 until 2005-06, Prop. 36 provided annual appropriations of $120 million General Fund for related substance abuse treatment

programs. The Offender Treatment Program was an adjacent program, and the two programs were funded fully, then partially over the course of the next several years. The 2009-10 Budget included minimal federal funding and no General Fund for the programs. The two programs have remained with no funding since that time.

Drug court programs combine judicial monitoring with intensive treatment services over a period of about 18 months typically for nonviolent drug offenders. In general, these are county-administered programs through which the state provides funding and oversight. There are two main programs – the Drug Court Partnership Act program created in 1998 that supports adult drug courts in 32 counties and the Comprehensive Drug Court Implementation Act program created in 1999 that supports adult, juvenile, family, and some Dependency Drug Courts in 53 counties.

Overview of 2011 Realignment

In his first proposed budget for the 2011-12 fiscal year, Governor Brown called for a vast and historic realignment of government services in California. In his January 2011-12 budget summary, Governor Brown stated that realignment of government in California will allow governments at all levels to focus on becoming more efficient and effective. The Governor sought to more clearly define the role of the state and local government in service delivery. In his summary, the Governor stated the goal of realignment is to find the level of government where a service can best and most cost-effectively be delivered, and then provide a permanent funding source.

Through a series of budget bills and trailer bills, many provisions of the Governor's proposal to realign public safety and health and human services to counties were enacted into law. One of the primary vehicles for the 2011 Realignment is AB 118 (Committee on Budget), Chapter 40, Statutes of 2011, which transfers the equivalent of $5.569 billion of annual state fiscal responsibilities for "public safety programs" to counties. AB 118 also creates the account structure and allocations for some of this funding, and dedicates 1.0625 percent of existing state sales tax revenue to fund these local costs in 2011-12.

2011 Realignment and Mental Health Services

For the 2011-12 fiscal year only, AB 100 (Committee on Budget), Chapter 5, Statutes of 2011, amended the MHSA to allocate, on a one-time basis, $861 million in MHSA funds to counties to support the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, Medi-Cal specialty mental health managed care, and mental health services provided to special education students. In separate legislation, the mandate on county mental health departments to provide mental health services to special education students was repealed, thereby transferring the federal mandate to back to school districts.

EPSDT is a federally mandated program that requires the state to provide Medi–Cal beneficiaries under age 21 with any physical and mental health services that are deemed medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, including services not otherwise included in the state's Medicaid plan. Prior to the 2011 Realignment, the EPSDT program was funded by the General Fund and federal funds with the counties paying a 10-percent share of cost above a specified baseline.

County Medi-Cal specialty mental health managed care plans administer mental health managed care and are responsible for ensuring that Medi–Cal beneficiaries receive specialty mental health services. Under a federal waiver, specialty mental health services are "carved out" of the Medi–Cal Program administered by the Department of Health Care Services (DHCS), which provides physical health care. Prior to the 2011 Realignment, county specialty mental health plans were funded with 1991 realignment funds, state General Fund funds, and federal funds.

In addition to the one-time funding shift of MHSA funding, AB 100 also made changes to MHSA administration, including reducing the percentage amount available from MHSA revenues for state administration from 5 percent to 3.5 percent, requiring monthly distributions from the MHSA Fund, having the "state" (instead of DMH) administer the MHSA Fund, and having the Mental Health Services Oversight and Accountability Committee provide technical assistance to counties.

Administrative Transfer from DMH to Department of Health Care Services
In addition to the one-time fund shifts made by AB 100, AB 102 (Committee on Budget), Chapter 29, Statutes of 2011, transfers from DMH to DHCS, effective July 1, 2012, the state administrative functions for the operation of Medi-Cal Specialty Mental Health Managed Care, the EPSDT Program, and applicable functions related to federal Medicaid requirements. AB 102 states legislative intent that the transfer occur in an efficient and effective manner, with no unintended interruptions in service delivery to clients and families, and that the transfer accomplish improved access to culturally appropriate community-based mental health services; effectively integrate the financing of services to more effectively provide services; improve state accountabilities and outcomes; and provide focused, high-level leadership for behavioral health services within the state administrative structure.

AB 102 required DHCS, in collaboration with DMH and the California Health and Human Services Agency (Agency), to create a state administrative and programmatic transition plan, in consultation with stakeholders, that included specified components to guide the transfer of Medi-Cal specialty mental health managed care and the EPSDT Program to DHCS. DHCS was required to provide the transition plan to all fiscal committees and applicable policy committees of the Legislature by October 1, 2011. AB 102 required the state administrative transfer to conform to the state administrative transition plan provided to the Legislature. Finally, AB 102 also authorized the transition plan to also be updated by the Governor and provided to the Legislature upon its completion, but no later than May 15, 2012.

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

- That DHCS improve business practices (examples include maximizing the claiming of federal funds; improving the claims reimbursement system, streamlining the cost reporting and settlement processes; eliminating redundancies in the provider certification process; facilitating same day billing for mental and

physical health care services; integrating audits; integrating information technology systems; and, reducing processing times);

- That DHCS assure access and improve services (examples include adopting community-based best practices, such as peer support and maximizing the use of social rehabilitation services; increasing the use of telepsychiatry; focusing on prevention and early intervention; ensuring state staff are knowledgeable about mental health services; assuring children's mental health policy expertise; assuring providers can continue to serve clients during and after the transfer; continuing progress in assuring cultural competence of services; addressing racial, ethnic, and cultural disparities in access to care and outcomes; reducing discrimination and stigma experienced by clients; eliminating disparity in access to services; integrating services; facilitating coordination with non-Medi-Cal mental health services; incentivizing the use of community settings; and assuring accountability in the mental health system and, of its providers and administrators);
- That DHCS ensure stakeholder participation (examples include providing regularly scheduled venues for regular stakeholder engagement; consulting with stakeholders on program changes, efficiencies, regulations, State Plan Amendments, and waiver amendments; engaging stakeholders in ongoing quality improvement, including county representation in assessment of legal issues and court decisions that require county implementation; facilitating stakeholder participation by funding travel to meetings; and, clearly identifying individuals that serve as state contacts for programs and services).

2011 Realignment and Substance Abuse Treatment

DADP was created in 1979 and is responsible for administering prevention, treatment, and recovery services for alcohol and drug abuse. California's statewide treatment, recovery and prevention network consists of public and private community-based providers serving approximately 230,000 people annually. The 2011 budget plan realigns several substance abuse treatment programs that were previously funded through the General Fund. The following are the major substance abuse treatment programs realigned:

- Regular and Perinatal Drug Medi–Cal. The Drug Medi–Cal program provides drug and alcohol–related treatment services to Medi–Cal beneficiaries. These services include outpatient drug free services, narcotic replacement therapy, day care rehabilitative services, and residential services for pregnant and parenting women.
- Regular and Perinatal Non Drug Medi–Cal. The Non Drug Medi–Cal program provides drug and alcohol–related treatment services generally to individuals, including women's and children's residential treatment services, who do not qualify for Medi–Cal.
- Drug courts. Drug courts link supervision and treatment of drug users with ongoing judicial monitoring and oversight. There are several different types of drug courts including: (1) dependency drug courts, which focus on cases involving parental rights; (2) adult drug courts, which focus on convicted felons

or misdemeanants; and (3) juvenile drug courts, which focus on delinquency matters that involve substance–using juveniles.

As part of the 2011-12 budget plan, funding for specific alcohol and other drug programs was shifted from the state to local governments through AB 118 and AB X1 16 (Committee on Budget), Chapter 13, Statutes of 2011. A total of about $184 million of DADP programs (Regular and Perinatal Drug Medi–Cal, Regular and Perinatal Non Drug–Medi–Cal, and Drug Courts) were shifted to the counties. Under the 2011 Realignment, funding for these programs is deposited into four separate subaccounts within the newly created Health and Human Services Account of the Local Revenue Fund 2011. Under Realignment 2011, state sales tax will comprise the dedicated revenue to support these programs, instead of the state General Fund.

Administrative Transfer from DADP to DHCS

In addition to the fund shifts in Realignment 2011, AB 106 (Committee on Budget), Chapter 32, Statutes of 2011 transferred the administrative functions for DMC Program that were previously performed by DADP to DHCS. DHCS, in collaboration with DADP, is required to develop an administrative and programmatic transition plan that includes specified components to guide the transfer of the DMC Program to DHCS. To inform the creation of the administrative and programmatic transition plan, DHCS and DADP are required to convene stakeholders to receive input from consumers, family members, providers, counties, and representatives of the Legislature concerning the transfer of the administration of DMC functions performed by DADP to DHCS.

AB 106 required DHCS to provide the transition plan to all fiscal committees and appropriate policy committees of the Legislature by October 1, 2011, and to provide additional updates to the Legislature during budget subcommittee hearings after that date, as necessary.

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

- That the DMC Program transfer involve a program transformation by DHCS, and that the program transfer and stakeholder engagement present an opportunity to consider how the state can identify changes or efficiencies in services, policies and procedures;
- That DHCS ensure there would be no interruption or delay in claims processing during and after the transfer of the DMC Program;
- That DHCS review the treatment authorization request TAR process for fee-for-service medication services that interact with DMC Program to avoid TAR delays that result in the loss of treatment opportunities for beneficiaries and frustration for providers;
- That the DMC Program provider certification process affects access, and that DHCS evaluate the process and involve providers in the development and review of proposed changes;

- That benefits provided under the current DMC Program are outdated, and that services be augmented beyond the five services currently covered and include additional federally approved therapies (buprenorphine, Vivitrol and other new drugs);
- That benefits provided under the DMC Program include drug testing coverage and more, individual counseling; and allow for home counseling and intensive outpatient program service);
- That current regulations interfere with the delivery of appropriate health care, and that DHCS instead only follow federal requirements;
- That the provider application and certification process is duplicative and unnecessary and DHCS should instead rely on national accreditation;
- That DHCS evaluate and streamline the billing process, and allow same day billing if more than one service is provided in a single visit;
- That DHCS address problems with claiming denials; recoupment of funds; lengthy claims processing and reimbursement; and improve communication between the state and providers;
- That rate setting for the DMC Program remains a state function and that it not be delegated to counties;
- That DHCS review reporting requirements and eliminate cost reports; and,
- That DHCS retain experienced and expert staff in the field of substance abuse disorders, that DHCS have leadership that reports directly to the director, and that the program retain its dedicated focus and separate identity and not be engulfed by DHCS' current Medi-Cal program administration.

Governor's Budget Proposal for Community Mental Health

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

Specifically, in regards to community mental health, the budget proposes to:

1. Provide a permanent funding structure for 2011 Realignment (Medi-Cal specialty mental health managed care plan services and the EPSDT program).
2. Adopt trailer bill language to proceed with statutory changes necessary to transfer the administrative functions for Medi-Cal specialty mental health managed care plan services and the EPSDT program from DMH to DHCS.
3. Transfer the remaining non-Medi-Cal community health programs, including 58 positions and budget authority of $104.7 million ($16.3 million state operations, $88.3 million local assistance) ($15.6 million General Fund) from DMH to six other departments as described in the chart below. A description of some of these programs follows the chart.

As discussed previously, the reorganization of behavioral health began in 2011-12. The Administration intends that this proposal completes these efforts by transferring the remaining mental health programs to various state departments that perform related or

similar functions. The Administration believes the consolidation of mental health, substance use disorder, and physical health at DHCS will provide for a continuum of care for consumers in preparation for health care reform in 2014.

Behavioral Health Reorganization: Department of Mental Health Functions

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

Programs to be transferred to the Department of Health Care Services

The majority of existing community mental health programs and functions are proposed to be transferred to a new Division of Mental Health and Substance Use Disorders Services within DHCS, concurrent with the proposed transfer of most state-level programs within DADP, which is also proposed to be eliminated. In addition to the transfer of these programs, the Administration proposes to create a new Deputy Director, Mental Health and Substance Use Disorder Services, who would lead this new division. The new Deputy Director would be a Governor's Appointee and would require Senate confirmation.

Oversight of Certain MHSA Components. DHCS would be responsible for the financial oversight of MHSA funds (although the exact responsibilities have not yet been determined) and the collection of data relating to certain MHSA programs (Full Service Partnerships). In addition, DHCS would be responsible for MHSA state-level issue resolution which is a process by which consumers and stakeholders have a mechanism to resolve issues related to MHSA. And finally, DHCS would be responsible for MHSA Statewide Prevention and Early Intervention Projects (Suicide Prevention, Student Mental Health Initiative, and Stigma and Discrimination Reduction Programs).

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

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

Programs to be transferred to the Department of Public Health

Office of Multicultural Services. The Office of Multicultural Services (OMS) was established in 1998 and provides direction to DMH for promoting and establishing culturally and linguistically competent mental health services within the public mental health system through actions targeted both within and external to DMH. The OMS works with community partners to eliminate racial, ethnic, cultural, and language disparities within mental health programs and services.

The Administration proposes to consolidate the OMS at DMH into the proposed Office of Health Equity at the Department of Public Health. The budget proposes to create the new Office of Health Equity by consolidating OMS, the Department of Health Care Services' Office of Women's Health, and the Department of Public Health's Office of Multicultural Health, Health in All Policies Task Force, and Healthy Places Team. The Administration's intention is to create a more

comprehensive and integrative approach to better address issues of health disparity and promotion of healthy communities.

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

Program to be transferred to the Department of Social Services

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

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

Program to be transferred to the Department of Education

Early Mental Health Initiative. The EMHI is a school-based program funded with Proposition 98 funds; the Administration believes that being located within the Department of Education will provide the most opportunity for the program to leverage additional resources.

Program to be transferred to the Office of Statewide Health Planning & Development (OSHPD)

MHSA Workforce Education and Training. The MHSA workforce education and training component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. OSHPD currently operates the Loan Assumption Program and the Administration believes it has the existing infrastructure, experience and technical ability to effectively monitor grants and program activities. The Administration also states that this transfer will increase efficiency, reduce duplication and align the program with health care reform planning.

Program to be transferred to the Mental Health Services Oversight & Accountability Commission (MHSOAC)

Training Contracts for Consumer Groups, Technical Assistance, and Program Evaluation. The Administration states that these functions are consistent with the role of the MHSOAC, per the changes adopted in AB 100 and

that placing these functions within the MHSOAC will reduce duplication as the MHSOAC currently has similar contracts with stakeholder entities.

Issue to Consider

Placement of Community Mental Health Functions in Other Departments
Community mental health programs are proposed to be transferred to six different departments. Careful consideration must be made to ensure that the proposed placement of these programs makes sense and can be carried out effectively by the proposed department. For example, the Administration is proposing to transfer the licensing of mental health facilities to DSS. However, DSS is not currently involved in the licensing of health facilities. Rather, DPH is currently responsible for the licensing of health facilities in the state. It is not clear why the Administration has proposed to transfer this function to DSS rather than DPH, which already performs a similar function.

Incorporation of Stakeholder Input on Reorganization
The Administration facilitated a series of stakeholder meetings in various locations throughout the state during the summer of 2011 in order to seek input on the transfer of Medi-Cal programs from DMH to DHCS. According to the Administration, stakeholders also provided input on the proposed transfer of non-Medi-Cal mental health programs and functions. According to the DMH Community Mental Health Stakeholder Summary Report, stakeholders generally had concerns in the following five areas: (1) state-level executive leadership for community mental health is essential and that mental health expertise not be lost with the shifting of mental health functions away from DMH, (2) the benefits and challenges to local control, (3) the importance of cultural competence leadership and reducing disparities, (4) protecting the integrity of the Mental Health Services Act, and (5) the importance of the role of mental health consumers and their families. An alternative proposed by some stakeholders is the creation of a single state agency that oversees community mental health and substance use disorder programs mirroring the federal government structure. How the Administration's proposal addresses these key concerns needs to be evaluated during the budget subcommittee processes.

Key Pieces of Information Not Yet Available
Details on proposed changes to certain key state oversight functions are not yet available. For example, AB 100 eliminated state approval of county MHSA plans; however, as contained in AB 100, the Legislature expects the state to establish a more effective means of ensuring county performance compliance with the MHSA. Information on this new process is not yet available.

Similarly, as discussed earlier in this document, as part of the stakeholder meetings, participants highlighted the opportunity to consider how the state can identify changes or efficiencies in services, policies, and procedures for community-based mental health programs. How or if the Administration plans to address these concerns and potential opportunities for programmatic improvement is still unclear.

According to the Administration, this proposed consolidation not only offers the potential for administrative efficiencies, but also has the potential to offer fuller integration of health and behavioral health care services to consumers in need of these critical services. The state's 1115 Medicaid Waiver, federal health care reform, and the Mental Parity Act of 2008 also offer constructive opportunities for a more inclusive and comprehensive delivery model. However, careful deliberation between the Administration, mental health advocates and providers, Medi-Cal county specialty mental health plans, and the Legislature must occur to ensure a thoughtful and transparent reorganization.

Governor's Budget Proposal for Alcohol and Drug Programs

Outstanding Transition Efforts Affecting Alcohol and Drug Programs

Related to efforts discussed previously in this background paper, in regard to substance use disorder (SUD) services, the Governor's budget for 2012-13 proposes to:

1. Provide a permanent funding structure for the programs that were part of the 2011 Realignment, specifically Drug Medi-Cal Treatment Program (DMC Program), Non Drug Medi-Cal, and Drug Courts.

   Trailer bill language on a superstructure for realignment has yet to be received from the administration and issues with the realignment implementation for the current year are still coming forward from counties and stakeholders.

2. Propose trailer bill language to proceed with statutory changes necessary to transfer the administrative functions for the DMC Program from DADP to DHCS.

   The administration recently released its proposed trailer bill language. Stakeholders are reviewing it and reacting with issues and questions around governance, rates, contracts, and regulatory control. Further discussion and review of this trailer bill will follow, as will oversight over how the DMC Transition Plan aligns with the trailer bill, what issues stakeholders have in addition to what is captured in the Plan, and how monitoring, oversight, and corrective action for the DMC transfer, effective July 1, 2012, will occur.

Further Proposal to Eliminate DADP

The Governor's budget for 2012-13 additionally proposes to eliminate DADP entirely effective July 1, 2012 and redirect funding and positions for certain SUD services to other departments. This proposal would transfer the remaining non-Medi-Cal SUD programs, including 231.5 positions and budget authority of $322.103 million ($32.166 million state operations, $289.937 million local assistance) ($34.069 million General Fund) from the DADP to three departments as described in the chart below. A description of programs affected follows the chart.

The Administration states that the proposal follows the actions taken previously for DADP in the 2011-12 Budget and that the transfer of remaining departmental responsibilities to other state departments will integrate activities within those new placements.

Administration's Proposal: Department of Alcohol and Drug Program Functions

FUNCTION OR PROGRAM	RECIPIENT DEPARTMENT POSITIONS/TOTAL FUNDING
Administration of SAPT Block Grant and other SAMHSA Discretionary Grants, Data Collection Function, Reporting and Analysis, Statewide Needs Assessment and Planning, Program Certification, Technical Assistance and Training, Substance Abuse Prevention Activities, Resource Center, Parolee Services Network	**Department of Health Care Services** $305.572 million ($285.937 local assistance, $19.635 state operations) 161.5 Positions
Counselor Certification, Narcotic Treatment Programs, Driving Under the Influence Programs, Office of Problem Gambling	**Department of Public Health** $12.002 million ($4.0 local assistance, $8.002 state operations) 34.0 Positions
Program Licensing	**Department of Social Services** $4.529 million (all state operations) 36.0 Positions

Programs to be transferred to the Department of Health Care Services

The majority of SUD programs and functions, described below, are proposed to be transferred to a new Division of Mental Health and Substance Use Disorders Services within DHCS, concurrent with the proposed transfer of most state-level programs from DMH, which is also proposed to be eliminated. In addition to the transfer of these programs, the Administration proposes to create a new Deputy Director, Mental Health and Substance Use Disorder Services, that would lead this new division. The new Deputy Director would be a Governor's Appointee and would require Senate confirmation.

Administration of the SAPT Block Grant. DHCS would be responsible for the financial oversight of the Substance Abuse Prevention and Treatment (SAPT) Block Grant. DADP is the Single State Authority designee for receiving and administering the SAPT Block Grant. The SAPT Block Grant, ADP's largest source of federal funding, supports the state's prevention, treatment and recovery network. Ninety-two percent of the funding is allocated to local communities through county allocations and technical assistance and training contracts; a minimum of 20 percent of the Block Grant funds must be spent on primary prevention services. DADP is responsible for ensuring that SAPT Block Grant requirements are achieved and reported annually in each year's SAPT Block Grant application. Many of the requirements have significant fiscal consequences if they are not met and, therefore, require careful monitoring by various branches within DADP.

Administration of other SAMHSA Block Grants. Further information on these block grants was not provided by the Administration at the time of this writing.

Data Collection, Reporting and Analysis. Further information on the specific functions and tasks associated with this set of activities was not provided by the Administration at the time of this writing.

Statewide Needs Planning and Development. Pursuant to SAPT Block Grant requirements, DADP generates an annual Needs Assessment Report, which analyzes treatment and prevention data as well as prevalence, consumption and consequence trend data. The report identifies service needs and gaps in California's publicly funded system. This systematic needs assessment is instrumental in developing local and statewide plans and establishing data-informed policies for federal and state allocations.

Program Certification. Further information on this was not provided by the Administration at the time of this writing.

Technical Assistance and Training. Further information on this was not provided by the Administration at the time of this writing.

Substance Abuse Prevention Activities. The DADP Program Services Division (PSD) is responsible for policy development and monitoring of comprehensive statewide prevention, treatment and recovery systems to prevent, reduce, and treat SUD problems. PSD consists of Prevention, Treatment and Recovery Services. The PSD Prevention Services' stated mission is to develop and maintain a comprehensive statewide prevention system to prevent and reduce substance use problems, and to improve the health and safety of the citizens of California by:

- Modifying social and economic norms, conditions, and adverse consequences resulting from alcohol, tobacco and other drugs availability, manufacturing, distribution, promotion, sales, and use; and,
- Effectively addressing at-risk and underserved populations and their environments.

The SAPT Block Grant requires a minimum of 20 percent of the state's grant award to be expended on primary prevention services. The six primary prevention strategies include:

- Alternatives;
- Community-Based Process;
- Education;
- Environmental;
- Information Dissemination; and,
- Problem Identification and Referral.

Resource Center. The DADP Resource Center (RC) has four statewide lines of business: (1) the RC Call Center responds to requests for information and makes treatment/information referrals to counties, (2) the Clearinghouse distributes Alcohol and other Drug (AOD) informational materials across the state to individuals, schools, organizations, including faith-based organizations, and state

agencies as well as to conferences, (3) the RC operates the state AOD prevention and treatment website with downloadable materials and develops special sections for evolving issues such as alcoholic energy drinks, and (4) the Lending Service holds almost 6,000 unique AOD materials for statewide use.

Parolee Services Network (PSN). The PSN provides community-based alcohol and drug treatment and recovery services to parolees in 17 California counties. It is administered jointly by ADP and the California Department of Corrections and Rehabilitation (CDCR). The program design provides up to 180 days of treatment and recovery services. Funding is provided by CDCR. The PSN places parolees in appropriate AOD treatment and recovery programs, either from the community parole systems or immediately upon release from prison custody. The goals are to improve parolee outcomes as evidenced by fewer drug-related revocations and related criminal violations, to support parolee reintegration into society by encouraging a clean and sober lifestyle, and to reduce General Fund costs for incarceration and parole supervision.

Programs to be transferred to the Department of Public Health

Counselor Certification. DADP approves certifying organizations (COs) which register and certify individuals to provide AOD counseling. Each CO must meet regulatory requirements in order to remain an approved CO.

Narcotic Treatment Programs (NTP). DADP currently has the sole authority to license NTPs. NTPs provide replacement narcotic therapy in outpatient, medically supervised settings to people addicted to opioids. Services include, but are not limited to, replacement narcotic medication and counseling. DADP monitors these clinics and programs, and ensures federal Drug Enforcement Agency requirements are met.

Driving Under the Influence (DUI) Programs. DADP currently has sole authority to license DUI programs. DADP's role is to issue, deny, suspend or revoke licenses of DUI alcohol and drug education and counseling programs. The purpose of the DUI program is to reduce the number of repeat DUI offenses by providing a state-licensed DUI program for offenders, and to provide participants an opportunity to address problems related to the use of alcohol and/or other drugs. Annually, DUI programs serve an average of 150,000 clients. The county board of supervisors, in concert with the county alcohol and drug program administrators, determines the need for DUI program services and recommends applicants to the state for licensure. DADP licenses programs, establishes regulations, approves participant fees and fee schedules, and provides DUI information.

Office of Problem Gambling. The Office of Problem Gambling (OPG):

- Administers a statewide toll-free problem gambling helpline providing crisis management and referrals to treatment services.

- Develops a strategic plan for periods of five years in collaboration with the OPG Advisory Group.
- Provides technical assistance and training to health care professionals, educators, non-profit organizations, gambling industry personnel and law enforcement agencies related to the signs and symptoms of problem gambling behavior and available resources.
- Conducts outreach to multi-cultural and vulnerable populations (such as youth and seniors) to educate about problem gambling behavior and negative consequences.
- Coordinates annual Problem Gambling Awareness Week Campaign.
- Conducts research to determine efficacy of programs and ensure the delivery of evidence-based practices.
- Initiates innovative problem gambling programs including evaluation components to deliver ground breaking services.
- Administers the California Problem Gambling Treatment Services Program, delivering a continuum of services including telephone interventions, outpatient, intensive outpatient and residential care.
- Trains and authorizes licensed multi-lingual therapists throughout the state to ensure access to care.
- Develops program standards in policies and procedures and assures accountability through on-site provider compliance monitoring reviews.
- Collects, analyzes and disseminates treatment client demographics and outcomes data.

Program to be transferred to the Department of Social Services

Program Licensing. DADP currently has sole authority to license facilities located in California which provide 24-hour residential non-medical services to adults with problems related to AOD abuse which require AOD treatment services. DADP certifies programs for the DMC Program. DADP offers voluntary AOD certification to residential and non-residential programs which exceed minimum levels of quality and are in compliance with state standards.

Issues to Consider

History of Proposal. As summarized earlier, the 2011-12 Budget included the realignment of SUD services and the transfer of state administrative functions for the operations of the DMC Program to DHCS. At the same time that these proposals were being contemplated in May 2011, the Administration proposed to also eliminate DADP, as it is again proposing now. The Legislature chose at that time to reject the elimination proposal for several reasons, including timing of the proposal and lack of a full vetting with the Legislature and stakeholders. Little detail on the planning and process for the proposed elimination and transfer was provided at that time.

Current Proposal Lacks Detail. The current elimination proposal lacks detail on (1) the rationale for the elimination and what real program outcomes are goals for the reorganization, (2) the readiness and appropriateness of receiving departments to take on

the DADP positions, functions, and oversight, (3) accountability and transparency in the implementation of this elimination and transfer, and (4) assurances that the elimination and shifting will not disrupt services for consumers, patients, and providers dependent on current DADP functions. Stakeholder reaction to the proposal and the reflection of any feedback from stakeholders within the proposal is unknown at this time. Policy and oversight considerations require time and attention, and are further challenged without a detailed proposal.

Fiscal Assessment. The proposal from the Administration contains no cost savings as a result of the DADP elimination and attendant transfer of all functions to three departments. Without a thoughtful, thorough transition plan to understand how this transfer would occur over a phased-in period and under what principles and terms, it is difficult for the Legislature to evaluate the Administration's claim that the proposal is cost neutral, as it is possible that the transition may produce costs within government. Stakeholders, including counties, providers and consumers, may also face increasing costs as their services and programs are affected by new relationships with new departments, offices, and bureaus in place of their current relationships with DADP.

Questions for the Administration

Current Year

AB 102 Implementation

(1) AB 102 (Committee on Budget), Chapter 29, Statutes of 2011 states that the transfer of Medi-Cal mental health from the Department of Mental Health (DMH) to the Department of Health Care Services (DHCS) is intended to improve access to culturally-appropriate community-based mental health services, integrate the financing of services to more effectively provide services, improve state accountabilities and outcomes, and provide high-level leadership focused on behavioral health services within the Administration. How have the transition plans accounted for these goals?

(2) What are the key outstanding milestones related to the transition of Medi-Cal specialty mental health? What risks might the Administration face in meeting these milestones?

(3) What steps have been taken to address the concern, frequently expressed during stakeholder meetings, that reimbursements may be interrupted during the transition period and its aftermath?

AB 106 Implementation

(4) AB 106 (Committee on Budget), Chapter 32, Statutes of 2011 authorized the transfer of administration of the Drug Medi-Cal Treatment Program and applicable federal Medicaid functions from the Department of Alcohol and Drug Programs (DADP) to DHCS, effective July 1, 2012, and required DHCS to submit a transition plan to guide the transfer in a manner that results in no unintended interruptions in service delivery to clients and families, as well as improve access to the service and more effectively integrate financing, among other primary goals. How have the transition plan and its attendant updates accounted for these goals?

(5) What progress has been made toward a seamless transfer of the program by July 1, 2012, and what issues does the Administration foresee as key outstanding or delayed tasks and milestones that the Legislature needs to be made aware of at this time?

(6) What steps have been taken to address the issues in program administration, billing, and the benefit structure for the Drug Medi-Cal Treatment Program frequently raised by stakeholders?

AB 102 and AB 106

(7) For the programs realigned last year, what is the Administration's view on providing programmatic flexibility to counties to provider higher or lower level of services or different reimbursement structures than under current law, versus requiring counties to operate these programs consistent with past practices?

(8) For the mental health and substance use disorder programs that were realigned last year, how does the state envision it will change oversight of service delivery?

(9) One of the themes in the stakeholder comments referenced in the transition plans is that DHCS should use the transition to improve current processes. Please describe what program practices DHCS will change as part of assuming administrative responsibility over transferred programs.

Budget Year

Consolidation

(10) Why integrate DMH and DADP in the manner that has been proposed?

(11) How does the Administration plan to avoid interruptions of mental health and substance use disorder services during the proposed departmental restructuring?

(12) Many stakeholders view this transition as a time to identify changes or efficiencies in services, policies, and procedures; how does the Administration plan to address these potential changes or efficiencies?

Oversight

(13) How will DHCS evaluate the effectiveness of county mental health service delivery systems and substance use disorder programs and contracts?

(14) With the elimination of state approval of county Mental Health Services Act (MHSA) plans, how is the state going to establish an effective means to ensure county performance that complies with the MHSA?

(15) Given the movement of DADP functions to several departments under the proposal, what interdepartmental entity or bridges will be created to monitor substance use disorder services across state government and ensure that there is coordination where possible?

Licensing & Quality Improvement

(16) What is the Administration's rationale for transferring the DMH licensing and certification of Mental Health Rehabilitation Centers (MHRCs) and Psychiatric Health Facilities (PHFs) to the Department of Social Services (DSS) rather than the Department of Public Health (DPH)?

(17) What is the rationale for the splitting of licensing and certification functions for substance use disorder providers between DSS and DPH? How will coordination of these functions operate under this scenario?

(18) How will the Administration ensure that DSS licensing staff, who review facilities that are often more custodial in nature, have the requisite training and expertise to review MHRCs and PHFs, facilities that are uniquely designed for individuals with serious mental illness? In the same vein, what readiness exists at DSS to evaluate outpatient substance use programs and 24-hour residential services providers of substance use services?

Leadership

(19) What is being done to recruit candidates to fill the critical new high level leadership position(s)? Is the proposed pay structure adequate to attract competitive candidates?

(20) Are the new positions and organization chart designed for the transfer of both Medi-Cal and non-Medi-Cal programs in 2012-13?

Workforce

(21) A new statewide five-year plan on Workforce, Education, & Training is required by statute. As the Governor has proposed to transfer all Mental Health Service Act (MHSA) Workforce, Education, & Training functions to the Office of Statewide Health Planning & Development (OSHPD), how will OSHPD work with the Mental Health Planning Council in developing the next 5-year plan?

Federal Block Grant

(22) The Administration's proposal includes movement of Substance Abuse Prevention and Treatment (SAPT) Block Grant administration to DHCS. The grant requires an annual Needs Assessment and Planning Report which analyzes treatment and prevention data, as well as prevalence, consumption, and consequence trend data that identifies alcohol and other drug services needs and gaps in California's system. How will these duties fare under the elimination proposal and what exact steps are in place to assure that the requirements of the grant are met and that the grant is administered properly?

Health Equity

(23) The Governor proposes to transfer the DMH Office of Multicultural Services and related contracts to a new "Office of Health Equity" at the DPH, while both Medi-Cal Specialty Mental Health and MHSA – which are proposed to be transferred to DHCS – are similarly charged with ensuring cultural competency and reducing disparities. How will DPH work collaboratively with DHCS to prevent overlapping or redundant requirements related to the promotion of health equity?

(24) Does the Administration intend to make any changes to the state-level expenditures currently used to support DMH contractors? For example, the contracts for consumer and family member organizations, including those that represent ethnic and cultural communities?

(25) What goals does the Administration have for the improvement in quality of and access to substance use services? How will these be measured and on what timeline?

Questions for Counties, Providers and Consumers

Current and Budget Year

(26) What are your primary concerns with the Administration's proposals to reorganize mental health and substance use disorder programs?

(27) What, if any, information about the proposed reorganization have you been waiting for from the Administration in order to evaluate its effects on the group(s) that you represent?

(28) What have you learned from the ongoing efforts to transfer Medi-Cal related mental health and Drug Medi-Cal Treatment Program functions that can inform what the Administration is proposing to do to further change how mental health and substance use disorder services are administered?

(29) What are your main questions or concerns for the July 1, 2012 transfer that the Legislature and Administration should be made aware of at this time?

(30) Do you think the proposed reorganization will make it easier for you to work with the state?

(31) What program regulations, practices and policies would you like to see changed if DMH and DADP are merged with DHCS?

(32) What state-level organization of these programs and services would be best for consumers? If this involves a transfer, what transfer process and timeline would you recommend?