

## ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

Assembly Member Dave Jones, Chair

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## **CONSENT ITEMS**

### **4440 DEPARTMENT OF MENTAL HEALTH**

#### **ISSUE 1: TRANSFER TRAUMATIC BRAIN INJURY RESPONSIBILITIES**

Assembly Bill 398 (Monning, Chapter 439, Statutes of 2009) transfers the administrative responsibility for the Traumatic Brain Injury program from the Department of Mental Health (DMH) to the Department of Rehabilitation (DOR). The Governor's budget proposes to transfer \$1.172 million (Traumatic Brain Injury Fund) and one position from the DMH to the DOR to reflect this transfer.

#### **ISSUE 2: TRANSFER OF SAN MATEO PHARMACY AND LABORATORY SERVICES PROGRAM**

The DMH proposes a decrease of \$2.4 million (\$932,000 General Fund and \$1.5 million federal reimbursements) for 2010-11 to reflect the transfer of the San Mateo Pharmacy and Laboratory Services Program to the Department of Health Care Services (DHCS) effective as of July 1, 2010.

This program was operated as a "field test" for many years and has now been incorporated into San Mateo's comprehensive health care system. Based upon analysis and discussions with San Mateo and the DHCS, it was agreed to transfer the administration of this program to the DHCS

#### **ISSUE 3: CONVERT STAFF COUNSEL POSITION TO PERMANENT**

The DMH presently has three attorneys who are assigned to the Mental Health Services Act (MHSA) area. One of these positions sunsets on June 30, 2010 and the DMH proposes an increase of \$113,000 (MHSA Funds) to make it permanent.

The DMH states this position needs to be made permanent due to "growing legal needs" related to the MHSA, such as regulations development, contract and policy document development, administrative proceedings, and litigation work.

Further they note that implementation of the auditing of MHSA funded programs will commence soon and there is a legal need to establish an appeals process for disputed audit findings, as well as the drafting of additional regulations for this process.

## 4140 OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT

### ISSUE 1: MENTAL HEALTH LOAN ASSUMPTION AWARDS PROGRAM

#### Budget Issue

OSHPD is requesting an increase of \$2,543,000 in 2010-11 and \$2,537,000 ongoing from the Mental Health Services Fund to increase the amount available for the Mental Health Loan Assumption Program (MHLAP) awards. The MHLAP awards grants to mental health practitioners working in the public mental health system in hard to fill or retain positions, as determined by County Mental Health Directors. This additional funding will allow expansion from 288 awards to 600 awards. This request also would expand MHLAP eligible professionals to include Licensed Professional Clinical Counselors (LPCC) and LPCC interns.

#### Background

The MHSAs (Proposition 63) requires the development of a five-year plan to remedy the shortage of qualified mental health service providers by making loan forgiveness programs available to current and prospective employees in California's public mental health system. Under the Workforce, Education and Training (WET) section of the MHSAs, the DMH partnered with the County Mental Health Directors Association (CMHDA) and the Mental Health Services Oversight & Accountability Commission (MHSOAC) in developing a ten year expenditure plan which includes the MHLAP. The MHLAP has been through two award cycles and anticipates receiving as many as 2,000 applications. The following chart illustrates the significant, and still unmet, demand for the program:

MHLAP (March 2009)	
Applications received	1,222
Applications awarded	288
Debt burden of applicants	\$56,544,823
Amount requested	\$15,460,101
Amount awarded	\$2,285,277

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## ITEMS TO BE HEARD

### 4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

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#### OVERALL BACKGROUND

##### **Background — Mental Health Services Act, Proposition 63 of 2004**

The MHSA imposes a 1 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., Prop 63 funds are to *supplement* and not supplant existing resources).

Most of the Act’s funding is to be expended by County Mental Health for mental health services consistent with their approved local plans (3-year plans with annual updates) and the required five key components of the Act. The following is a brief description of the five components:

- **Community Services and Supports.** This component represents the programs and services identified by each County Mental Health Department through its stakeholder process to serve unserved and underserved populations, with an emphasis on eliminating disparities in access and improving mental health outcomes for racial/ethnic populations and other unserved and underserved populations.
- **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.
- **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 to promote interagency collaboration.
- **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.

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

In addition to the five components above, the MHSA allows for up to five percent of the total revenues received by the fund in each fiscal year to be expended on State support, including the OAC, Department of Mental Health, Mental Health Planning Council and other State entities.

#### **MHSA Fiscal Report—January 2010**

The DMH is required to provide two semi-annual fiscal updates, in January and May, to the Legislature regarding revenues and expenditures of MHSA Funds. The most recent report reflects the following information for revenues and expenditures.

#### **DMH Report on Mental Health Services Act Funds as of January 2010**

<b>Proposed Revenues and Expenditures of MHSA</b>	<b>Actual 2008-09</b>	<b>Estimated 2009-10</b>	<b>Proposed 2010-11</b>
MHSA Deposited Receipts	\$1,292,600,000	\$1,428,900,000	\$1,030,800,000
Total Expenditures	\$1,120,959,000	\$1,330,797,000	\$1,597,355,000
• Local Assistance	\$1,084,523,000	\$1,284,000,000	\$1,102,700,000
• Governor's Proposed Diversion of MHSA for State Programs	--	--	\$452,332,000
• - State Administration	\$36,136,000	\$46,797,000	\$42,323,000
Difference: Receipts & Expenditures	\$171,641,000	\$98,103,000	-\$566,555,000
Adjusted Beginning Balance*	\$2,232,750,000	\$2,149,360,000	\$1,691,453,000
Reserve (Items 3 + 4)	\$2,404,391,000	\$2,247,463,000	\$1,124,898,000

\*All figures are from the DMH January 2010 Report, except for the adjusted beginning balance, which is from the Fund Condition Statement for the MHSA Funds (Page 158, Volume 2, Governor's Budget).

<b>MHSA: Local Assistance Expenditures</b>			
<b>Local Expenditure by Component</b>	<b>Actual 2008-09</b>	<b>Estimated 2009-10</b>	<b>Proposed 2010-11</b>
Community Services & Supports	\$650,000,000	\$900,000,000	\$783,600,000
Prevention and Early Intervention	\$252,900,000	\$310,000,000	\$196,500,000
Innovation	\$71,000,000	\$71,000,000	\$119,600,000
Workforce Education & Training, & State Level Projects	\$2,523,000	\$3,000,000	\$3,000,000
Capital Facilities & Technology	\$108,400,000	--	--
<b>LOCAL ASSISTANCE TOTAL</b>	<b>\$1,084,523,000</b>	<b>\$1,284,000,000</b>	<b>\$1,102,700,000</b>

The DMH states that over \$3.2 billion (MHSA Funds) has been expended through 2008-09. Additionally, \$1.3 billion (MHSA Funds) is estimated to be expended in 2009-2010 and \$1.6 billion (MHSA Funds) in 2010-11.

The table below reflects MHPA Funds expended for State Administration which cannot exceed five percent of the annual MHPA revenues. It should be noted that the 2010-11 amounts reflect the Governor's proposal to reduce all administrative items by ten percent on a pro-rata basis in order to stay within the five percent cap. This issue will be discussed further below.

### **Mental Health Services Act: State Administrative Expenditures**

<b>DMH Report: State Administrative Expenditures</b>	<b>Actual 2008-09</b>	<b>Estimated 2009-10</b>	<b>Proposed 2010-11</b>
Judicial Branch	\$395,000	\$1,000,000	\$893,000
State Controller's Office	\$21,000	\$295,000	\$727,000
Consumer Affairs Regulatory Board	\$236,000	\$306,000	\$91,000
Office of Statewide Health Planning & Dev.	\$499,000	\$929,000	\$583,000
Aging	\$93,000	\$236,000	\$218,000
Alcohol & Drug programs	\$501,000	\$254,000	\$272,000
Health Care Services	\$670,000	\$968,000	\$752,000
Managed Risk Medical Insurance Board	\$86,000	\$173,000	\$159,000
Developmental Services	\$1,030,000	\$1,121,000	\$984,000
Mental Health	\$26,604,000	\$34,305,000	\$30,739,000
Mental Health Oversight & Acct Commission (OAC)	\$4,089,000	\$4,089,000	\$4,115,000
Rehabilitation	\$162,000	\$220,000	\$198,000
Social Services	\$759,000	\$734,000	\$712,000
Education	\$430,000	\$921,000	\$613,000
CA State Library	\$72,000	\$171,000	\$165,000
Board of Governor's – Community College	\$37,000	\$158,000	\$208,000
Military Department	--	\$451,000	\$406,000
Department of Veterans Affairs	\$452,000	\$466,000	\$460,000
Department of Finance – FISCAL	--	--	\$28,000
<b>Total State Administration</b>	<b>\$36,136,000</b>	<b>\$46,797,000</b>	<b>\$42,323,000</b>

### **Purpose and Description of Commission**

The Mental Health Services Oversight and Accountability Commission (OAC) was established in 2005 and is composed of 16 voting Members who meet criteria as contained in the Act.

The OAC works in collaboration with clients, their family members and underserved communities, to ensure that Californians understand that mental health is essential to overall health. The purpose of the OAC is to hold public systems accountable and provide oversight for eliminating disparities, promoting mental wellness, recovery and resiliency, and ensuring positive outcomes for individuals living with serious mental illness and their families.

Among other things, the role of the OAC is to:

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

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## **Questions**

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The Subcommittee requests the OAC to answer the following questions:

1. Please provide a brief description of the Commission, it's core functions and recent accomplishments.
2. When will the statewide evaluation of the MHSA be completed?

**ISSUE 1: INDEPENDENCE OF MHSOAC****Budget Issue**

Last year's budget trailer bill made changes to the MHSA including clarifying that the OAC operate separately from the DMH. To that end, the Governor's 2010-11 budget proposes to transfer \$4.589 million (MHSA Funds) and 22 positions from the DMH to the OAC. Furthermore, and as discussed in more detail later in the agenda, the DMH proposes to reduce this amount by 10 percent (\$474,000 in MHSA Funds) to reflect a proposed pro rata reduction of State administration in order to stay within the 5 percent administrative cap requirement of the MHSA. Therefore, the net amount proposed to be shifted to the OAC is \$4.115 million (MHSA Funds) for 2010-11.

All of the 22 positions being transferred were originally established specifically for the OAC operations, and they include the following:

<b>POSITION TITLE</b>	<b>NO. OF POSITIONS</b>
Executive Officer	1
Staff Counsel III	1
Mental Health Administrator	1
Mental Health Program Supervisor	2
Consulting Psychologist	1
Staff Mental Health Specialist	8
Associate Mental Health Specialists	3
Information Officer II	1
Staff Services Analyst	2
Office Technician	2
<b>TOTAL</b>	<b>22</b>

According to the OAC, the transferred resources will enable them to, among other things, conduct and continue the following activities:

- Review, comment and approve County Plans for the various components of the MHSA;
- Develop policy related to the implementation of the MHSA and associated statutory mandates;
- Provide for a comprehensive evaluation of the MHSA (two phases);
- Provide community outreach and education;
- Convene monthly OAC meetings;

- Continue work with the five committees within the OAC framework (Client and Family Leadership; Services; Evaluations; Cultural and Linguistic; and Funding and Policy);
- Provide vision, leadership, and oversight necessary to prevent mental illness from becoming severe and disabling and transform the public and private systems charged with providing services, and support to Californians living with mental illness;
- Develop strategies to combat and overcome stigma related to mental illness;
- Advise the Governor and Legislature regarding actions the State may take to improve care and services for individuals experiencing mental illness; and
- Identify critical issues related to the performance of County Mental Health programs and refer the issues to the Department of Mental Health.

#### 2009 Statutory Changes to the MHSA

AB 3X 5 (2009 budget trailer bill) made statutory changes to the MHSA Act to assist in the implementation and effectiveness of the Act, including the following:

- Clarifies that the OAC shall administer its operations separate and apart from the DMH;
- Clarifies that the OAC may enter into contracts, obtain data and information from the DMH, or other State and local entities that receive MHSA Funds, regarding programs and projects; and
- Provides for the OAC to participate in the joint State-County decision-making process for training, technical assistance, and regulatory resources to meet the mission and goals of the State's mental health system.

#### Mental Health Services Act—"Administrative Cap" of Five Percent

The MHSA allows up to five percent of the total annual revenues in each fiscal year to be used for State administrative expenditures, including the OAC and other State entities.

As discussed more comprehensively under the Department of Mental Health later in this agenda, the Administration is proposing a “pro-rata” 10 percent reduction in administrative expenditures for 2010-11 due to an expected drop in total MHSF Fund revenues and the need to stay within the five percent cap as required by the Act.

**STAFF COMMENT**

Though the OAC was established in 2005, in prior years its appropriation has been budgeted within the DMH. Over time, concerns were raised regarding the need for the OAC to have its own appropriation item and to operate separate and apart from the DMH, as intended by the MHSF Act. With the passage of budget trailer bill ABX3 5, Statutes of 2009, a transfer of funds from the DMH to a separate line-item for the OAC is warranted.

However, as referenced above, the Administration is also proposing to reduce the OAC by \$474,000 (MHSF Funds) to address the need to maintain the “administrative cap” of 5 percent. The proposal is to reduce all Administrative functions, equally by 10 percent, rather than to prioritize reductions to the various Administrative functions. Moreover, the concern about exceeding the 5 percent cap has lessened as MHSF revenues have surpassed the November expectations. The DMH has indicated that the May Revise will include an update on MHSF revenues and a new assessment of the 5 percent administrative cap.

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**4440 DEPARTMENT OF MENTAL HEALTH**

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**ISSUE 1: PRO RATA MHSA ADMIN REDUCTION**

There are 17 State departments that receive MHSA Funds for administrative purposes for a total of \$46.8 million for 2009-2010 (current-year). The DMH contends that due to an expected drop in the receipt of MHSA revenues for 2010-11, a reduction of \$4.8 million (MHSA Funds), or about 10 percent, is necessary to keep State administrative expenditures within the MHSA Act required five percent cap.

The proposal is to reduce all Administrative functions, equally by 10 percent, rather than to prioritize reductions to the various Administrative functions. Moreover, the concern about exceeding the 5 percent cap has lessened as MHSA revenues have surpassed the November expectations. Therefore, the May Revise will include an update on MHSA revenues and an update to this proposal.

**STAFF COMMENT**

If an adjustment is needed to stay within the five percent cap, the Administration should prioritize how the reduction is taken, as compared to an across-the-board pro-rata reduction, and should consult with the OAC on prioritizing State administrative resources.

**ISSUE 2: SHIFT PROPOSITION 63 FUNDS TO DMH PROGRAMS**

The Governor's proposed 2010-11 budget includes two separate proposals to shift Proposition 63 funds to backfill General Fund in two DMH programs: 1) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); and 2) Mental Health Managed Care. One proposal is a regular 2010-11 budget proposal in the amount of \$452 million while the second proposal is one of the Governor's "trigger" proposals, in the amount of \$847 million, which would be in addition to the \$452 million. The Governor's budget proposes no reductions to EPSDT or Mental Health Managed Care and fully funds these programs.

The DMH explains that with either proposal, it would be incumbent upon the counties to then decide how to deal with the loss of Proposition 63 funds. With the first proposal, DMH believes that counties would not necessarily have to reduce community Prop 63-funded programs and services. Mental health advocates and stakeholders strongly disagree.

Proposition 1E of May 2009

This Proposition would have authorized a fund-shift of \$226 million in 2009-2010 and \$234 million in 2010-11 from MHSA funds to backfill for General Fund support in the EPSDT Program. Proposition 1E was defeated by voters in the special election of May 2009 (66.4 percent voted no).

**ISSUE 3: CAREGIVER RESOURCE CENTERS – GOVERNOR'S 2009 VETO****Budget Issue**

Last year, the Governor proposed elimination of Caregiver Resource Centers (CRCs), by proposing to eliminate all \$10,547,000 in General Fund support (100% of program funding) for the program. The Legislature agreed to reduce funding for the program to \$7.6 million, however the Governor subsequently vetoed an additional \$4.8 million. The program funding remains at \$2,918,000.

**Background**

The CRCs provide services and support for caring for an adult family member at home with a cognitive impairment, such as Alzheimer's disease, stroke, Parkinson's disease, and other chronic or degenerative cognitive disorders.

Prior to budget reductions to the program in 2009, there were eleven CRCs in California serving all 58 counties. The CRCs provide a variety of assistance to caregivers of family members with a cognitive impairment to enable those adults to remain in their homes for as long as possible. Some of the assistance provided includes consultation and care planning, counseling and support groups, psycho-educational groups, education and training, legal and financial planning, respite care, and other mental health interventions. The purpose of CRCs is to help delay, if not eliminate, the admission of family members to long-term care institutions.

As a result of last year's substantial reduction, CRCs are serving an estimated 73 percent fewer people.

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**Questions**

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The Subcommittee has asked the DMH to answer the following question:

Has there been an increase in former CRC family members being institutionalized in long-term care facilities as a result of this reduction?

**ISSUE 4: OFFICE OF PATIENT RIGHTS LENGTH OF CONTRACT****Budget Issue**

Based upon information provided by the DMH at the request of Subcommittee staff, it would be cost-beneficial for the DMH to lengthen the contract term, as contained in existing statute, for its Patients' Rights services.

Section 5370.2 of Welfare and Institutions Code requires the DMH to contract with a single nonprofit agency that meets specified criteria for the purpose of providing patients' rights services for persons with mental illness residing in State Hospitals. The DMH is to contract on a multi-year basis for a contract term of up to three years.

Information provided by the DMH shows that considerable staff time is utilized by the Administration to conduct the contract process. Specifically, it takes from 13 to 16 months to develop a bid package and proceed through the various State procedural processes. If the contract term were lengthened to five-years, administrative time would be saved.

**ISSUE 5: INCREASE IN DMH LEGAL POSITIONS****Budget Issue**

The DMH has sent the Legislature a Spring Finance Letter (SFL) requesting 6 new legal positions at a cost of \$3,076,000 General Fund. The SFL also proposes to redirect this amount of General Fund, in the form of savings, from the Sex Offender Commitment Program (SOCP) to the DMH Legal Office. DMH explains that the increased legal workload is due to the Attorney General's Office (AGO) changing its policies and discontinuing performing legal work for various state departments, including the DMH.

**Background**

Up until recently, the DMH has been represented by the AGO for litigation and court appearances. In September of 2009, the AGO informed DMH of policy changes that will substantially reduce the amount of legal services provided by the AGO to DMH. According to the Administration, there is significant work that can be done by the DMH Legal Office at less cost and staff than required by the AGO. The AGO requested that DMH no longer request their services in the following:

- ***Sexually Violent Predator (SVP) release hearings*** – held in Superior Court concerning the conditions for community release of SVP; DMH provides clinical expertise and assistance.
- ***Order to Show Cause (OSC) and Habeas Corpus hearings*** – contempt allegations against DMH and its Directors in an attempt to force admission of Incompetent to Stand Trial individuals at a faster rate.
- ***Probate Code section 3200 cases*** – involuntary medication cases in which in-state hospital patients have refused medication for physical ailments which are often urgent.
- ***Business records and subpoenas*** – superior court challenges in matters where DMH is not a party which includes SVP commitment hearings.

The DMH explains that the less complex aspects of the new legal workload can be handled by the DMH Legal Office, with increased staffing, whereas the more substantial and complex cases must be handled by contracting with private attorneys. Specifically, in-house attorneys at DMH can handle OSCs, relating to IST admissions issues, SVP placement hearings, Writ of Habeas Corpus hearings, Probate Code 3200 involuntary treatment hearings, and hearings necessary to resolve disputes regarding subpoenas of records. Outside private attorneys would need to be retained to handle litigation that involves full trials, such as torts (medical malpractice, negligence, etc.). The DMH states that the AGO did not authorize the DMH Legal Office to cover these types of cases, and only authorized the DMH to contract with private counsel for these cases. Moreover, the DMH states that their Legal Office does not have the capacity to handle "full blow, complex litigation, with voluminous discovery, preparation for and conducting depositions, complicated motions and trials lasting days or weeks."

**STAFF COMMENT**

The Administration has proposed covering the cost (\$3,076,000) of these new legal positions with General Fund savings from another program - the SOCP. The Legislature can usually expect to see an updated estimate on workload and costs for the SOCP in the May Revise. It is somewhat unusual for the Administration to combine a changing cost estimate of one program with a request for increased funding for a separate program into one request. Arguably these should be handled as two separate issues. The DMH points out that the SOCP and the DMH Legal Office are part of the same appropriation.

## **OVERALL DEPARTMENT OF MENTAL HEALTH BACKGROUND**

### **Purpose and Description of Department**

The DMH administers state and federal statutes pertaining to mental health treatment programs, including programs that serve Medi-Cal enrollees. The department also directly administers the operation of five State Hospitals (Atascadero, Coalinga, Metropolitan, Napa and Patton) and two acute psychiatric programs at the California Medical Facility in Vacaville and the Salinas Valley State Prison.

### **Purpose and Description of County Mental Health Plans**

Though the department oversees policy for the delivery of mental health services, Counties (i.e., County Mental Health Plans) have the primary funding and programmatic responsibility for the majority of local mental health programs as prescribed by State-Local Realignment statutes enacted in 1991 and 1992.

Specifically, counties are responsible for: 1) all mental health treatment services provided to low-income, uninsured individuals with severe mental illness, within the resources made available; 2) the Medi-Cal Mental Health Managed Care Program; 3) the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program for children and adolescents; 4) mental health treatment services for individuals enrolled in other programs, including special education, CalWORKs, and Healthy Families; and 5) programs associated with the MHSA.

### **Overview of Medi-Cal Mental Health Services Waiver**

California provides “specialty” mental health services under a comprehensive Waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services.

County Mental Health Plans are the responsible entity that ensures services are provided. Medi-Cal clients must obtain their specialty mental health services through the County.

The DMH is responsible for monitoring and oversight activities of the Counties to ensure quality of care and to comply with federal and State requirements. The DHCS is the “single State agency,” as designated by the federal CMS, for overall responsibility of California’s Medi-Cal Program. The DHCS delegates the responsibility for the administration of mental health programs to the DMH. Ultimately, both departments are responsible for the administration of this program.

### Mental Health Services for Medi-Cal Enrollees

Medi-Cal enrollees may receive mental health services through the Medi-Cal Mental Health Managed Care system or through the Medi-Cal Fee-For-Service system. The Mental Health Managed Care system is administered by the DMH through contracts with counties (County Mental Health Plans).

County Mental Health Plans may directly provide services and/or contract with local providers to provide services. If the County Mental Health Plans contract with local providers, it selects and credentials its provider network, negotiates rates, authorizes services and provides payment for services rendered.

Services provided through the Fee-For-Service system are general mental health services offered through individual providers who contract with the DHCS or service provided through managed care health plans.

### Governor's Proposed Funding for the DMH

The table below displays the Governor's proposed budget for Community Mental Health Programs and the State Hospitals. A total of almost \$4.6 billion (\$1.5 billion General Fund) is proposed for 2010-11. This appropriation level does not include County Realignment Funds of about \$1 billion which is separately administered by County Mental Health Plans.

<b>GOVERNOR'S PROPOSED 2010-11 DMH BUDGET</b>				
<i>(Dollars in Thousands)</i>				
<b>Summary Of Expenditures</b>	<b>Actual</b>	<b>Estimated 2009-10</b>	<b>Proposed 2010-11</b>	<b>\$ Change</b>
<b>Program Source</b>				
Community Services Program	\$3,245,352	\$3,356,269	\$3,160,667	-\$195,602
Long Term Care Services	\$1,301,726	\$1,239,264	\$1,400,568	\$161,304
MHSA Oversight & Accountability	\$2,912	\$4,739	--	transferred
<b>Total, Program Source</b>	<b>\$4,549,990</b>	<b>\$4,600,272</b>	<b>\$4,561,253</b>	<b>-\$39,019</b>
<b>Funding Source</b>				
General Fund	\$1,914,497	\$1,697,777	\$1,459,342	-\$238,435
General Fund, Proposition 98	\$2,743	\$27,257	\$15,000	-\$12,257
Mental Health Services Fund (Proposition 63)	\$1,112,993	\$1,319,394	\$1,582,771	\$263,377
Federal Funds	\$64,362	\$64,055	\$64,230	\$175
Reimbursements	\$1,453,912	\$1,490,134	\$1,439,427	-\$50,707
Traumatic Brain Injury Fund	\$1,141	\$1,172	--	transferred
CA State Lottery Education Fund	-\$8	\$104	\$99	-\$5
Licensing & Certification Fund	\$350	\$379	\$384	\$5
<b>TOTAL DEPARTMENT</b>	<b>\$4549,990</b>	<b>\$4,600,272</b>	<b>\$4,561,253</b>	<b>-\$39,019</b>

## STATE HOSPITAL ISSUES

### Expenditures for State Hospitals

Expenditures for the State Hospital system have increased exponentially in the past several years from \$775.1 million (\$624.4 million General Fund) in 2004 to over \$1.373 billion (\$1.289 billion General Fund) as proposed for 2010-11. *This represents an increase of about \$665 million in General Fund support, or a 107 percent General Fund increase in only six-years.*

The DMH contends these increased expenditures are attributable to: 1) compliance with the continued implementation of a settlement agreement with the federal government regarding the Civil Rights for Institutionalized Persons Act (CRIPA); 2) employee compensation adjustments required by the Coleman Court; 3) increasing penal code-related commitments; (4) continued activation of Coalinga State Hospital; and 5) expansion of Salinas Valley Psychiatric Program.

### Governor's Proposed Budget for State Hospitals

The DMH directly administers the operation of five State Hospitals—Atascadero, Coalinga, Metropolitan, Napa and Patton--, and two acute psychiatric programs at the California Medical Facility in Vacaville and the Salinas Valley State Prison.

The Governor's January Budget proposes expenditures of \$1.373 billion (\$1.289 billion General Fund) for 2010-11 which reflects a net increase of \$16.5 million (increase of \$19.1 million General Fund) for 2010-11 as compared to the current-year. This adjustment will be discussed in detail below.

### Key Adjustments to State Hospitals in Budget Act of 2009 (July)

The following key adjustments were enacted in July for 2009-2010:

- Reduction of \$136.7 million (\$128.2 million General Fund) through Control Section 3.90 regarding furloughs.
- Increase of \$25 million (General Fund) to address State Hospital bed issues related to the Coleman Court.

### Classifications of Patient Populations & Funding Sources

Patients admitted to the State Hospitals are generally either: 1) civilly committed; or 2) judicially committed. These referrals come from County Mental Health departments, the courts, and the CA Department of Corrections and Rehabilitation (CDCR).

As structured through the State-Local Realignment statutes of 1991/92, County Mental Health Plans contract with the state to purchase State Hospital beds for civilly-committed individuals when appropriate (versus using community-based services). Counties reimburse the state for these beds using County Realignment Funds. Judicially committed patients are treated *solely* using state General Fund support. The majority of the General Fund support for these judicially committed patients is appropriated through the DMH, along with some reimbursement from the CDCR, primarily for services provided at the two acute psychiatric programs.

Penal Code-related patients include individuals who are classified as: 1) not guilty by reason of insanity (NGI); 2) incompetent to stand trial (IST); 3) mentally disordered offenders (MDO); 4) sexually violent predators (SVP); and 5) other miscellaneous categories as noted.

The DMH uses a protocol for establishing priorities for penal code placements. This priority is used because there are not enough secure beds at the State Hospitals to accommodate all patients. This is a complex issue and clearly crosses over to the correctional system administered by the CDCR. The DMH protocol is as follows:

1. Sexually Violent Predators have the utmost priority due to the considerable public safety threat they pose.
2. Mentally Disordered Offenders have the next priority. These patients are former CDCR inmates who have completed their sentence but have been determined to be too violent to parole directly into the community without mental health treatment.
3. *Coleman v. Schwarzenegger* patients must be accepted by the DMH for treatment as required by the federal court. *Generally* under this arrangement, the DMH must have State Hospital beds available for these CDCR patients as required by the Special Master, J. Michael Keating Jr. If a DMH bed is not available the inmate remains with the CDCR and receives treatment by the CDCR.
4. Not Guilty by Reason of Insanity is the next priority.
5. Incompetent to Stand Trial is the last priority. It should be noted that there are about 250 to 300 individuals who are incompetent to stand trial who are presently residing in County jails due to the shortage of beds within the State Hospital system.

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**Questions**

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The Subcommittee has requested the DMH to answer the following questions:

1. Please explain what the impact of furloughs has been on state hospitals that require staffing 24 hours a day.
2. Please explain the number of state employee psychiatrists engaged in supervisory or administrative tasks, such as auditing and data collection?
3. Please explain DHM's use of contract psychiatrists. How much of this is attributable to furloughs? What is the cost of a contract psychiatrist as compared to a state employee psychiatrist?

**Update on Civil Rights for Institutionalized Persons Act (CRIPA)**

In July 2002, the U.S. DOJ completed an on-site review of conditions at Metropolitan State Hospital. Recommendations for improvements at Metropolitan in the areas of patient assessment, treatment, and medication were then provided to the DMH.

Since this time, the U.S. DOJ identified similar conditions at Napa, Patton, and Atascadero (Coalinga was not involved). The Administration and US DOJ finally reached a Consent Judgment for an "Enhanced Plan" of operations on May 2, 2006.

The Consent Judgment also appointed a Court Monitor to review implementation of the Enhanced Plan and to ensure compliance. Failure to comply with the Enhanced Plan would result in legal proceedings against the DMH and possible Receivership.

Under the Consent Judgment, the DMH has until *November 2011* to fully comply with the "Enhanced Plan" to improve patient treatment and hospital conditions. At this time the Court Monitor will depart and the DMH is to assume full responsibility for compliance.

The Enhanced Plan provides a timeline for the Administration to address the CRIPA deficiencies and included agreements related to treatment planning, patient assessments, patient discharge planning, patient discipline, and documentation requirements. It also addresses issues regarding quality improvement, incident management and safety hazards in the facilities.

Based on recent fiscal data, the Legislature has approved about \$29.4 million (General Fund) to enhance care at the four hospitals under the Consent Judgment (Coalinga State Hospital has not been formally included by the DOJ) to meet CRIPA requirements.

The Legislature receives periodic updates from the DMH regarding compliance. The Subcommittee has requested the DMH to provide an update, and has posed specific questions as noted below.

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**Questions**

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The Subcommittee has requested the DMH to respond to the following questions:

1. Please provide a brief summary of the CRIPA compliance status.
2. Which key areas are proceeding well and which key areas need improvement?
3. DMH, What are the next key steps in 2010-11 for full compliance to be achieved?

**Update on Coleman Court and DMH Activities**

The DMH provides inpatient mental health treatment to Coleman class inmate-patients referred by the CA Department of Corrections and Rehabilitation (CDCR). System-wide, the DMH operates a total of 886 beds for Coleman of which 336 beds are in the State Hospitals and 550 beds are in psychiatric programs within the CDCR institutions (Salinas and Vacaville prisons). These beds and services are located as follows:

- Atascadero State Hospital – 256 Intermediate Care Beds
- Coalinga State Hospital - 50 Intermediate Care Beds
- Patton State Hospital - 30 Intermediate Care Beds
- Salinas Valley Psychiatric - 254 Intermediate Care Beds
- Vacaville Psychiatric - 114 Intermediate Care Beds & 182 Acute Beds, and four Beds for suicide prevention

The DMH states that two other large projects are also underway which pertain to the Coleman class of inmate-patients. A 64-bed Intermediate Care Facility addition for Vacaville is scheduled to be completed in August 2012 (CDCR Long-Range Bed Project) and the DMH would begin its activation and the admission of patients four-months after its completion. The DMH budget proposes an increase of \$840,000 (General Fund), to begin activities associated with this project.

Another component of the CDCR Long-Range Plan is an integrated 1,722 medical and mental health hospital to be operated by the CDCR and DMH. As part of this arrangement, the DMH is committed to operate 475 licensed inpatient mental health beds for high custody Coleman class inmate-patients. These 475 beds will be comprised of 432 Intermediate Care Beds and 43 Acute Care Beds. Though this project is currently in the planning stage, it is expected to be fully-occupied by December 2013.

The Budget Act of 2009 (July) appropriated \$25.3 million (General Fund) to the DMH in response to a March 29, 2009 order from the Coleman Court to develop proposals to meet certain short-term, intermediate, and long-term State Hospital beds needs of this plaintiff class.

The \$25.3 million (General Fund) amount assumed the establishment of 162 beds, mainly at the acute-psychiatric and Intermediate Care levels and the hiring of 250 positions, including clinical staff and security personnel to provide mental health treatment services and security. The Coleman Court approved the DMH plan on June 18, 2009.

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## **Questions**

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The Subcommittee has requested the DMH to provide an update on key Coleman Court-related activities, and any key concerns with implementation issues.

**Current Year State Hospital Population Over-Estimated**

The State Hospital budget for the current-year assumes a caseload of 6,202 patients which is significantly higher than the trend reflected in the actual patient census.

As shown in the table below, the most recent patient census reflects a caseload of only 5,727 patients, or 475 patients less (7 percent) than provided for in the current-year budget.

**DMH State Hospital Patient Caseload: Current Year (2009-2010)**

Category of Patient	Current Year Budgeted Caseload	Actual Census March 3 <sup>rd</sup>	Difference
Sexually Violent Predators (SVPs)	858	806	-52
Mentally Disorder Offenders (MDOs)	1,225	1,166	-59
Not Guilty by Reason of Insanity (NGI)	1,238	1,233	-5
Incompetent to Stand Trial (ISTs)	1,189	1,105	-84
Penal Code 2684s & 2974s (referred for treatment by CDCR)	1,048	788	-260
Other Penal Code Patients (various)	143	146	+3
CA Youth Authority Patients	30	20	-10
County Civil Commitments	471	463	-8
<b>TOTAL PATIENTS</b>	<b>6,202</b>	<b>5,727</b>	<b>-475</b>

The Legislative Analyst's Office (LAO) has updated their analysis from January and is recommending a current-year reduction of \$10 million (General Fund). The LAO reduction accounts for patient population decreases for the IST, MDO and NGI categories, but does not include the CDCR category of commitments since these pertain to the Coleman Court and other matters which pertain to correctional inmates. The reduction assumes a \$67,242 bed cost which equates to the half-year cost of a bed. This calculation corresponds to the methodology agreed to with the Administration in 2002.

**STAFF COMMENT**

The current year caseload estimates will be updated in May Revise.

## Proposed Budget-Year Adjustments for the State Hospitals

### Budget Issue

The DMH proposes an increase of \$16.5 million (increase of \$19.1 million General Fund) for 2010-11 as compared to the current-year. This increase is attributable to three proposals as follows:

### Proposed Population Increase

The DMH contends the State Hospital patient population will increase by 180 patients for a total caseload of 6,382 patients. An increase of \$16.9 million (General Fund) to fund 188 Level-of-Care staff for this estimated population adjustment is assumed. As noted in the current-year adjustment above, the population estimate needs to be re-tooled. As such, the May Revision will likely significantly modify this projection.

<b>State Hospital Caseload Summary Projection (DMH Estimate)</b>			
<b>Patient Category</b>	<b>Estimated 2009-10</b>	<b>Estimated 2010-11</b>	<b>Increase</b>
Sexually Violent Predators (SVPs)	858	90	62
Mentally Disordered Offenders (MDOs)	1,225	1,264	39
Not Guilty By Reason of Insanity	1,238	1,235	-3
Incompetent to Stand Trial	1,189	1,202	13
Penal Code 2684s & 2974s** (Referred for treatment by CDCR)	1,048	1,112	64
Other Penal Code Patients	143	148	5
CA Youth Authority Patients	30	30	0
County Civil Commitments	471	471	0
<b>TOTAL</b>	<b>6,202</b>	<b>6,382</b>	<b>180</b>

\*\* Of this caseload, 766 patients in 2010 would reside in Psychiatric Programs at Vacaville and Salinas, and 346 patients would be in State Hospital facilities.

### Coalinga SH Activation

An increase of \$1.7 million (General Fund) to fund 15 Non-Level-of-Care positions is proposed to continue the activation of Coalinga State Hospital, a 1,500 bed secured facility which is designed specifically to serve the Sexually Violent Predator (SVP) patient population. The DMH states that these positions will be used to support CRIPA staffing ratios and to support a Forensic Unit at the facility.

### Coleman Bed Expansion at Vacaville

An increase of \$840,000 (General Fund) to support 9 positions as part of the phase-in of staffing for the 64-bed high custody Intermediate Care Facility at Vacaville is proposed. Of this amount, \$218,000 is for the positions (both clinical and administrative) and \$622,000 is for equipment and furnishings for office space for the treatment staff.

CA Department of Corrections & Rehabilitation (CDCR) Referral to the DMH

Specified sex offenders who are completing their prison sentences are referred by the CDCR and the Board of Parole Hearings to the DMH for screening and evaluation to determine whether they meet the criteria as SVP.

When the DMH receives a referral from the CDCR, the DMH does the following:

*Screening.* The DMH screens referred cases to determine whether they meet legal criteria pertaining to SVPs to warrant clinical evaluation. Based on record reviews, about 42 percent are referred for evaluation. Those not referred for an evaluation remain with the CDCR until their parole date.

*Evaluations.* Two evaluators (Psychiatrists and/or Psychologists), who are under contract with the DMH, are assigned to evaluate each sex offender while they are still held in state prison. Based on a review of the sex offender records, and an interview with the inmate, the evaluators submit reports to the DMH on whether or not the inmate meets the criteria for an SVP. If two evaluators have a difference of opinion, two additional evaluators are assigned to evaluate the inmate. Offenders, who are found to meet the criteria for an SVP, as specified in law, are referred to District Attorneys (DAs). The DAs, then determine whether to pursue their commitment by the courts to treatment in a State Hospital as an SVP.

If a petition for a commitment is filed, the clinical evaluators are called as witnesses at court hearings. Cases that have a petition filed, but that do not go to trial in a timely fashion may require updates of the original evaluations at the DA's request. The amount of time it takes to complete the commitment process may vary from several weeks to more than a year depending on the availability of a court venue and the DA's scheduling of cases. While these court proceedings are pending, offenders who have not completed their prison sentences continue to be held in prison. However, if an offender's prison sentence has been completed, he or she may be held either in county custody or in a State Hospital.

SB 1128 (Alquist, Chapter 337, Statutes of 2006)

This legislation made changes in law to generally increase criminal penalties for sex offenses and strengthen state oversight of sex offenders. For example, it requires that SVPs be committed by the court to a State Hospital for an undetermined period of time rather than the renewable two-year commitment provided under previous law.

This law also mandates that every person required to register as a sex offender is subject to assessment using the State-Authorized Risk Assessment Tool for Sex Offenders (SARATSO) a tool for predicting the risk of sex offender recidivism.

Proposition 83 of November 2006—“Jessica’s Law”.

Approved in November 2006, this proposition increases penalties for violent and habitual sex offenders and expands the definition of an SVP. The measure generally makes more sex offenders eligible for an SVP commitment by: 1) reducing from two to one the number of prior victims of sexually violent offenses that qualify an offender for an SVP commitment, and 2) making additional prior offenses “countable” for purposes of an SVP commitment.

Rising State Hospital Costs

The State Hospital expenditures are increasing at an *exorbitant rate* growing from \$775.1 million (\$624.4 million General Fund) in 2004 to over \$1.373 billion (\$1.289 billion General Fund) as proposed for 2010-11. This represents an increase of about \$665 million in General Fund support, or a 107 percent General Fund increase in only six-years. As such, a cost containment proposal at the May Revision is warranted.

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**Questions**

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The Subcommittee has requested the DMH to respond to the following questions:

1. Please provide a *brief* summary of the *key* population changes.
2. Please describe the major cost drivers in state hospitals.

## COMMUNITY MENTAL HEALTH ISSUES

### Only One-year Extension for Mental Health Services Waiver & Need for Changes

The DHCS was informed by the federal Centers for Medicare and Medicaid (CMS) in September 2009 that California's comprehensive Medi-Cal Specialty Mental Health Services Waiver would only be approved for one-year, to September 30, 2010, instead of the requested two-year renewal period which is standard.

Changes to the Waiver and California's State Medi-Cal Plan will need to be made and several of these changes are due to continued federal audit concerns related to State administration of the program. How these changes may affect services to people with serious mental illness is not clear at this time. The Waiver covers two programs within the DMH: 1) the EPSDT Program for children; and 2) Mental Health Medi-Cal Managed Care Program.

Under an agreement reached between the State (DHCS and DMH) and the federal CMS, California must submit an amendment for the Medi-Cal Program (referred to as a "State Plan Amendment") in order for California to have the Waiver extended for another year (to September 30, 2011).

According to the DHCS and DMH, a draft State Plan Amendment has been submitted to the federal CMS. According to the Administration, the required State Plan Amendment is to address the following key concerns:

- **Updating Coverage.** The State must provide updated language for specialty mental health services, provider descriptions and qualifications and a description of the medical necessity criteria that Medi-Cal clients must meet to be eligible for these services. These changes are critical and must be approved by the federal CMS for the Waiver to continue beyond September 2010.
- **Reimbursement Processes.** All Medi-Cal Waivers must demonstrate cost-effectiveness to the federal government. In turn, the federal government requires certain reporting to monitor and track cost-effectiveness. Due to federal audit concerns, considerable changes must be made regarding the State's accounting and reimbursement processes.

### Federal CMS Concerns Stem from Audit Issues

The federal CMS has expressed considerable concerns regarding the operation of this Waiver through two “final” audits which are public and one “draft” audit which is not public but was provided to the Administration in September 2009.

The draft audit—“Review of Certified Public Expenditures Used to Finance Medi-Cal Payments in CA’s Specialty Mental Health Services Program”—reviewed five counties to examine financial components to the program, including the use of CPEs to obtain federal funds, payment reconciliation processes, and final cost settlement processes. The selected counties included Los Angeles, Sacramento, San Diego, San Francisco, and Orange. In addition, the review encompassed the State’s rules for calculating certain payments (upper payment limit) and the definition of mental health specialty services. Many of the outcomes from this draft, confidential federal CMS audit generated the need for the State Plan Amendment and Waiver changes.

The two previously released audits noted the following *key concerns*:

- The DHCS and DMH systems are not adequate to comply with federal requirements, resulting in total mental health program expenditures likely to be significantly misstated.
- The DHCS does not appear to provide adequate oversight over the Medi-Cal Mental Health Services Program, specifically over the processing of DMH invoices.
- California’s existing provider reimbursement methods, processes, and policies are not fully consistent with federal law, particularly regarding interim payment, reconciliation and cost-settlement processes.
- California must implement controls to ensure that the process used to count County Realignment Funds (i.e., “certified public expenditures”—CPEs) towards the federal match, meets federal requirements.

### Ongoing Concerns with Fiscal Integrity

Significant fiscal management issues have been raised regarding the State’s administration of the overall Medi-Cal Specialty Mental Health Waiver, including five reports prepared by the independent Office of Statewide Audits and Evaluations, as well as the two released fiscal audits by the federal CMS. The DHCS was provided an increase of \$331,000 (total funds) for three positions in the 2009 Budget Act to enable them to respond to federal CMS audits and to continue making improvements in the coordination and management of the Medi-Cal Mental Health Waiver. The CHHS Agency was statutorily required to provide an Action Plan (receipt pending) to more comprehensively implement needed changes from all of these previous fiscal reviews and audits.

CA Health & Human Services Agency “Action Plan” Is Overdue

Trailer bill legislation last year, as contained in ABX4 5, Statutes of 2009, required the CHHS Agency to provide the Legislature with an Action Plan.

The Action Plan was due to the Legislature on February 1, 2010 in order to fully problem solve and remedy continued concerns, as well as to facilitate any needed discussion and review through the Legislature’s budget and policy committee processes.

The purpose of the Action Plan is to facilitate coordination of core programmatic functions between the DHCS and DMH regarding the following items:

- Activities for the development and maintenance of the State’s Medi-Cal Mental Health Waiver;
- Reimbursement of County Mental Health Plans and providers of mental health services;
- Implementation of the State’s “Short-Doyle II” Data System; and,
- Implementation of federal CMS audits, fiscal reviews, and related items.

Mental Health Supplemental Payments Program

The Budget Act of 2009 established a new “Mental Health Services Supplemental Payment Program” to authorize the use of County CPE’s for costs of mental health services provided to Medi-Cal clients that exceed their current payment levels. Participation in the program by Counties is voluntary.

The supplemental payment would consist of the difference between the current Fee-for-Service rate being paid for these services and the actual costs to the counties to provide the mental health services. It is anticipated that supplemental federal payments will provide a total of \$27.7 million (federal funds) for 2008-09, \$55.4 million (federal funds) for 2009-2010, and \$27.7 million (federal funds) in 2010-11. There is no General Fund impact to this program.

To-date, no federal funds have been received since the State Plan Amendment needed for implementation is now part of the overall Waiver and audit change package being negotiated with the federal CMS.

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**Mental Health Services for Special Education Pupils (AB 3632) Program**

The federal government mandates that schools provide mental health services to special education students who need them. California, through AB 3632, chooses to meet this mandate by requiring county mental health services to provide these services. However, the state has not fully reimbursed counties for these services. According to the DMH, total claims submitted for the past three fiscal years amounts to a total of \$211.9 million, and the state paid counties \$51.2 million from the 2009-10 appropriation. This leaves a remaining balance of \$160.7 million still owed to counties.

Counties point out that while these mental health services to special education students are critical services, this federally-mandated program is not a "means-tested" program, meaning a family's income or other resources have no bearing on the student's qualification for free mental health services. Nevertheless a result of the state not reimbursing the counties fully for providing these services, counties must redirect realignment funds for this purpose, thereby reducing resources and services available specifically for low-income populations.

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**Questions**

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The Subcommittee has requested the DMH and DHCS to respond to the following questions:

1. Please provide an update on the Waiver and the key concerns of the federal CMS in only providing the State with a one-year approval.
2. What are the key aspects of the State Plan Amendment?

## **Implementation of Short-Doyle System--Phase II**

### Background

The Short-Doyle computer system processes Medi-Cal claims regarding behavioral health and drug and alcohol treatment services from Counties and select direct providers with the DMH, and the Department of Alcohol and Drug (DADP). The current system is operated jointly by the DHCS, DMH and DADP.

The system processes about 1.5 million claims monthly with annual approved claims of over \$1 billion. The current mainframe claims adjudication system was built in the early 1980's.

With the implementation of the federal Health Insurance Portability and Accountability Act (HIPAA) in 2002, considerable modifications needed to be made to the system (Phase I). These changes were generally completed in 2004 as a stop-gap measure.

From 2004 to the present, concerns have been raised regarding the system, including the following:

- State and federal audit concerns identified serious flaws, including payment information was not matched (warrants and payments were not captured), and adjustments to claims were done outside of the system.
- Payment cycle for claims was far below standards and reimbursement to Counties and providers took from 90 to 120 days to be provided.
- Adjudicated claim data was not compatible with other Medi-Cal data and could not be effectively cross-checked.
- Long-term technical support was not feasible for many reasons, including the need to operate in manual batch mode and having antiquated codes.

Since 2006, the Administration has focused its efforts on the Short Doyle Phase II portion of the project to have a more fully integrated, functional claims adjudication system.

Changes to the Short-Doyle system, a critical system for claims processing for Medi-Cal specialty mental health services, have been on-going for several years. A revised Short-Doyle system is necessary to address critical payment system problems and various State and federal audit control issues.

As of January 2010, the Administration proceeded with a phased-in approach to bring Counties and certain direct providers into the modified system. The Administration states that 39 counties, including Los Angeles, have submitted claims for processing; additional counties are expected to submit claims as they work through a variety of technical issues.

The Administration states they are providing technical assistance to Counties and will also be “re-engineering” some of their own business practices within the DMH to ensure that payments are made to Counties and providers within 30-days (upon completion of changes).

According to the DHCS and DMH, the key benefits to Short-Doyle Phase II are the following:

- “Clean” claims from Counties and other providers to be paid within 30-days as contained in State statute (Section 927 of the Government Code).
- Payment data is reconciled (warrants and payments are matched).
- Claim adjustments are automated, and prompt notification of denied claims will be made.
- Claim data is standardized for reporting purposes.
- Availability of claim status inquiry and response.
- Uses industry standard software for administration and operation.
- Electronic data flow to departmental accounting systems.

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## **Questions**

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The Subcommittee has requested the DMH and DHCS to respond to the following questions:

1. Please provide a brief overview of key components to Short-Doyle Phase II and progress on implementation, including how community mental health partners are involved.
2. What key implementation steps are pending and what risks are involved with next steps? Is the Medi-Cal/Medicare dual-eligibles claiming process being clarified?

## **MEDI-CAL MENTAL HEALTH MANAGED CARE**

### How Mental Health Managed Care is Funded

Under this model, County Mental Health Plans generally are at risk for the state matching funds for services provided to Medi-Cal recipients and claim federal matching funds on a cost or negotiated rate basis. County MHPs access County Realignment Funds (Mental Health Subaccount) for this purpose and can use Mental Health Services Act Funds where appropriate.

An annual state General Fund allocation is also provided to the Counties. The State General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have included changes in the number of eligibles served, factors pertaining to changes to the consumer price index (CPI) for medical services, and other relevant cost items. The State's allocation is contingent upon appropriation through the annual Budget Act.

Based on the most recent estimate of expenditure data for Mental Health Managed Care, County MHPs provided a 49 percent match while the state provided a 51 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

### Summary of Budget and Issues

The DMH proposes total expenditures of \$350 million (\$89.2 million General Fund, \$61.2 million Mental Health Services Act Funds, and \$199.6 million federal reimbursements) for the Mental Health Managed Care Program in 2010-11.

The DMH proposal assumes the following key changes for 2010-11:

- ***Proposes to Redirect Mental Health Services Act Funds.*** Redirects \$61.2 million in MHSA Funds from locals to backfill for General Fund support through legislation to amend the MHSA of 2004 which would require voter approval.
- ***Program Cost Increases.*** Provides an increase of \$23.4 million (\$11.7 million General Fund and \$11.7 million federal reimbursements) due to increased caseload and utilization of services.

- **Receipt of Federal Funds—ARRA Extension.** Assumes savings of \$25.4 million (General Fund) due to increased federal funding of 61.59 percent in Medi-Cal through the American Recovery and Reinvestment Act (ARRA). The Governor assumes this level of ARRA funding will be extended for another six months to June 30, 2010.
- **Receipt of Federal Funds—Increase Base to 57 Percent.** Assumes savings of \$30.6 million (General Fund) through federal law changes which would increase California's "Federal Medical Assistance Percentage" (FMAP) to an average received by other states nationwide. This is part of the Governor's overall federal request. This savings is contained within Control Section 8.65 of the Budget Bill.
- **Continues Reduction From Budget Act of 2009.** Continues as a baseline adjustment the reduction of \$64 million (General Fund) in 2009, based on data from the DMH which stated that these funds were expended on outpatient services that were not federally reimbursable. As such, the DMH noted that Counties could choose to provide these services using their own funds, and not state General Fund support intended for Medi-Cal clients.

It should be noted that no cost-of-living-adjustment has been provided by the State for this program since the Budget Act of 2000, due to the Governor's vetoes.

## **EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM (EPSDT)**

### Background

Specifically, EPSDT is a federally mandated program that requires States to provide Medicaid (Medi-Cal) recipients under age 21 any health or mental health service that is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, including services not otherwise included in a state's Medicaid (Medi-Cal) Plan. Examples of mental health services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling. Most children receive Medi-Cal services through the EPSDT Program.

Though the DHCS is the "single state agency" responsible for the Medi-Cal Program, mental health services including those provided under the EPSDT, have been delegated to be the responsibility of the DMH. Further, County Mental Health Plans are responsible for the delivery of EPSDT mental health services to children. In 1990, a national study found that California ranked 50<sup>th</sup> among the states in identifying and treating severely mentally ill children. Subsequently due to litigation (*T.L. v Kim Belshe* 1994), the DHCS was required to expand certain EPSDT services, including outpatient mental health services. The 1994 court's conclusion was reiterated again in 2000 with respect to additional services (i.e., Therapeutic Behavioral Services—TBS) being mandated. The state has lost several lawsuits and is required to expand access to EPSDT mental health services.

County MHPs must use a portion of their County Realignment Funds to support the EPSDT Program. Specifically, a "baseline" amount was established as part of an interagency agreement in 1995, and an additional 10 percent requirement was placed on the counties through an administrative action in 2002. According to the DMH, about \$84.9 million (County Realignment) is estimated to be expended in 2010-11 to meet this county requirement.

### Summary of Budget and Issues

The DMH proposes total expenditures of \$1.191 billion (\$391.156 million Mental Health Services Act Funds, \$61.176 million General Fund, \$653.8 million federal reimbursements, and \$84.9 million County Realignment Funds) for the EPSDT Program for 2010-11. This reflects a *net* increase over the current-year of \$123.8 million (total funds).

The DMH proposal assumes the following *key changes* to EPSDT for 2010-11:

1. **Proposes to Redirect Mental Health Services Act Funds.** Redirects \$391.2 million in MHSA Funds from locals to backfill for General Fund support through legislation to amend the MHSA of 2004 which would require voter approval.
2. **Estimate Cost Adjustments.** Increases by \$106.9 million (General Fund) to reflect increases in costs, utilization, and some caseload.
3. **Emily Q. Plan.** Provides a total of \$16.8 million (General Fund), to address issues related to the Emily Q. plan. The Emily Q. Plan is the result of a legal settlement in which a Special Master has crafted a nine-point plan for the provision of Therapeutic Behavioral Services which the DMH and County Mental Health Plans are required to implement. This plan is being phased-in over time.
4. **Reimburses for County Deferral.** Increases by \$15.796 million (General Fund) to reimburse County Mental Health Plans for deferred payments from 2009 to be paid in 2010.
5. **Past Audit Settlements on EPSDT.** Increases by \$16.1 million (\$2.2 million General Fund) for audit settlements due from the DMH to the counties for fiscal years 1998-99 through 2004-05. The DHCS and DMH need to clarify if the federal CMS will provide federal matching funds for this purpose.
6. **Receipt of Federal Funds—ARRA Extension.** Assumes savings of \$61.2 million (General Fund) due to increased federal funding of 61.59 percent in Medicaid (Medi-Cal) through the American Recovery and Reinvestment Act (ARRA). The Governor assumes this level of ARRA funding will be extended for another six months to June 30, 2010.
7. **Receipt of Federal Funds—Increase Base to 57 Percent.** Assumes savings of \$73.9 million (General Fund) through federal law changes which would increase California's "Federal Medical Assistance Percentage" (FMAP) to an average received by other states nationwide. This is part of the Governor's overall federal request.

### Summary of Budget Actions Taken in 2008

Due to fiscal constraints, three changes were enacted in the EPSDT Program in 2008. These changes were significantly less drastic than the Governor's overall proposals for the program.

Specifically, the Legislature adopted two of the Governor's proposals to: 1) establish a unit within the DMH to monitor EPSDT claims; and 2) eliminate the Cost-of-Living-Adjustment using the federal home health market basket which is applied to the Schedule of Maximum Allowances used for rates. These actions, taken in Special Session (AB 3X 5, 2008), were to save \$29.2 million (\$14.6 million General Fund) in 2008-09. These changes are presently ongoing.

In addition, in lieu of more drastic reductions, the Legislature enacted statutory changes to require the DMH to implement a "*Performance Improvement Project (PIP)*" for the EPSDT Program. This action was taken in lieu of yet other reductions proposed by the Governor that would have potentially eliminated some children from treatment. The PIP was assumed to save \$12.1 million General Fund in 2008-09 by targeting coordination and integration of care for children through case management, and by achieving certain administrative efficiencies. This is also an ongoing change.

### Summary of Budget Actions Taken in 2009 (July)

The revised Budget Act of 2009 provided a total of \$1.038 billion (\$364.8 million General Fund and \$674.1 million federal reimbursements) for the EPSDT Program. This reflected the following key adjustments:

- Increased by \$226.7 million (General Fund) to reflect the lack of passage of Proposition 1E (May 2009) and its proposed use of MHSA Funds.
- Decreased by \$122.1 million (General Fund) to reflect receipt of enhanced federal American Recovery & Reinvestment Act (ARRA) funds.
- Reduced by \$53.4 million (General Fund) to reflect elimination of State funding for county programs developed using MHSA Funds that the Administration contends increases services within the EPSDT Program.
- Increased by \$19 million (General Fund) to reflect Emily Q court order requiring the department to implement a nine point plan regarding certain services.
- Decreased by \$4.9 million (General Fund) to reflect revised technical caseload and expenditure adjustments.
- Deferred \$15.8 million (General Fund) in payments to counties to reimburse prior year cost settlement claims for the EPSDT Program.

## 5180 DEPARTMENT OF SOCIAL SERVICES

### ISSUE 1: CASH ASSISTANCE PROGRAM FOR IMMIGRANTS

The Governor's budget proposes to eliminate the Cash Assistance Program for Immigrants (CAPI), for General Fund savings in 2010-11 of \$107.3 million. Under the Governor's proposal, 10,886 CAPI recipients who are lawfully residing in the U.S. would thus lose this assistance in 2010-11.

#### BACKGROUND

California created CAPI in 1998 under Governor Wilson after federal law began excluding these individuals. CAPI provides basic living benefits to aged, blind, and disabled legal immigrants that are equivalent to Supplemental Security Income and/or State Supplemental Payment (SSI/SSP) program benefits, less \$10 per individual and \$20 per couple. SSI/SSP grants for individuals were reduced to \$845 per month and grants for couples are \$1,407 per month (at the MOE floor) in the 2009-10 budget. For CAPI, individuals thus currently receive \$835 and couples receive \$1,387 at the highest level, if no other income is received by the household. Average grant levels are lower - \$640.85 for the Base CAPI cases, based on actual expenditures through February 2009.

CAPI recipients in the base program include the following immigrants: 1) those who entered the U.S. prior to August 22, 1996, and are not eligible for SSI/SSP benefits solely due to their immigration status; and, 2) those who entered the U.S. on or after August 22, 1996, but meet special sponsor restrictions (have a sponsor who is disabled, deceased, or abusive). The extended CAPI caseload includes immigrants who entered the U.S. on or after August 22, 1996, who do not have a sponsor or have a sponsor who does not meet the sponsor restrictions of the base program.

To be eligible for CAPI, individuals must successfully complete the application process, including the following: apply for SSI/SSP; meet the income criteria (monthly income, after certain amounts are disregarded, cannot be greater than the maximum monthly CAPI benefit amount); and, meet the resource criteria (the resources a person may own cannot be greater than \$2,000 for an individual or \$3,000 for a couple). CAPI participants may be eligible for Medi-Cal, In-Home Supportive Services (IHSS) and/or Food Stamp benefits.

#### Federal Developments

Advocates state that although progress has been gradual, recent developments should allow a significant number of CAPI recipients (refugees and other humanitarian immigrants) to secure two to three years of SSI, allowing the state to collect payments retroactive to October 2008 in many cases.

In Fall 2008, Congress enacted a temporary extension of SSI benefits for most refugees and humanitarian immigrants who had reached the end of their eligibility period. This group had been eligible to receive benefits only during the first 7 years after obtaining the relevant status. The Social Security Administration (SSA) issued instructions for implementing the SSI Extension for Elderly and Disabled Refugees Act (P.L. 110-328). Humanitarian immigrants whose benefits ended due to this time limit may receive at least two additional years of benefits, retroactive to October 2008. Their benefits may continue for an additional year, until September 30, 2011, if they have a pending naturalization application or are waiting to be sworn in as a U.S. citizen. Humanitarian immigrants newly applying for SSI, or whose benefits have not yet expired, can receive SSI during the nine-year period since they were granted the relevant status, or if they have a pending naturalization application.

### **SSI Advocacy**

"Qualified" immigrants who were in the US lawfully on August 22, 1996, and have a disability are eligible for SSI. Seniors who have been unable to prove that they have a disability may receive CAPI while pursuing their SSI claim. Until 1999, the Social Security Administration (SSA) did not have procedures for evaluating the disability of elderly applicants, since previously applicants over age 65 had been able to receive SSI based on their age. But since elderly immigrants who were in the US lawfully on 8/22/96 also needed to show disability, the SSA needed to develop procedures for evaluating disability for these older immigrants. The result is that the vast majority of qualified immigrants who were in the US lawfully on 8/22/96 are successful in moving to SSI, provided that they have assistance in making their application.

LA County's CAPI SSI Advocacy Program (SSIAP), which was implemented at the beginning of 2002, assists CAPI participants through the SSI application process and works with the Social Security Administration to expedite SSI approvals for CAPI participants.

Under SSI disability standards for the elderly which were developed after CAPI was implemented, many elderly immigrants are considered disabled, thus making them eligible for federally-funded SSI instead of CAPI. When CAPI SSIAP began, 55% of all CAPI participants were aged 65+ and entered the U.S. prior to August 22, 1996. At that time, all of these participants were assisted in the SSI application process, with a better than 76% approval rate, which substantially reduced the State's CAPI costs.

CAPI SSIAP now includes all other potentially SSI-eligible CAPI participants. As of January 1, 2010, 9,448 SSI applications had been filed through L.A. County's CAPI SSIAP of which 7,541 (or 80%) have been approved for SSI. This includes 1,400 humanitarian immigrants who had been terminated from SSI due to the expiration of their seven-year eligibility period and whose SSI benefits were reinstated for at least two additional years (three years if they apply for citizenship) because of the passage of the federal "SSI Extension for Elderly and

Disabled Refugees Act," on September 30, 2008. Because of CAPI SSIAP, SSA has reimbursed over \$22 million in CAPI benefit payments to the State, and the State has saved an estimated \$51.7 million in annual CAPI benefit payments due to the 7,541 SSI approvals (based on the avoidance of 12 months of CAPI benefits for each CAPI recipient approved for SSI).

### **Expected Impact**

Advocates state that vulnerable seniors and persons with disabilities will certainly face hunger or homelessness if CAPI is eliminated. Immediately following the passage of the 1996 welfare law, a number of immigrants who faced the loss of their SSI grant threatened to or committed suicide.

### **PANELISTS**

- Department of Social Services
- Department of Finance
- Legislative Analyst's Office
- Vanessa Cajina, California Immigrant Policy Center
- Phil Ansell, Los Angeles County Department of Public Social Services
- Public Comment

### **Possible Questions**

- The majority of CAPI participants live independently and depend totally on their CAPI benefits. How many of these individuals would become homeless and unable to make ends meet if CAPI is eliminated?
- How many sponsored CAPI participants would be able to meet their basic needs if CAPI is eliminated?
- If CAPI is eliminated and these individuals transition to GR, how will they survive on the GR/GA grant which is (approximately) one fourth of the CAPI payment and offered for only three months out of the year?
- Some of the CAPI participants reside in Non-Medical Out-of-Home Care facilities. If CAPI is eliminated, how will these individuals continue to live without this type of care?

### **Staff Recommendation:**

Staff recommends holding the budget for CAPI open at this time.

**ISSUE 2: CALIFORNIA FOOD ASSISTANCE PROGRAM**

The Governor's budget proposes to eliminate the California Food Assistance Program (CFAP), for General Fund savings in 2010-11 of \$56.2 million. Under the Governor's proposal, 37,000 CFAP recipients who are lawfully residing in the U.S. would thus lose their food benefits in 2010-11.

**BACKGROUND**

The California Food Assistance Program was created in 1997 to mitigate the impact of federal food stamp rule changes on legal non-citizens. The program provides food assistance to legal immigrants over 18 and under 65 years of age who are otherwise eligible for food stamps, but for their citizenship status. Recipients must meet all other Food Stamp Program rules and requirements. The program's benefits and administrative costs are entirely state-funded. Participation has changed as the federal government has restored benefits for many immigrants over time. The average monthly food benefit per person is \$112. Caseload in this program has decreased, down from a high of 97,000 in 2002.

**Expected Impact**

A number of studies have examined the impact of the loss of food benefits on immigrants. When federal rules initially eliminated many non-citizen households from the Food Stamp Program, "food insecurity" rose substantially. States that provided food assistance to immigrants, such as California, were "able to arrest and reverse this rise in food insecurity."

Research has also found that non-citizens are not the only ones in the households affected by changes in food aid. Food insecurity among citizen children in the household also increases substantially. Thus the elimination could also be expected to negatively affect other household members, including kids, as the overall level of food resources available to the family would decrease. Also lost would be the economic activity generated by these food benefits. Generally, every \$1 in food stamps generates \$1.84 economic activity.

Advocates state that mitigating the impact elimination of the program would be impossible. The emergency food system would be the likely, but impractical, mitigating agent. The emergency food system, despite its strengths, cannot fully provide the level of assistance nor the flexibility of food resources currently provided by CFAP. Food banks are already dealing with soaring demand.

**PANELISTS**

- Department of Social Services
- Department of Finance
- Legislative Analyst's Office
- Vanessa Cajina, California Immigrant Policy Center
- Elizabeth Gomez, Alameda County Community Food Bank
- Phil Ansell, Los Angeles County Department of Public Social Services
- Public Comment

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**Possible Questions**

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- There has been an increase of 30% in the number of CFAP households, statewide, from July 2008 - December 2009 (4,751 CFAP households to 6,168 CFAP households). Are there other programs in place where these households are expected to go so they can eat?
- There has been an increase of 51% of federal Food Stamp households with a CFAP member from July 2008 - December 2009 (10,392 CFAP/federal households to 15,682 CFAP/federal households). Are there other programs in place where these households are expected to go so they can eat?
- How will cutting nutrition benefits to these needy households struggling to make ends meet assist them to eat and still pay for shelter and their other subsistence needs?

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**Staff Recommendation:**

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Staff recommends holding the budget for CFAP open at this time.

**ISSUE 3: RECENT NONCITIZEN ENTRANTS PROGRAM**

The Governor proposed to eliminate the Recent Noncitizen Entrants Program (RNE), affecting 24,000 individuals who depend on the program for basic assistance. If the TANF Emergency Contingency Fund (ECF) is extended, this proposal will result in \$22.5 million General Fund savings and a loss of \$36.3 million in federal funds. If the ECF is not extended past September 30, 2010, the proposal results in \$47.6 million in General Fund savings in 2010-11, and the state would forego \$11.1 million in federal funds.

**BACKGROUND**

The federal law that created TANF, PRWORA, excluded most legal immigrants entering the U.S. after the date of enactment (August 22, 1996) from receiving TANF program benefits for the first five years they are in the country. PRWORA does provide exceptions for certain noncitizens including refugees, asylees, veterans, and current military personnel. The CalWORKs program continued aid to certain groups of noncitizens that became ineligible with the implementation of PRWORA, including battered noncitizens, those Permanently Residing in the United States Under Color of Law, Legal Permanent Residents, Conditional Entrants, and Parolees.

Under this proposal, approximately 24,000 recipients in approximately 9,500 cases will lose eligibility for CalWORKs assistance and associated employment services, including child care. Immigrants in the CalWORKs program must meet all other eligibility guidelines. The state receives credit for its "maintenance of effort" obligation by serving these low-income families with children.

**Expected Impact**

Advocates state that the proposed elimination of services places approximately 24,000 lawfully residing immigrant parents and children at risk of destitution. The Governor's proposal ignores the consequences of eliminating a family's source of income, child care, job training and education. CalWORKs provides these services to families with no other recourse. The denial of services to these 24,000 individuals will have ripple effects, when they cannot pay rent to landlords, child care providers will lose state payments, and local merchants will lose business from the direct stimulus that CalWORKs provides in communities.

A surprisingly high portion of TANF participants are women and children fleeing domestic violence, who rely on the grant to secure safety and to survive apart from their abusers. According to a 2003 study from the California Institute for Mental Health, women in the CalWORKs program suffered domestic violence at a rate of over eighty percent. The immigrants targeted in the Governor's cuts include "qualified" battered immigrants who have filed petitions under the Violence Against Women Act, persons paroled into the U.S. for humanitarian

reasons, and lawful permanent residents who also may be domestic violence survivors. Lawful permanent residents with sponsors can receive assistance only if they show that they are either domestic violence survivors or would go hungry or homeless without assistance. These rules ensure that only the most vulnerably and needy families receive services. Elimination of the RNE and these essential services could prevent many from leaving a dangerous situation or otherwise place them and their children at risk.

### **PANELISTS**

- Department of Social Services
- Department of Finance
- Legislative Analyst's Office
- Susan Bowyer, CalWORKs Client Advocate
- Vanessa Cajina, California Immigrant Policy Center
- Public Comment

### **Possible Questions**

- What are the options for participants under this elimination proposal?
- How many children are affected by this proposal?

### **Staff Recommendation:**

Staff recommends holding the budget for RNE open at this time.