File No. 140759 Committee Item No. 3
Board Item No. 13

# COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

**Committee:** Budget & Finance Committee **Date** October 8, 2014

**Board of Supervisors Meeting** **Date** October 21, 2014

| Cmte | Board | |
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| ☐ | ☐ | Motion |
| ☒ | ☒ | Resolution |
| ☐ | ☐ | Ordinance |
| ☐ | ☐ | Legislative Digest |
| ☐ | ☐ | Budget and Legislative Analyst Report |
| ☐ | ☐ | Youth Commission Report |
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**OTHER** **(Use back side if additional space is needed)**

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**Completed by:** Linda Wong **Date** October 3, 2014
**Completed by:** L.W. **Date** October 14, 2014

[Mental Health Services Act 2014-2017 Integrated Plan]

**Resolution adopting the Mental Health Services Act 2014-2017 Integrated Plan.**

WHEREAS, The Mental Health Services Act (MHSA) was enacted through a ballot initiative (Proposition 63) in 2004 that provides funding to support new and expanded county mental health programs; and

WHEREAS, In order to access MHSA funding, counties are required to 1) develop Three-Year Program and Expenditure Plans, and Annual Updates, in collaboration with stakeholders; 2) post the plans for a 30-day public comment period; and 3) hold a public hearing on the plan with the County Mental Health Board; and

WHEREAS, Recently enacted legislation, Assembly Bill 1467 (AB 1467), adds the requirement that stakeholder-developed plans be adopted by County Boards of Supervisors prior to submission to the State; and

WHEREAS, The MHSA specifies five major program components for which funds may be used and the percentage of funds to be devoted to each component. These components are: Community Services and Supports (CSS); Capital Facilities and Technological Needs (CFTN); Workforce Development, Education and Training (WDET), Prevention and Early Interventions (PEI); and Innovation (INN); and

WHEREAS, The San Francisco Department of Public Health has submitted and received approval for three-year program and expenditure plans for each MHSA component; and

WHEREAS, In compliance with MHSA regulations, the San Francisco Department of Public Health's Community Behavioral Health Services section has developed an MHSA Integrated Plan, having worked with stakeholders to develop the plan, posted the plan for public comment, and held a public hearing with the San Francisco Mental Health Board; and

WHEREAS, The San Francisco Mental Health Services Act 2014-2017 Integrated Plan, a single plan that brings together all MHSA components, provides an overview of progress implementing the various component plans in San Francisco and Identifies new investments planned for fiscal year 2014-15; and

WHEREAS, San Francisco County is projected to receive MHSA revenue of $30,973,615 for Fiscal Year 2014-2015 and this projection has been submitted to be included in the FY 14-15 Annual Appropriations Ordinance; now, therefore, be it

RESOLVED, That the San Francisco Mental Health Services Act 2014-2017 Integrated Plan is adopted by the Board of Supervisors.

RECOMMENDED:

Barbara A. Garcia, MPA
Director of Health

City and County of San Francisco
Edwin M. Lee
Mayor

**San Francisco Department of Public Health**
Barbara A. Garcia, MPA
Director of Health



July 7, 2014

Angela Calvillo, Clerk of the Board
Board of Supervisors
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco, CA 94102-4689

Dear Ms. Calvillo:

Attached, please find an original and two copies of a proposed resolution for Board of Supervisors approval that would adopt of the San Francisco Mental Health Services Act 2014-2017 Integrated Plan.

The Mental Health Services Act was enacted in 2004 through a ballot initiative (Proposition 63) and provides funding to support new and expanded county mental health programs. San Francisco's three-year program and expenditure plan, called the Integrated Plan, was developed through a broad and inclusive stakeholder process and was reviewed by the Mental Health Board. Recently enacted State legislation requires adoption of the Integrated Plan by the Board of Supervisors.

The following is a list of accompanying documents (three sets):

- The San Francisco Mental Health Services Act 2014-2017 Integrated Plan
- San Francisco Mental Health Services Act 2014-2017 Integrated Plan At-A-Glance

It is our hope that the resolution may be considered by the Board of Supervisors prior to its summer recess. Please feel free to contact me at 415.554.2769 with any questions. Thank you for your assistance and consideration.

Sincerely,

Colleen Chawla
Deputy Director of Health/Director of Policy & Planning

# San Francisco Mental Health Services Act

## 2014-2017 Integrated Plan

*The Mental Health Services Act of San Francisco is a program of the Department of Public Health – Community Behavioral Health Services*

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# MHSA COUNTY COMPLIANCE CERTIFICATION

County: _____

| Local Mental Health Director | Program Lead |
|---|---|
| Name: | Name: |
| Telephone Number: | Telephone Number: |
| Email: | Email: |
| County Mental Health Mailing Address: | |

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

_____ _____

Local Mental Health Director/Designee (PRINT) Signature Date

County:_____

Date:_____

# MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: _____

☐ Three-Year Program and Expenditure Plan
☐ Annual Report
☐ Annual Revenue and Expenditure Report

| Local Mental Health Director | Program Lead |
|---|---|
| Name: | Name: |
| Telephone Number: | Telephone Number: |
| Email: | Email: |
| County Mental Health Mailing Address: | |

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by the law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for other counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/report is true and correct to the best of my knowledge.

_____ _____

Local Mental Health Director/Designee (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, _____, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated _____ for the fiscal year ended June 30, _____. I further certify that for the fiscal year ended June 30, _____, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/report is true and correct to the best of my knowledge.

_____ _____

County Auditor Controller/City Financial Officer (PRINT) Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

## Directors' Message

In San Francisco, as in all counties throughout California, the success of the Mental Health Services Act (MHSA) is measured by how effectively it transforms local mental health systems. This 2014-17 Integrated Plan reflects our commitment to the principles outlined in the MHSA and the progress we are making to actively engage clients, consumers, and families; to promote wellness, recovery, and resilience; and to implement integrated models of care.

In 2012-13, we continued to make significant strides in meeting the priorities and goals identified in our previous community-wide MHSA planning efforts. The MHSA has enabled us to further build a service approach that is culturally and linguistically responsive to the needs of children, transition age youth, adults, and older adults. Our treatment services are being enhanced through a focus on recovery and a greater recognition of the central role that consumers, clients, and family members play in self-directing care. We strengthened our dedication to prevention and early intervention by promoting resilience, expanding interpersonal connections, and raising individuals' general level of health and well-being before serious mental health issues develop. We continued to learn from innovative strategies that encouraged creativity and aimed to improve outcomes. Moreover, we encouraged entry into and retention in our behavioral health workforce through trainings and professional development opportunities to help us meet the increasing demands on our system. In the years ahead, we will also continue to improve our monitoring and evaluation activities in order to effectively meet the outcome and performance objectives of our MHSA-funded programs.

Our progress is deeply rooted in the integral contributions of a broad, diverse network of stakeholders that includes consumers, family members, behavioral health service providers, MHSA-funded community contractors, MHSA staff, representatives from other systems of care (e.g., education, human services), and San Francisco MHSA Advisory Committee members. We appreciate and respect the hard work and commitment of our partners to best practices and for their valuable participation at various levels of the MHSA process.

We will continue to reflect on all that we have learned thus far and continue promoting a culture of recovery, resiliency, and wellness. Alongside our community partners and stakeholders, MHSA will continue to play a critical role in strengthening and expanding the public mental health system in San Francisco.

We look forward to the years ahead.

**Jo Robinson, MFT**
**Director, Community Behavioral Health Services**

**Marlo Simmons, MPH**
**Director, San Francisco MHSA**

# 1. Introduction

In November 2004, California voters approved Proposition 63, now known as the Mental Health Services Act (MHSA), intended to expand and transform community mental health services throughout California. While the proposition passed with 54% of the vote statewide, San Francisco voted 74% in favor of the act. MHSA funding, revenue from a 1% tax on any personal income in excess of $1 million, is distributed to respective county mental health systems under regulations developed by the State.

The MHSA called upon local counties to transform their public mental health systems to achieve the goals of raising awareness, promoting the early identification of mental health problems, making access to treatment easier, improving the effectiveness of services, reducing the use of out-of-home and institutional care, and eliminating stigma toward those with severe mental illness or serious emotional disturbance. Counties were also required to collaborate with diverse community stakeholders in order to realize the MHSA's vision of recovery and wellness. This vision was based on the belief in the strengths and resiliency of each person with mental illness and has been fundamental to the development of more comprehensive, innovative, culturally responsive services for individuals and families served by local mental health systems.

WELLNESS · RECOVERY · RESILIENCE

As dictated by the law, the majority of MHSA funding that San Francisco receives are dedicated to the development and delivery of treatment services. In San Francisco, MHSA funding has allowed for expanded access to intensive treatment services, housing, employment services and peer support services for thousands of individuals with mental illness, 50% of who are homeless or at-risk of becoming homeless. Promising outcomes from MHSA investments include declines in arrests, mental and physical health emergencies, school suspensions and expulsions, and the number of days in residential treatment.

Prop 63 also stipulates that 20% of the funds support programs "effective in preventing mental illnesses from becoming severe" and "reducing the duration of untreated severe mental illnesses." This commitment to prevention and early intervention is historic and moves the mental health system towards a "help-first" instead of a "fail first" strategy.

It will not be money alone that transforms the public mental health system. The greatest promise of the Mental Health Services Act: it is a vision of outreach and engagement, a philosophy of recovery and wellness, a belief in the strength and resiliency of each person with mental illness, and recognition that they are to be embraced as equal members of our community. Recovery from mental illness is not only possible, it is to be expected.

## MHSA Guiding Principles

Five MHSA principles guide planning and implementation activities:

1. **Cultural Competence.** Services should reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access.
2. **Community Collaboration.** Services should strengthen partnerships with diverse sectors to help create opportunities for employment, housing, and education.
3. **Client, Consumer, and Family Involvement.** Services should engage clients, consumers, and families in all aspects of the mental health system, including planning, policy development, service delivery and evaluation.
4. **Integrated Service Delivery.** Services should reinforce coordinated agency efforts to create a seamless experience for clients, consumers and families.
5. **Wellness and Recovery.** Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives.

## General Characteristics of San Francisco

San Francisco is a seven by seven square mile, coastal, metropolitan city and county. Though geographically small, it is the second most densely populated major city in the country and fourth most populous city in California (17,179 people per square mile). The city is known for its culturally diverse neighborhoods where over twelve different languages are spoken. The most recent U.S. Census found that San Francisco has a population of 805,235 people and experienced mild growth since the last census (four percent). Although San Francisco was once considered to have a relatively young population, it has experienced a decrease among children and families with young children; there are more people moving out of San Francisco than moving in. The high cost of living and increasing rents (both residential and commercial) are several causes of the flight. Approximately 6,500 homeless individuals and 670 homeless families with children reside in San Francisco. Twelve percent of residents live under the poverty level. In addition, over the next two decades, it is estimated that 55 percent of the population will be over the age of 45, and the population over age 75 will increase from seven percent to 11 percent. The projected growth in San Francisco's aging population has implications on the need for more long-term care options moving forward. For additional background information on population demographics, health disparities, and inequalities, see the 2012 Community Health Status Report for the City and County of San Francisco located at http://www.cdph.ca.gov/data/informatics/Documents/San%20Francisco%20CHSA_10%2016%2012.pdf.

## Community Program Planning (CPP) and Stakeholder Engagement

The MHSA reflects a new and unique process of implementing public policy through collaboration with multiple stakeholders and advocates with a range of knowledge and experience.

### From the Beginning

In San Francisco, the MHSA planning process commenced in 2005 with the creation by the Mayor of a 40 member citywide Behavioral Health Innovation (BHI) Task Force, headed by the Deputy Director of Health. The BHI Task Force was responsible for identifying and prioritizing mental health needs in the community and developing a Three Year Program and Expenditure Plan. The BHI Task Force held over 70 meetings over a five month period with consumers, their families, behavioral health service providers, representatives from the criminal justice system, educational professionals, human services providers and administrators, and members of the community. Information was collected through provider surveys, peer-to-peer interviews, penetration analyses, transcripts and summaries of meetings, as well as 80 position papers received from various constituents. This process resulted in the development of a Three Year Program and Expenditure Plan for the Community Services and Supports component. The plan was submitted to the Department of Mental Health in November 2005 and was approved in March 2006.

The planning process continued for the other MHSA funding components, following the successive releases of each component's Plan guidelines. Each of these planning processes built upon the recommendations of the respective committees and workgroups established during the 2005 community-wide planning meetings.

- **Workforce Development, Education, and Training (WDET)** planning meetings were held for eight months from April to December 2007. The Plan was submitted in March 2008 and approved in September 2008.
- **Prevention and Early Intervention (PEI)** planning meetings were held for six months from January 2008 to July 2008. The Plan was submitted to both the Department of Mental Health and the Oversight and Accountability Commission for their review and approval in February 2009. The plan was approved in April 2009.
- **Capital Facilities and Information Technology** planning processes were held separately. The Plan for the Capital Facilities component was submitted in April 2009, after a series of three community planning meetings held in February 2009. The Information Technology component CPP involved two informational meetings and six community planning meetings from November 2008 to April 2009. The Plan was submitted in March 2010 and was approved in August 2010.
- **Innovation** community meetings were held from April through August 2009. The Plan was submitted in March 2010 and approved in May 2010.

## Priority Populations

Exhibit 1 highlights the priority populations identified through a variety of community program planning activities for the following MHSA funding components.

**Exhibit 1. SF MHSA Priority Populations**

| Priority Populations | Not Age Specific | Children | Transitional Age Youth | Adults | Older Adults |
|---|---|---|---|---|---|
| **CSS Plan** | ▪ LQBTQ communities | ▪ CPS/Foster Care<br>▪ Juvenile justice involvement<br>▪ Homeless<br>▪ Mental illness co-occurring with autism<br>▪ Undocumented<br>▪ Suicide<br>▪ Trauma resulting from witnessing or being a victim of violence | ▪ Violence<br>▪ Youth aging out of foster care<br>▪ Juvenile Justice involvement<br>▪ Lack of employment or inability to work<br>▪ Trauma resulting from witnessing or being a victim of violence<br>▪ First break. prevention management<br>▪ Homeless | ▪ Homeless<br>▪ Hospitali-zation<br>▪ Suicide<br>▪ Inability to work<br>▪ Trauma resulting from witnessing or being a victim of violence<br>▪ Incarceration | ▪ Hospita-lized in high levels of care<br>▪ Homeless<br>▪ Dementia<br>▪ Suicide<br>▪ Isolation |
| **PEI** | ▪ Trauma exposed individuals and families<br>▪ LGBTQ populations<br>▪ Stigma and discrimination reduction<br>▪ Suicide prevention<br>▪ Underserved ethnic communities (e.g., Mayan, Filipino, Vietnamese)<br>▪ Underserved language communities (e.g., Russian, Tagalog, Spanish, Cantonese)<br>▪ Faith-based organizations and groups | ▪ Children at risk of or experiencing juvenile justice involvement<br>▪ Children at risk for school failure<br>▪ Children in stressed families | ▪ Individuals experiencing onset of serious psychiatric illness | | ▪ Older adults with unidenti-fied mental health concerns |

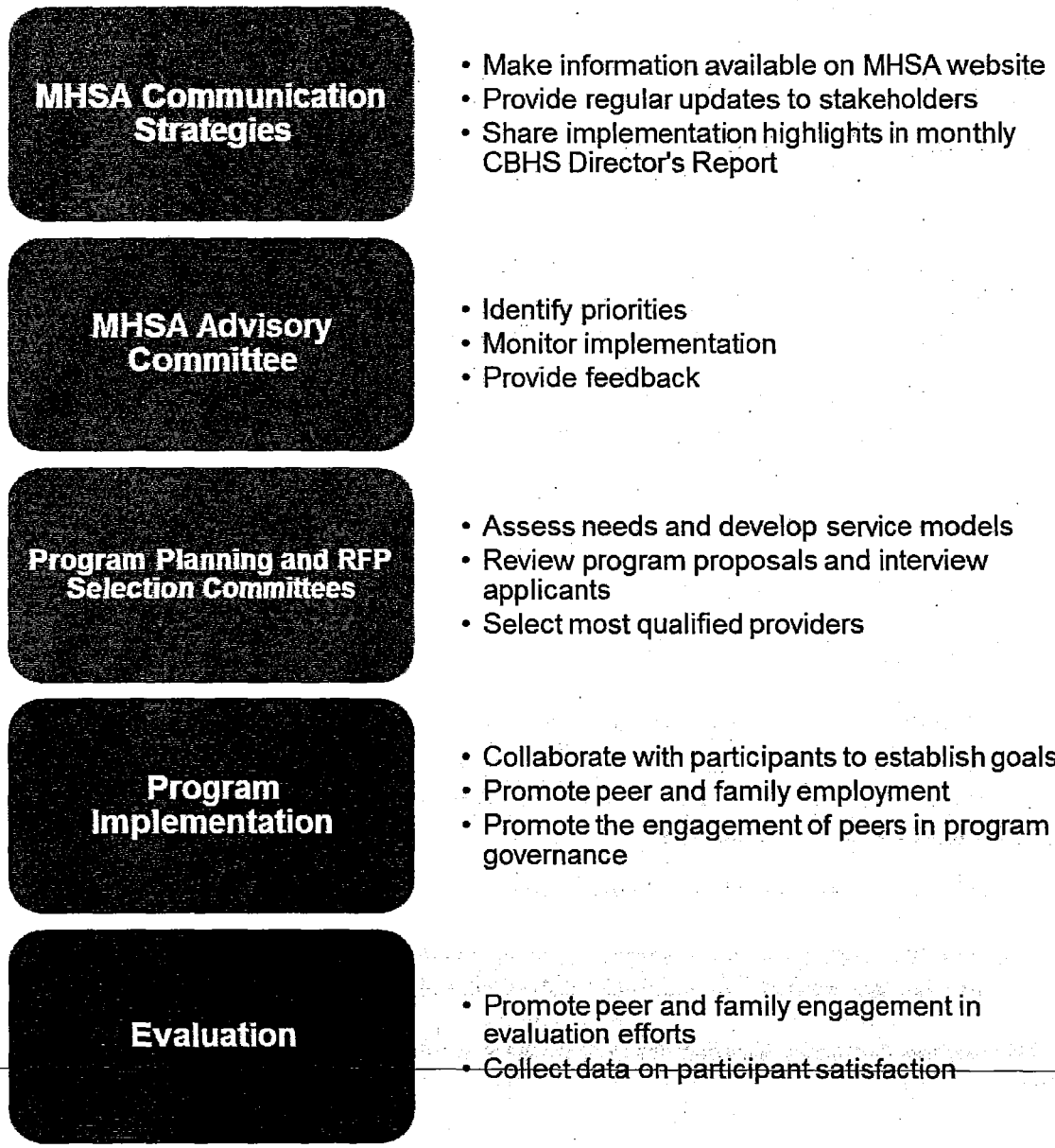
**Exhibit 1. SF MHSA Priority Populations**

| Priority Populations | Not Age Specific | Children | Transitional Age Youth | Adults | Older Adults |
|---|---|---|---|---|---|
| **WDET** | ▪ Promote hiring of underserved cultural populations<br>▪ Promote hiring of consumers and family members to deliver peer services | | | | |
| **INN** | ▪ Hoarding<br>▪ Vocational Services<br>▪ Peer Services<br>▪ Transgender<br>▪ Complimentary wellness/healing practices (e.g. mindfulness, drumming)<br>▪ Bayview/Visitacion Valley<br>▪ Churches | | | | ▪ Socially isolated |

## Community Program Planning (CPP) and Stakeholder Engagement Activities

Exhibit 2 provides a visual overview of San Francisco's ongoing community program planning activities. SF MHSA employs a range of strategies focused on upholding the MHSA principles and engaging stakeholders in various ways at all levels of planning and implementation. Our CPP provides various opportunities for stakeholders to participate in the development of our three-year plans and annual updates and to stay informed on our progress implementing MHSA-funded programs. This section provides a description of our general CPP activities. In addition to the broad strategies described below, each section in this report includes highlights of program-specific CPP activities.

Exhibit 2. Key Components of the SF MHSA Program Planning Process




**MHSA Communication Strategies**

Through a variety of communication strategies, we seek to keep stakeholders and the broader community informed about MHSA. We do this through our website and regular communication with other groups, contributing content to the monthly Community Behavioral Health Services (CBHS) Director's Report and providing regular updates to stakeholders.

The **San Francisco MHSA website, www.sfmhsa.org,** is in the process of being updated to incorporate a more user-friendly design, up-to-date information about MHSA planning processes, published documents and updates, and monthly meeting notices. The redesigned website, hosted now through the SF DPH website, will showcase frequent program highlights and successes.

*MHSA Annual Implementation Updates*

The following provides examples of partner presentations conducted by MHSA staff over the last year. These presentations are intended to provide information as well as collect input:

- Community Behavioral Health Services Adult System of Care Providers – June 7, 2013
- Community Behavioral Health Services Adult System of Care Leadership – June 11, 2013
- Community Behavioral Health Services Children System of Care Providers – July 16, 2013
- Community Behavioral Health Services Children System of Care Leadership – July 8, 2013
- San Francisco Mental Health Board – July 10, 2013
- San Francisco Health Commission, Community and Public Health Committee – August 20, 2013
- Combined MHSA Advisory Committee and Provider Meeting – October 16, 2013
- San Francisco Sentencing Commission – March 26, 2014

The **monthly CBHS Director's Report** provides another forum for sharing information about the implementation of MHSA with a broad group of stakeholders. Each month, MHSA provides updates about program implementation, upcoming meetings and other MHSA news.

## MHSA Advisory Committee

The SF MHSA Advisory Committee is an integral component of community engagement because it provides guidance in the planning, implementation, and oversight of the MHSA in San Francisco. In order to build on the previous and ongoing participation of local stakeholders, the purpose of the MHSA Advisory Committee includes the following:

- Work collaboratively with CBHS to support broad community participation in the development and implementation of MHSA initiatives
- Guide MHSA resources to target priority populations as identified in existing MHSA plans
- Ensure that San Francisco's mental health system adheres to the MHSA core principles

The MHSA Advisory Committee Meetings for FY 13-14 were as follows. Example agenda items are also included.

- June 19, 2013 – Ongoing evaluation activities, 12N, and improving the CP process
- August 21, 2013 – Structure of MHSA Advisory Committee, school-based programs and Full-Service Partnership (FSP) programs
- October 16, 2013 – Combined MHSA Advisory Committee and Provider Meeting
- February 19, 2014 – Housing, FSP, and Capital Facilities proposals for Integrated Plan
- April 16, 2014 – WDET proposals for Integrated Plan

*Advisory Committee Structure and Membership*

- Consists of up to 25 members who are consumers, family members, and providers
- Includes consumers and family members of at least 51% of total membership
- Reflects MHSA priority populations and areas of mental health expertise
- Has no term limits for membership
- Consists of two co-chairs (the MHSA Director and one consumer) who develop Advisory Committee agendas and facilitate meetings
- Convenes an Executive Committee of members who are nominated by the larger group to review membership every year
- Holds meetings every two months (meetings alternate between meetings at MHSA and our partnering community-based organizations)
- Encourages community participation at meetings

*Composition of FY13-14 SF MHSA Advisory Committee*

In addition to including representatives from education, social services, drug and alcohol service providers, and various health care providers, the Advisory Committee includes representation from diverse populations and priority groups as listed below.

- Thirteen service providers (59 percent), 12 consumers (55 percent), and seven family members (32 percent)
- Six service providers worked with PEI-funded programs, four service providers each worked with WET- and CSS-funded programs, and three service providers worked with INN-funded programs
- Whites (37 percent), African Americans/Blacks (17 percent), Native Americans (13 percent), Latinos (13 percent), Asians (13 percent), and Native Hawaiians/Pacific Islanders (7 percent)
- Gay, lesbian, or queer (11 percent), questioning (5 percent), and bisexual (5 percent) individuals
- Twelve females (55 percent), seven males (32 percent), two individuals of another gender (9 percent), and one transgender female (5 percent)
- Members' ages ranged from 30 to 72 and the average age was 43 years old
- Two members (9 percent) speak Spanish and one member (5 percent) speaks Cantonese

SF MHSA has identified specific gaps in membership, and is actively working to recruit stakeholders representing transitional age youth, law enforcement, and veterans.

*Improving Consumer Engagement*

SF MHSA has had many successes engaging consumers and family members at every level of the CPP process and in the implementation of the vast majority of programs. Over the last year, it has been a challenge to achieve our goal of having 51% consumer representation in all MHSA Advisory Committee meetings. We are pursuing two strategies to address this trend.

SF MHSA has recently formalized a partnership with the Mental Health Association of San Francisco (MHA-SF), with the goal of increasing consumer representation and participation in Advisory meetings. MHA–SF will assist with the following objectives:

- Developing a Consumer Training Institute with the goal of increasing parity, inclusion, and representation of consumer members

- Supporting the consumer Co-Chair of the MHSA Advisory Committee to participate in developing meeting agendas and presentations for each meeting
- Recruiting at least eight new consumers/individuals with lived experience of mental health conditions to serve as standing members of the committee.
- Identifying strategic objectives, including policy issues related to stigma/awareness and developing partnerships with community-based organizations/business leaders to advance stigma change efforts as part of the MHSA Advisory Committee's focus

SF MHSA has also been working to foster a stronger collaboration with the CBHS Client Council. The Client Council is a 100% consumer/client driven and operated advisory body. The mission of the Client Council is to advance the cause of the San Francisco mental health consumer/client to protect their rights, to advocate their issues, and ensure their participation on all phases of systematic changes in services, implementation of programs, and treatment development. The goal of the Client Council is to advise CBHS regarding policies and practices that directly influence consumers/clients in mental health and substance abuse services. As a result of this new collaboration, the Client Council and MHSA Advisory committee share some members. SF MHSA also plans to have bi-annual joint meetings of these two advisory bodies.

**Program and Populations Planning and RFP Selection Committees**

In addition to the MHSA Advisory Committee, SF MHSA includes elements of community program planning (CPP) when developing each of our new programs. Frequently, this takes the form of an ad hoc committee made of various stakeholders, including people with expertise or lived experience of specific populations. The MHSA principle of engaging consumers and family members is applied to all programs. The following are two examples of the work of these committees.

*Socially Isolated Older Adults Planning Committee (INN)*

In 2011-12, the MHSA Advisory Committee identified Socially Isolated Older Adults as a priority population. SF MHSA convened a group of stakeholder to develop an innovative service model designed to improve outcomes for this community. The planning process spanned the course of two months between October and December of 2011. Consumers and other stakeholders were involved in developing an innovative peer-to-peer service model and later, through the request for proposal (RFP) selection process.

*First Impressions (INN)*

Prior to the development of the First Impressions RFP, several stakeholder committee meetings were held to gather feedback and recommendations on areas of program development, policies, implementation and budgeting. Stakeholders included consumers, family members of consumers, vocational providers and leaders in the community. Committee meetings were held on 8/15/12, 8/13/12, 9/12/12, 9/19/12 and 10/24/12. Consumers were heavily involved in the review process and consisted of one-third of the voting panel. Consumers scored the proposals and also scored the program interviewees to ensure this stakeholder voice was well heard.

### Program Implementation

The active engagement of stakeholders in planning continues into implementation. Providers and consumers are partnering with stakeholder groups to ensure programs are collaborating with other initiatives. Examples of our stakeholder engagement in implementation include the following:

- Providers from MHSA-funded agencies meet on a regular basis to discuss local MHSA program activities and to provide feedback.
- Population Focused Mental Health Promotion Contractors Learning Circles: In order to promote a culturally competent and inclusive process, SFMHSA is holding a series of meetings called 'Learning Circles' with population-focused programs to collectively discuss and agree on service types, activities and outcomes. These shared performance objectives will then be measured and reported on for the next fiscal year. The Learning Circles also provide an opportunity for programs to share their progress on implementation, goals and strategies for evaluation.

## Peer Employment is a Critical Element of Community Program Planning

In drafting the guidelines for Prop 63, an emphasis was placed on the importance of consumers in the mental health workforce. Certification programs were created at both San Francisco State and City College of San Francisco. In addition, all programs are encouraged to hire peers as members of program staff. In FY 12-13, thirty-two (32) grantees/contracts indicated that their program employs consumers or participants through MHSA funding, totaling over 167 peers as employees. Consumers could be found working in almost all levels and types of positions, including: peer mentors, health promoters, community advocate, workgroup leaders, teaching assistants, and management. Several programs have positions created specifically for clients and consumers, including mentoring, advocacy, and peer facilitators.

Additionally, some programs reported that – while they do not offer employment – they are able to pay a small stipend, award a scholarship, or offer seasonal employment. In addition to those who hire consumers, three additional grantees indicated that they offer volunteer opportunities for consumers to be involved in the program. Activities for volunteer and stipend workers vary and include supporting summer programs, teaching workshops, providing peer mentoring, and data collection. In some instances, clients who have graduated or finished participating in the program have come back to work or volunteer within the organization. In one example, two former participants returned to assist with peer groups. In another, previous graduates returned as mentors and senior mentors to lead summer programming.

### Evaluation

In any given year, there are between 75-85 actively funded MHSA programs. MHSA funded staff within the CBHS Office of Quality Management plays an active role in supporting evaluation activities for MHSA, providing another opportunity to actively engage stakeholders. One highlight of this work, the MHSA Evaluation Impact Group, is detailed below.

The MHSA Evaluation Workgroup, recently renamed to the MHSA Impact Group, provides technical assistance (TA) on evaluation and program improvement activities for non-full service partnership MHSA-funded programs in a group setting. Specifically, the Impact Group is a workshop where programs come to design evaluations, develop measurement tools and learn how to carry out evaluation activities. As needed, MHSA evaluators also follow-up with programs on a one-on-one basis to increase a program's capacity in carrying out specific evaluations. The evaluators also conduct workshops to enhance communication, reporting and dissemination of outcomes and program impact, particularly to the client community.

The Impact Group has created a collaborative, supportive forum for CBHS to facilitate high quality evaluation activities in a peer discussion format. The program representatives have expressed their appreciation for technical training that is delivered in a conversational, understandable format, as well as the peer–to-peer support and engagement between programs.

MHSA Impact Group activities have included:

- Training in evaluation techniques, such as focus groups, logic models, survey design, PDSA model for improvement
- Individual TA with programs to develop evaluation goals, tools and reports
- Presentations from MHSA programs
- Guidance on defining MHSA contract objectives
- Guidance on submitting program reports for the MHSA Annual Report
- Guidance on DPH data collection policies and strategies

In April 2014, the MHSA Impact Group has begun to work more closely with the Population-focused Mental Health Prevention and Wellness Promotion PEI programs. Guided by each program's objectives and activities, the Impact Group is helping to identify appropriate measurement tools and provide direction on methods for effective data collection to support outcomes reporting.

## San Francisco's Integrated MHSA Service Categories

As discussed in the introduction to this report, San Francisco's initial MHSA planning and implementation efforts were organized around MHSA funding components (e.g., Community Services and Supports (CSS), Workforce Development Education and Training (WDET), Prevention and Early Intervention (PEI), and Innovation (INN)). In partnership with different stakeholders, Revenue and Expenditure Plans were developed for each of these components.

The MHSA, however, required that these plans be ultimately merged into a single Integrated Plan. Through our community planning efforts, SF MHSA realized that developing an Integrated Plan with a common vision and shared priorities is difficult when funding streams were used as the framework. In partnership with our stakeholders, SF MHSA simplified and restructured the MHSA funding components into seven MHSA Service Categories in order to facilitate streamlined planning and reporting (see Exhibit 3 below).

These MHSA Service Categories have allowed us to plan programs and services for specific populations and to expand our continuum of services with clear outcomes – including integration of peers into service delivery, promoting culturally competent care, increasing access to housing and employment, and developing high quality recovery-oriented treatment services.

It is important to note that the majority of our MHSA Service Categories include services funded by INN. INN funding is intended to provide our mental health system with an opportunity to learn from new practices or approaches that will support system change and improve client, consumer, and family outcomes.

**Exhibit 3. SF MHSA Service Categories**

| SF MHSA Service Category | Description |
|---|---|
| Recovery-Oriented Treatment Services | ▪ Includes services traditionally provided in the mental health system (e.g., individual or group therapy, medication management, residential treatment)<br>▪ Uses strengths-based recovery approaches |
| Mental Health Promotion & Early Intervention (PEI) Services | ▪ Raises awareness about mental health and reduces stigma<br>▪ Identifies early signs of mental illness and increase access to services |
| Peer-to-Peer Support Services | ▪ Consumers and family members are trained and supported to offer recovery and other support services to their peers |
| Vocational Services | ▪ Helps consumers secure employment (e.g., training, job search assistance and retention services) |
| Housing | ▪ Helps individuals with serious mental illness who are homeless or at risk of homelessness secure or retain permanent housing<br>▪ Facilitates access to short-term stabilization housing |
| Behavioral Health Workforce Development | ▪ Recruits members from unrepresented and under-represented communities<br>▪ Develops skills to work effectively providing recovery oriented services in the mental health field |
| Capital Facilities/ Information Technology | ▪ Improves facilities and IT infrastructure<br>▪ Increase client access to personal health information |

## Developing this Integrated Plan

Our Integrated Planning effort was coordinated by a planning group comprised of the SF MHSA Director and Program Managers of specific MHSA initiatives (e.g., WDET, INN, PEI) with independent consulting firm Harder+Company Community Research providing planning and facilitation services. The group met for five two-hour planning retreats from October 2011 to January 2012. We incorporated the stated priority populations and goals in the MHSA, as well as revisited the local priorities and needs identified in previous planning efforts. All of the CPP strategies discussed in the previous section were employed in developing this plan. Additional strategies employed in this process are listed below.

- Reviewed previous three year Program and Expenditure plans submitted for each MHSA component. This was done to understand how well priorities identified in those plan have been addressed, as well as to determine if all programs had been implemented as originally intended.
- Reviewed MHSA regulations, laws and guidelines released by the State (e.g. DMH, OAC, CalHFA) to ensure all mandated information would be incorporated in this plan.
- Reviewed informational materials produced by CalMHSA, CMHDA, and OSHPD
- Reviewed Annual Program Reports and demographic data submitted by contractors and civil service programs.

Much of this Integrated Plan is made up of programs implemented through previous plans. Most of our CPP activities over the last year have been focused on the development of this plan.

## Local Review Process

In addition, our stakeholder process involved various opportunities (e.g. advisory committee meetings, client council meetings) to share input in the development of our Integrated Planning effort and to learn about the process of our MHSA-funded programs. Please see the components on MHSA Communication Strategies and MHSA Advisory Committee for a specific list of meeting dates and topics.

- Community Behavioral Health Services Executive Committee – June 25, 2013 to plan for the Integrated Plan
- MHSA Advisory Committee meetings focused on the Integrated Plan include:
  - February 19, 2014 – Housing, FSP, and Capital Facilities proposals for Integrated Plan
  - April 16, 2014 – WDET proposals for Integrated Plan
- San Francisco Chapter, National Alliance on Mental Illness (NAMI) – February 19, 2014 to present and discuss the Integrated Plan
- San Francisco Client Council meetings:
  - November 19, 2013 – Vocational Services
  - December 17, 2013 – FSP expansion proposal
  - February 18, 2014 –Peer-to-Peer services
  - May 20, 2014 – Integrated Plan overview

**30-Day Public Comment Period**

In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of San Francisco's MHSA Annual Update Report was posted on the SF MHSA website at http://www.sfdph.org/dph and http://sfmhsa.org. Our MHSA Integrated Plan was posted for a period of 30 days from **May 16, 2014** to **June 18, 2014.** The Plan was also emailed to over 90 community members, many of whom are leaders to large distribution lists. Members of the public were requested to submit their comments either by email or by regular mail. In addition, the Integrated Plan was presented at the following meetings to gather stakeholder input for the public comment and review process:

- CBHS Adult and Older Adult System of Care Provider meeting – June 6, 2014
- CBHS Children and Families System of Care Provider meeting – June 17, 2014
- Client Council – June 17, 2014
- Department of Public Health, Director Garcia's Integrated Steering Committee meeting – June 18, 2014
- MHSA Advisory Committee meeting – June 18, 2014
- San Francisco Mental Health Board Hearing – June 18, 2014

**Public Hearing**

Following the 30-day public comment and review period, a public hearing was conducted by the Mental Health Board on **June 18, 2014.**

**Comments Received**

Comments received from the public hearing include the following:

| Community Member | Content of Comment | Response |
|---|---|---|
| **Terezie Bohrer** | Ms. Bohrer asked for clarification about adult full service partnership program cost per clients, who most likely be participated in the MediCal program – indicated it was unclear if the cost per client includes Medi-Cal and expressed concern that it is misleading as currently presented. | The cost per client calculations include only MHSA funding. A note to this effect will be added to the cost per clients sections for all programs that generate MediCal revenue. – FSP, and PREP |
| **Michael Gause** | Mr. Gause expressed an interest in having more public discourse on the plan and local implementation of MHSA. | MHSA staff welcomes the offer from the MHA-SF to host additional community forums and to increase the number of individuals involved in the community planning process. |

**The table below summarizes additional comments from stakeholders during the 30-day public comment period:**

| Community Member | Content of Comment | Response |
|---|---|---|
| **Terri Bryne, S.O.L.V.E. Program Coordinator** | Mental Health Association of San Francisco (MHA-SF) Staff submitted letters outlining similar comments. | • In FY 14/15, SF MHSA is planning to develop and launch a Peer Leadership Academy to train and support peers to be more engaged in the MHSA Community Planning Process. |

| | | |
|---|---|---|
| **Michael Gause, Deputy Director**<br><br>**Stephen Marks, Training and Evaluation Director** | • Increased funding and support for Consumer Leadership and Training<br>• Support for Peer Crisis Respite<br>• Increased Support for Consumer Outreach and Engagement | MHSA is also planning to expand the Peer MH Certificate Program to include an advanced training curriculum for emerging Peer Leaders and Supervisors. In addition, our Peer-to-Peer Employment Services are being restructured and part of that work includes a focus on skill building and professional development of Peer Staff.<br>• The recently released Mayor's CARE Task Force recommendations include a call for a Peer Respite Center at SFGH. MHSA has committed Peer staff and resources from the Peer-to-Peer budget to the Respite Center.<br>• Many MHSA programs include elements of outreach and engagement. MHSA welcomes partnerships with MHA-SF staff to ensure Peers are as involved in this work as possible. |
| **Julian Plumadore* Community Advocate for the Mental Health Association of San Francisco (MHASF)**<br><br>***Julian also serves as a Co-Chair for the SF MHSA Advisory Committee.** | Recommendations for developing a Consumer Training Program for peer employees in San Francisco include:<br><br>• Begin with a survey targeted to peers currently employed by MHSA-funded programs in San Francisco.<br>• Discuss the foundation of peer roles.<br>• Provide Essential Skills training. | Peers are included in the development of all new programs developed and funded by MHSA. These elements will be presented for consideration to the Planning/Advisory Committees tasked with developing the Leadership Academy and the Advanced Peer Certificate. |

| | | |
|---|---|---|
| **Eduardo Vega, Executive Director, MHA-SF** | The following are themes from a letter submitted by Mr. Vega two days prior to the close of the 30-day public comment period.<br>• The plan contains substantially positive and important directions for utilizing San Francisco county Mental Health Services Act (MHSA) dollars in the upcoming three years.<br>• I am concerned that San Francisco community members were not adequately engaged with the MHSA planning process as required by MHSA State regulations.<br>• He proposes to delay the public hearing and extend the public comment period to allow for 1) public forums, 2) additional outreach by his organization, 3) to consolidate public comment/discussion in a separately distributed document. | The following are themes from a response letter from SF MHSA Director, Marlo Simmons:<br>• The Integrated Plan is the product of an extensive Community Planning Process that began in February 2012.<br>• The plan provides a detailed overview of the CPP and how SF MHSA actively involves stakeholders on all levels of MHSA planning and implementation.<br>• We were not able to extend the comment period, as doing so would have resulted in a delay submitting the plan to the SF Board of Supervisors until after they return from their summer break.<br>• The work of SF MHSA is constantly evolving and includes countless opportunities for you and your agency to get more involved in ongoing SF MHSA work.<br>• For FY 14/15, our CPP plans include: 1) working to strengthen ties between the MHSA Advisory Committee and the CBHS Client Council, 2) including funding for a Peer Leadership Academy in a soon-to-be-released RFQ, and 3) working with the Advisory Committee to develop a more formal structure, including clearer roles and responsibilities, and new recruitment strategies. |

## Organization of this Report

This report illustrates progress in transforming San Francisco's public mental health system to date, as well as efforts moving forward. The following seven sections describe the overarching purpose of each of San Francisco's MHSA Service Categories. Each program section includes information on the background and community need, a program overview, the target population and numbers served, projected outcomes, as well as the participant engagement and community program planning (CPP) process. The outcomes listed for each section are the outcomes SF MHSA intends to report in annual updates. Plans to expand certain service categories or develop new programs are highlighted and discussed at the end of each section.

The program sections also include estimates of budget expenditures for FY14-15, as well as costs per client based on projected annual goals for clients and individuals to be served. These numbers are an approximation only. Consequently, these amounts should be regarded with caution and utilized for informational purposes only.

* Placeholder: Board of Supervisors Resolution

# 2. Recovery-Oriented Treatment Services

Recovery-Oriented Treatment Services include services traditionally provided in the mental health system including screening and assessment, clinical case management, individual or group therapy and medication management. These services support the MHSA's philosophy that mental health needs are not defined by symptoms but rather by a focus on achieving, maintaining, and promoting the overall health and well-being of the individual and family. The MHSA's philosophy recognizes and builds upon the areas of life in which individuals are successful by promoting strengths-based approaches, emphasizing the recovery process, and encouraging resilience to help individuals live with a sense of mastery and competence.

The majority of MHSA funding for Recovery-Oriented Treatment Services is allocated to Full Service Partnership (FSP) Programs. The remaining funds are distributed to the following: (1) the Behavioral Health Access Center, (2) the Prevention and Recovery in Early Psychosis Program, (3) Trauma Recovery Programs, (4) the Integration of Behavioral Health and Juvenile Justice, (5) the Integration of Behavioral Health and Primary Care, (6) Dual Diagnosis Residential Care and (7) Expanding Outpatient Clinic Capacity. INN funding also supports several programs in this MHSA service category.

## Full Service Partnership Programs

### Background and Community Need

Full Service Partnership (FSP) programs were designed to serve Californians in all phases of life who experience the most severe mental health challenges because of illness or circumstance. This population has been historically underserved and has substantial opportunity for benefits from improved access and participation in quality mental health treatment and support.

The FSP model is grounded in earlier efforts, namely Assembly Bill 2034 (AB 2034) and its predecessors. AB 2034 was unique in its focus on serving homeless individuals with serious mental illness, the "housing first" mandate, flexible funding, and the collection and reporting of client and systems outcomes in "real time". The final analysis of ABV 2034 reported substantial quality of life improvements, as well as marked cost savings for our systems of care. Accordingly, the primary purpose of Proposition 63 was to expand this proven model to everyone who needed that level of care. Counties are mandated by MHSA to spend 51% of MHSA funds on FSP.

### Program Overview

FSP programs reflect an intensive and comprehensive model of case management based on a client and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) to lead independent, meaningful, and productive lives. Full Service Partnerships embrace client driven services and supports with each client choosing services based on individual needs. Unique to FSP programs are a low staff to client ratio, a

24/7 crisis availability and a team approach that is a partnership between mental health staff and consumers. FSP programs are capable of providing an array of services well beyond the scope of traditional outpatient services. FSP programs address emotional, housing, physical health, transportation, and other needs that will help them function independently in the community.

Nine FSP programs served a diverse group of clients in terms of age, race/ethnicity, and stage of recovery. This plan includes an expansion of FSP services for TAY and adults and the creation of FSP programs for children 0-5 and their families.

**Exhibit 4. Summary of Full Service Partnership Programs**

| Target Population | Lead Agency | Services |
|---|---|---|
| Children, Youth & Their Families | Seneca SF Connections | ▪ Provide SB 163 Wrap Around services so adolescents stay in family settings within the community and achieve permanency and stability.<br>▪ Access community resources to address the needs of the youth.<br>▪ Facilitate transition to TAY services as they age out of CYF services.<br>▪ Empower the caregiver to care for the child. |
| | Family Mosaic Project | ▪ Provide intensive case management and wrap around services to children and their families to enable the child to remain at home and progress in a natural environment.<br>▪ Provide or arrange for mental health services, therapeutic services, mentoring, respite care, and other services as individually developed through the development of a comprehensive plan. |
| | Family Service Agency | ▪ Provide physical health care, mental health treatment, medication management, substance abuse treatment, employment assistance, post-employment support, benefits assistance and advocacy, and peer support integrated into single service teams. |
| Transitional Age Youth (TAY)<br>ages 16-25 | Community Behavioral Health Services - TAY | ▪ Work closely with housing services to help secure housing for the target population.<br>▪ Utilize flexible funding to purchase specialized services and supports.<br>▪ Develop comprehensive assessment and treatment care plans.<br>▪ Provide intensive services that include mental health treatment and substance abuse counseling.<br>▪ Link clients to employment/job coaching/placement, education training on independent living skills, referrals to legal assistance, recreation and social activities, and coordinate with HSP for transitional and supportive housing. |

**Exhibit 4. Summary of Full Service Partnership Programs**

| | | |
|---|---|---|
| | | ▪ Conduct outreach to homeless encampments, parks homeless shelters, and food programs, and other service locations.<br>▪ Address immediate needs of potential clients such as food, shelter, clothing, and other amenities. |
| | Family Service Agency | ▪ Provide health screening and first aid, dispense medications, prescribe psychotropic medications with supervision from a psychiatrist and arrange for medical treatment.<br>▪ Provide mental health and substance abuse treatment and case management.<br>▪ Assist with initial application for benefits such as food stamps, Medi-Cal, SSI, and other benefits. |
| | Hyde Street Community Services | ▪ Provide services to adult residents of the Tenderloin neighborhood of San Francisco<br>▪ A multi-disciplinary staff works together to address the often complex problems of the client population.<br>▪ Adhering to a philosophy of providing integrated services, the program welcomes individuals with co-morbid substance abuse problems and addresses those issues in both individual and group treatment. |
| Adults<br><br>ages 26-59 | SF Fully Integrated Recovery Service Team | ▪ Provide services (e.g., individual or group therapy, medication management) to individuals with SMI who have been homeless for an extended time. Additional MHSA funded supports include payee services and vocational training. |
| | UCSF Citywide Case Management Forensics | ▪ Promote wellness and recovery.<br>▪ Stabilize mental health symptoms and improve and sustain quality of life.<br>▪ Provide wrap around services adhering to a Recovery Model, including: intensive case management, individual and group therapy, medication support services, peer support, and crisis intervention.<br>▪ Provide integrated services including employment services, recreational and community integration activities, benefits advocacy, money management, linkage to primary care, and stable housing. |
| | CBHS Transitions | ▪ Small pilot focusing on care coordination from hospital discharge to successful engagement with an outpatient clinic |
| | | ▪ Meet clients where most often found: non-office settings such as streets, shelters and SROs |
| Older Adults<br><br>ages 60+ | Family Service Agency | ▪ Conduct assessment and evaluation<br>▪ Offer mental health treatment, including dual disorder services both individual and group<br>▪ Provide case management services and crisis intervention<br>▪ Engage clients in vocational assessment and rehabilitation services.<br>▪ Link clients to housing and follow-up in-home services. |

## Target Population

The target population for FSP programs include low-income adults (18-60 years old), with histories of serious and persistent challenges and often homelessness, in need of intensive case management and other intervention. The programs are especially designed to anticipate problems before they become emergencies.

## Budget and Costs per Client

FSP expenditures for fiscal year 2014-15 are projected to be $9,491,468. The projected per-client costs are detailed below.

**Exhibit 5: Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Full Service Partnership: CYF (0-5) | 40 clients | $400,000 | $10,000 |
| Full Service Partnership: CYF (6-18) | 270 clients | $1,415,000 | $5,241 |
| Full Service Partnership: TAY (18-24) | 90 clients | $1,076,468 | $11,961 |
| Full Service Partnership: Adults (18-59) | 537 clients | $5,850,000 | $10,894 |
| Full Service Partnership: Older Adults (60+) | 87 clients | $750,000 | $8,621 |

## Projected Outcomes

Since the inception of MHSA, the Full Service Partnership programs have demonstrated improved outcomes in client functioning. During time spent in FSP treatment, clients register improvements in **residential settings** reflected in the shift in days away from shelter/temporary housing, homeless, criminal justice, and hospital settings to more stable settings. Rates of **emergency events**, such as arrests, mental health or psychiatric emergencies (which include substance use related events) and physical health emergencies, as well as school suspensions and expulsions for young children and TAY, also show dramatic reductions for clients enrolled in the FSPs.

In addition, a DCR Workgroup is convened monthly. The committee continues to monitor the quality of DCR data for FSP outcomes reporting. The committee is working closely with programs providing online support, training and data coding technical assistance. In the coming year, the Workgroup plans to develop a "DCR Case Management" report. This new report will display client data for each FSP program, by case manager, on domains not previously reported on for San Francisco FSPs, such as: Legal

(payee status), Financial Benefits, Connection to Primary Care, Education and Employment/Vocational Training.

### Graduation: The Ultimate FSP Outcome

A team of FSP staff, DPH evaluators and MHSA staff joined the California Institute for Mental Health (CiMH) 15-county Learning Collaborative focusing on "Advancing Recovery Practices (ARP)" that ran for 14 months ending March 2013. The SF MHSA team extended the work an additional year, completing in March 2014.

The primary goals included:

- Increase client and provider discussions of recovery
- Implement tools and protocols that support client graduations into the community
- Increase client graduations into the community

CiMH provided an intensive structured curriculum to build capacity for recovery-oriented, strengths-based mental health care, as well as change management under the Institute for Healthcare Improvement's well-established Model for Improvement. Through the iterative testing process and discussions, the team developed a Recovery Checklist that has been adapted and adopted by other programs.

**Clients who Met Treatment Goals (Graduated)**

The percentage of FSP clients discharged who met goals improved, albeit modestly. Before discussions began on the graduation criteria, zero (0) clients were discharged having "met goals". With participation in the ARP Learning Collaborative, increased emphasis on facilitating "graduations", and implementation of the Recovery Checklist, the rate of overall discharges declined, but the percentage who discharged having met treatment goals increased on average.

## Program Specific Community Program Planning (CPP) Activities

Full Service Partnership programs engage a diverse cadre of stakeholders to assist in the planning and development of appropriate programming to meet the needs of the target population. Most of the FSP programs have an advisory committee made up of clients, family members, staff and other concerned citizens that meets regularly to discuss the current workings of the program, successes, as well as opportunities for improvement. Together, the committee members strategize on how to expand and capitalize on what is working well and the changes needed to make the program better able to support the clients as they move towards wellness and recovery.

The programs also employ individuals with lived experience navigating the mental health system. These individuals not only play a key role in supporting the clientele, but these peers are also instrumental in

informing the program planning process. Because they have also received, and are still receiving, mental health support services, they fully understand what clients are going through and what might help them.

## Expanding Access to FSP Services

The Full Service Partnership funding expansion planning process spanned from July 2013 to April 2014 and involved engaging and eliciting feedback from hundreds of stakeholders who have a vested interest and knowledge of the populations serviced by these programs.

All of the Full Service Partnership (FSP) programs were engaged in the planning process, as were the various ongoing planning bodies that help to inform the work of CBHS, such as the MHSA Advisory Committee and the CBHS Client Council. The leadership staff at CBHS also had a chance to voice their suggestions.

The following outlines the proposed expansions for FSP services:

**TAY and Adult FSP programs** each have significant waitlists of individuals in need of intensive, wrap-around services. In order to help address that need for individuals with severe mental illness, it has been proposed that additional funding be allocated to create additional FSP capacity by adding more clinical staff. The proposal would allow for two of the most impacted adult FSP programs to receive funding to hire additional staff. Specifically, the additional funding would hire two clinicians at one of the FSPs and a Cantonese-speaking case manager. Further, an additional clinical staff person is desired to help serve the increasing TAY population that is in need of FSP services. With additional capacity, we can keep the client/clinician caseload ratios in line with best practice. Proposed are the following program specifics:

- Cantonese speaking clinician

**Children aged 0-5** are not being adequately served in our system of care. This is particularly true for youngest children who are in foster care or who have otherwise experienced trauma and are in need of intensive mental health services. The family as a unit, as opposed to just the young child, would be the target of the intervention. The idea is that MHSA could contract with a mental health agency to provide FSP services to the 0-5 population and their families, with the following program specifics:

- Serve approximately 16 young children and their families who are experiencing stressors and traumas, such as violence, abuse, and out-of-home placement.
- Low caseload (approximately six to eight families per clinician)
- Staffing: one Clinical Supervisor; two Licensed Clinicians; two Health Worker II with substance abuse expertise; two Resource Specialist to assist families obtain housing and other basic needs; one Parent Peer, and one Youth Peer. All members of the staff will have expertise in early childhood development.

# Behavioral Health Access Center

## Background and Community Need

Designed in 2008 to promote more timely access to behavioral health services and to better coordinate the intake and referral process for individuals seeking services, the Behavioral Health Access Center (BHAC) was one of the first projects funded by MHSA. The BHAC is a portal of entry into San Francisco's overall system of care and co-locates the following five behavioral health programs: 1) Mental Health Access for authorizations into the Private Provider Network, 2) the Treatment Access Program for assessment and placement into addiction and dual diagnosis treatment, 3) the Offender Treatment Program (formerly SACPA Prop 36) to place mandated clients into addiction and dual diagnosis treatment, 4) Centralized Opiate Placement Evaluation (COPE) and Office-Based Buprenorphine Induction Clinic (OBIC) for evaluation and placement into Opiate Replacement Therapy, and 5) the CBHS Pharmacy that provides buprenorphine for Integrated Buprenorphine Intervention Services (IBIS) clients, methadone maintenance for Office-Based Opioid Treatment (OBOT) clients, ambulatory alcohol detoxification medications for Treatment Access Program clients, specialty behavioral health medication packaging and serves as a pharmacy safety net for all CBHS clients.

## Program Overview

As a program that serves clients on both a drop-in and appointment basis, BHAC seeks to provide the necessary care coordination for all San Franciscans in need of behavioral health care. BHAC has relied on MHSA resources to increase the depth of clinical care and other services. Through the provision of additional staff, clients receive a higher quality of care and are linked to services within a meaningful period of time. This helps increase positive client outcomes and improves access to care. BHAC programs are supported by an expanded team of MHSA-funded staff, including:

- A Psychiatric Nurse Practitioner who provides expertise in treatment planning, identification of primary care concerns, and stabilization of behavioral health issues
- Two Eligibility Workers who help increase client access to entitlements (e.g., Medi-Cal, Healthy SF, and SFPATH) and to care through linkages with the Private Provider Network
- Two clinical pharmacists who provide expertise in client medication management services (e.g., drug specific monitoring) and lead client medication groups. A full-time pharmacy technician who assists the CBHS Pharmacists to provide Substance Use Disorder Treatment medications, clinical tracking and support to prescribers.

## Target Population

The BHAC target population includes multiple underserved populations including the chronic and persistently seriously mentally ill, substance use disorder and dual diagnosis clients. A substantial number of clients are indigent, homeless, non-English speaking, and/or in minority populations

One of the pharmacists is bilingual and provides direct client treatment for medication management, medication review, and smoking reduction services to the Cantonese-speaking population at Chinatown North Beach Clinic and Sunset Mental Health Center.

### Budget and Costs per Client

Behavioral Health Access Center expenditures for fiscal year 2014-15 are projected to be $803,751. The projected per-client costs are detailed below.

**Exhibit 6: Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Behavioral Health Access Center | 1857 clients | $803,751 | $433 |

### Projected Outcomes

BHAC seeks to achieve the following outcomes:

- Provide timely access to behavioral health and physical health care
- Increase access to public benefits programs
- Improve system medication use:
  - Improve prescribing for Substance Use Disorder by all prescribers at CBHS
  - Reduce polypharmacy of psychiatric medications
  - Improve safe and appropriate prescribing of benzodiazepines

### Program Specific Community Program Planning (CPP) Activities

BHAC employs both peer navigators and peer specialists. Clinical pharmacists engage clients and their caregivers in the community and clinic by providing bilingual drug information and pharmacy education at meetings such as those held by the Family Alliance and CTNB Schizophrenia support group, as well as at clinical pharmacist Q & A sessions. Clinical pharmacists also engage with stakeholders and clients who are employed by CBHS in the planning and development of smoking reduction and healthy living programs.

## Prevention and Recovery in Early Psychosis (PREP)

### Background and Community Need

Roughly half of all lifetime mental disorders have been shown to start by the mid-teens and three-fourths by the mid-20s. Severe disorders like schizophrenia are typically preceded by earlier behavioral, social and emotional signs and symptoms that seldom receive clinical attention. Research shows that

intervening during the early stages of psychosis improves outcomes. However, treatment is often not accessed until a number of years later. Missing this critical window for early intervention can lead to greater suffering, trauma and functional deterioration.

## Program Overview

PREP is an early intervention treatment program for schizophrenia and early psychosis for individuals between the ages of 16 and 30 to support symptoms remission, active recovery, and full engagement with family, peers, and coworkers. This model is based on established programs internationally in Australia and the United Kingdom, and nationally in the state of Maine, among other sites. PREP treatment services include the following: algorithm-based medication management, cognitive rehabilitation, cognitive behavioral therapy for early psychosis, multi-family groups (MFG), strengths-based care management, and neuropsychiatric and other advanced diagnostic services. PREP has a significant outreach component that obtains referrals of appropriate clients into the program, and that is designed to reduce the stigma of schizophrenia and psychosis in general and promote awareness that psychosis is treatable.

Since its launch in 2010, the PREP program has demonstrated positive outcomes with participants demonstrating reductions in mental health symptoms and increases in functioning, quality of life, engagement in services and satisfaction with services. The program has also significantly reduced hospitalizations among participants.

## Target Population

PREP serves youth and young adults between the ages of 14-35, with most clients being transitional age youth (TAY) who fall between the ages of 16 and 24. The program targets individuals who had their first psychotic episode within the previous two years or who, as identified in the PREP diagnostic assessment, are at high risk for having their first episode within two years. Due to the nature of psychosis – which strikes without regard to income or socioeconomic status – the distribution of cases is expected to approximate the demographic distribution of youth and young adults in San Francisco, but with a somewhat greater proportion of low-income youth and families. PREP partner organizations Larkin Street Youth Services and the Sojourner Truth Foster Care Agency work with special populations of at-risk youth (i.e. foster care and homeless youth).

PREP operates citywide and offers services at the PREP San Francisco office. However, when requested, therapists and staff meet with clients at offsite locations (e.g. client's home, school, etc.) throughout the city. PREP also conducts outreach throughout San Francisco and recently began conducting additional outreach to the Bayview Hunters Point neighborhood (zip code: 94124).

## Budget and Costs per Client

PREP expenditures for fiscal year 2014-15 are projected to be $931,770. The projected per-client costs are detailed below.

**Exhibit 7. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Prevention and Recovery in Early Psychosis (PREP) | 110 clients | $931,770 | $8471 |

## Projected Outcomes

The PREP program seeks to achieve the following outcomes:

- Participants will have reduced symptoms of depression, anxiety and psychosis
- Participants will have reduced number of acute psychiatric inpatient hospital episodes
- Participants will develop and use resources to function more effectively and independently, and build capacity to cope with challenges they encounter
- Participants with goals of obtaining positions in competitive employment will engage in new employment or education
- Participants will report high levels of satisfaction and engagement.

## Program-Specific Community Program Planning (CPP) Activities

PREP promotes participant involvement in program outreach through the PREP Youth Advisory Council (PYAC). PYAC conducts youth professional development training and provides them with skills to conduct outreach to their peers. In FY 12-13, MHA-SF screened, interviewed and hired eight PYAC members, including two current PREP clients and one PREP Alumnus.

# Trauma Recovery Program

## Background and Community Need

Children and youth impacted by trauma, including community violence, face serious risk for multiple health and social problems including physical injury, post-traumatic stress syndrome, incarceration, and social isolation. Cultural, linguistic and socially relevant services serve as vehicles in the engagement, assessment, differential diagnosis and recidivism of youth and their families. Services that integrate various interventions – e.g. crisis intervention, family support, case management and behavioral change -- within the context of values, beliefs and norms rooted in the community being served have been well documented and underscore the importance of providing culturally proficient models of service.

The Trauma and Recovery project was selected during the original CSS planning process to address the need for community-based, client-driven prevention and early intervention for individuals, families and communities impacted by violence.

## Program Overview

The Trauma and Recovery Program aids youth and families through comprehensive services that aim to reduce psychiatric symptoms, increase functioning and increase coping skills and lessen the likelihood for further intervention in the future. Crisis response and mental health assessment services for students occur on select public school campuses, and services emphasize collaboration with students' parents/caregivers. In addition, one-time and on-going mental health support of teachers, staff and parents/caregivers are available on an individual and group basis.

The original Trauma Recovery Program involved two MHSA-funded lead agencies partnering with a web of community based organizations. The organizations center on frontline violence prevention and intervention responder programs that deliver outreach, assessment, crisis and short-term counseling, and case management. Additionally, these lead agencies provide mental health consultation to this web of organizations, where the treatment's focus is recovery from traumatic response and the symptoms that stem from chronic and/or complex trauma.

Beginning in FY 13-14, the program was expanded to include funding for another agency to implement a pilot to address the unmet mental health needs of Latino youth and families who are traditionally unwilling to pursue treatment from the mental health system, and whose resistance is further exacerbated by geographical/ gang boundaries that preclude youth from accessing scarce mental health resources due to their location in danger zones. With a focus on addressing the pervasive trauma experienced by this community, the pilot program includes a treatment model that combines culturally informed, evidence-based substance abuse and mental health practices. The pilot also includes mental health training and consultation for agency staff.

## Target Population

The programs described above provide individual and family centered intervention to the following target populations.

- **Youth ages 14 to 25 and their families who reside in the Mission District and Latinos citywide with trauma recovery services.** The target population is youth and their families affected by street and community violence. This program primarily focuses on the 94110, 94112, 94102 and 94103 zip codes. Individuals and/or families suffering from or at-risk of trauma will receive face-to-face assessments and treatment with Clinical Case Managers, with individuals receiving an average of three to nine months of sessions. The focus of treatment is recovery from traumatic response and the symptoms that stem from chronic and/or complex trauma.

- **School-aged public school students who reside in communities that struggle with violence (Bayview Hunter's Point, Potrero Hill and Western Addition).** Clients represent a diverse mix of race/ethnic groups including African American, Latino, Asian & Pacific Islander and Caucasian. Youth are assessed and linked to services via crisis response and mental health assessments delivered at public school campuses. Students served are either referred or identified by school staff as in need of help but do not qualify for specific mental health programs offered on campus.

## Budget and Costs per Client

The expenditures for Trauma Recovery Services for fiscal year 2014-15 are projected to be $547,000, the majority of which are allocated to direct services. The expenditures for specific service modalities are listed in Exhibit 8 below.

**Exhibit 8. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Direct Service | 83 clients | $351,174 | $4,231 |
| Consultation Services | 461 participants | $195,826 | $425 |

## Projected Outcomes

The recovery and trauma programs seek to achieve the following outcomes:

- Participants will experience improvements in symptoms of depression, anxiety, self-concept and/or behavior
- Participants, including youth, parents, and community violence response staff, will have increased understanding of trauma related conditions and appropriate interventions
- Participants will report fewer trauma-related emotional and psychological symptoms (e.g., irritability, feelings of hopelessness, avoidant behaviors)

## Program-Specific Community Program Planning (CPP) Activities

Participants are engaged throughout the program design and implementation phases through the following activities:

- **Consumer participation in Program Design:** Peace Dialogues' participants are instrumental in the design of the program and lead the implementation and facilitation of efforts with the support from program staff.
- **Consumer participation in evaluation of Mental Health Interventions:** program participants take pre- and post-test surveys that inform the impact and design of the program's efforts. Clients are asked to self-report on the benefits of mental health services and provide the mental health specialist with feedback for when therapy is not working for them during their treatment time.

## Expanding Trauma Recovery Services in District 10


For over three decades, community violence has had a devastating impact on of communities within San Francisco's Southeast Sector or "District 10". Today, trauma affects many young people and their families, with damaging long-term physical and emotional impacts. According to data from the City and County of San Francisco's Community Behavioral Health System, 64% of children and youth in District 10 have been exposed to at least one type of trauma and more than one third of all child and youth clients have been exposed to multiple types of traumatic events (38% and 36%, respectively).

While community violence and the resulting trauma have been identified by community members, public health representatives, and the City as one of the most important issues impacting District 10, not enough has been done to provide systematic and sustainable healing and treatment service. On November 13, 2012, approximately fifty providers, experts and members of the City and County of San Francisco convened for the Southeast Trauma Summit, partially funded by MHSA, to create a practical plan to effectively address the healing needs of residents impacted by community violence and trauma within District 10. The purpose of the summit was to:

- Identify best practices for trauma related to community violence in the Southeast.
- Identify service providers within the Southeast Sector to provide healing and treatment for youth and families impacted by trauma related to community violence.
- Develop strategies to shift City funding to culturally competent providers within the Southeast sector to provide treatment and healing services for trauma related to community violence.

The summit emphasized a new approach to community violence and resulted in recommendations to meet the needs of the residents of District 10 in a coordinated fashion. MHSA is currently working with community representatives and organizers of the Trauma Summit to develop and implement a Treatment and Response Approach that incorporates recommendations outlined in the D-10 Trauma Summit Report. While details of a program and expenditure plan need to be developed and a competitive bidding process is pending, $200,000 has been allocated to this effort.

# Integration of Behavioral Health into the Juvenile Justice System

## Background and Community Need

Both nationally and locally in San Francisco, over 70% of youth involved in the juvenile justice system have behavioral health problems. Detention offers a critical window to link youth to appropriate mental health services. However, alarmingly high numbers of youth in juvenile justice systems nationwide have untreated mental health needs that may be the basis of their delinquent and risk-taking behaviors and pose obstacles to rehabilitation, thus contributing to increased recidivism.

With different roles to play, probation and community mental health can be at odds about how to best address the needs of youth who have committed crimes and have had difficulty engaging in treatment. In the absence of objective information, especially at a time of crisis, these differences can undermine collaboration, breakdown communication and result in uncoordinated and opinion-driven plans that lead to the wrong door or no services, and ultimately, poor outcomes for youth.

## Program Overview

**AIIM (Assess, Identify Needs, Integrate Information, and Match to Services) Higher** takes a collaborative path that eliminates subjectivity and puts standardized identification of youth needs and strengths with the Child Adolescent Needs and Strengths (CANS) assessment at the center of a structured decision-making, service planning and treatment engagement process. AIIM Higher is a probation-behavioral health assessment and planning program that connects and supports the engagement of youth and families in appropriate and effective services. AIIM provides a continuum of services including: behavioral health screening within the juvenile justice system; consultation with probation, courts, and other legal stakeholders and community providers; resource referral and information; standardized assessment; and linkage and engagement services for youth and families; and family-driven care planning. AIIM provides services through a multidisciplinary team that includes a psychologist, social workers, a psychiatrist, and an occupational therapist.

In addition to the core services described above, AIIM Higher oversees three therapeutic court programs, the Juvenile Wellness Court, the Juvenile Drug Court, "SF-ACT" and the Competency

Attainment Program. The **SF-ACT Intensive Outpatient Treatment program based at Civic Center Secondary** is an unprecedented collaboration among the Superior Court, Juvenile Probation, Department of Children, Youth & Families, SFUSD, the Department of Public Health, Richmond Area Multi-services, Inc., and Catholic Charities, it is also supported in part by MHSA funding and will serve 40 youth during this pilot year.

MHSA also provides funding to support a half-time **Psychiatrist at the Juvenile Justice Center** to provide medication management and support services to incarcerated youth in an effort to improve outcomes after discharge.

## Target Population

The programs making up the Integration of Behavioral Health and Juvenile Justice serve youth ages 11-21 and their families. African American and Latino youth are overrepresented in the juvenile justice system and make up the majority of who is served. AIIM Higher operates citywide and serves youth and their families wherever they feel most comfortable whether it is at home, school or in the community. Services are also offered at the Juvenile Justice Center, 375 Woodside Ave, Room 225 and 606 Portola Avenue.

## Budget and Costs per Client

Program expenditures for Integration of Behavioral Health and Juvenile Justice for fiscal year 2014-15 are projected to be $470,189. The projected per-client costs are detailed below.

**Exhibit 9. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Integration of Behavioral Health Into the Juvenile Justice System | 512 clients | $470,189 | $918 |

## Projected Outcomes

- Youth and their families are engaged in services
- Youth participants who transition back into the community are successfully linked to behavioral health services
- Recidivism rates among AIIM youth will be decreased
- Participants will report a decrease in their needs and risks and improvement in life functioning on their most recent Child and Adolescent Needs and Strengths (CANS) assessment

- Probation and providers are collaborating more in the management and delivery of enhanced services

# Integration of Behavioral Health and Primary Care

## Background and Community Need

Too many people go without their mental health needs being adequately identified and addressed. Of equal concern is the substantial physical suffering and premature death for individuals with serious mental illness. To address these concerns, the Department of Public Health has been making great strides to integrate physical and behavioral healthcare. In 2009, after an extensive community planning process, DPH decided to implement the Primary Care Behavioral Health Model in DPH primary care clinics. In this model, behavioral health clinicians work as a member of a primary care team providing services to patients in primary care clinics. Services include the delivery of brief, evidence-based and practical interventions, consultation to primary care team members, and participation in population-based care "pathways," and self- and chronic-care management services (e.g., class and group medical visits). MHSA has provided resources to support this initiative.

## Program Overview

MHSA supports behavioral health staff stationed at the following Primary Care Clinics:

- Chinatown Public Health Clinic – Disability Clinic
- Cole Street Clinic
- Larkin Street Youth Clinic
- Curry Senior Center Primary Care Clinic
- Southeast Health Center

MHSA also supports primary care staff stationed at the following mental health clinics:

- South of Market Mental Health
- Behavioral Health Access Center
- Chinatown Child Development Center

## Target Population

The target populations for these services are individuals and families served in primary care clinics with unidentified behavioral health concerns, as well as individuals and families served in mental health clinics with complex physical health issues or unidentified physical health concerns.

## Building Bridges: Linking Clinic Integration Activities with School-Based Services (INN-Funded)

**Building Bridges,** now in its second year, was designed to test a staffing model to promote **interagency collaboration** between DPH Community Health Programs for Youth (CHPY) clinics and San Francisco Unified School District. Youth living in neighborhoods like Hunter's Point, Sunnydale, and other neighborhoods in the Southeast section of San Francisco, are at significant risk for exposure to community violence, family upheaval and other factors that may cause and exacerbate behavioral health problems. Reaching many of these youth in the community is often difficult due to (1) stigma associated with accessing mental health services, (2) youth not knowing where to go if they are interested in services, and (3) fears around consent and confidentiality. Additionally, many youth with mental health issues go to primary care services with physiological complaints that are actually psychological in nature. For these youth, an **interagency collaborative** approach between schools where youth should be daily, community behavioral health providers and primary clinics potentially supports increased access for youth and a streamlined system for professional linkages and referrals for care.

The addition of an INN-funded position enabled the **Balboa Teen Health Center (BTHC)** to increase individual behavioral health services from 2,280 to 2,605 individual encounters, and overall groups by approximately 10%. Moreover, as this position was filled by a Cantonese-speaking therapist, service utilization by this population of youth, many of whom tend to present with anxiety and depressive disorders, increased by 17%. MHSA funds have allowed the **3rd Street Youth Center and Clinic** to build significant school-linked services in the southeast sector of the city and attempting to better address the significant overall health needs of the youth in this community. The MHSA-funded psychologist allowed deeper connection with more youth, to build rapport, and eventually support stronger connections to other services that are clinic-based in their community. The MHSA-funded position of a social worker at **Hawkins Clinic,** located in Visitacion Valley has created major inroads in working more effectively with youth, particularly males, from the that southeastern neighborhood. These youth are highly likely to have experienced significant trauma in their lives which affects both their positive development and attachment to school.

## Budget and Costs per Client

Program expenditures for Integration of Behavioral Health and Primary Care for fiscal year 2014-15 are projected to be $1,179,270. The projected per-client costs are detailed below.

**Exhibit 10. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Integration of Behavioral Health and Primary Care | 2000 clients | $1,179,270 | $590 |

### Projected Outcomes

Programs seek to achieve the following outcomes:

- Increase the provision of behavioral health screening and intervention in primary care settings
- Increase the provision of evidence-based short-term treatment interventions at DPH primary Care Clinics
- Decrease in symptom levels from baseline
- Increase number of referrals to specialty mental health clinics
- Increase the number of individuals with behavioral health concern that are successfully managed in a primary care setting

### Enhancing Integration with Behavioral Health Homes

MHSA is supporting the implementation of a novel model of integrated care called the Behavioral Health Homes (BHH) by funding the Chief Medical Officer for the BHH Initiative. In his role, Dr. James Ryan Shackelford will be responsible for the strategic planning, oversight, and implementation of the initiative. Within a BHH, clients will receive an increased level of team-based care related to their physical conditions including primary care services for acute and chronic conditions, coordination with medical and surgical specialists as well as with social service and community agencies, system navigation, and enhanced service integration through team-based care, quality improvement and population management principles. Dr. Shackelford will work closely with SF Health Network executive leaders in Primary Care, Behavioral Health and Ambulatory Care to create the training structure that will sustain this Model of Integrated Care uniformly across SFHN Behavioral Health Clinics.

## Dual Diagnosis Residential Treatment

### Background and Community Need

Residential treatment was identified as a priority by the MHSA planning task force in San Francisco. Specifically, the original CSS plan called for additional beds to offer an opportunity for consumers undergoing acute crisis to receive support towards stabilization, and engage in a partnership with the system towards recovery.

## Program Overview and Target Population

Dual diagnosis residential treatment services are provided to individuals who do not have Medi-Cal coverage and who would otherwise not be eligible for services. As a result of the Affordable Care Act (ACA), more individuals are now eligible to enroll in MediCal than ever before. SF MHSA intends to partner with the service provider and other stakeholders to evaluate how ACA may impact the target population for this program.

## Budget and Costs per Client

HealthRight 360 expenditures for fiscal year 2014-15 are projected to be $85,309. The projected per-client costs are detailed below.

**Exhibit 11. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Dual Diagnosis Residential Treatment | 25 clients | $85,309 | $3,412 |

## Projected Outcomes

The dual diagnosis residential treatment and support programs seek to achieve the following outcomes:

- Clients are linked to an appropriate level of continuing care and support
- Clients are linked to a primary care home
- Clients will avoid hospitalization for mental health reasons for the duration of their stay
- Clients will report increased quality of life (versus self-report at intake)

## Program Specific Community Program Planning (CPP) Activities

Peer staff conducts outreach to the provider community, criminal justice system, homeless shelters, medical providers and other substance abuse treatment programs through regular presentations, participation in community meetings, and public health meetings.

# Expanding Outpatient Mental Health Clinic Capacity

## Program Overview and Target Population

In recognition of disparities in access to behavioral health treatment for certain populations, this program has expanded the staffing capacity at outpatient mental health clinics to better meet the treatment needs of underserved communities. Funding through this initiative has allowed for expanded capacity at the following clinics to serve the populations noted.

- South of Market Mental Health Clinic – homeless individuals with dual diagnosis
- South East Mission Geriatrics – older adults
- Mission Mental Health – monolingual Spanish speaking adults

**New Position: MHSA Wellness and Recovery Program Manager**

The FY 13-14 MHSA budget includes an additional position for a MHSA Wellness and Recovery Program Manager. Once hired, this Program Manager will work collaboratively with CBHS staff, consumers and other community stakeholders to develop, implement and evaluate projects to promote the principles and practices of wellness and recovery across the CBHS systems of care. The position will also entail identifying and supporting the implementation of evidence-based and promising practices, designing and conducting research and planning activities, and developing and conducting training, as well as providing technical assistance.

## Projected Outcomes

Programs seek to achieve the following outcomes:

- Increase access to care for underserved communities
- Improve the capacity of clinics to provide culturally competent care

## Budget and Costs per Client

Expanding outpatient mental health capacity expenditures for fiscal year 2014-15 are projected to be $338,323. The projected per-client costs are detailed below.

**Exhibit 12. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Expanding Outpatient Mental Health Clinic Capacity | 150 clients | $338,323 | $2,255 |

# 3. Mental Health Promotion and Early Intervention (PEI) Services

In half of the lifetime cases of mental health disorders, symptoms are present in adolescence (by age 14); in three-quarters of cases, symptoms are present in early adulthood (by age 24). There are often long delays between onset of mental health symptoms and treatment. Untreated mental disorders can become more severe, more difficult to treat, and cause co-occurring mental illnesses to develop. Currently, the majority of individuals served by CBHS enter our system when a mental illness is well-established and has already done considerable harm (e.g. prison, hospitalization or placement in foster care) despite the fact that many mental health disorders are preventable and early intervention has been proven to be effective.

With a focus on underserved communities, the primary goals of Mental Health Promotion and Early Intervention (PEI) Services are to raise awareness about mental health, address mental health stigma, and increase access to services. PEI builds capacity for the provision of early intervention services in community-based settings where mental health services are not traditionally provided (e.g. community-based organizations, schools, ethnic specific cultural centers and health providers).

The PEI service category is comprised of the following: (1) Stigma Reduction (2) School-Based Mental Health Promotion (K-12), (3) School-Based Mental Health Promotion (Higher Ed) (4) Population-Focused Mental Health Promotion, (5) Mental Health Consultation and Capacity Building, and (6) Comprehensive Crisis Services. INN funding also supports several programs in this MHSA service category.

### Statewide PEI Projects

MHSA included funding for three Statewide Prevention and Early Intervention Projects: Suicide Prevention, Student Mental Health Initiative, and Stigma and Discrimination Reduction. In 2009, San Francisco received an annual allocation for Prevention and Early Intervention Statewide Projects of $755,100 for a period of four years. San Francisco allocated this funding to the Joint Powers Authority known as the California Mental Health Services Authority (CalMHSA). CalMHSA was founded by member counties to jointly develop, fund, and implement mental health services projects and educational programs at the State, regional, and local levels.

Since the adoption and implementation of the existing CalMHSA PEI Statewide Implementation Plan in 2011, the investment by counties and the impact of the statewide PEI Projects resulted in CalMHSA Board actions to continue to find a funding solution for continuing PEI Statewide Projects. In support of this plan to sustain statewide PEI work, San Francisco, has proposed making a contribution of $100,000 in FY 14-15, or 2% of its local PEI allocation to CalMHSA.

## Stigma Reduction

### Program Background

Sharing Our Lives, Voices and Experiences

(SOLVE) is a stigma elimination program. SOLVE trains people in the community who have been living with mental health challenges to share their personal experiences. By telling their stories, these peer educators help to reduce the social barriers that prevent people from obtaining treatment. The SOLVE Speakers Bureau consists of an array of people who have had challenges in their lives with mental health conditions and who come forward to talk openly about these experiences by sharing their stories of struggle, hope and triumph with others. SOLVE's mission aims to decrease the fear, shame and isolation of those with mental health challenges and conditions through peer education.

## Target Population

SOLVE speakers reach individuals including community members, public policy makers, health care providers, corporate and community leaders, students and school employees, law enforcement and emergency service providers, and behavioral health providers. Geographically, SOLVE will target individuals 18 years or older within communities that are severely under-served and less likely to access or obtain support for prevention, wellness, and recovery. These areas include the Tenderloin, Mission, Bayview/Hunter's Point, Excelsior, Chinatown, and Visitacion Valley neighborhoods in San Francisco. SOLVE will work with community centers, religious institutions, and schools in each of these areas to deliver culturally-specific neighborhood-based presentations and provide linguistically appropriate referral materials. SOLVE will also leverage community and partnership resources in order to provide interpretation for presentations to monolingual Chinese, Russian, Spanish, and Tagalog-speaking audiences. In addition, SOLVE will target more of the diverse gender-variant community within San Francisco.

## Budget and Costs per Client

SOLVE expenditures for fiscal year 2014-15 are projected to be $175,000. The projected per-client costs are detailed below.

**Exhibit 13. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| SOLVE Stigma Reduction | 1600 participants | $175,000 | $109 |

## Projected Outcomes

The SOLVE program seeks to achieve the following outcomes:

- Presentation attendees will:
  - Demonstrate a better understanding of the effects of stigma on people with mental health challenges and conditions

- Demonstrate a better understanding of mental health challenges and conditions,
- Express less fear/more acceptance of people with mental health challenges

- Peer Educators will report experiencing reduced self-stigma, reduced risk factors, improved mental health, improved resilience and protective factors, increased access to care and empowerment

### Program Specific Community Program Planning (CPP) Activities

The 25-30 consumers trained and supported to be SOLVE speakers are engaged in all elements of program implementation and evaluation. Experienced SOLVE speakers are involved in the training of new speakers.

## School-based Mental Health Promotion (K-12)

### Program Overview

School-Based Mental Health Promotion – a collaboration of community-based organizations and San Francisco K-12 campuses – applies school-based best practices that address non-academic barriers to learning. These programs support student success by combining the full spectrum of prevention, early intervention, and linkages to behavioral health services (e.g., wellness promotion workshops, family engagement and support, career planning, mentoring, crisis intervention, case management) with existing resources already housed in school settings. Presently, these services are provided at the following schools:

- Burton High School
- Balboa High School Teen Health Center
- Charles Drew Preparatory Elementary School
- Hillcrest Elementary School
- James Lick Middle School
- June Jordan High School
- San Francisco School of the Arts High School

### Target Population

The target population for these programs is low-performing students who are experiencing school difficulties due to trauma, immigration stress, poverty, and family dysfunction.

### Budget and Costs per Client

School-based Mental Health Promotion (K-12) expenditures for fiscal year 2014-15 are projected to be $991,000. The projected per-client costs are detailed below.

**Exhibit 14. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| School-Based Mental Health Promotion (K-12) – Prevention Activities | 3009 clients | $495,500 | $165 |
| School-Based Mental Health Promotion (K-12) – Early Intervention Activities | 700 clients | $495,500 | $708 |

## Projected Outcomes

The School-Based programs endeavor to increase the capacity of school staff to address the behavioral health needs of the children in their care, as well as empower the youth themselves to seek and engage in supportive services. Specifically, they seek to achieve the following outcomes:

- Teachers will report that they can respond more effectively to student's behavior.
- Students will show a marked reduction in the frequency of behavioral or emotional outbursts in the classroom,
- Students will be able to identify services they can access for support and will rate their comfort level in accessing these services as moderately comfortable or better.
- Students will be able to identify skills they can successfully utilize to reduce stress or other related symptoms.

### Spotlight on K-12 Programs' Evaluation Efforts

K-12 programs' evaluation efforts are centered on five providers – three in high school settings and two in elementary school settings. All five programs identified a common outcome. Elementary providers chose to focus on teacher self-efficacy, while the high school providers focused on school connectedness, with an emphasis on positive relationships with adults in school. Elementary programs used the Teacher Opinion Survey, while high school programs used a slightly adapted section of the California Healthy Kids Survey.

Programs have currently completed the collection of pre-survey data from providers working in elementary schools, and have 36 teacher surveys. The high school providers work with students on a rolling basis and anticipate collecting more pre and post-surveys. Surveys from 70 students have been collected so far.

Programs will also collect qualitative data in the form of feedback from teacher focus groups at elementary sites, student interviews at high school sites, and interviews with providers to document lessons learned for future MHSA evaluation efforts.

### Program Specific Community Program Planning (CPP) Activities

The School-Based programs will continue to engage school-based staff in the development and implementation of the interventions provided on-site. Programs based in high school recruit and train peers to conduct outreach, psycho-social education and peer support. In addition, staff, as well as youth, will continue to take part in the robust program evaluation that is currently being conducted in partnership with all the school-based programs and lead by consulting firm Learning for Action.

## School-based Mental Health Promotion (Higher Education)

### Program Overview

School-based programs focused on higher education include partnerships with California Institute of Integral Studies (CIIS) and the Student Success Program at San Francisco State University. The CIIS MHSA project expands student support services within CIIS's School of Professional Psychology (SPP) program to increase recruitment and retention of students from underrepresented groups through a variety of activities (e.g. trainings, individualized educational plans, workshops on the management, referrals). An innovative program on the San Francisco State University (SFSU) campus, the Student Success Program – located in the College of Health and Social Sciences – is designed to increase university access and enrollment, enhance retention and maximize graduation rates among consumers, family members of consumers and members of underserved and underrepresented communities who are preparing for careers in the public behavioral health field.

### Target Population

Target populations are behavioral health consumers, family members of consumers and members of communities that are underserved and underrepresented in the public behavioral health workforce – e.g. African Americans, Latinos, Native Americans, Asian Pacific Islanders and students who identify as LGBTQQI. The program is designed to support transitional age youth and adults who have experienced bio psychosocial and environmental stressors that have negatively impacted their academic performance (e.g. mental/physical health issues, poverty, substance abuse, incarceration).

### Budget and Costs per Client

School-based Mental Health Promotion (Higher Education) expenditures for fiscal year 2014-15 are projected to be $417,226. The projected per-client costs are detailed below.

**Exhibit 15. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| School-Based Mental Health Promotion (Higher Education) – Prevention Activities | 14,901 individuals | $208,613 | $14 |
| School-Based Mental Health Promotion (Higher Education) – Early Intervention Activities | 470 individuals | $208,613 | $444 |

### Projected Outcomes

School-based programs focused on higher education seek to achieve the following outcomes:

- Increase university access and enrollment
- Enhance retention and maximize graduation rates among individuals and family members with lived experience
- Expand student support services including initial assessment, individual planning, academic and peer counseling

### Program Specific Community Program Planning (CPP) Activities

Student Success Program services are student-driven and include counseling, coaching, advising, crisis intervention, career planning and professional development, peer mentorship, community building and social activities. Both school programs actively engage student in the development, implementation and evaluation of programming.

## Population-Focused Mental Health Promotion and Early Intervention

### Background and Community Need

San Francisco's original PEI plan included a Holistic Wellness Initiative that was adapted from a model of best practices developed for San Francisco's Native American population (i.e., the Holistic System of Care for Native Americans in an Urban Environment). The Holistic Wellness Initiative, designed to meet the cultural and linguistic needs of other underserved populations focused on increasing: 1) participants' problem-solving capacity and accountability for personal wellness; 2) knowledge about the early symptoms of potentially severe and disabling mental illness; and 3) inter-dependence and social connections within families and communities. San Francisco's holistic wellness work has not only been influential in reaching underserved communities, but has also helped reduce barriers to access.

## Program Overview

Our community planning efforts have prompted us to utilize available MHSA resources more effectively to further reduce disparities to service access. By broadening the Holistic Wellness Initiative to the Population-Focused Mental Health Promotion service category, we are more intentional about San Francisco's focus on underserved and priority populations, including: 1) racial/ethnic populations; 2) gay, lesbian, transgender and questioning individuals; 3) socially isolated older adults; and 4) homeless individuals. This service category has allowed us to assess MHSA services more comprehensively, avoid duplication, and promote cultural congruency and competence. In addition, population-focused mental health promotion services are centered on acknowledging the healing practices, ceremonies and rituals of diverse communities, with an emphasis on understanding the cultural context first and working in partnership with programs to design culturally relevant and appropriate services. Programs also honor participants' cultural backgrounds and practices of mental health while also making available a variety of services centered on non-clinical support.

Like other PEI programs, this service area centers on raising awareness about mental health, reducing stigma, intervening early, and increasing access to services. And what differentiates this cohort of programs from other PEI programs is that it concentrates its efforts on very specific groups, based upon ethnicity, culture, age, sexual orientation, and homelessness.

These Population Focus programs benefit the African American, Asian and Pacific Islander, Native American, Latino/Mayan, Arab, Homeless Adults, Homeless/System Involved Transitional Age Youth, and LGBTQ communities by honoring their histories, cultural and spiritual beliefs around health and mental health, and their community defined practices toward wellness.

Programs funded in this service category provide the following:

- **Outreach and Engagement:** Activities intended to establish/maintain relationships with individuals and introduce them to available services; raise awareness about mental health.
- **Wellness Promotion:** Activities for individuals or groups intended to enhance protective factors, reduce risk-factors and/or support individuals in their recovery; promote healthy behaviors (e.g. mindfulness, physical activity)
- **Screening and Assessment:** Activities intended to identify individual strengths and needs; result in a better understanding of the health and social concerns impacting individuals, families and communities, with a focus on behavioral health issues.
- **Service linkage:** case management, service coordination with family members; facilitate referrals and successful linkages to health and social services, including specialty mental health services.
- **Individual and Group Therapeutic Services:** Short-term (less than 18 months) therapeutic activities with the goal of addressing an identified behavioral health concern or barrier to wellness.

## Exhibit 16. Population-Focused Programs

| Target Population | Program | Services |
|---|---|---|
| Socially Isolated Older Adults | Older Adult Peer-to-Peer Services Network* (INN) | New INN funded pilot program (FY14-15) to develop and implement peer-to-peer support services in a network of organizations providing health, nutrition and social supports to seniors. |
| | Older Adult Behavioral Health Screening and Response Project | Home-based behavioral health screening, brief interventions and service linkage. |
| | Curry Senior Drop-in Center | Wellness activities, health care, housing support services and service linkage to older adults in the Tenderloin neighborhood. |
| Asian & Pacific Islander | Asian & Pacific Islander Youth & Family Community Support Services | Outreach and therapeutic services tailored to A&PI youth. |
| | Asian & Pacific Islander Health Parity Mental Health Colaborative | New initiative convened workgroups consisting of at least ten community-based organizations and at least 50 community members from three API communities (Southeast Asians, Filipino, Samoan) that reflect the greatest disparity in mental health access. Implementing work plans each workgroup created to provide culturally competent and holistic mental health promotion and early intervention services and to develop capacity of partner organizations to understand and address mental health. |
| | Collaboration with the Faith-Community (INN) | Engages faith-based organizations and families in Bayview/Hunter's Point and Visitaction Valley in order to increase mental health awareness, decrease stigma, and provide social support for consumers, community members, and peers. |
| African American | African American Holistic Wellness Program | Wellness workshops, community cultural events, support groups, and healing circles for African Americans living in the Bayview, Oceanview, and Western Addition neighborhoods |
| | Ajani African American Outreach and Engagement | Outreach activities to engage individual, family, and group therapy to African American families who live in low-income communities, are affected by mental illness, and/or are impacted by racism. |
| Mayan/Indigenous Latino | Indigena Health & Wellness Collaborative | Workshops that focus on different health topics and cultural activities, community forums on trauma and spiritual and cultural Mayan/Indigenous ceremonies, self-risk and needs assessments, individual therapeutic services, training, and outreach. |

**Exhibit 16. Population-Focused Programs**

| Target Population | Program | Services |
|---|---|---|
| **Native American** | Native Wellness Center: Living in Balance | Outreach and engagement, wellness promotion, individual and group therapeutic services, pro-social community building events, direct services, and service linkage. |
| **Homeless Adults** | Holistic Violence Prevention & Wellness Promotion Project | Prevention activities that address safety in the community through the Healing, Organizing, & Leadership Development Program, completes mental health screenings, and holds community violence prevention events |
| | Tenderloin Self-Help Center | Low-threshold services (peer counseling, case management, peer-led support groups, employment resource center) for those who do not otherwise utilize traditional service delivery models |
| | Sixth Street Self-Help Center | Counseling and case management support, holistic behavioral health services and primary care triage, support groups, and socialization activities for residents of the Sixth Street/South of Market neighborhood |
| **Homeless or System Involved TAY** | ROUTZ TAY Wellness Services | Drop-in programming (e.g., group and individual counseling, psychiatric consultation, medication management, crisis planning, and psychoeducation) |
| | TAY Multi-Service Center | Community outreach and education, delivers coordinated clinical case management services, and screens TAY for development leadership services |
| | SF4TAY.com | SF4TAY.org is a TAY-specific website to improve outreach to transitional age youth. This comprehensive, searchable resource directory allows young adults to easily access information in order to connect with the range of services available to them. Services in health, workforce, education, and housing are listed on one central site. |
| **LGBTQ** | Transgender Wellness* (INN) | Peer staff conduct outreach, facilitate wellness/ recovery groups, peer counseling and system navigation and linkage for transgender clients. This program is described in the Peer-to-Peer services category, but is also considered an important component of the Population Focused work. |
| **Arab Refugees** | Arab Refugee Support Group | Focused on planning that will provide culturally responsive mental health support. |

*Both the Transgender Wellness and Older Adult Peer Support programs are 'locally approved' INN projects. Due to changes to the budget and scope of each project, this plan includes revised INN Proposals to be submitted to the MHSOAC (see Appendices A and B).

## Target Population

Exhibit 17 details each target population's approximate size, risk factors, target neighborhoods, and population-specific strategies.

## Exhibit 17. Profiles of Target Populations

| Target Population | Size of population | Risk Factors | Target Neighborhoods | Population Specific Strategies |
|---|---|---|---|---|
| **Socially Isolated Older Adults** | 136,000 at least 60 years of age* | Social isolation, poverty, language barrier | Citywide | In-home partnership with food services, warm Line, behavioral health screening in primary care settings |
| **Asian Pacific Islander** | 271,274* | Linguistic isolation, immigration, economic instability | South of Market (94103), Tenderloin (94102, 94109), Bayview Hunters Point (94124), Potrero Hill (94108) and Visitacion Valley (94134) | API Health Parity Coalition (to address health disparities), holistic and culturally relevant health promotion, community building |
| **African American** | 48,780* | Trauma, poverty, incarceration, stressed families | Bayview (94124), Oceanview (94112) and Western Addition (94115) areas | Partnerships with churches, Healing Circles, wellness promotion activities (e.g. Mindfulness workshops, community cultural events), training and coaching sessions (e.g. healthy eating workshops, positive self-esteem for girls, Triple P parenting group), group therapy (e.g. , Grief & Loss group) and individual therapy |
| **Mayan and Latino** | Latino: 121,774*<br>Mayan: >10,000 | Poverty, cultural and linguistic barriers, unstable housing and homelessness, stressed families (related to cultural and racial discrimination and immigration), violence and trauma, recent immigration | Mission (94110, 94103) and Tenderloin (94102) Districts, Richmond (94115) | Culturally relevant and linguistically appropriate services, culturally informed model |

## Exhibit 17. Profiles of Target Populations

| Target Population | Size of population | Risk Factors | Target Neighborhoods | Population Specific Strategies |
|---|---|---|---|---|
| **Native American** | 4,024* | Trauma, stressed families, school failure, incarceration, isolation | Mission District (94110) and Citywide | Holistic approaches incorporating Native American values and traditions, community building events, wellness promotion, Talking Circles |
| **Homeless Adults** | 6,514** | Unemployment, poverty, substance use, incarceration, domestic violence, trauma | Citywide | Wrap around services, peer-based self-help model, harm reduction model, community building |
| **System Involved TAY and Homeless TAY (ages 16-24)** | 2200 on probation****<br><br>Over 1000 receive either General Assistance or support from CalWorks****<br><br>Over 200 age out of foster care each year****<br><br>4500-6800 homeless annually** | Unemployment, homelessness, criminal justice involvement, poverty, trauma | Citywide | Multi-service centers, community outreach, prevention and early intervention services, peer-based services |
| **LGBTQ** | 94,027***** | Discrimination, homophobia, transphobia, isolation, housing and economic instability | Citywide | Providing anti-stigma training, wellness & recovery services for Transgender community |

** 2010 U.S. Census Bureau*

***San Francisco Homeless Count Report*

****San Francisco Mayor's Office of Housing and Office of Economic & Workforce Development 2010-14 Five-Year Consolidated Plan*

*****The Mayor's Task Force on Transitional Youth Report: Disconnected Youth in San Francisco*

****** http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-Same-Sex-Couples-GLB-Pop-ACS-Oct-2006.pdf*

## Budget and Costs per Client

Population-focused mental health promotion expenditures for fiscal year 2014-15 are projected to be $2,751,970. The projected per-client costs are detailed below.

**Exhibit 18. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Population-Focused Mental Health Promotion — Prevention Activities | 25,687 individuals | $1,375,985 | $54 |
| Population-Focused Mental Health Promotion — Early Intervention Activities | 4,578 individuals | $1,375,985 | $301 |

## Projected Outcomes

Population-Focused Mental Health Promotion objectives will focus on five service types: outreach and engagement, screening and assessment, individual and group therapeutic services, wellness promotion and service linkage. Programs seek to achieve the following shared objectives:

- Individuals will be identified with a need referred to mental health and other social services.
- Individuals will be screened and identified as needing mental health/behavioral health services
- Individual case/care plan goals will be achieved.
- Participants will report increased social connectedness, quality of life, harm reduction and help seeking behavior.
- Individuals will receive one-on-one therapeutic services.
- Individuals will participate in wellness promotion activities.
- Individuals and families will be successfully linked to mental health and/or other social services.

## Program-Specific Community Program Planning (CPP) Activities

Participant involvement plays an integral role in the planning process for population-focused mental health promotion programs. In preparation for new PEI regulations and the FY14-15 contract cycle, SFMHSA is partnering with all seventeen population-focused programs to create shared performance objectives that will measure common service types, such as outreach and engagement, screening and assessment, and individual and group therapeutic services. Because population-focused programs specifically target underserved communities, it is especially critical to partner with these organizations

to spread awareness around mental health. In addition, this involves a level of translation between the communities and the mental health system, as the term and concept do not exist in certain languages and/or are stigmatized.

In order to bridge these barriers and promote a culturally competent and inclusive process, SFMHSA is holding a series of meetings called 'Learning Circles' with population-focused programs to collectively discuss and agree on service types, activities and outcomes. These shared performance objectives will then be measured and reported on for the next fiscal year. The Learning Circles also provide an opportunity for programs to share their progress on implementation, goals and strategies for evaluation.

# Mental Health Consultation and Capacity Building

## Background and Community Need

Mental health consultation builds upon the understanding that the social and emotional well-being of a child is squarely linked to the relationships that child has with the adults/caretakers in their lives. Mental health consultation services are built upon an approach that involves mental health professionals working with non-clinical staff to enhance their provision of mental health services to clients. Specifically, the consultation model is built on the relationships of a trained consultant with mental health expertise working collaboratively with staff, programs, and families of children (from birth to school-aged) to improve their ability to prevent, identify, treat, and reduce the impact of mental health challenges. Ultimately, the consultative relationship seeks to achieve positive outcomes for children and youth in their community-based settings (such as school and neighborhood hubs) by using an indirect approach to foster their social and emotional well-being.

Consultation services differs from many other approaches or evidence-based practices in that they are not scripted (i.e., there is no curriculum to follow). The services are characterized by adherence to a core set of principles (e.g., relationship-based) as opposed to delivery of specific activities in a prescribed sequence. Accordingly, consultation services encourage customized service delivery to meet the diverse needs of various children, families, and school and/or community programs.

## Program Overview

The San Francisco **Early Childhood Mental Health Consultation Initiative (ECMHCI)** is grounded in the work of mental health professionals who provide support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5) and are delivered in the following settings: center-based and family child care, homeless and domestic violence shelters, permanent supportive housing facilities, family resource centers, and substance abuse treatment centers. The Initiative is made possible through a partnership between four county agencies: San Francisco's Department of Public Health/Community Behavioral Health Services; Human Services Agency; Department of Children, Youth, and Their Families;

and First 5 San Francisco. Funding for the Initiative is contributed by all four county agencies, and it also includes funds provided by Mental Health Services Act (MHSA). Services may include case consultation, program consultation, training and support for staff and parents, referrals for specialized services (e.g., developmental and learning assessments, occupational therapy, help with Individualized Education Plans, psychotherapy), therapeutic playgroups, direct psychotherapeutic intervention with children and families, crisis intervention, parent education and support groups, and advocacy for families.

The **Youth Mental Health Consultation Program** seeks to improve the lives of in and at-risk youth by providing direct service (crisis intervention and short-term therapy) and facilitating a sustainable change process within the systems through which youth receive services. Specifically, the program provides consultation to community-based agencies that serve low-income, at-risk youth. The target agencies have limited access to mental health resources and may include but are not limited to community centers, violence prevention programs, juvenile justice programs, afterschool programs, and cultural centers. The staff and youth from these agencies represent a diverse spectrum of cultural backgrounds including male, female, inter-generational, LGBTQ, Latino, African-American, Caucasian, and Asian.

The goal of the **Spring Project** is to support high risk pregnant women and new parents struggling with the stress of poverty, often in combination with mental health and/or substance abuse problems and issues associated with traumatic immigration, through the transition from pregnancy to parenthood in order to help ensure healthy outcomes for their infants and toddlers. This is achieved through the provision of mental health consultation and related direct mental health services to constituents within pre and postnatal primary care clinics at San Francisco General Hospital through the SPRING Project. The primary consultation site is the High Risk Obstetrics Clinic. Consultation will also be provided, when requested, to the Labor and Delivery, Nursery and the Kempe Pediatric Clinic staff.

## Target Population

The primary target population is at-risk children who by virtue of poverty, trauma, immigration stress, and family dysfunction are at-risk for social, emotional and cognitive delays that can have lasting negative repercussions to the quality of their future lives.

Consultation services focuses the intervention not necessarily on the children themselves, but rather on the adults in their lives – teachers, parents, child care providers, doctors, and other caretakers. Consultation services seek to build the adults' capacity to understand and address the behavioral health needs of the children for which they provide care.

## Budget and Costs per Client

Mental health consultation and capacity building expenditures for fiscal year 2014-15 are projected to be $831,855. The projected per-client costs are detailed below.

**Exhibit 19. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Mental Health Consultation and Capacity Building | 8596 clients | $831,855 | $97 |

## Projected Outcomes

These consultation programs endeavor to increase the capacity of school staff and caregivers to address the behavioral health needs of the children in their care, as well as provide direct treatment services to those children and families with more complex behavioral health needs. Specifically, they seek to achieve the following outcomes:

- Staff will report that consultation services increased their understanding of children/youth needs and development and helped them communicate more effectively with parents of children who have challenging behaviors.
- Staff receiving consultation services will report that they were satisfied with the services received from their mental health consultant.
- Staff receiving consultation services will report an improvement in job skills as it relates to addressing the behavioral needs of the children and youth in their care.
- Pregnant women identified as high risk for serious psychiatric difficulties who are typically lost to treatment will be retained.
- Pregnancy outcomes will improve for infants born to mothers with significant psychiatric concerns.
- Obstetric and pediatric providers will demonstrate increased awareness regarding the risks associated with maternal depression for women and infants, effective strategies for intervention, and the critical role of cultural competence in service delivery.

## Program-Specific Community Program Planning (CPP) Activities

Child care providers, staff and parents are intimately involved in all aspects of the program design of all three programs. Furthermore, community members and stakeholders are involved in the ECMHCI funding proposal review process and selection of grantees. The Youth Agency Mental Health Consultation engage the youth they serve to assess what is working well and what programmatic improvements need to be made.

# Comprehensive Crisis Services

## Background and Community Need

Comprehensive crisis response and stabilization services have long been considered a crucial element of public behavioral health systems. There is a considerable body of evidence suggesting that comprehensive crisis services can improve outcomes for consumers, reduce inpatient hospital stays and costs, and facilitate access to other necessary behavioral health services and supports. Crisis response to incidents of violence can reduce the long-term impact of complex trauma exposure. Due to the pressing need for services to address the needs of children, youth, adults and families impacted by violence and mental health crisis – a need that has been highlighted through various MHSA Community Program Planning efforts – MHSA PEI funding supported a significant expansion of crisis response services in 2009.

## Program Overview

Comprehensive Crisis Services (CCS) is a mobile, multidisciplinary, multi-linguistic agency that provides acute mental health and crisis response services. CCS is comprised of four different teams (see Exhibit 20). These teams provide caring and culturally competent assistance throughout the San Francisco community. Services include: follow up contact within a 24-48 hour period of the initial crisis/incident; short term case management; and therapy to individuals and families that have been exposed to trauma. MHSA funds four members of the crisis response team.

**Exhibit 20. Summary of San Francisco Comprehensive Crisis Services**

| Team | Services and Target Populations |
|---|---|
| Mobile Crisis Treatment | Provides behavioral health crisis triage, in-the-field crisis assessments/interventions, & short-term crisis case management for individuals age 18 years or older. |
| Child Crisis | Offers 5150 assessments & crisis intervention for suicidal, homicidal, gravely disabled and out of control children and adolescents regardless of health insurance status. Clients with publically funded health insurance or have no health insurance are provided crisis case management, hospital discharge planning, and medication support services. |
| Crisis Response | Provides mobile response to homicides, critical shootings, stabbings, and suicides; provides clinical support, therapy, and crisis case management services to individuals and families affected by community violence and critical incidents. |
| Crisis Wrap | Delivers up to 18-month intensive mental health wraparound services including education support, respite, mentoring, placement stabilization, and family support to youth who are under the age of 18 and are either wards of the court through the Department of Human Services or Juvenile Justice System. |
| Multi-Systemic Therapy | Delivers an intensive family-based treatment that focuses on multiple systems (home, school, community, peers) that affect juvenile offenders between the ages of 12 and 17.5. Provides parents/caregivers with the skills and resources to address chronic, violent, or delinquent behaviors and serious mental health problems. |

## Budget and Costs per Client

Comprehensive crisis services expenditures for fiscal year 2014-15 are projected to be $494,988. The projected per-client costs are detailed below.

**Exhibit 21. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Comprehensive Crisis Services | 306 clients | $494,988 | $1,618 |

## Projected Outcomes

*Individual*

- Participants will learn and use effective coping strategies to address an acute mental health crisis, grief, loss, and trauma exposure
- Participants will access mental health services within a 30 day period from being exposed to a traumatic event or an acute mental health crisis

*Program*

- CRT staff will provide more community base services to assist individuals that are trauma exposed
- After being notified of a trauma exposed individual by San Francisco Police and/or San Francisco General Hospital, CRT will outreach to those individuals within a 24 hour period of being notified.

*System*

- Individuals in need of mental health services related to trauma exposure are identified and referred by the San Francisco Police Department and San Francisco General Hospital. This early identification and referral leads to timely intervention and a reduction in the burden of suffering caused by delay in or lack of access to services.

As a result of this intervention, communities in San Francisco that are most affected by violence and trauma-exposure will have better access to effective and timely crisis and case management services, which will reduce disparities in access to care and prevent the development of more chronic and severe impairment in trauma-exposed individuals. Beginning in 2014, Crisis Services is collaborating with Quality Management to articulate clear outcome objects and assess areas for program improvement based on evaluation data.

## Program-Specific Community Program Planning (CPP) Activities

The Crisis Response Team has developed a partnership with the Mayor's Office and the Street Violence Intervention Program (SVIP) and meets weekly to coordinate client care, monitor outcomes and to improve client quality of care. Focus groups which involve clients and providers assist with program planning and the evaluation of the program.

# 4. Peer-to-Peer Supports: Clinic and Community-Based

## Background and Community Need

Peer support is an integral element of a recovery-oriented behavioral health system, and provision of behavioral health support by persons who have had experience with these issues innately brings empathy and empowerment that can inspire recovery in others. MHSA funding for Peer-to-Peer Support Services gives peer providers, who have significantly recovered from their illnesses, the opportunity to assist others by teaching how to build the skills necessary that lead to meaningful lives. The programs that provide Peer-to-Peer Support Services are described below. INN funding also supports several programs in this MHSA service category.

## Program Overviews

### *Peer Response Team (INN)*

Only a small proportion of the 12,000 - 15,000 San Franciscans with serious hoarding and cluttering issues receive any form of treatment. Unfortunately, most interventions occur after eviction proceedings are underway or after the individual is homeless. The Peer Response Team (PRT) was created to provide peer support and assistance navigating the community and systems of care for individuals dealing with hoarding and cluttering challenges. PRT is dedicated to educating the public and service providers to reduce public stigma and to help break down the isolation and self-stigma of their peers and encourage them with positive role models of coming out, recovery, and participation in peer community.

### *NAMI Pilot*

The National Alliance for Mental Illness (NAMI) offers outstanding peer-directed programs in education and support. In partnership with NAMI-SF, three core NAMI programs are now being offered in primary

care and mental health clinics in San Francisco. NAMI Family-to-Family Education is a 12-week curriculum that offers a wide range of information about mental illness and assists caregivers in understanding how the experience of mental illness affects their family member. NAMI Peer-to-Peer Recovery Education is a nine-week program that combines lectures, interactive exercises, and structured group process to promote awareness about the impact of mental illness. This program will be translated to Spanish. In *Our Own Voice: Living with Mental Illness* is an interactive, multi-media consumer presentation designed to educate the general public and to change attitudes. Trained consumers, some of whom speak Spanish, share personal experiences of living with mental illness and convey messages of treatment, access and recovery.

### *Peer Specialist Mental Health Certificate*

While all peer programs provide ongoing training and support, there is a growing need to provide comprehensive training for consumers interested in a career path in peer counseling. Every year the number of employment opportunities increase for individuals interested in providing culturally congruent peer counseling and support, resource linkage, and skill building trainings to clients of outpatient clinics or other wellness and recovery programs. The Peer Specialist Mental Health Certificate provides a standardized certification based on nationally adopted ethics and principles and helps to prepare individuals for various peer positions throughout the San Francisco community. The Peer Specialist Mental Health Certificate is a 12-week program designed to prepare consumers and/or family members with the basic skills and knowledge for entry-level employment in the behavioral/mental health system of care and with academic/career planning that supports success in institutions of higher learning. This program gives participants the opportunity to meet and network with behavioral health professionals through a career and resource fair and facilitates the possibility of future vocational or employment opportunities.

### *Office of Self Help (OSH)*

The Office of Self Help is a consumer-staffed self-help program providing counseling, groups, activities, social support, education, information referral and Oasis drop-in center. Initial healthcare is available from a nurse practitioner. Dual diagnosis self-help groups are available on-site. Shuttle service is available to transport friends and family members to visit patients in out-of-county facilities. MHSA funds three different parts of the Office of Self Help: obtaining and stabilizing increased cultural staff and language capacity, additional shuttle services for families to visit out of county locked facilities, and a Warm Line.

### *Transgender Wellness Program (INN)*

The MHSA program will provide on-site wellness and recovery groups and system navigation for clients. Clients can be seen for peer to peer counseling in individual and group settings. The target population for these groups will continue in FY14-15 to be transgender individuals living in San Francisco. While the focus of the groups is primarily trans women of color, all trans clients are welcome. Consumers are also given the opportunity to be paid stipends to work and organize the Transgender Health and Wellness

Fair. MHSA peer staff is also involved in creating a safe space for HIV+ trans women of color as part of a collaboration with SFPDH Tom Waddell clinic and API Wellness/Trans Thrive Program. This locally approved INN-funded pilot program seeks to learn how to develop and implement effective peer-to-peer support services in a network of organizations providing health, nutrition and social supports to seniors. Due to changes to the budget and scope of the project, a revised INN Proposal will be submitted to the MHSOAC (see Appendix A).

***CBHS Consumer Employment Services***

The program improves the care for consumers accessing services by including those that have had lived experience within multi-disciplinary treatment teams. The Consumer Employment Program provides well-trained staff able to fill the need for peer employees at various clinics. This program has helped consumers find appropriate, much-needed services and provided hope to program participants while continuing to work on the staff's own health and wellness. The Consumer Employment Services provide support and basic training for entry level employment in a behavioral health setting. There are 43 MHSA-funded peers employed in this program.

For peer employees, the basic objective is to provide peer-to-peer training and practice that includes 1) learning and applying Wellness and Recovery principles to peer-to-peer support practice, 2) developing basic job skills and 3) receiving on-the-job practice in clerical/administrative support, general peer support in system navigation and/or basic wellness and recovery group facilitation. Job coaching and skills development training are provided to support skills development. Central to these objectives are providing a recovery and wellness based consumer employment program that integrates empowerment, hope, a process for using one's personal lived experience to create a safe place for relationship and community building for peers in the community. The Consumer Employment Services are designed and delivered by individuals who have lived experienced as a mental health consumer, or a family member or significant other of a consumer.

For consumers receiving support from their peers, the goal of this program is to help consumers and/or family members become and stay engaged in the recovery process, learn and develop new skills and develop a positive support system that maintains their wellness and recovery. The services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery. Peer-to-Peer Counseling Services to support consumers in their recovery include one-on-one peer counseling support, navigation support through various systems of care, drop-in support, and group support that includes art groups, socialization groups, skill-building groups, WRAP groups, exercise groups, and many more.

Specifically, the consumer employment services utilize two practices, which are the wellness and recovery model and the supported employment model. The model encourages consumer and behavioral health to collaborate to educate consumers about recovery strategies, illness information, coping with stress and navigating the behavioral health system of care, as well as other public health services. The supported employment model uses employment as a key element in recovery from

mental illness and co-occurring disorders (and the related issues of homelessness). The model asserts that programs providing employment services in concert with practical and social supports are a valuable resource for people with behavioral health & Recovery and Wellness issues.

***LEGACY***

LEGACY has the opportunity to try out new approaches by working with families and youth to combat the stigma of those suffering from mental health issues.

Family Programming

Family specialists and a family coordinator, with system experience, helps guide and empower families whose children are being served in the behavioral health and other child serving systems. The family specialists help caregivers navigate the comprehensive network of services available to children, youth and their families. In addition to the one-on-one peer support, the family specialists facilitate three innovative and family-driven initiatives that promote family-driven care and support the wellness and recovery goals of families served in the behavioral health system. These include: 1) the Family Advisory Network; 2) the Incredible Years & Positive Parenting Program training; and 3) the Sista Circle. MHSA funds 3.5 FTE peer staff to coordinate the family programs. In addition, "the drumming circle" will be a wellness approach that engages families, individuals and the community in a shared, participatory and collaborative activity intended to generate a sense of well-being, relaxation, community support and cultural revitalization. The circle will integrate various modalities; creating and maintaining a safe space, establishing community, sharing conversation and story about wellness, collective drumming, song and culturally based wellness tools.

Youth Programming

The overall goal of the youth mentoring program is to hire peer mentors who are former consumers of the various systems (juvenile justice, mental health, foster care and special education) who have achieved stability and have the ability to assist other young mental health consumers achieve resiliency and recovery as defined by the individual consumer. The youth mentoring program interventions and specific activities include: physical activities for health and fitness, education on nutrition and exercising, journal writing, conferences with teachers to discuss behavior/grades, explore academic challenges and solutions, tutoring and support with school projects, practice/review of English language with Spanish speaking mentee, provide psycho- education on the importance of therapy and medication management, introduce mentees to new activities and encourage social engagement, Boys and Girls club memberships, support on individuation development, time management skill building, create and implement responsibility action plan (chore chart), and decrease isolation by taking mentee out of the house for activities.

## Target Population

The Peer-to-Peer Supports Services' target population will include underserved and underrepresented San Francisco mental health consumers and their family members who: have experience in the community behavioral health systems, may be interested in a mental health career path, may benefit from additional educational training, and may benefit from learning new skills within a wellness and recovery peer program. The underserved and underrepresented San Francisco mental health consumers and their family members may include African Americans, Asian & Pacific Islanders, Latinos/as, Native Americans, and Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQQ) individuals. The target population includes individuals who have accessed the system of care as a consumer, former consumer or a family member.

## Budget and Costs per Client

Peer-to-Peer expenditures for fiscal year 2014-15 are projected to be $2,210,000. The projected per-client costs are detailed below.

**Exhibit 22. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Peer-to-Peer Supports: Clinic and Community-Based | 2550 clients | $2,210,000 | $867 |

## Projected Outcomes

The Peer-to-Peer Programs seek to achieve the following outcomes:

- Participants will report an increased ability to manage hoarding and cluttering behaviors.
- Participants will report an increased problem solving capacity and responsibility and accountability for their wellness.
- Participate who indicated at enrollment that their housing at risk will report a decreased risk.
- Participants will complete the program (i.e. graduate) thus increasing readiness for entry-level employment/internship/volunteerism in the behavioral health system.
- Course graduates will indicate higher-level of engagement within the health and human services.
- Consumers will have enhanced problem solving skills, and responsibility and accountability for their wellness.
- Clients will report an increased quality of life.
- Consumers will have improved social norms, attitudes.
- Transgender Wellness consumers will report an increase in quality of life.
- Youth program participants will report an increase in improvement at school.
- Participants will report an increase in socialization and a feeling of an increased sense of community.

- Consumers receiving peer-to-peer services will report an increase in their overall quality of life.
- Consumers receiving peer-to-peer services will report a decrease in social isolation and an increase in community integration.

## Program Specific Community Program Planning (CPP) Activities

The Peer-to-Peer Programs are committed to consumer involvement, and the programs will demonstrate a partnership with consumers of mental health and their families, and various stakeholders. All of the Peer-to-Peer Programs are staffed by consumers, former consumers and/or family members of consumers. These consumer staff has been involved in all areas of mental health policy, program planning, implementation, monitoring, quality improvement, evaluation and budget allocations. Per the report of the peer staff themselves, "we have been consistent in coming up with new ideas on how to better work with the CBHS consumer population" and "we come together to form a united front for peer education and hiring". The Peer-to-Peer Programs will continue to give consumers a voice in their care and assist them with identifying their own goals. Before new programs are launched, consumers are actively involved in the program planning and provider selection process.

### Celebrating Successes in Recovery and Wellness

**MHSA Awards Ceremony:** The MHSA Awards Ceremony is an Innovations project that publicly honors current and former clients in MHSA-funded programs in San Francisco. Consumers/peers are recognized for their personal achievements in wellness and recovery in a formal celebration that includes a delicious sit-down meal, entertainment, and awards.

In 2012, the awards ceremony was an Olympics themed event. At this event, 120 individuals and teams were honored for their achievements in recovery.

On October 11, 2014, the Third Annual MHSA Awards Ceremony was held, and it has been our largest ceremony thus far. The event's theme was "Bay to Breaking Stigma". At this highly anticipated event:

- 23 agencies referred individuals for awards
- 225 consumer nominations were awarded
- 33 nominators attended the Awards Ceremony
- 400 individuals attended the event

Unique to this project, the awards ceremony and all of the activities prior to the event are planned and coordinated by a 15-20 consumer planning body, with the assistance of the Mental Health Association of San Francisco and SF MHSA. The planning process for this event usually takes six months and included outreach, choosing an event theme, selecting award criteria, logistics, presenting awards, and entertainment.

### *Request for Proposal (RFP) Planned for CBHS Consumer Employment Services*

San Francisco began integrating Peer Specialists into the mental health service delivery system by hiring six Peer Navigators in 2008. Today, CBHS employs 85 peers in a variety Peer-to-Peer Programs. To better coordinate the recruitment, training, placement, support and supervision of peer staff within the CBHS System of Care and community settings, CBHS has recommended the selection of a single service provider to oversee and support the CBHS Peer-to-Peer Programs. Through a competitive bidding process, CBHS will identify a service provider to provide management of these programs. The provider selected will use input from peers regarding program development, implementation, evaluation and long-term strategic planning. CBHS is requesting that the service provider hire all peer staff currently employed by CBHS. This model will help peers to be a part of a larger infrastructure to better utilize resources, opportunities for advancement and find strength in a larger support system. This model can create a stronger program that promotes program expansion and streamlines services.

### *Expanding Peer-to-Peer Services to Reach Socially Isolated Older Adults*

Through a stakeholder process that involved older adult service providers and peers, social isolation was identified as one of the key concerns for older adults living in San Francisco. The goals for this new INN-funded program will be to: (1) produce programming (e.g., culturally-informed training curriculum, supervision/support plan, engagement tools) that will improve our system of support for socially isolated adults, (2) build effective partnerships between individuals and organizations who provide peer support services and programs for socially isolated adults, and (3) develop a more coordinated system of care for socially isolated adults. This locally approved INN funded pilot program seeks to learn how to develop and implement effective peer-to-peer support services in a network of organizations providing health, nutrition and social supports to seniors. Due to changes to the budget and scope of the project, a revised INN Proposal will be submitted to the MHSOAC (see Appendix B).

### *Expanding Peer-to-Peer Services in Mental Health Clinics*

The FY 14-15 MHSA budget includes five new Health Worker positions. These positions will provide an opportunity to hire peers that have developed advanced skills in providing peer support and integrating these new staff into clinic-based teams.

# 5. Vocational Services

## Background and Community Need

Since mental health issues can be a barrier to employment, it is imperative that vocational services be incorporated into mental health treatment. Treatment programs must be ready to serve the many consumers with serious mental illness who must find and maintain employment in a very short time period.

MHSA funding for vocational services assists consumers and family members in securing and maintaining meaningful employment. According to SAMHSA, "Work as a productive activity seems to meet a basic human need to be a contributing part of a group. It is critical that the meaning of work be understood in the context of each individual's personal values, beliefs, and abilities; cultural identity; psychological characteristics; and other sociopolitical realities and challenges." In collaboration with The California Department of Rehabilitation, the San Francisco Department of Public Health has identified a need for various training and employment support programs to meet the current trends and employment skill-sets necessary to be successful in the competitive workforce. Many mental health consumers have identified interest in various career paths but lacked support and skills training to secure an employment opportunity.

## Program Overviews

### *Department of Rehabilitation Vocational Co-op Program*

The San Francisco District of the Department of Rehabilitation (DOR) and the City and County of San Francisco's Community Behavioral Health Services (CBHS) will combine staff and resources to provide vocational rehabilitation services to mutual consumers of mental health. DOR and CBHS will determine eligibility and functional capacities, assist a consumer to develop an Individualized Plan for Employment (IPE), provide vocational counseling, as well as provide services and service coordination that will lead to a successful employment outcome. DOR and CBHS will partner with a service provider to meet the various and diverse needs of the community; UCSF Citywide Employment Program – FSP Program. CBHS will oversee the program and the provider will implement the following services: Vocational Assessment Services; Employment Services; and Retention Services. All clients served under this MHSA funded portion of the program will be clients already receiving services in the UCSF Citywide's FSP Intensive

Case Management Program. All clients will meet criteria for severe mental illness and have current or history of criminal justice involvement.

CBHS will also provide a Vocational Coordinator who will assist in planning, coordinating services between DOR and CBHS and providing overall administrative support to the CBHS contract. The Vocational Coordinator will also provide outreach to CBHS consumers and CBHS staff to inform them about this cooperative program and its services.

### *i-Ability Vocational IT Program*

I-Ability provides culturally competent, consumer-driven and strengths-based vocational services meeting the needs of consumers. The program prepares consumers to provide information technology (IT) support services (e.g. desktop, help desk) at the CBHS IT Department through its Vocational Information Technology Training Program. The i-Ability Vocational IT program will have three components:

- Avatar Helpdesk, a single point of contact for end users of the CBHS electronic health record system ("Avatar") to receive support.
- Desktop, a single point of contact for end users of CBHS computers/hardware to receive support and maintenance within CBHS computing environment.
- Advanced Avatar Helpdesk, a single point of contact for end users of the CBHS electronic health record system ("Avatar") to receive support.

The program design will include providing vocational services including but not limited to: vocational assessments, job skills training, on-site work experience, vocational counseling and job coaching, and classes/workshops aimed at skills development and building strengths towards employment readiness.

### *First Impressions (INN)*

First Impressions (FI) is a basic construction and remodeling vocational program that will assist mental health consumers in learning marketable skills, receive on-the-job training and mentoring, and secure competitive employment in the community. The program is based on the MHSA's Recovery Model which is founded on the belief that all individuals – including those living with the challenges caused by mental illness – are capable of living satisfying, hopeful, and contributing lives. First Impressions will provide three months of classroom education/training, six months of paid fieldwork experience, vocational assessment, coaching, and job placement support and retention services each year. The ultimate goal is for consumers to learn marketable skills while being a part of the transformation of the CBHS Mental Health Care System by creating a welcoming environment in the wait rooms of DPH/CBHS clinics.

The FI program is a collaboration of the UCSF Citywide Employment Program, Asian Neighborhood Design and CBHS. Citywide Employment Program staff conducts extensive job development activities to create relationships with businesses and employers. Citywide Employment Program staff provides support and coaching into the workforce and connect participants to additional resources as needed

(e.g. Department of Rehabilitation, educational/training resources, housing, benefits, and clothing & transportation resources.)

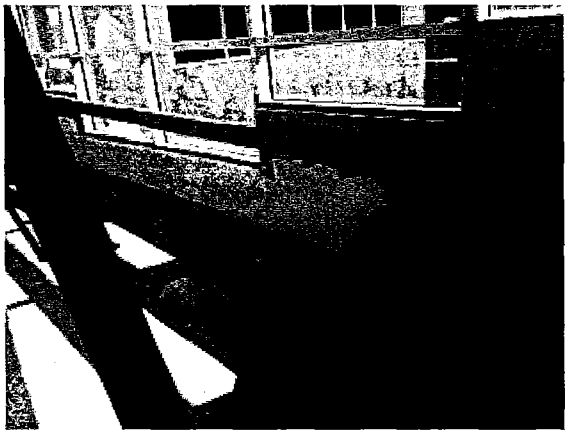
### *Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) (INN)*

Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) is led by the Housing and Urban Health Clinic. This pilot program adapted an existing nutrition and exercise protocol into a community mental health setting and integrated shopping and cooking skills training. This program will educate consumers on atypical antipsychotics about the connection between diet and health, how to shop based on what is locally available, healthy cooking, and how to exercise to improve fitness and health.

Participants were recruited from SFDPH clinics serving residents of supportive housing sites and directly from single room occupancy hotels (SROs), primarily in the Tenderloin, Mission, and South of Market neighborhoods. These neighborhoods provide little to no access to cooking facilities and have a dearth of outlets for affordable fresh foods.

### *SF First Vocational Training Program*

The SF FIRST Vocational Training Program is designed to offer each trainee a one to five hour per week stipend position to learn necessary skills for successful employment. Some of the positions will be located at South of Market Mental Health Services, home base for the FSP SF FIRST Intensive Case Management (ICM) team. Other trainee positions will be located in the community.



The SF FIRST Vocational Training Program will offer training and feedback regarding both practical work skills and psychosocial coping skills for job retention. Practical work skills will include learning the skills needed to work as a donations clerk, janitor, café worker, packaging and assembly line worker, peer group activity facilitation, etc. Supportive counseling for job retention addresses issues such as organizational skills, time management, delaying gratification, communication skills, conflict resolutions skills, goal-setting and hygiene maintenance for the workplace.

## Target Population

The target populations for vocational services are San Francisco residents including transitional age youth, adults and older adults, who are consumers of mental health. Many clients will be living in single resident occupancy unit (SROs) or will report a pending legal charge or history of criminal justice involvement. A portion of the vocational services will strive to improve the health and well-being of underserved homeless persons while primarily serving individuals who experience severe mental illness, chronic and severe medical conditions and/or substance abuse related issues.

Over 70% of the consumers receiving vocational services through these MHSA-funded programs will be FSP clients participating in an intensive case management program identified as needing additional support to help consumers reach their wellness goals. Particular outreach will be to consumers who are interested in vocational assessment, training and/or competitive employment and may benefit from a structured vocational program. Most consumers, if not all, will be receiving behavioral health services through CBHS.

## Budget and Costs per Client

Vocational services expenditures for fiscal year 2014-15 are projected to be $762,155. The projected per-client costs are detailed below.

**Exhibit 23. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Vocational Services | 204 clients | $762,155 | $3,736 |

## Projected Outcomes

The vocational services programs seek to achieve the following outcomes:

- Consumers will utilize their new skills and secure employment in the competitive workforce and also retain this employment for at least 90 days.
- Consumers will receive intake and support with finding employment.
- Trainee graduates will have met their vocational goals.
- Enrolled trainees will successfully complete both the classroom and internship training, for applicable programs.
- Trainee graduates will indicate improvements to their coping abilities.
- Peer leaders will be provided an opportunity to learn new leadership, group facilitation and mentoring skills.
- Participants will be provided education on wellness and nutrition.

## Program-Specific Community Program Planning (CPP) Activities

The vocational services programs demonstrate a partnership with consumers of mental health and their families, and various stakeholders in mental health policy, program planning, implementation, quality improvement and evaluation. These programs will be committed to consumer involvement and community input in all elements of program operations. Consumers will continue to design and lead the outreach planning efforts to help increase participation in programming. Marketing such as flyers, brochures and job fair promotion will continue to be designed by consumers currently or previously

receiving services in vocational services. Consumers will continue to participate in quarterly meetings to provide insight, recommendations and input on policies, program planning and quality assurance.

Some programs will continue to have post-cohort focus groups to solicit similar feedback regarding the curriculum of the program, recruitment process, accessibility, and effectiveness. Vocational services will continue to give consumers a voice in their care and assist them with identifying their own wellness goals while taking into consideration the needs of the community. The Peer Leader role and expansion of the programming was a direct result of consumer feedback and involvement in program planning.

# 6. Housing

The Housing service category helps address the need for a continuum of accessible and safe supportive housing to help formerly homeless clients with serious mental illness or severe emotional disorders maintain their housing. This service category includes Emergency Stabilization Housing, FSP Permanent Housing, ROUTZ Transitional Housing for TAY and other MHSA Housing Placement and Supportive Services.

## Emergency Stabilization Housing

Emergency stabilization units (ESUs) provide short-term housing stability for clients who are homeless or have been discharged from the hospital or jail. The twenty-five ESUs are located within three single room occupancy (SRO) hotels in San Francisco. The units are available to Full Service Partnership clients, Intensive Case Management clients and Central City Hospitality House.

## FSP Permanent Housing

In 2007, the state provided counties with a one-time allocation of MHSA funds to pay for capital costs to develop 10,000 units of housing, as well operating reserves for each new unit created. San Francisco expended its full initial housing allocation of $10 million. In addition, San Francisco added $2.16 million from CSS to housing in 2007-08. There are a total of 57 MHSA-funded housing units developed with capital funding. These units help those who are homeless or at risk of homelessness and are located in various neighborhoods in San Francisco including the Tenderloin, Rincon Hill, and Ingleside (see Exhibit 24). An additional nine units will be open next year (1100 Ocean and Rosa Parks). Summaries of these developments are provided below. SF MHSA also has a contract with Tenderloin Neighborhood Development Corporation for 21 units of permanent housing at three of their affordable housing sites, as well as a small contract with Community Housing Partnership for a few units of permanent housing at Cambridge, another non-DAH supportive housing site.

MHSA-funded housing units are developed within larger mixed-population buildings with on-site supportive services coordinated with and linked to the larger infrastructure of supports provided by Full Service Partnership programs. San Francisco is the only county in California to use its MHSA dollars beyond the housing allotment for permanent units. Because of that addition, San Francisco has accrued approximately $300,000 in interest, and is working with the Mayor's Office of Housing and Community Development to allocate these funds for three additional units at the Rosa Parks development described below that will require a new application.

**Exhibit 24. Summary of MHSA Permanent Supported Housing Units***

| Target Population | Development | Developers | MHSA-Funded Units (N=63) |
|---|---|---|---|
| | *Rosa Parks* | | 3 |
| Older Adults | *Polk Senior Housing*<br>990 Polk St. | Tenderloin Neighborhood Development Corporation & Citizens Housing Corporation | 10 |
| | *Drs. Julian & Raye Richardson Apartments*<br>365 Fulton St. | Community Housing Partnership & Mercy Housing California | 12 |
| Adults | *Kelly Cullen Community*<br>220 Golden Gate Ave. | Tenderloin Neighborhood Development Corporation | 17 |
| | *Rene Cazenave Apartments*<br>530 Folsom St. | Community Housing Partnership & BRIDGE Housing | 10 |
| Veterans | *Veterans Commons*<br>150 Otis St. | Swords to Plowshares & Chinatown Community Development Center | 8 |
| TAY | *Ocean Avenue Affordable Housing Project*<br>110 Ocean Ave. | Bernal Heights Neighborhood Center & Mercy Housing California | 6** |

*Developed with one-time capital housing funds
** Under construction in 2014

## Tenderloin Neighborhood Development Corporation: Polk and Geary Senior Housing

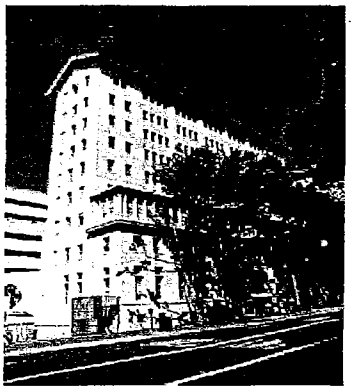
**Polk Senior Housing**

The **Polk and Geary** senior building, built in partnership with Citizens Housing Corporation, represents an innovative approach to address homelessness by combining services-rich supportive housing units within a larger low-income population. Ten of the units are fully accessible, and the remaining units are adaptable for individuals with disabilities. Fifty units are set aside for formerly homeless seniors; the rents and services for residents of these units are subsidized by the City of San Francisco.

**Community Housing Partnership: Richardson Apartments**

**Drs. Julian and Raye Richardson Apartments,** opened in 2011, is a five-story development including 120 studio units of housing for extremely low income, formerly chronically homeless individuals. Located at the corner of Fulton & Gough streets, the building also includes ground floor retail commercial space, common space and social service program space. Twelve units are designated for the MHSA Housing Program. The University of California-San Francisco Citywide Case Management team works with SFDPH's Housing and Urban Health Clinic (HUHC) and three adult Full Service Partnerships (FSPs) to provide the 12 MHSA residents with integrated recovery and treatment services appropriate for severely mentally ill adults to help them live in the community and to maintain the greatest possible independence, stability and level of functioning. Community Housing Partnership manages the property.

**Swords to Plowshares: Veterans Commons**



**Veterans Commons,** opened in 2012, is an adaptive re-use of a nine-story steel-frame and concrete structure at 150 Otis Street in San Francisco. The building was originally constructed in 1916 as the City's first Juvenile Court and Detention Home, but now consists of permanent, affordable rental housing with on-site supportive services for homeless veterans. The project houses 76 U.S. veterans, eight of whom qualify for the MHSA Housing Program.

The development includes space for intensive supportive services, including space for counseling, group meetings, case management, and social activities. Swords to Plowshares manages the property.

### Tenderloin Neighborhood Development Corporation: Kelly Cullen Community

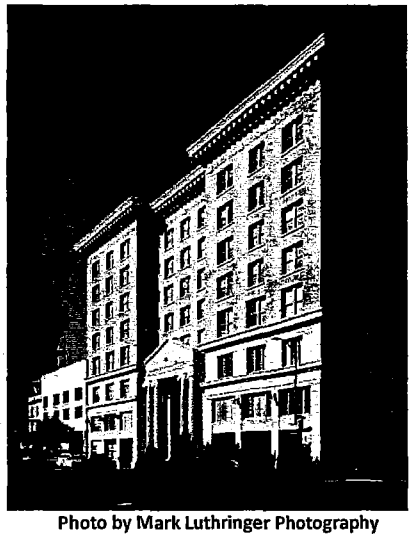
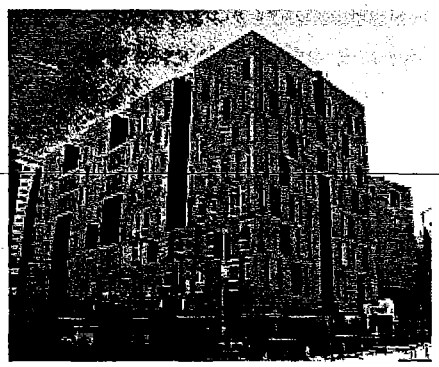


Photo by Mark Luthringer Photography

**Kelly Cullen Community** is a $95 million renovation of the former Central YMCA at 220 Golden Gate and provides 172 efficiency studio units for chronically homeless individuals, including 17 MHSA units. Completed in 2012, the project includes a ground floor SFDPH-managed health and wellness clinic and a corner commercial retail space.

### Community Housing Partnership: René Cazenave Apartments



The recently completed **Rene Cazenave** Apartments were developed in cooperation between Community Housing Partnership and BRIDGE Housing, and designed by Leddy Maytum Stacy Architects. The project was selected by the San Francisco Redevelopment Agency (SFRA), to develop affordable housing in the new Transbay Redevelopment Area. Rene Cazenave Apartments is the first

of several development sites that will serve as a gateway to the SFRA's vision of a new "main street" along Folsom Street. Following completion of the project, Community Housing Partnership remains the owner and property manager of the site.

Rene Cazenave Apartments is a mid-rise, eight-story building that includes a total of 120 apartments. Twelve of these apartments are 1-bedroom units, while 108 are studios. Overall, 10% of the units are handicap accessible and all other units are adaptable for handicap use. All tenants are formerly homeless individuals and are being referred through the San Francisco Department of Public Health.

## FSP Permanent Housing Still in Development

### Mercy Housing: 1100 Ocean Avenue

The **Ocean Avenue** development is a new construction project that will include 70 units of housing for families and transitional aged youth (TAY) and one property manager unit. The building will consist of a mix of studios, one, two and three-bedroom units available to residents making no more than 50% of the area median income. Twenty-five units will be restricted at 20% of the area median income. It is anticipated that this project will start construction in mid-2013, with a seventeen-month construction period.

Six of the project's 25 TAY units will be reserved for the MHSA Housing Program. An integrated services team will provide the youth community with a full range of on-site and off-site resources, including community-building events, educational opportunities, information and referrals to local social services, case management and crisis prevention and intervention. In addition, Community Behavioral Health Services, will work with property management and two TAY Full Service Partnerships to provide the 25 TAY residents with integrated recovery and treatment services appropriate for severely mentally ill youths to help them live in the community and to maintain the greatest possible independence, stability and level of functioning. Mercy Housing Management Group, an affiliate of Mercy Housing California, will manage the property.

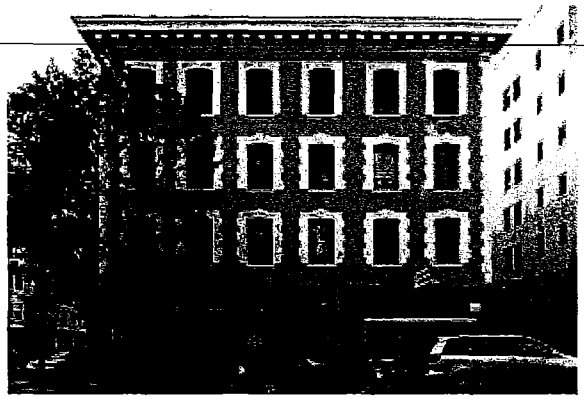
### Rosa Parks II Senior Housing

San Francisco has accrued approximately $300,000 in interest, and is working with the Mayor's Office of Housing and Community Development to allocate these funds for three additional units at the Rosa Parks development described below that will require a new application.

**Rosa Parks II Senior Housing (RPII)** is a proposed 98-unit, five-story affordable senior housing development. The project is located at the corner of Turk and Webster streets in the Western Addition neighborhood of San Francisco, California. RPII will be constructed on the parking lot of an existing public housing facility, Rosa Parks, an eleven-story, 198-unit building owned and operated by the Housing Authority of the City and County of San Francisco since 1959. Site control is held by Rosa Parks II, L.P. through a pre-paid 75-year ground lease with the Housing Authority of the City and County of San Francisco as ground lessor. Rosa Parks II, L.P., a limited partnership of which a Tenderloin Neighborhood Development Corporation (TNDC) affiliate serves as the general partner, has owned the RPII site since fall 2009 when Citizens Housing transferred ownership to TNDC before it disbanded. Citizens Housing was awarded site control of RPII in 2006 through a competitive RFP process. In 2011, TNDC received HUD 202 capital advance funding and project rental assistance for 100% of the units.

## ROUTZ Transitional Housing for Transition-Aged Youth (TAY)

### Larkin Street Youth Services: Aarti Hotel



Youth with mental health and substance abuse issues have unique and complex needs for housing. To expand the availability of housing for this population, San Francisco allocated additional General System Development (GSD) funds to develop housing for transition aged youth with Larkin Street Youth Services. The MHSA ROUTZ TAY Housing Partnership provides 40 housing slots at the **Aarti Hotel** (located at 391 Leavenworth Street) and 10 additional slots at scattered housing sites. In fall 2011, the Aarti Hotel completed its renovation and LSYS began providing supportive services for TAY with serious mental illness including intake and assessment, like skills training, wraparound case management, mental health interventions, and peer based counseling.

## Housing Placement and Supportive Services

Established by the San Francisco Department of Public Health in 1998, the Direct Access to Housing (DAH) is a permanent supportive housing program targeting low-income San Francisco residents who are homeless and have special needs. A "low threshold" program that accepts adults into permanent housing directly from the streets, shelters, hospitals and long-term care facilities, DAH strives to help tenants stabilize and improve their health outcomes despite co-occurring mental health issues, alcohol and substance abuse problems, and/or complex medical conditions. MHSA has allowed for Direct Access to Housing to expand capacity to serve MHSA clients with the addition of an Intake Coordinator and a Nurse Practitioner. The Intake Coordinator works to place clients in the setting most appropriate to their needs. DAH's varied portfolio of housing sites and individual referral prioritization system allows for tailored placement based on clinical needs of the population based on their:

- Level of medical acuity
- Substance use severity
- Homeless situation
- Match between clients' needs and available on-site services
- Availability and match of a DAH unit

The Nurse Practitioner (currently vacant) will allow DAH to better meet the needs of clients placed in their 1500 units, all of which have a history of homelessness and the majority with mental health challenges.

### Budget and Costs per Client

Housing expenditures for fiscal year 2014-15 are projected to be $2,393,610. The projected per-client costs are detailed below.

**Exhibit 25. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Emergency Stabilization Housing (50% FSP) | 181 individuals | $393,637 | $2,175 |
| Full-Service Partnership Permanent Housing (Capital Units and Master Lease) | 91 individuals | $650,000 | $7,143 |
| ROUTZ TAY Transitional Housing (50% FSP) | 74 individuals | $1,089,465 | $14,723 |
| Housing Placement and Supportive Services (Direct Access to Housing) (20% FSP) | 500 individuals | $260,508 | $521 |

## Evaluation of Housing

MHSA and CBHS Quality Management staff are currently collaborating with Abbott Consulting to carry out an outcomes analysis for MHSA-funded housing interventions that will produce reports that address eligibility process, services and outcomes for all MHSA Housing activities described above. The compilation will be carried out in 2014-15 and shared with a variety of stakeholders in San Francisco to provide a basis for decision-making regarding future program improvements and new initiatives.

*MHSA Housing Evaluation Plan*

Consultants will work with SFDPH to prepare and implement an analysis of housing activities administered by SFDPH with MHSA funding. The report will describe a logic model to reflect San Francisco's MHSA Housing theory of change. Evaluators will consult with DPH, the funder representatives, housing developers, program service providers, and clients and their families to clarify the goals and objectives for the program, and will contact respected intermediary experts on health and housing goals and outcomes to offer a broad perspective.

Process questions will be developed based on the programs' stated principles, the funding guidelines, and a client impact process analysis. Outcome questions will study:

- Housing and homelessness outcome measures
- Health and wellness measures
- Individual factors associated with outcomes
- Placement permanency

- Program and contextual factors

Data collection will be based on detailed records on housing retention, income changes, health data, and other indicators. Evaluators also expect to conduct interviews and surveys of client participants and provider staff.

Additional information will be gathered through focus groups, interviews with treatment providers and direct program staff, and with clients and their families. Evaluators will consult with the following stakeholder groups:

- Funders
- Advisory Board
- Stabilization program staff
- FSP Staff
- Clients in stabilization program
- Clients in permanent housing
- Family members

The evaluators will create an initial report after three months. This report will focus on permanent housing placements and will preview initial findings. A final, comprehensive report will then be prepared, demonstrating the data trends, outcomes, and any program concerns. The report will include process and program recommendations and submitted to DPH staff for distribution.

## Meeting Unmet Housing Needs: Next Steps for MHSA

*Feasibility Study for Additional Housing*

The housing sites developed with MHSA funding provide homes to those who have struggled with the brutal combination of mental illness and homelessness. San Francisco recognizes that many more homes are needed and is currently looking to identify its best options for new housing opportunities for MHSA consumers. MHSA has embarked on a project to look into the feasibility of expanding various housing models to meet the needs of families and individuals served by MHSA Full Service Partnerships (FSPs). This report to DPH, when completed, will present different housing models, such as rapid rehousing with short/medium term subsidies; long term subsidized scattered site housing, and site-based permanent supportive housing like the projects already developed. The report will also consider the short and long-term costs associated with each housing model, and the development and service capacity within DPH to deliver each model. This will include costing out additional capital in comparison to scattered site leasing. SF MHSA has not ruled out an additional set-aside, but does not have any certain allocations either.

# 7. Behavioral Health Workforce Development

The Behavioral Health Workforce Development service category addresses the shortage of qualified individuals who provide services in San Francisco's public mental health system. This includes developing and maintaining a culturally competent workforce that includes individuals with client and family member experience who are capable of providing client- and family-driven services that promote wellness, recovery, and resiliency. This service category includes 1) the Mental Health Career Pathways Program, 2) Training and Technical Assistance, 3) Residency and Internship Programs, and 4) (state-funded) Financial Incentive Programs.

In 2009, MHSA received an initial $4.6 million allocation of MHSA funding to support Workforce, Development, Education and Training (WDET) activities. San Francisco has developed a strong collection of activities san programs designed to achieve WDET goals. Through CPP activities, the decision was made to sustain MHSA WDET activities, described below, with CSS funds.

## Training and Technical Assistance

MHSA funding for Training and Technical Assistance seeks to increase local capacity to 1) deliver mental health interventions that reflect MHSA vision and values, 2) develop expertise necessary to effectively plan, implement and evaluate MHSA programs, 3) teach, learn and share information, best practices and "lessons-learned" with each other, participants and stakeholders 4) develop capacity for traditional and non-traditional mental health partners, agencies or systems to participate and help lead the transformation of the mental health system through the MHSA.

### CBHS Trainings

The MHSA supports additional capacity in the CBHS Training Unit to: support and coordinate training and technical assistance efforts for CBHS clinicians, providers, consumers, and family members, and support CBO training efforts that address and adhere to the principles of MHSA. Training topics include wellness and recovery, evidenced based practices, cultural competence, intensive case management, and the integration of primary care and mental health services.

## Identifying Workforce Development Priorities: CBHS Workforce Disparities Analysis

Consulting firm Learning for Action (LFA) conducted an analysis of a sample of medical (MD/NP) and masters level clinical (MSW/MFT) providers in the San Francisco public mental health system of DPH Community Behavioral Health Services (CBHS) civil service staff and contractors. The analysis provides a description of the demographics and language capacity in this workforce, and a comparison of these characteristics with those of the MediCal-eligible population in San Francisco. The sample includes 251 civil service providers (73 medical providers and 178 clinical providers) and 281 contractor providers (51 medical providers and 230 clinical providers). **Key takeaways of the analysis include the following:**

- Male providers are significantly less likely than female providers to serve in masters level clinical positions.
- Some ethnic disparities are apparent based on type of position held by providers. This is especially true for MDs/NPs, with 52% (civil service) and 76% (contractor) positions being held by white staff. African Americans represent 5% of staff and only 3% (1 individual) of medical providers. Additionally, there are no Native American clinical or medical staff providers in either the civil service or contractor workforce samples, and only three Latino medical providers. The extremely small number of African American and Latino medical providers, and complete absence of Native American medical providers, in this workforce sample indicates both a considerable mismatch in the ethnic makeup of providers when compared to the population in need of public behavioral health care and a need for increased ethnic diversity in this job tier.
- Limited additional data on San Francisco's civil service behavioral health workforce suggest that the paraprofessional workforce is more ethnically diverse than that of masters-level providers. In particular, while African Americans are underrepresented among medical and clinical behavioral health care positions, they are more than twice as likely as white staff to be in paraprofessional civil service positions, and make up more than a third of the paraprofessional civil service workforce.
- Overall, 66% of civil service providers and 58% of contractor providers report fluency in at least one additional language other than English. Twenty-five languages—the most common of which are Spanish, Cantonese and Mandarin—are represented among the 328 providers who speak an additional language. A notable exception in the match between provider language capacity and need is in the case of Cantonese speakers, where the proportion of providers speaking Cantonese is only half that of the population in need.

While this data has been helpful in developing preliminary priorities for MHSA funded workforce development activities in FY 14-15, additional data analysis and CPP are needed to finalize a set of priorities. The CPP work in this area is ongoing and includes an effort underway to more systematically collect demographic data and linguistic capabilities of all civil services and contract staff.

## Developing Expertise in Group Treatment

As a pathway of treatment for clients presenting with complex mental health and substance abuse issues, CBHS leadership identified the need for providers to offer group treatment models of care. The result is the implementation of Seeking Safety and Illness Management and Recovery (IMR) both being evidenced based practices under SAMHSA.

*Seeking Safety*

Two years ago, the CBHS Group work Committee launched a system-wide implementation of Seeking Safety, and organized the training of a hundred clinicians from over thirty CBHS programs, who all agreed to implement Seeking Safety groups for at least a year at their agencies. This initiative was part of promoting group-work – instead of just individual counseling – as a pathway of treatment for clients presenting with common problems, one of which is Seeking Safety for trauma and substance abuse.

The newly-trained Seeking Safety counselors met quarterly during the first year in 2012 to support each other in the launching of their groups, and to problem-solve implementation barriers with CBHS central administration. Follow-up trainings and implementation manuals, along with evaluation support through Quality Management, were provided by CBHS. A survey conducted last month with Seeking Safety clinicians showed continued interest in CBHS trainings and support for Seeking Safety implementation.

*Illness Management and Recovery (IMR)*

The Illness Management and Recovery Model (IMR) is an evidence based program, developed and supported by SAMHSA. The model is comprised of a series of weekly sessions in which facilitators help people who have experienced psychiatric symptoms to develop personalized strategies for managing their mental illness and moving forward in their lives.

In 2013, San Francisco trained more than 50 providers in IMR facilitation. In 2014, CBHS adopted and renamed IMR as "Wellness Management and Recovery" (WMR) and is carrying out a pilot of WMR, in the group format, in eight behavioral health care sites. The groups at each site are expected to last between three and ten months. In the sessions, practitioners work collaboratively with participants, offering a variety of information, strategies, and skills that they can use to further their own recovery. There is a strong emphasis on helping participants set and pursue personal goals, as well as put strategies into action in their everyday lives.

## Evaluation of the Wellness Management and Recovery (WMR) Pilot

CBHS and Quality Management are working with Learning for Action (LFA) to evaluate the Wellness Management and Recovery (WMR) pilot, which was previously known as the Illness Management and Recovery (IMR) model. The evaluation will last two years and center on how WMR is being implemented and outcomes for clients, participating clinics and clinicians, and the system of care as a whole. The primary evaluation goals are to:

- Understand whether WMR is being implemented as intended, and/or how it is being adapted to best meet the needs of consumers in each group
- Identify barriers to implementing WMR to help improve future processes
- Assess early changes participating consumers experience toward recovery and wellness
- Impact of WMR on clinic capacity, access, and productivity (year two only)

Evaluation data will be collected in several ways. Clinical data will be derived from Avatar, the electronic health record system, with support from Quality Management. Weekly check-in forms will be completed by facilitators and participants as a therapeutic intervention more than an assessment tool; however, they will be reviewed to support measures such as goal setting and involvement of learning partners and/or significant others, as well as for indicators of any outcomes that surface. LFA will provide brief surveys to be completed by WMR consumers at the beginning of WMR and at the second-to-last WMR group. LFA will also conduct interviews with a sample of consumers participating in WMR to understand their experiences and gather feedback. Finally, LFA will interview WMR providers to learn more about how WMR was implemented, barriers to implementation and outcomes from facilitators' perspectives.

*Medicinal Drumming: A Culturally Affirming Group Practice*

The availability of culturally congruent services is insufficient to meet the needs of San Francisco's diverse communities. Historically, western-based therapeutic services focus on the individual, while culturally diverse communities are generally group oriented. The American Psychological Association contends that new and alternative methods are needed to address the needs of the masses. Through research and applied practice, Dr. Sal Núñez and the community- defined evidence project have demonstrated that the Medicinal Drumming praxis engages large groups of diverse populations through an interconnected journey of wellness and recovery. To promote knowledge about and expand access to Medicinal Drumming, SF MHSA launched a pilot apprenticeship program last year that recruited and trained staff from health and social service providers. Participants attended trainings, received supervision and consultation during the integration of the drumming praxis into their agency and community. As a result of this pilot, the Medicinal Drumming method has been incorporated as a wellness and recovery model at several local clinics and campuses, such as Hospitality House, Instituto Familiar De La Raza, California Institute of Integral Studies, and City College of San Francisco. While the formal evaluation report is still being developed, feedback from the trainees, as well as the over 200

drumming group participants from the partner organizations, has been very positive. As a result, we plan to support the project for an additional year.

## Adolescent/TAY Provider Capacity Building

The purpose of adolescent/TAY provider capacity building is to improve communication and coordination of health related activities and services among youth/young adult providers across service sectors – including CBOs, DPH, UCSF, SFUSD, Juvenile Justice, workforce development and housing – while also building provider capacity and support systems. The target population includes providers throughout the city with attention to those serving under-served populations and subgroups of youth and young adults such as TAY, LGBTQ, ethnic/racial minorities, and homeless youth. Many of the providers served are located in the Southeast Sector, Mission District, and Ingleside-Excelsior-Crocker Amazon.

## 12N LGBTQ Sensitivity Training for Providers (INN)

Chapter 12N of the San Francisco Administrative Code requires all City departments to provide training that will increase sensitivity and reduce stigma against lesbian, gay, bisexual, transgender youth. All staff who work with or whose work directly impacts youth are required to complete the 12N training. Agencies receiving $50,000 annually from the city must also ensure training of their staff. The 12N ordinance specifies that the following content must be included:

- Sensitivity training to LGBT youth with disabilities
- Mental health issues
- HIV
- Immigration challenges
- Diverse ethnic backgrounds
- Sexual abuse histories
- Homeless and runaway backgrounds
- Non-accepting households.

Goals of 12N Project were to develop a youth-inspired training video on LGBTQ sensitivity issues, supporting documents, a training format and conduct pre/post evaluation to bring the City into compliance with the ordinance. Members from several organizations/commissions carried out the project training implementation and evaluation:

- San Francisco Youth Commission
- San Francisco Community Programs for Youth
- San Francisco Human Rights Commission
- San Francisco Community Behavioral Health Services, including Quality Management, Cultural Competence and MHSA staff.

The collaborative effort produced a powerful, informative video that was widely viewed, generated discussion among City employees and began to affect changes in practice at some work sites that serve

youth. DPH is integrating this video into ongoing mandated trainings for staff and contractors. Many other City Departments have requested to also use the training. While INN funding was expected to be used for ongoing implementation and evaluation, other sources of funding have been identified and INN funding is no longer needed. SF MHSA is currently working to develop a learning report for this project.

## Budget and Costs per Client

Training and Technical Assistance expenditures for fiscal year 2014-15 are projected to be $386,000. The projected per-client costs are detailed below.

**Exhibit 26. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Training and Technical Assistance | 4,727 participants | $386,000 | $82 |

## Projected Outcomes

Training and Technical Assistance programs seek to achieve the following outcomes:

- Increase knowledge and skills delivering recovery oriented services
- Promotes culturally competent service delivery
- Promotes meaningful inclusion of clients/family members
- Promotes an integrated service experience for clients and their family members
- Promotes community collaboration

## Expanding Training and Technical Assistance

*Mental Health Outreach Workers (MHOW) Training Program (INN – proposed)*

This plan includes a proposal for a new INN project (see Appendix C). The Mental Health Outreach Workers (MHOW) Training program aims to train San Francisco street outreach workers, exposed to constant community trauma, on how to best meet the mental health needs of the clients that they encounter in the field, and also how to best deal with one's own experience with trauma. Three sub-communities of outreach workers have been identified by local CPP as frontline programs coming in contact with high rates of trauma. These are: Homeless Youth Outreach Workers Programs and Street Violence Outreach workers, and Asian Community Outreach workers. In total, a cohort of 60 outreach workers will be trained (20 per sub-community).

*Trauma Informed Systems Initiative*

The Trauma Informed Systems Initiative focuses on the system-wide training of a workforce that will develop a foundational understanding and shared language, and that can begin to transform the system from one that asks "What is wrong with you?" to one that asks "What happened to you?". The initiative strives to develop a new lens with which to see interactions that reflect an understanding of how trauma is experienced in both shared and unique ways.

To date, the vetting process for the Trauma Informed Systems Initiative has included over 400 people within the DPH system including providers, non-providers, primary care and various peer and advocacy groups. Feedback, suggestions and observations from these meetings have guided the development process from the beginning. Developed materials include a full, interactive curriculum designed to support our workforce in understanding essential aspects of trauma and to create shared language with which to begin responding in a trauma informed way in their work environments. Live trainings will be offered on a rolling basis, system-wide for open, online registration through the training department. Trainings will begin in March 2014 and continue twice monthly until June 2014 when trainings will become weekly. Outcomes for the initiative include the following:

- Practitioners receive coordinated training and coaching in order to disseminate change
- Regular process and outcome evaluations associating the training initiative with concrete changes in service delivery, service excellence and staff satisfaction.
- Focus on equity and disparity includes fully involving communities, families, youth and consumers in the development and evaluation of the initiative
- Evident leadership support to provide the infrastructure necessary for sustainability including policy development, timely training, skillful supervision and coaching

The Trauma-Informed System of Care (TIS) project evaluation design will include key components of a comprehensive quality improvement performance management system that will capture relevant process and outcome data. This will include the following:

- Development of a well-articulated theory of change
- Development and implementation of a Provider Survey and interviews with partners and providers to assess systems change outcomes
- Development of a systems change tracking tool that will capture measures such as staff days on the job (reduced absenteeism), increased client engagement (reduced no-shows/dropouts), reduced personnel actions, and client satisfaction
- Assessment of youth outcomes through the administration of the CMHS Child Outcome Measures for Discretionary Programs, which collects performance measure data in areas such as mental illness symptomatology, employment/education, stability in housing, etc.

## Mental Health Career Pathways Program

The Mental Health Career Pathways Program focuses on developing a workforce pipeline that will usher in the next generation of mental health and behavioral health practitioners and include members of

underserved and underrepresented communities. The agencies and programs involved in this program are described below.

## Community Mental Health Worker Certificate (CMHC)

The Community Mental Health Worker Certificate (CMHC) program at City College of San Francisco (CCSF) is a 16-unit program based on the mental health wellness and recovery model, which focuses on the process of recovery through consumer-directed goal setting and collaboration between mental health service consumers and mental health providers. The program trains a diverse group of front-line health workers to provide culturally responsive mental health and recovery services to the client population in San Francisco. The program focuses on engaging people with lived experience with mental health services and their family members as mental health care workers. The curriculum promotes the workforce skills needed to be gainfully employed as a mental health worker, and to enhance the knowledge base of existing mental health employees. In addition, students have access to critical supports designed to facilitate student retention and success in the program, including the following:

- Peer Care Manager who helps students navigate the college system, make linkages with other services, develop a personalized and comprehensive wellness and recovery action plans to support their academic participation and success
- Behavioral Health Specialist Intern who helps manage any mental health related needs
- Financial Aid Counselor who is available to students at the beginning and end of each semester to streamline processing of CMHC students' financial aid needs
- CCSF's Disabled Students Programs and Services (DSPS), which dedicates one DSPS counselor to CMHC so that students have expedited access to appointments
- A Career Development and Placement Center counselor, who helps students develop their resume, interview skills, and a professional portfolio, as well as provides assistance with internship placement

## Summer Bridge

Summer Bridge is an eight-week summer mentoring program for current and recently graduated San Francisco public high school students age 16-20 who are interested in psychology and want to explore career opportunities in the field. The Summer Bridge Program goals and outcomes are to: 1) promote awareness of psychological well-being and 2) foster interest in health and human services as career options. The program participants meet 12 hours a week at our partner location, Horizons Unlimited in the Mission. Attendees hear presentations by guest speakers on topics ranging from identity, self-expression, mental health and stigma, LGBTQQ issues among adolescents and their families, body image and self-esteem, and personal stories from professionals in the field of mental health. The participants have also gone on various field trips: a RAMS staff training on racism and mental health, a visit to SFDPH/CBHS, a tour of San Francisco State University and meetings with undergraduate and graduate faculty members, and an introduction to the RAMS Child, Youth and Families Outpatient Clinic to learn about psychotherapy and the youth-oriented services provided by the agency.

## Budget and Costs per Client

Career Pathways expenditures for fiscal year 2014-15 are projected to be $269,365. The projected per-client costs are detailed below.

**Exhibit 27. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Career Pathways | 98 individuals | $269,365 | $2,749 |

## Projected Outcomes

Mental Health Career Pathways programs developed outcome objectives that address the following MHSA goals specifically related to creating a workforce pipeline for mental health and behavioral health practitioners. These programs aim to increase:

- Interest in behavioral health careers for targeted populations
- Enrollment in post-secondary behavioral health training programs for targeted populations
- Building of a diverse workforce that reflects communities' ethnic, cultural, linguistic, sexual orientation, and religious/spiritual backgrounds
- Optimization of expertise that mental health consumers and their families bring to the public mental health labor market
- Imbue current public mental health workforce with relevant knowledge of cultural congruency and community defined practices, research and evaluation

## Expanding (High School) Career Pathways

Given the need to recruit a more diverse behavioral health workforce – especially individuals from African American and Latino communities, San Francisco is exploring a strategy to begin this work in the high schools. Faces for the Future program (FACES) is nationally recognized for work in healthcare career preparation work with high school students. San Francisco Unified School District's (SFUSD) John O'Connell High School has begun planning to implement programming focused on behavioral health professions.

O'Connell High School's FACES's signature work based model will be coupled with psychosocial components imbued throughout the program. The four cornerstones of the school's lab design will be 1) career exposure, 2) academic support, 3) wellness and 4) youth leadership development. In addition, FACES will provide wrap around services to its students, addressing basic needs of food, health, safe transportation and mental/emotional support. For their internships, O'Connell High School students will be placed with community partners, where they will learn about public health practice, how mental health and behavioral health is interwoven into that practice and how to deliver culturally responsive

care. Although the details of this partnership are still being finalized, the FY 14-15 MHSA budget includes an allocation of $100,000 for this project.

# Residency and Internship Programs

The goal of the Fellowship Program for Public Psychiatry in the Adult System of Care is to further develop fellows' knowledge and skills in behavioral health research (e.g., smoking cessation for Asian Pacific Islanders, health care utilization by LGBTQ individuals) and services for adults diagnosed with severe mental illness. In order to address San Francisco's behavioral health workforce shortages and supplement its existing workforce, the MHSA funds psychiatric residency and internship programs leading to licensure (see Exhibit 28 below).

**Exhibit 28. Summary of Residency and Internship Programs**

| Lead Agency | Program | Focus |
|---|---|---|
| San Francisco Department of Public Health | Fellowship Program for Public Psychiatry in the Adult System of Care | To further develop fellows' knowledge and skills in behavioral health research (e.g., smoking cessation for Asians, health care utilization by LGBTQ individuals) and services for adults diagnosed with severe mental illness |
| UCSF Langley Porter Psychiatric Institute | Child & Adolescent Psychiatry Fellowship Program | To further develop fellows' knowledge and skills in psychiatric evaluations and services for children ages 4 to 18, the Community Behavioral Health system, and working with diverse populations |

## Budget and Costs per Client

Residency and internship expenditures for fiscal year 2014-15 are projected to be $364,000. The projected per-client costs are detailed below.

**Exhibit 29. Cost per Client**

| Program | Annual Goal | Annual Cost | Cost per Client |
|---|---|---|---|
| Residency and Internships | 804 individuals | $364,000 | $453 |

## Projected Outcomes

The Fellowship program seeks to achieve the following outcomes:

- Promote psychiatrists' continued work in the public mental health system.
- Expand the availability of psychiatric services using the fellows.

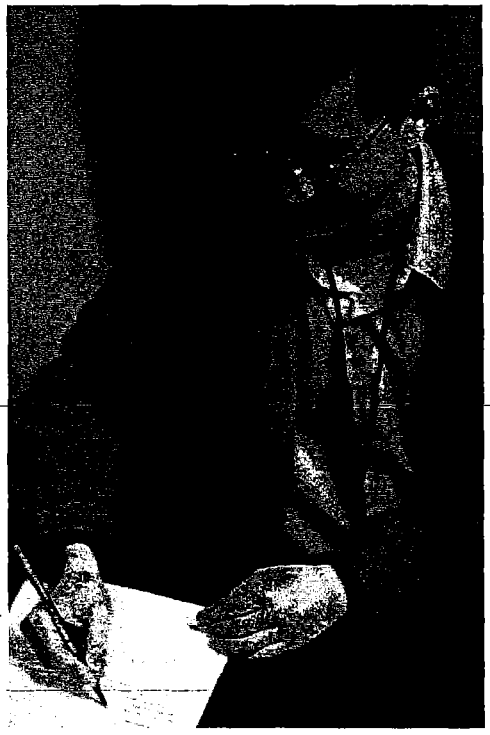
## Expanding Internship Opportunities

The FY 13-14 MHSA budget includes a new CBHS Internship Coordinator position, which is yet to be hired. As highlighted in the FY 13-14 Update, the new Coordinator will work with CBHS staff, university and college graduate level (Master's level and PhD level) programs and graduate student interns to develop, implement and evaluate a centralized and coordinated public mental health internship/practicum program with the City & County of San Francisco's Department of Public Health [DPH] – Community Behavioral Health Services [CBHS] clinics and its program sites. Duties for the position include the following:

- Plan a program design that will coordinate DPH-CBHS internship opportunities and placements,
- Outreach to potential clinical supervisors throughout CBHS
- Work with university/college graduate programs to develop and execute standardized-contracts between DPH-CBHS clinics and program sites & the respective universities/colleges
- Work with DPH-CBHS clinics and program sites to ensure that in-service/in-house trainings are scheduled and carried out in compliance with the respective graduate level programs
- Work with DPH-CBHS clinics and program sites to develop standardized forms, policies and procedures to document graduate students' internship/practicum

## State-funded Financial Incentive Programs

MHSA funding from the State, administered by OSHPD, supports stipends, scholarships, and loan forgiveness programs that serve as financial incentives to recruit and retain both prospective and current mental health employees. While we do not administer these funds locally, MHSA staff does help with outreach for the program described below.



The **Mental Health Loan Assumption Program (MHLAP)** is one resource that encourages mental health providers to practice in underserved locations in California by authorizing a plan for repayment of some or all of their educational loans in exchange for their service in a designated hard-to-fill/retain position in the public mental health system. The Mental Health Loan Assumption Program (MHLAP) awards recipients up to $10,000 with a required 12-month service obligation.

**The Licensed Mental Health Service Provider Education Program** (LMHSPEP) -- for Department of Public Health (DPH) civil service and DPH-contractor employees who are working in mental health service settings. The Licensed Mental Health Service Provider Education Program (LMHSPEP) awards recipients up to $15,000 with a required 24-month service obligation.

This year all applications were done online at

www.calreach.oshpd.ca.gov. If an individual qualifies, he or she can apply for both programs – but can only accept one award. For full details, visit www.healthprofessions.ca.gov

# 8. Capital Facilities/Information Technology

MHSA funding for Capital Facilities allows counties to acquire, develop, or renovate buildings to support the delivery of MHSA programs. Funds may also be used to develop community-based, less restrictive settings that will reduce the need for institutionalization or incarceration. MHSA funding for Information Technology (IT) supports upgrades to clinical and administrative information systems as well as improvements to consumers' and family members' access to personal health information within various public and private settings.

## Capital Facilities

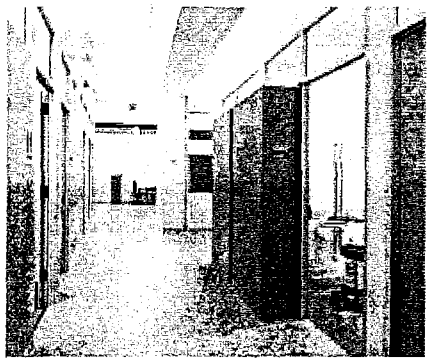
The original MHSA Capital Facility Program and Expenditure Plan included projects to renovate three buildings – Silver Avenue Health Center, Redwood Center and Sunset Mental Health. Subsequent proposals were approved to support renovation projects at Southeast Health Center and a new integrated clinic at 220 Golden Gate. This plan also calls for an annual investment of $500,000 in capital improvements, beginning in FY 14-15 with the South of Market Mental Health Center.

**Silver Avenue Family Health Center (SAFHC)** was the first capital project to be completed, facilitating the co-location of mental health professionals in primary healthcare settings by adding six new private counseling rooms, a large group room, waiting and reception area, and administrative space.

**The Redwood Center** was identified in the original MHSA plan for capital projects as a potentially appropriate site as a dual diagnosis-ready residential treatment facility. The Redwood Center is located on property owned by the Public Utilities Commission (PUC) in San Mateo County. SFDPH was forced to terminate the renovation process in early fiscal year 2012-13 because of financial and operational challenges and limitations posed by the site's designation as "historical." In fiscal year 2014-15, we will reassign an estimated $1.4 million that was originally slated for the Redwood Center. These unspent capital dollars will be used to augment renovations of the Southeast Health Center.

**The Sunset Mental Health Services** included an expansion of office space (e.g. new kitchen, meeting room) to accommodate growth in staff size. In addition, there were updates to the waiting room, such as an addition of digital media broadcasting mental health message and improvements to the interior design. The site also underwent increases in security to protect clients and staff, as well as in accessibility (e.g. meet current guidelines for the American with Disabilities Act). A new ventilation and heating system was installed.

**Tom Waddell Urban Health Clinic** In addition to MHSA-funded housing units, Kelly Cullen Community included a new 12,000-square-foot Integrated Housing and Urban Health Clinic (IHHC). Two federally qualified health centers, the Housing and Urban Health Clinic and Tom Waddell Clinic, were relocating to this site which will serve 25,000 people annually. The new IHHC includes offices for IHHC staff, 17 exam rooms, one group behaviorist office, two nursing/vitals offices, seven counseling spaces, three intake/benefits stations, a pharmacy, a phlebotomy lab, a large group meeting room and a waiting area with reception desk that can accommodate approximately 30 patients. The new clinic provides integrated physical, mental, and substance abuse services onsite with an emphasis on holistic services, wellness, and permanence.



## Southeast Health Center Expansion/Integration Project

The enhancement of the Southeast Health Center (SEHC), which is partially funded by MHSA, will allow for the integration of behavioral health services, substance abuse services, crisis intervention and specialty services, and citywide behavioral health services. This **Southeast Health Campus** will bring together the expertise of existing children's behavioral health services and primary care. This growth is expected to increase SEHC's capacity to serve an estimated 1,250 additional children and families. SEHC will also be able to operate on evenings and weekends and better meet the schedules of working parents.

The project focuses on the renovation and expansion of an existing one-story 18,000 square feet primary care neighborhood health clinic in the Bayview Hunters Point neighborhood of San Francisco, located at 2401 Keith Street. It will be implemented in two distinct phases: 1) renovation of the existing 18,000 sq. ft. facility by 2016 and 2) construction of a two-story, approximately 23,000 square feet

addition by 2019. The intent of both the renovation and expansion is to facilitate the delivery of a more integrated and efficient neighborhood based health care system. Specific project goals include:

- Redesigning for enhanced patient/work flow
- Redesigning to facilitate patient-centered team-based care
- Integrating behavioral health into Primary Care teams
- Creating an inviting and family friendly environment for patients
- Co-locating new clinical and ancillary specialty services, including behavioral health, urgent care, radiology, and laboratory
- Providing space for community-oriented health and wellness programs and services.

### Expanding Capital Improvements to Mental Health Clinics

Most mental health clinics in San Francisco have serious need for capital improvements. This plan calls for an annual investment of $500,000 in capital improvements, beginning in FY 14-15 with an allocation of $300,000 for capital improvements at the South of Market Mental Health Center. The balance of the annual capital investment will be made available pending additional CPP activities.

The enhancement of the South of Market Mental Health (SOMMH) clinic will support the creation of a Wellness Center and a more welcoming environment for MHSA consumers in the underserved South of Market area of San Francisco. SOMMH currently serves over 1300 consumers.

The South of Market Mental Health clinic was identified as a project site because of the need to upgrade this outpatient mental health clinic facility to provide a more accessible, welcoming and clinically effective facility for clients with serious mental illness. Renovations will upgrade the facility to promote maximum consumer empowerment and engagement within a wellness center environment. Renovation will result in an expansion of the capacity and access to existing services as well as the provision of new wellness services. The renovations will coincide with a change in the service delivery modality from a traditional medical model to a low-threshold environment providing multiple avenues for consumers to engage in services at their own pace.

A planning committee has been formed and includes local stakeholders such as adults and seniors with severe mental illness, families of consumers, providers, law enforcement, education, social service providers and providers of alcohol and substance abuse treatment. Future meetings will focus on gathering feedback and input on the decision-making in areas of planning and implementation, monitoring, quality improvement, evaluation and budget allocation.

## Information Technology

The initial SF MHSA Information Technology (IT) Plan, approved in 2010, was developed through an extensive community planning process led by an MHSA-IT Planning Committee. The plan included three program areas: 1) Consumer Portal, 2) Consumer Employment and 3) System Enhancements. CBHS has accomplished much of what was outlined in the initial plan. However, the CBHS IT landscape has

changed considerably the last four years since the planning process, thus resulting in the need to adapt the plan. Additional expenditures in the System Enhancements program area have been and will be needed to make basic IT infrastructure improvements required to respond to the changing landscape. In addition, as Avatar has been implemented and input has been collected from staff and consumers about IT infrastructure, a need has emerged for more basic improvements than originally planned.

## Changing Landscape

In response to the changes in the health care arena, the CBHS IT department has been integrated with the overall Department of Public Heath (DPH) wide IT department. The consolidation of the two departments will assist with the coordination of projects and resources that will lead to better coordination in the delivery of services to clients. Clients will see the benefits through the implementation of enterprise wide solutions that will facilitate their ability to coordinate their care between behavioral health and primary care clinics.

- **Implementation of Avatar:** In 2008, Netsmart of New York was funded to acquire and implement the Avatar suite of products (a.k.a. the "SF Avatar" project). SF Avatar is designed to drive the Behavioral Health Information System (BHIS) from point of entry through registration, eligibility determination, clinical record keeping, billing, revenue collection, accounting, reporting, administrative and clinical decision support, quality management, and research and outcomes reporting.
- **Affordable Care Act:** CBHS actively pursued enrollment of Eligible Providers (EPs) in the Federal and California State Meaningful Use (MU) program since the end of 2012. In the first quarter of 2013, 47 EPs from the civil services programs have signed the Incentive Assignment Form and 40 EPs have further been registered with CMS. CBHS postponed attesting for MU in response to the larger IT re-organization as enterprise solutions were being explored. In the meantime, the System of Care has developed Team-Based Care model, emphasized role-definition of each profession, and strengthened Care Coordination centered on a particular client, all of which will facilitate implementation of MU-required practices. CBHS is currently actively evaluating the timing for MU attestation with California State.

## Implementation Update

The following provides highlights of the original IT Plan's three program areas: 1) Consumer Portal, 2) Consumer Employment and 3) System Enhancements with updates on implementation and how elements of the project have been adapted in response to the changing environment.

*Consumer Portal*

- ✓ The original IT Plan proposed **purchasing *Consumer Connect* by NetSmart**, assistive language technology and voice recognition software.

**Update:** The Consumer Portal solution provided by NetSmart through the Avatar application will not be used. San Francisco Department of Public Health (DPH) decided in 2013 to pursue an Enterprise Client

Portal solution, enabling consumers to view their health records and communicate with providers via a web-based system that is accessible to them at anytime, from any computer. Funding for the enterprise portal has been allocated within the larger DPH IT Department. As such, the funds that were provided by MHSA for the NetSmart Consumer Portal have been re-allocated to fund professional services related to System Enhancements. This includes efforts dedicated to the on-going improvement and support of the Avatar application (Electronic Health Record used by mental health).

✓ The original IT Plan proposed **making computing resources and internet access available to consumers** at forty provider sites.

**Update:** Given the status of the enterprise Consumer Portal implementation, this project is on hold at this time. The DPH Client Portal Project has designated a Client Engagement Workgroup to develop work plans, identify personnel and material resources, and recruit and educate clients for the use of Portal. One of the important functions of this Workgroup is to ensure that suggestions from clients and client advocacy groups are integrated in the planning and implementation of the Client Portal and its enrollment process.

The Consumer Portal project outcomes remain the same:

- Increase consumer participation in care
- Improve communication between consumers and/or family members and their care team
- Reduce medication errors
- Improve appointment attendance
- Help keep consumer information up-to-date
- Promote continuity of care with other providers

*Consumer Employment*

✓ The original IT Plan proposed a **Document Imaging project** to hire consumers to convert paper health records in batch format as well as on-going service document scanning into the electronic health record.

**Update:** The department decided to postpone implementation of document imaging that would have scanned all existing client paper charts into Avatar. The funds that were slated for this project are currently being used to provide additional structure, specificity and support to the Help Desk Vocational Training Program. Initially, Avatar Help Desk and Desktop programs were combined. The funds were used to separate these programs into two distinct tracks; one more focused on desktop support and the other more dedicated to application support. The department plans to implement the document imaging of some documents, such as those that may be presented by clients (social security card, identification cards, etc.). The utility and scope of this project are still under review.

✓ The original IT Plan proposed a **Consumer IT Support: Desktop and Help Desk** to provide a single point of contact for consumer and family member end users to receive IT support accessing the consumer portal, including answering, triaging and responding to calls from

consumers/family members. Desktop Support services include installing, diagnosing, repairing, maintaining, and upgrading PC hardware and equipment to ensure optimal performance.

**Update:** This project was modified to focus on desktop support in order to provide participants with a more specialized and targeted vocational experience. Participants learned skills related to the steps required to deploy new workstations, including imaging, logistics of deployment, removal of old hardware, break-fix and equipment tracking. Participants also worked on special projects such as the implementation of new desktop rooms. They also assisted in supporting the desktop needs for the department's Project Homeless Connect, in which workstations are stood up in an offsite location for the purposes of providing on-site registration into mental health and substance use disorder services. A new desktop support workshop was recently built out on the main floor of the CBHS Administration Building. Accomplishments for this successful program include the following:

- Consumer employment programs have been a huge success for CBHS. Participants have successfully graduated from the program with only one out of approximately 40 participants choosing to drop out for personal reasons. The growth, leadership and initiative of the participants are apparent in a number of projects where the participants have identified a need and taken initiative to complete a task, such as documenting a particular procedure or creating an Access database for tracking tickets.
- Reviewers from a site visit by the California External Quality Review Organization (EQRO) were impressed by the IT vocational programs and asked to utilize these programs as a model for other counties throughout the state.
- Two graduates of the vocational programs were hired on as full-time employees in IT. They work side-by-side with other IT staff and have been a valuable addition to our team.
- The program is in the process of hiring four part-time staff to assist in the deployment of desktops.
- Many of the graduates have gone to obtain employment outside of CBHS in the competitive job market.

### Expanding Consumer Employment

SF MHSA will focus on further efforts to enhance basic IT infrastructure by hiring five graduates of CBHS vocational programs to assist in the deployment of desktops to behavioral health programs. Graduates hired will receive on the job training which will help expand their knowledge base and make them more competitive in the job market.

*System Enhancements*

- ✓ The original IT Plan proposed hiring staff to **implement the plan, specifically an MHSA Consumer Advocate** to facilitate consumer involvement and participation in planning and implementation and an **IT Engineer** to support the infrastructure of increased broadband, extranet servers and a large number of consumer users to the system.

**Update:** The Consumer Advocate was hired in 2013 within the IT applications department. Some of the activities that individuals are involved include the following: attending the Client Council to keep them informed about developments (especially around a consumer portal), developing video training

materials for users of the Avatar application as well as for the trainees in the Avatar Help Desk, participating in planning meetings regarding consumer engagement in the department wide consumer portal, participating in the Clinical Leadership Workgroup and working with Avatar Help Desk trainers to continue to develop the program.
The IT Engineer was hired in 2013. Some of the activities that individual is involved include the following: improving the connectivity at behavioral health sites and supporting servers that host the Avatar application and other applications that support the activities of CBHS.

✓ The original IT Plan proposed **ePrescribing access** to additional licenses to ensure that all CBHS prescribers use a single mode of prescription maintenance.

**Update:** The department purchased the following licenses: There are currently one hundred prescribers and 202 non-prescribers.

✓ The original IT Plan proposed **Point of Service (POS) document imaging** to provide for printing and scanning back into the Avatar client record the forms and treatment plans necessary to complete the electronic record for each client.

**Update:** This project is on hold at this time. The project has been modified from the original proposal. Initially the intention was to scan all paper charts into Avatar. This part of the project has been postponed.

✓ The original IT Plan proposed **eSignature,** specifically electronic signature capabilities to provide ready access to signed notices, consents and treatment plans for consumers and care providers.

**Update:** Signature pads were purchased, and SF MHSA is planning a later deployment than had initially been anticipated.

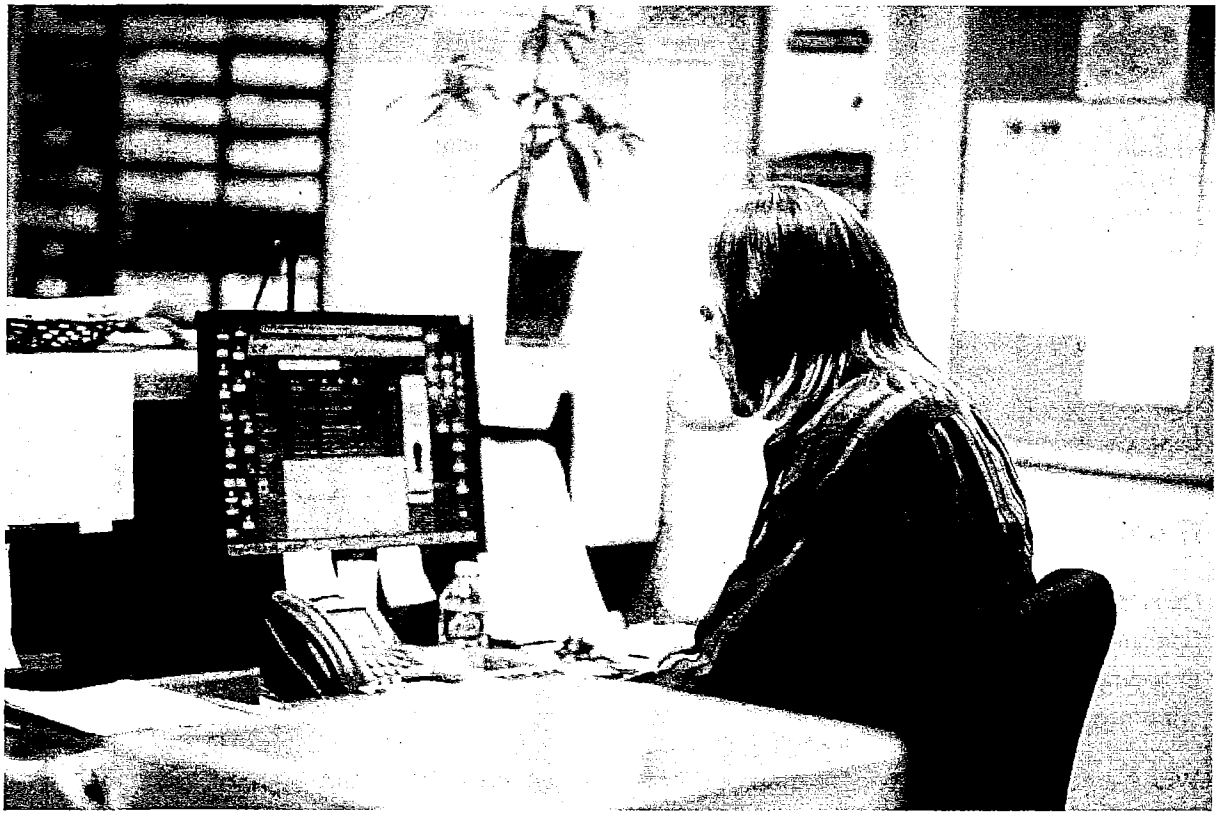
## IT Community Program Planning (CPP) Activities

CBHS is committed to providing regular updates to the Client Council. During initial planning for the Consumer Portal, a survey was developed with Client Council input to find out consumers' level and use of technology, interest in using technology and to gather which features would be most important to consumers.

With the decision to implement an enterprise consumer portal, the DPH Client Portal Steering Committee appointed a Patient Engagement Workgroup to focus on engaging and provisioning clients into the portal as well as the HIE. This workgroup is comprised of members who have extensive experience in working with client advocacy, vocational training, and peer support groups. One of the accomplishments of this workgroup was to engage clients to participate in the DPH Client Portal Naming Contest in January 2014. Clients submitted their recommendations for naming the Portal. After several rounds of voting, "my SFHealth" was chosen to be the DPH Portal Name. Future client involvement will

include designing the Portal Access Webpage and planning and facilitating peer groups to register and access the Client Portal.

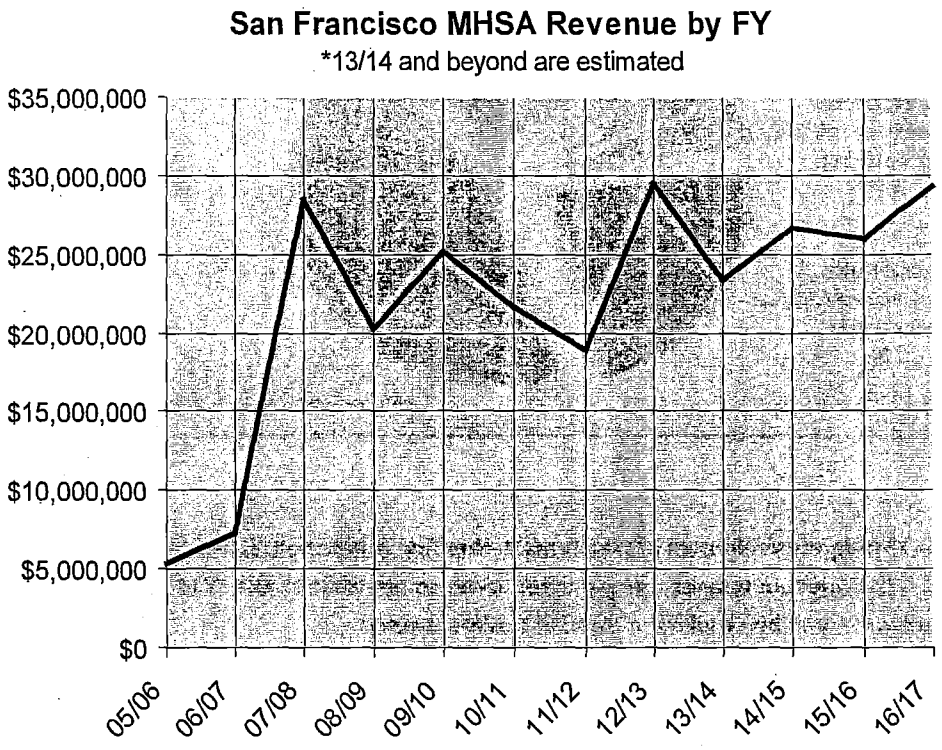
Finally, the CBHS IT Department actively seeks consumer input to continue to make improvements to the Vocational Program. The CBHS IT Department conducts group exit interviews of graduates from the vocational program. These interviews provide an unbiased means of sharing thoughts and feelings about the program because they are conducted without the RAMS Trainers /Supervisors. Some of the changes and improvements that have been a direct result of feedback from these exit interviews include: 1) changing the program from six months to 12 months, 2) creating an Advanced Help Desk track that offers leadership opportunities for graduates as well as chances to learn more skills, and 3) some specific curriculum changes.



# 9. MHSA Budget

Declines in San Francisco's MHSA revenue occurred in fiscal years 2010-11 and 2011-12 due to the budget downturn that affected California. Revenues for FY 12-13 showed growth. Projections through FY 2016-17 suggest that MHSA revenue will level off (see Exhibit 30 below).

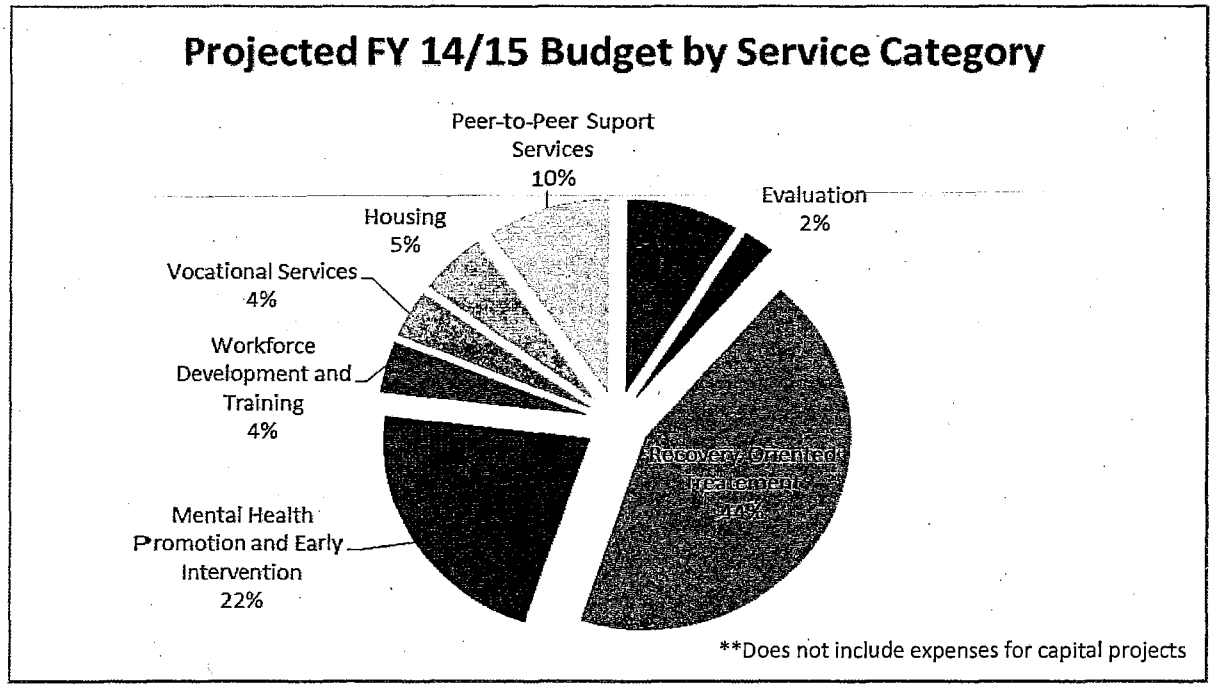
**Exhibit 30. San Francisco MHSA Revenue by Fiscal Year**




MHSA expenditures for FY 14-15 are estimated to be $30,973,615. Expenditures included one hundred FTE personnel (civil service) and 70 contracted programs with 46 organizations.

As shown in Exhibit 31, the majority of MHSA funds (44%) supported Recovery-Oriented Treatment Services followed by Mental Health Promotion and Early Intervention services (22%). MHSA funding was distributed to other service categories including Housing (5%), Peer-to-Peer Support services (10%), Behavioral Health Workforce Development and Training (4%), and Vocational Services (4%). All service categories included funding for INN-related projects.

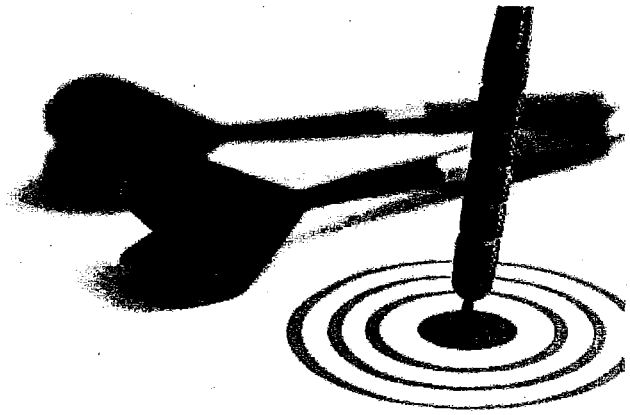
**Exhibit 31. Projected FY 14-15 Budget by Service Category**




**The MHSA FY-14-15 budget breakdown of programs by funding component is located in Appendix D. FY15-16 and FY17-18 projected budgets are expected to be comparable to the FY14-15 budget. Final budgets for future years will be provided in Annual Update reports.**

# 10. Moving Forward

## The Future of the MHSA in San Francisco



In the years ahead, we will continue to transform San Francisco's public mental health system. Within the constraints of the resources available, the MHSA will play an important role in strengthening and expanding the transformation of public mental health services locally and throughout California. Our future efforts will include the dissemination of our 2014-17 Integrated Plan that brings together all of the MHSA components. We will also continue to improve our monitoring and evaluation activities in order to effectively meet the outcome and performance objectives of our MSHA-funded programs.

# 11. Appendix A: Transgender INN Proposal

**Date:** 4/9/14

**County:** San Francisco County

**Work Plan #:** 16

**Work Plan Name:** Transgender Pilot Program (TPP)

**Purpose of Proposed Innovation Project (check all that apply):**

☒ **Increase access to underserved groups**

☐ Increase the quality of services, including better outcomes

☐ **Promote interagency collaboration**

☐ Increase access to services

***ADAPTED* INN Program – REVISED submission as this project was approved through our local process****

*Briefly explain the reason for selecting the above purpose*

Years of budget cuts to HIV prevention programs have significantly reduced services to the transgender community. Multiple programs closed in a three year period including Tenderloin Health, Ark House, Restoration House, Transcending, and T-lish. At the MHSA community advisory meetings and recent peer events, individuals spoke to the need of the creation of a program that would help address the Wellness and Recovery of the transgender community.

According to a 2011 study published the National Center for Trans Equality, here is the outlook for transgendered people:

- 41% have attempted suicide
- 50% of the respondents reported having to educate their provider on trans care
- 26% reported worsened health conditions because they postponed care
- Trans clients experience high of violence and harassment leading to PTSD and other mental health conditions

These statistics are even higher when translated into issues faces by Trans women of color. In San Francisco, we come in contact with large sections of the consumer populations that are not linked into any services. The consumers identify stigma, discrimination, and lack of cultural relevant outreach as reasons why they do not access the mental health system.

The Transgender Pilot Program (TPP) hopes to increase linkages to services and improve client engagement in services. The focus will be on Trans Women of color, a group identified as the hardest to engage.

Specifically, the new program will learn how to do the following:

- Produce programming – including a culturally-informed training curriculum, supervision/support plan, and engagement strategies and tools that will improve the system of support for Trans Women of color.
- Build effective partnerships between individuals and organizations who provide peer support services and programs for Trans Women of color
- Discover engagement strategies for Trans Women of Color considering Gender Reassignment Surgery
- Engage clients into services and re-engage those that have fallen out over time.

There simply is no existing practice that has been studied that shows the best way to engage this population, despite the risk factors and high rates of untreated mental health issues.

**Project Description**

The Program will employ three strategies and evaluate each one. One involves support groups. The second is outreach. The third is an annual Transgender Health Fair as a one stop shop for linkages to services. The ways will be tested so we can learn the positives and drawbacks of each form of access. These methods will be compared individually and against each other.

The Transgender Pilot Program will consist of four weekly peer-led support groups and community outreach activities. Each of the four support groups will have a different focus. They will all be strength-based and resiliency-focused with the overarching goal of supporting consumers to engage in services. 1) The first group will be focused on pre-treatment/pre-placement services. The group will provide linkages to services in the community as well as resource development. 2) The second group will be a Wellness and Recovery Focused group that targets clients that are more engaged in the community, yet require support. 3) The third group will be in cooperation with Tom Waddell Health Center. They have identified a need for a group focused on building resilience and wellness for their HIV positive clients enrolled in services. TPP will not be providing these direct services, however, TPP will host the site with the goal of creating a collaborative process in which to learn from one another and also to increase engagement in care sites outside of the group. 4) The final group will be one that covers issues related to transgender health. The group will also sponsor a monthly testing site for HIV, STIs, and Hepatitis C.

In regards to outreach, the peer counselors will perform three types of activities. 1) The first will be street outreach. The peer counselors will hand out flyers for groups, invite clients to participate, and provide information about available services relevant for the transgender community. 2) The second type of outreach will be patient education. The peer counselors will be providing patient education for clients who are contemplating Gender Reassignment Surgery through the program provided by the San

Francisco Department of Health. 3) The final type of outreach will be the peer-organized, peer-led Transgender Health Fair. The Health Fair will be an opportunity to directly link clients into county services. The event will involve tabling by service providers, health screeners, peer counselors and will have presentations that impact Health and Wellness.

**Target Population**

The target populations will include socially isolated Trans women of Color individuals living in San Francisco who are living with mental illness or are at risk for developing such issues, with particular emphasis on those who are low-income. We want to learn to improve access to our county system to know how to prioritize resources.

**Expected Outcomes/Positive Change:** If this project is successful, the primary outcomes would be:

- An increase in consumer engagement in clinic and clinical services
- An increase in client satisfaction with level of connection and engagement
- A decrease in social isolation
- An increase in consumers who have engaged in health and wellness programs provided by the community

**Program Goals Include:**

The peer counselors will help build trusting relationships with transgender individuals, advocate for and model recovery and wellness, and create linkages to community resources, treatment services, and social activities. The County will get a jump start on how to allocate resources as more and more Trans Women are seeking services.

The groups will be launching points for education and engagement in community services. The consumers will be provided the opportunity for service providers to directly come to them, in order to increase access to services. In addition, consumers will be given a forum to share ideas regarding services that are available in the broader community at large. This project will then evaluate utilization of those linkages.

In the education and preparation course for gender reassignment surgery, the small peer counseling groups will allow the consumers to obtain detailed, first hand information about the potential benefits and risks involved. The peer counselors will conduct panel presentations for potential clients and the community at large. The goal will be to have a pool of potential clients matched to peer counselors who can help them navigate the healthcare system while minimizing the stress involved with the process, therefore improving clinical outcomes.

Examples of community collaborations include targeting:

- Community-based organizations who serve transgender consumers
- Clinics that currently serve transgender individuals
- Community settings where transgender people socialize

- Medical providers that specialize in transgender care
- Peer counselors working in the community

**Title 9 General Standards:** *TPP will apply the following general standards.*

- **Community Collaboration:** TPP will work in partnership with mental health clinic staff, the CBHS executive and operation teams, SF mental health clinic staff, building contractors, and clients/consumers from SF mental health clinics.
- **Cultural Competence:** The hiring of Trans for TPP will have a deep involvement that reflects the clients that they serve. Trans consumer specifically report a sense of connection with a place where they see staff that "look like them". Peers will be part of the hiring process.
- **Client Driven:** TPP is an empowerment driven approach in which the clients receiving services and running activities such as the Transgender Health Fair
- **Wellness, Recovery and Resilience focus:** By empowering consumers in the program development of the services they desire, we anticipate that this process will strengthen their individual wellness and recovery and improve other areas of their life.
- **Integrated Service Experience:** TPP is a service integration model in its very nature. TPP consumers will be provided direct access by bringing the service providers to them, within an environment where they feel comfortable.
- **Family-driven:** TPP will be a client, family, and community-driven program. This program will understand and embrace the notion that families should be involved and are often an integral component of the health and wellness of consumers. TPP will have an evening group one time per month in which partners and friends can also access services along with their loved ones, the consumers.

Contracted Activities may include, but are not limited to the following:

- Identify community partner organizations
- Identify traditional and non-traditional venues where transgender individuals access services
- Develop outreach and engagement strategies to address the needs of the target population
- Create culturally specific programming for transgender clients
- Provide ongoing training and professional development support for the peer counselors

**Contribution to Learning**

Learning Question: What are effective peer support strategies and practices for Trans women of color that will improve their engagement in mental health services, encourage social inclusion, and encourage community engagement?

Specifically targeting Trans women of color from a peer wellness framework is an approach that has not yet been tried at a county level. Moreover, using the peer-to-peer support model to address the needs of this population is also a new and innovative approach. Transgender individuals are chronically under-employed due to stigma and other barriers. While peers are mobilized to provide linkages in community agencies, this program seeks to learn about direct connections into county programs.

The program would be new for this area and an adapted practice on a broader level. We hope to learn from the consumers receiving services and from the peers providing support, to further continue to develop a successful model that other counties may follow.

We predict that our overall system of care will be improved in the following ways: 1) strengthen the network of peer support services; 2) increase linkages between mental health, transgender individuals and the community; and 3) increase engagement in overall peer-based wellness and recovery services. This project will engage consumers in the process of how they want services to look. It will reduce stigma as it increases access to services. The consumers will have investment and ownership.

What we will learn is whether our three selected strategies are effective. Next, we can determine is one stands out above the others. We will have some evidence and ability to make policy recommendations based on our learnings.

**Project Measurement**

As we roll out the program, we will be continually monitoring whether or not the three types of program are creating increased access and levels of engagement.

First we will evaluate each type of program individual, measuring it's efficacy with engagement and linkage. Then, we will do comparative analysis. What are the effective elements of each program? How does the program increase linkages? What are the effective strategies to get clients to services? We also want to find a way to measure if participation was a one time event or did they actually engage in the service.

**Timeline**

**Phase I- Start Up and planning (7/2014-12/2014)**

Program staff and consumers will spend the first six months of this project selecting methods of program evaluation. We will be looking for community input as a big piece of setting up the evaluation. Staff will be hired and become trained in the importance of evaluation.

**Phase II- Implementation (1/2015-12/2015)**

In this phase of the project, the program will be fully operational identifying a transgender population who is experiencing mental illness, assessing their social and behavioral health needs, and establishing a mutually-agreed upon relationships. We will collect baseline data for program participants and track changes over time. We will measure participant satisfaction and capture linkages.

**Phase III – Reflection, evaluation, and dissemination (1/2016-6/2016)**

In this phase, the qualitative evaluation gathered in implementation will be analyzed to determine the overall affect that using a peer-to peer support model had on the engagement and overall wellbeing of

the program participants. We will also assess the success of the peer support staff, the community partnerships and the added value of their collaborations. We will get feedback on their take on the program. We will draft our recommendations for the county leadership team and the State.

Leveraging Resources

The Project anticipates $20,000 in matching funds from another SFDPH department. The funds will be added to the overall budget to increase the capacity of the Friday Night Transgender Wellness Group.

Budget

YEAR ONE BUDGET

| | County Mental Health Department | Other Governmental Agencies | Community Mental Health Contract Providers | Total |
|---|---|---|---|---|
| **A. Expenditures** | | | | |
| **1.** Personnel Expenditures | **$206,461** | | | |
| 2. Operating Expenditures | **$8,000** | | | |
| 3. Non-recurring expenditures | | | | |
| 4. Training Consultant contracts | | | | |
| 5. Work plan management | **$25,735** | | | |
| 6. Evaluation | **$8, 000** | | | |
| **7. Total proposed work plan-Year 1 expenditures** | | | | |
| | | | | |
| **B. Revenues** | | | | |
| **1. Existing revenues** | | | | |
| **2. Additional revenues**<br>a.<br>b. | | | | |

| | | | | |
|---|---|---|---|---|
| 3. Total New Revenue | | | | |
| | | | | |
| 4. Total Revenues | | | | |
| C. Total funding requirements | $248,196 | | | |

YEAR TWO BUDGET

| | County Mental Health Department | Other Governmental Agencies | Community Mental Health Contract Providers | Total |
|---|---|---|---|---|
| D. Expenditures | | | | |
| 8. Personnel Expenditures | $206,461 | | | |
| 9. Operating Expenditures | $8,000 | | | |
| 10. Non-recurring expenditures | | | | |
| 11. Training Consultant contracts | | | | |
| 12. Work plan management | $25,495 | | | |
| 13. Evaluation | $8,000 | | | |
| 14. Total proposed work plan-Year 1 expenditures | | | | |
| E. Revenues | | | | |
| 3. Existing revenues | | | | |
| 4. Additional revenues<br>a.<br>b. | | | | |
| 3. Total New Revenue | | | | |

| | | | | |
|---|---|---|---|---|
| | | | | |
| 4. Total Revenues | | | | |
| F. Total funding requirements | $248,196 | | | |

# 12. Appendix B: Older Adult INN Proposal

**Date: 06/20/14**

**County: San Francisco County**

**Work Plan #: 15**

**Work Plan Name: Addressing the Needs of Socially Isolated Older Adults**

**Purpose of Proposed Innovation Project (check all that apply)**

☐ **Increase access to underserved groups**

☐ Increase the quality of services, including better outcomes

☐ **Promote interagency collaboration**

☒ **Increase access to services**

***ADAPTED* INN Program – REVISED submission as this project was approved through our local process****

*Briefly explain the reason for selecting the above purpose*

Social isolation has been identified as one of the key concerns for older adults living in San Francisco. Older adults, particularly those who do not have many community connections are one of the most *underserved* populations in the city of San Francisco. Though City Departments and CBO contractors currently provide high quality services to San Francisco's older adults, a smaller number of older adult subpopulations, particularly those that are isolated, have not had their mental health needs fully addressed. Further complicating outreach efforts to these sub-populations is the isolation itself, making it difficult to target services given the limited availability of reliable data on this population. However, it is known that certain factors put older adults at greater risk for isolation, including, but not limited to, the following: low-income, cultural and linguistic barriers, LGBT, lack of awareness of services, lack of appreciate interventions, stigma, lack of housing options, residence in SROs, and physical and/or cognitive impairments.

According to numerous studies, one of which published by the National Institutes on Health, found there to be a potentially strong correlation between perceived isolation and mental health problems, especially depression. Loneliness is a key predictor of depression among older adults, in particular. Similarly, perceived social support is more important for mental health outcomes than indicators of social connectedness, such as received support and network size. To the extent that mental health problems put individuals at risk for physical health problems, perceived isolation may also affect physical health through its impact on mental health.

One of the key tenets by which the Mental Health Services Act is grounded is wellness and recovery. We fully expect that those living with mental illness can have full lives filled with meaningful roles and strong relationships. One of the ways in which our programs and services embody the wellness and recovery philosophy is through the use of peers in service and support delivery. Peer-to-peer support uses other people with lived experience as a mental health services consumer or family member to engage, educate, and support others in the same circumstance. Research has shown this approach to be highly effective and empowering.

Therefore, the goal of this program is to decrease social isolation among older adults living Tenderloin neighborhood in San Francisco, and increase their access to services and supports through the use of peers. The Tenderloin is a highly depressed neighborhood with high rates of drug abuse, violence and prostitution.

In looking at similar models for service delivery, we found similar programs such as PATH and Philadelphia and Senior Reach in Colorado. These programs engage members from the community to help identify those that might be needed services for mental health issues in the community. In the Case of Senior Reach, workers are sent to engage socially isolated older adults in their homes. However, none of these programs adequate address our question as to how this program design would work in an area primarily made up of Single Room Occupancy Hotel rooms as the majority of the senior housing. In our community settings, the senior residents can be geographically be twenty feet from numerous people, yet still be completely isolated. By evaluating the program in this setting, the city could then decide is a similar program would work in other densely packed areas of the city serving others with mental health challenges.

Based on the national research mentioned above, approaching this challenge through a wellness and recovery lens to target such a high-need and marginalized population has not been previously. Here in San Francisco, we want to employ this innovative approach in a way that is consistent with the recovery lens through which develop all of our interventions. Specifically, the goal is to develop effective peer support strategies and practices for low-income socially isolated older adults that will *improve their engagement* in mental health services, encourage social inclusion, and decrease stigma and discrimination. A secondary goal is to develop a training curriculum and system of support for the "peer supporters" that will be employed by the program. We want to ensure that the peers who will "on the front lines" are well equipped to address the recovery needs of their clients, as well as attend to their own self-care needs so that they may continue of their wellness journey.

**Project Description**

The purpose of the funding endeavor is learn how to engage and connect socially isolated adults with social networks and behavioral health services through the use of the peer-to-peer model. Peer support services are defined as services provided by consumers, family members, and other individuals who are on their own recovery journey and have received training in how to be helpful to others who participate in mental health services. Peer support services are customized to the needs of individuals with and at-

risk for mental illness and include opportunities to advocate for themselves, meet their goals for recovery, make connections inside and outside of the mental health system, get a job, find better housing, and learn skills to live well and have a meaningful role in the community.

Specifically, the new program will endeavor to do the following:

- To produce programming – culturally-informed training curriculum, supervision/support plan, and engagement strategies and tools – that will improve our system of support for socially isolated older adults
- To build effective partnerships between individuals and organizations that provide peer support services and programs for socially isolated older adults
- To develop a more coordinated system of care for socially isolated older adults. The funded program should promote seamless collaboration between programs that are currently serving this population.

From the client/partner perspective, we expect that the funded program(s) will increase social connectedness, strengthen support for recovery and wellness, increase access to mental health services, and increase use of mental health services and support.

MHSA also seeks to make advances to our overall system of system of care. There is an expectation that this work will strengthen the network of peer support services, increase linkages between mental health, older adult systems of care, and the community, and increase cadre of peer supporters focused on the needs of socially isolated older adults. Moreover, as previously mentioned, we will test the effectiveness of developing a network of peer supporters that are highly training and supported in their role as helpers. We want to test how that support and professional development will maintain or increase their own feelings of recovery and wellness as it pertains to their mental health.

Lastly, from the beginning, the program will institute a plan for evaluating the effectiveness of the intervention. Evaluation outcomes should include an assessment of the impact of the outreach and engagement strategies used and the effectiveness of the peer curricula and training. The results from these evaluations must be well documented and reported.

C. Target Population

Socially isolated older adults living in San Francisco who are living with mental health challenges or are at risk for developing such issues, with particular emphasis on low-income older adults living in the Tenderloin neighborhood of San Francisco, a low-income area that is prone to violence. There is a growing body of research that has found that individuals living in poverty, and particularly those exposed to violence, have significant adverse mental health outcomes such as depression and risk for suicide, post-traumatic stress disorder (PTSD), aggressive and/or violent behavior disorders. We will attempt to learn whether our peer-based approach will help to mitigate some of these effects for socially isolated older adults.

D. Program Goals Include:

As mentioned above, this program will use peer supporters as its foundation. We will look at the best approaches for how peer supporters can build trusting relationships with socially isolated older adults, advocate for and model recovery and wellness, and create linkages to community resources, treatment services, and social activities.

One of the key goals of this effort is to build and/or strengthen a network of peer support services focused on engaging social isolated older adults. Integration and partnership amongst established community organizations will be a strong tenet of the program.

Potential traditional and non-traditional community partners will include:

- Community-based organizations who serve older adults;
- Educational and cultural institutions;
- Faith-based and spiritual organizations;
- Provider and professional organizations;
- Civic organizations;
- Business; and
- Individual content experts

E. Contracted Activities may include:

Contracted activities may include, but are not limited to the following:

- Identify selection criteria for peer supporters, and the best qualities that one should embody in order to effective serve in this capacity.
- Identify traditional and non-traditional venues where socially isolated older adults may be reached.
- Develop outreach and engagement strategies to address the needs of the target population.
- Conduct behavioral health assessments of the individuals identified.
- Develop a curriculum and training plan that emphasizes a strengths-based perspective.
- Create a supervision plan for the peer supporters.
- Provide ongoing training and professional development support for the peer supporters.

**Contribution to Learning**

Learning Question #1: Whether and how using a peer-to-peer system will effectively engage, empower, and instill protective factors for adverse mental health outcomes for socially isolated older adults living in the highly depressed neighborhood of the Tenderloin in San Francisco. Moreover, using the peer-to-peer support recovery-based model to address the needs of this population is a new and innovative approach-one that has not been attempted with our population. We can anticipate that through this effort socially isolated older adults will increase social connectedness, strengthen support for recovery

and wellness, increase their access to mental health services, and increase their use of mental health services. We also predict that our overall system of care will be improved in the following ways: 1) strengthen the network of peer support services; 2) increase linkages between mental health, older adult systems of care, and the community; and 3) increase cadre of peer supporters focused on the needs of socially isolated older adults.

Learning Question #2: How best to support the peer supporters in their learning as mental health professionals, as well as in their recovery journey from mental health challenges. We will learn from the peer supporters whether the work provides protective factors for them, the frequency and type of supervision and support they need, caseload capacity, as well as what is realistic regarding scope of work expectations.

**Timeline**

**Phase I- Start Up and planning (7/2014-12/2014)**

Program staff and consumers will spend the first six months of this project selecting community partners that employ peers that can engage and serve the older adult population. The program will also fine-tune their scope of work, hire needed staff, and establish the need infrastructure to run the program. Peers will hired and engaged in the planning process.

**Phase II- Implementation (1/2015-12/2015)**

In this phase of the project, the program will be fully operational identifying socially isolated adults, assessing their social and behavioral health needs, and establishing a mutually-agreed upon relationship/plan of care.

**Phase III – Reflection, evaluation, and dissemination (1/2016-6/2016)**

In this phase, the qualitative evaluation gathered in implementation will be analyzed to determine the overall affect that using a peer-to peer support model had on the engagement and overall wellbeing of the program participants. We will also assess the success of the community partnerships and the added value of their collaborations.

**Project Measurement**

These will be developed by agency that is awarded the grant to lead this project.

**Leveraging Resources (if applicable)**

**YEAR ONE BUDGET**

| | County | Other | Community | Total |
|---|---|---|---|---|
| | | | | |

| | Mental Health Department | Governmental Agencies | Mental Health Contract Providers | |
|---|---|---|---|---|
| **G. Expenditures** | | | | |
| **15.** Personnel Expenditures | | | | |
| 16. Operating Expenditures | | | | |
| 17. Non-recurring expenditures | | | | |
| 18. Training Consultant contracts | | | | |
| 19. Work plan management | | | | |
| 20. Evaluation | | | | |
| **21. Total proposed work plan-Year 1 expenditures** | | | | |
| **H. Revenues** | | | | |
| **5. Existing revenues** | | | | |
| **6. Additional revenues**<br>a.<br>b. | | | | |
| **3. Total New Revenue** | | | | |
| | | | | |
| **4. Total Revenues** | | | | |
| **I. Total funding requirements** | | | | |

YEAR TWO BUDGET

| | County Mental Health Department | Other Governmental Agencies | Community Mental Health Contract Providers | Total |
|---|---|---|---|---|
| **A. Expenditures** | | | | |
| 1. Personnel Expenditures | | | | |
| 2. Operating Expenditures | | | | |
| 3. Non-recurring expenditures | | | | |
| 4. Training Consultant contracts | | | | |
| 5. Work plan management<br>6. Evaluation | | | | |
| **7. Total proposed work plan- Year 2 expenditures** | | | | |
| **B. Revenues** | | | | |
| **1. Existing revenues** | | | | |
| **2. Additional revenues**<br>a.<br>b. | | | | |
| **3. Total New Revenue** | | | | |
| | | | | |

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|---|---|---|---|---|
| **4. Total Revenues** | | | | |
| **C. Total funding requirements** | | | | |

# 13. Appendix C: Mental Health Outreach Worker INN Proposal

**Date:** 5/2/14

**County:** San Francisco County

**Work Plan #:** INN # 16

**Work Plan Name:** Mental Health Outreach Workers (MHOW) Training Program

**Purpose of Proposed Innovation Project (check all that apply)**

☐ Increase access to underserved groups

☒ **Increase the quality of services, including better outcomes**

☐ Promote interagency collaboration

☐ Increase access to services

MHOW will increase the quality of services, including better outcomes in two unique ways. First, by training community outreach workers in mental health trauma so they may better serve their clients, and secondly, by helping outreach workers deal and heal with their own vicarious trauma, thus allowing them to be more present and empathetic to the communities that they serve.

Although that we anticipate that MHOW will increase access to underserved groups, promote interagency collaboration, and increase access to services for mental health consumers, we will not measure them in this initial pilot innovation project.

**Project Description**

The Mental Health Outreach Workers (MHOW) Training program aims to train San Francisco street outreach workers, exposed to constant community trauma, on how to best meet the mental health needs of the clients that they encounter in the field, and also how to best deal with one's own experience with trauma.

Three sub communities of outreach workers have been identified by our local CPP as frontline programs coming in contact with high rates of trauma. These are: Homeless Youth Outreach Workers Programs and Street Violence Outreach workers, and Asian Community Outreach workers. In total, a cohort of 60 outreach workers will be trained (20 per sub community).

The MHOW curriculum has been developed according to standards articulated by the Mayor's Office Violence Prevention Services and the Department of Public Health. Additionally, it will be informed by contemporary research findings and key geographic communities throughout the city. The training will

be conducted over the course of twelve months, with three hours per week of class time (e.g. Wednesday, 11am to 2pm) and at least two hours per week of homework. This project is unique in that the curriculum has not been piloted with its targeted audience- street violence workers and additionally it will be piloted with 2 unintended target audiences: homeless youth outreach worker and outreach workers working with the Asian Pacific Islander communities.

Additionally, MHOW is unique in that that outreach workders currently only receive limited or no mental health focused training. A recent pilot to enroll a few of outreach workers our Community Mental Health Certificate Program was unsuccessful. Lastly, there is currently no training/intervention of this kind in San Francisco.

The ultimate goal of this program is to develop advanced mental health outreach workers on how to work with individuals who have experienced trauma. Additional goals include:

- Stigma and discrimination reduction- because staff will have increased knowledge and practice skills in the realm of community mental health and mental health care, their perceived stigma of mental health and mental health care will be reduced.
- Trauma recovery- staff will have an increased knowledge and practice skills surrounding trauma recovery and will be applying these new skills through their street outreach, school outreach, and general outreach within their community.

**Expected Outcomes/Positive Change:** If this project is successful, the primary outcomes would be:

- An increase in consumer engagement with outreach services
- An increase in client satisfaction with services
- An increase in outreach worker morale
- An increase in appropriate referrals to mental health/substance use/housing services.
- Increase in awareness and recovery of one's own trauma symptoms
- Improved linkages with mental health services and supports for communities with high rates of trauma
- Increased staff knowledge and skills around community mental health with a broader understanding of violence, trauma caused by violence, vicarious trauma, and trauma recovery.

**Title 9 General Standards:** MHOW will apply the following general standards.

- **Community Collaboration:** MHOW will work in collaboration with the Mayor's Office Violence Prevention Services, Department of Public Health, community-based organizations, and outreach workers in order to share information and fulfill their common vision and goal. San Francisco MHSA (SF MHSA) is working in close collaboration with the Mayor's Office of Violence Prevention, the Department of Public Health's Crisis Response Team, local community based organizations and community stakeholders in the development, testing, implementation and evaluation of this training program. SF MHSA staff will be keeping all involved parties abreast –

via phone calls, emails, face-to-face meetings and quarterly updates -- of the program's development, testing/further testing, improvement/further improvement, and evaluation phases – including findings and recommendations.

- **Cultural Competence:** The MHOW framework has cultural humility content and culturally affirming practices embedded throughout its curriculum , which will support the mental health outreach workers' professional development in providing culturally responsive care in the community (e.g. Chapter 7: Practicing Cultural Humility of the textbook "Foundations for Community Health Workers"). Additionally, sub-communities of outreach workers (such as homeless youth, etc) are the focus of this pilot to ensure successful integration into the community.

- **Client Driven:** MHOW is inherently client driven in that the services take place where the client is at physically (street-based) and also emotionally.

- **Wellness, Recovery and Resilience focus: Integrated Service Experience:** The MHOW framework and curriculum will be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers. It will promote concepts key to the recovery for mental illness and trauma, such as: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

**Contribution to Learning**

MHOW is an **ADAPTED** mental health program, specific to outreach workers with vicarious trauma. MHOW is the first academy of its kind in San Francisco. The County of Los Angeles has a similar established learning institution for its street violence intervention and prevention workers, and key concepts and curriculum themes have been considered in the development of the MHOW Training Academy. Moreover, the successful SF MHSA-funded Community Mental Health Certificate Program's curriculum serves as the MHOW's core curriculum, with additional emphases in violence, trauma caused by violence, vicarious trauma and trauma recovery.

While there are other mental health outreach worker training curricula in the field, this MHOW curricula stands apart because it is (1) solidly based upon the SF MHSA-funded Community Mental Health Certificate program curriculum delivered by City College of San Francisco; (2) this community mental health program curriculum is elevated with the additional emphases on violence, trauma due to violence, vicarious trauma and trauma recovery; and (3) this curriculum will be tested with individuals who deliver non-licensed mental health care.

MHOW's learning goals are to learn how to staff and clients are affected by providing and delivering standardized community mental health trainings for critical street violence intervention and prevention staff; and (2) How does training a workforce in community mental health with additional emphases in violence, trauma caused by violence, vicarious trauma and trauma recovery, help them in their own trauma and vicarious trauma.

Additional MHOW Learning Goals:

1. Was the curriculum appropriate and relevant to the mental health outreach workers and their work in the community?
2. Was the curriculum appropriate for this particular staff? If no, why? What part(s) were inappropriate? If yes, how was it appropriate for this particular staff?
3. What part(s) of the curriculum were efficacious? (e.g. curriculum content, curriculum delivery such as manner of instruction, physical environment/setting for learning)
4. Was the testing of this adapted curriculum successful? Of the testing process, what was learned? What resonated for the mental health outreach workers? What didn't resonate for them? What curricula components were received, understood and practiced well? What curricula components were not received, understood and practiced well?
5. Did the curriculum increase consumer engagement? Are supervisors observing changed attitudes and behaviors of the mental health outreach workers?

**Timeline**

**Phase I- Start Up and planning (6/2014-9/2014)**

The 1st three months of planning will be dedicated to recruiting outreach workers to participate in the MNHOW training from the 2 targeted communities: street violence workers, homeless youth outreach workers, and API community outreach workers. Additionally, interviews and focus groups will be held; and data will be collected from the community and its evaluators, stakeholders, service providers, and consumers and family members of consumers to develop the evaluation plan for the MHOW project.

**Phase II- Implementation (9/2014-8/2015)**

This phase will be when the classroom instruction will occur. During this phase, evaluation will take place to track qualitatively how this process is affecting those who are involved.

**Phase III – Reflection, evaluation, and dissemination (9/2015-11/2015)**

Phase III will include the complete analysis of evaluation efforts of MHW. The learning report will be written and shared. Additionally, a public report back will also take place. If the approach proves successful CBHS/MHSA will consider expanding this program to all outreach workers in San Francisco.

**Project Measurement:**

*Is the MHOW curriculum relevant to the outreach worker segment of the mental health workforce?*

Measurement: mental health outreach workers can respond to a short questionnaire via survey monkey to report if the curriculum and its delivery was relevant to them and their community work.

*Was the intended audience of this curriculum delivery the appropriate audience?*

Measurement: mental health outreach workers can respond to a short questionnaire via survey monkey to report if the curriculum and its delivery was relevant to them and their community work.

*What are the contributions of this adapted curriculum? – the areas that have been affected/changed*

Determine how to measure MHOW are learning

*What part(s) of the curriculum and its delivery worked? What part(s) of the curriculum and its delivery did not work?*

Overall Program Outcomes:

- If MHOW is successful, MHSA San Francisco will use this model to fund additional training for outreach workers.
- If MHOW is successful, its innovative model will be adopted by other clinics in San Francisco, as well as other local and state mental health clinics.

**Leveraging Resources (if applicable)**

$12,500 matching planning grant (matching the Mayor's Office of Violence Prevention investment of $12,500)

N/A

**Budget**

| | County Mental Health Department | Other Governmental Agencies | Community Mental Health Contract Providers | Total |
|---|---|---|---|---|
| **A. Expenditures** | | | | |
| 1. Personnel Expenditures | **$125,000** | | | |
| 2. Operating Expenditures | **$80,000** | | | |
| 3. Non-recurring expenditures | **$70,000** | | | |
| 4. Training Consultant | **$10,000** | | | |

| | | | | |
|---|---|---|---|---|
| contracts | | | | |
| 5. Work plan management | **$10,000** | | | |
| 6. Evaluation | **$5,000** | | | |
| **7. Total proposed work plan expenditures** | **$300,000** | | | |
| **B. Revenues** | | | | |
| **1. Existing revenues** | $12,500 matching planning grant (matching the Mayor's Office of Violence Prevention investment of $12,500) | | | |
| **2. Additional revenues** a | | | | |
| **3. Total New Revenue** | | | | |
| | | | | |
| **4. Total Revenues** | | | | |
| **C. Total funding requirements** | | | | **$300,000** |

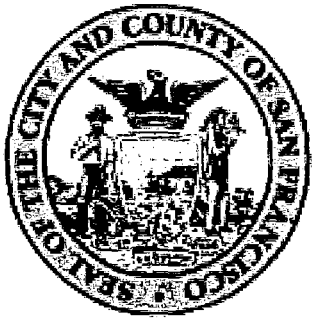
# 14. Appendix D: MHSA Budget of Programs by Funding Component

**The table below details the MHSA FY14-15 budget breakdown of programs by funding component. FY15-16 and FY17-18 projected budgets are expected to be comparable to the FY14-15 budget. Final budgets for future years will be provided in Annual Update reports.**

| SF MHSA Integrated Service Categories | Programs by Funding Component | FY 14/15 Projected Budget |
|---|---|---|
| | **Community Services and Supports (CSS)**<br>80% of total MHSA revenue (after INN calculated)<br>Per MHSA, 51% is allocated to serve FSP clients | |
| RTS | CSS Full Service Partnership 1. CYF (0-5) | $ 400,000 |
| RTS | CSS Full Service Partnership 2. CYF (6-18) | $ 1,415,000 |
| RTS | CSS Full Service Partnership 3. TAY (18-24) | $ 1,076,468 |
| RTS | CSS Full Service Partnership 4. Adults (18-59) | $ 5,850,000 |
| RTS | CSS Full Service Partnership 5. Older Adults (60+) | $ 750,000 |
| H | CSS FSP Permanent Housing (capital units and master lease) | $ 650,000 |
| RTS | CSS Other Non-FSP 1. Behavioral Health Access Center | $ 803,751 |
| RTS | CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP) | $ 931,770 |
| RTS | CSS Other Non-FSP 3. Trauma Recovery | $ 547,000 |
| RTS | CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care | $ 1,179,270 |
| RTS | CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System | $ 470,189 |
| RTS | CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment | $ 85,309 |
| P2P | CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (20% FSP) | $ 2,210,000 |
| VS | CSS Other Non-FSP 8. Vocational Services (30% FSP) | $ 228,252 |
| H | CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP) | $ 393,637 |
| H | CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP) | $ 260,508 |
| H | CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP) | $ 1,089,465 |
| RTS | CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity | $ 338,323 |
| | CSS Admin | $ 1,668,577 |
| | CSS Evaluation | $ 528,857 |
| | **SUBTOTAL Community Services and Support (CCS)** | **$ 20,876,376** |
| | **Workforce, Development Education and Training (WDET)**<br>5% - $1.6 million per year of CSS transferred to WDET | |
| WD | WDET 1. Training and TA | $ 386,000 |
| WD | WDET 2. Career Pathways | $ 269,365 |
| WD | WDET 3. Residency and Internships | $ 364,000 |
| | WDET Admin | $ 115,000 |
| | WDET Evaluation | $ 37,150 |
| | **TOTAL** | **$ 1,171,515** |

| SF MHSA Integrated Service Categories | Programs by Funding Component | FY 14/15 Projected Budget |
|---|---|---|
| | **Capital Facilities/IT**<br>One-time allocation and 5-10% per year of CSS funds transferred to CF | |
| CF/IT | Cap 1. Southeast Health Center | TBD |
| CF/IT | Cap 2. South of Market Mental Health | $ 300,000 |
| CF/IT | Cap 3. *TBD through CPP* | TBD |
| CF/IT | IT 1. Consumer Portal | $ 225,000 |
| VS | IT 2. Vocational IT (part of Vocational Services) | TBD |
| CF/IT | IT 3. System Enhancements | $ 225,000 |
| | IT Admin | $ 163,658 |
| | **TOTAL** | **$ 913,658** |
| | **TOTAL Community Services and Support (CSS) (including WDET & Capital Facilities/IT)** | **$ 22,961,549** |
| | **Prevention and Early Intervention (PEI)**<br>20% of MHSA Revenue (after INN calculated) | |
| PEI | PEI 1. Stigma Reduction | $ 175,000 |
| PEI | PEI 2. School-Based Mental Health Promotion (K-12) | $ 991,000 |
| PEI | PEI 3. School-Based Mental Health Promotion (Higher Ed) | $ 417,226 |
| PEI | PEI 4. Population Focused Mental Health Promotion and Early Intervention | $ 2,751,970 |
| PEI | PEI 5. Mental Health Consultation and Capacity Building | $ 831,855 |
| PEI | PEI 6. Comprehensive Crisis Services | $ 494,988 |
| | PEI Admin | $ 141,261 |
| | PEI Evaluation | $ 143,401 |
| | **TOTAL** | **$ 5,946,701** |
| | **Innovation (INN)**<br>5% of Prob. MHSA Revenue | |
| P2P | INN 7. Peer-Led Hoarding and Cluttering Support Team (part of Peer-to-Peer Support Services - P2P) | $ 215,735 |
| PEI | INN 8. Collaboration with the Faith Community (part of Mental Health Promotion and Early Intervention - PEI) | $ 150,000 |
| TBD based on specific projects | INN 9. Mini Grants | TBD |
| VS | INN 11. Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) (part of Vocational Services - VS) | $ 233,903 |
| RTS | INN 12. Building Bridges Clinic/School of Linking Project (part of Recovery Oriented Treatment Services - RTS) | $ 405,361 |
| VS | INN 14. First Impressions (part of Vocational Services - VS) | $ 300,000 |
| P2P | INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults (part of Mental Health Promotion and Early Intervention - PEI) | $ 200,000 |
| P2P | INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals (part of Mental Health Promotion and Early Intervention - PEI) | $ 159,087 |
| WD | INN 17. MH Certificate for Outreach Paraprofessionals (part of Workforce Development) | $ 200,000 |

| SF MHSA Integrated Service Categories | Programs by Funding Component | FY 14/15 Projected Budget |
|---|---|---|
| | INN Admin | $ 201,279 |
| | **TOTAL** | **$ 2,065,365** |
| | | |
| | **TOTAL PROJECTED FY 14/15 MHSA Budget *** | |
| | * FY 15/16 and 17/18 expected to be comparable to FY 14/15. | |
| | Final budgets for future years will be provided in Annual Updates. | **$ 30,973,615** |
| | | |
| | **MHSA Integrated Service Categories** | |
| | Recovery Oriented Treatment Services | **RTS** |
| | Mental Health Promotion and Early Intervention Services | **PEI** |
| | Peer-to-Peer Support Services | **P2P** |
| | Vocational Services | **VS** |
| | Workforce Development | **WD** |
| | Capital Facilities/IT | **CF/IT** |
| | Housing | **H** |




In San Francisco, MHSA-funded programs are administered by Community Behavioral Health Services, under the Community Programs division of the San Francisco Department of Public Health. We utilize existing networks within the Department of Public Health and in other civil services agencies, to provide high quality behavioral health services to children, transitional age youth, their families, adults and older adults. These services are provided in partnerships with clients, families, other agencies and community providers.

**http://sfmhsa.org/about_us.html**

SAN FRANCISCO MENTAL HEALTH SERVICES ACT (SFMHSA)

# INTEGRATED PLAN *At-A-Glance*

| S.F. MHSA INTEGRATED Service Categories | RFP likely Summer/Fall 2014 | MHSA Program Name (by funding component) | MHSA Program Summary | Projected FY 14/15 Budget | Integrated Plan Highlights |
|---|---|---|---|---|---|
| | | | **Community, Services and Supports (CSS)**<br>*80% of total MHSA revenue (after INN calculated)*<br>*51% must be allocated to serve FSP clients* | Total CSS Budget:<br>$21,427,522 | |
| Recovery Oriented Treatment Services | X | CSS Full Service Partnership 1. CYF (0-5) | A central component of MHSA, Full Service Partnership (FSP) programs reflect an intensive and comprehensive model of case management based on a client- and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with SMI or SED to lead independent, meaningful, and productive lives. Ten FSP programs serve a diverse group of clients in terms of age, race/ethnicity, and stage of recovery. Services include integrated, mental health treatment; intensive case management and linkage to essential services; housing and vocational support; and self-help support. | $ 400,000 | * Allocated $400K (plus additional EPSDT revenue TBD) to develop new FSP program for children 0-5 and their families. |
| Recovery Oriented Treatment Services | | CSS Full Service Partnership 2. CYF (6-18) | | $ 1,231,387 | |
| Recovery Oriented Treatment Services | | CSS Full Service Partnership 3. TAY (18-24) | | $ 1,076,468 | * FSP expansion described below includes new Case Manager for TAY. |
| Recovery Oriented Treatment Services | | CSS Full Service Partnership 4. Adults (18-59) | | $ 5,030,795 | * Allocated $600K (plus additional MediCal revenue TBD) to expand clinical capacity, housing access and peer supports.<br>* Expansion includes Cantonese speaking Case Manager and two Case Managers to serve forensics population.<br>* Transferred SF First FSP staff to new TRANSITIONS FSP+ focused on client transitions from hospital discharge to engagement in outpatient clinic care. |
| Recovery Oriented Treatment Services | | CSS Full Service Partnership 5. Older Adults (60+) | | $ 688,328 | |

| S.F. MHSA INTEGRATED Service Categories | RFP likely Summer/Fall 2014 | MHSA Program Name (by funding component) | MHSA Program Summary | Projected FY 14/15 Budget | Integrated Plan Highlights |
|---|---|---|---|---|---|
| Housing | | **CSS Full Service Partnership Housing Program** | Available to Full Service Partnership clients, the FSP Housing Program provides access to emergency stabilization housing, transitional housing for TAY, permanent supportive housing and other supports designed to help FSP participants gain access to and maintain housing. 71 units currently occupied - 9 new units still in the pipeline. | $ 614,548 | * Conducting a feasibility study of different models to expand access to housing.<br>* Evaluating the impact of housing with a focus on permanent placements.<br>* Purchasing 3 new units (Rosa Parks Sr. Apts) with interest earned from initial housing allocation. |
| Recovery Oriented Treatment Services | | **CSS Other Non-FSP 1. Behavioral Health Access Center** | The Behavioral Health Access Center (BHAC) is a portal of entry into San Francisco's overall system of care. BHAC co-locates the following five behavioral health programs: 1) Mental Health Access for authorizations into the Private Provider Network, 2) the Treatment Access Program for assessment and placement into addiction and dual diagnosis treatment, 3) the Offender Treatment Program to place mandated clients into addiction and dual diagnosis treatment, 4) Centralized Opiate Placement Evaluation (COPE) and Office-Based Buprenorphine Induction Clinic (OBIC) for evaluation and placement into Opiate Replacement Therapy, and 5) the CBHS Pharmacy. The Pharmacy, among its many services, provides specialty behavioral health medication packaging and serves as a pharmacy safety net for all CBHS clients. | $ 1,004,689 | * Expanded bilingual (Cantonese) pharmacy capacity |
| Recovery Oriented Treatment Services | X | **CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)** | PREP is an early intervention treatment program for schizophrenia and early psychosis for individuals between the ages of 16 and 30 to support symptoms remission, active recovery, and full engagement with coworkers, peers, and family members. PREP treatment services include: algorithm-based medication management, cognitive rehabilitation, cognitive behavioral therapy for early psychosis, multi-family groups (MFG), strengths-based care management, and neuropsychiatric and other advanced diagnostic services. | $ 931,770 | * Plan to strengthen linkage between PREP program and SF General Hospital, Psych Emergency Services (PES) and outpatient clinics. |
| Recovery Oriented Treatment Services | X | **CSS Other Non-FSP 3. Trauma Recovery** | The Trauma and Recovery Project addresses the need for community-based, client-driven behavioral health intervention for individuals, families and communities who are impacted by violence. Services include outreach, assessment, crisis and short-term counseling, case management and mental health consultation to community organizations. The focus of treatment is recovery from traumatic response and the symptoms that stem from chronic and/or complex trauma. | $ 647,225 | * Planning to expand access to trauma treatment services in Southeast San Francisco (D-10) by working with a community coalition to develop a new program model. Partnering with Trauma Training Initiative staff to oversee this effort. |

| SAN FRANCISCO MENTAL HEALTH SERVICES ACT (SFMHSA)<br>INTEGRATED PLAN *At-A-Glance* | | | | | |
|---|---|---|---|---|---|
| S.F. MHSA INTEGRATED Service Categories | RFP likely Summer/Fall 2014 | MHSA Program Name (by funding component) | MHSA Program Summary | Projected FY 14/15 Budget | Integrated Plan Highlights |
| Recovery Oriented Treatment Services | | CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care | Behavioral health clinicians work as a member of a primary care team providing services to patients in primary care clinics. Services include the delivery of brief, evidence-based and practical interventions, consultation to primary care team members and self- and chronic care management services. This program also supports primary care clinicians providing services in mental health clinics. | $ 1,474,087 | * Contributing to the development of Behavioral Health Homes (BHH). Behavioral Health Clinics where clients will receive an increased level of comprehensive team-based care. |
| Recovery Oriented Treatment Services | X | CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System | All youth detained for more than 72 hours at San Francisco's Juvenile Justice Center are assessed for behavioral health needs. Any identified needs are presented to the Juvenile Probation Department to be addressed in case planning with local courts. The program connects and supports the engagement of youth and families in appropriate and effective mental health services. MHSA also funds psychiatric services in the Youth Guidance Center Clinic – a clinic providing free primary health care, case management and psycho-social services to incarcerated youth ages 8-18. | $ 580,192 | * Expanded to serve youth on probation attending Civic Center High School. |
| Recovery Oriented Treatment Services | | CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment | Dual diagnosis residential treatment and support is provided to individuals who do not have MediCal coverage and who would otherwise not be eligible for services. An integrated model of care allows clients to receive the full spectrum of services, including substance abuse treatment, mental health services, primary medical care, case management, parolee services, workforce development, and gender-specific residential treatment homes for adults with co-occurring disorders. | $ 85,309 | * Will explore how ACA impacts need to fund services for non-MediCal population. |
| Peer-to-Peer Support Services | X | CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based | Peer-to-Peer Support Services provides individuals with lived experience in the mental health system the opportunity to assist their peers in developing the skills necessary to pursue meaningful roles in their lives. Many peer-support staff are graduates of the Peer Specialist Mental Health Certificate, a 12-week program designed to prepare consumers and/or family members with the skills & knowledge for entry-level employment in the behavioral/mental health system. In addition to the peer certificate programs, MHSA also funds a peer-run drop-in center and NAMI peer-led support and education groups in various CBHS clinics. | $ 2,468,875 | |

| S.F. MHSA INTEGRATED Service Categories | RFP likely Summer/Fall 2014 | MHSA Program Name (by funding component) | MHSA Program Summary | Projected FY 14/15 Budget | Integrated Plan Highlights |
|---|---|---|---|---|---|
| **Vocational Services** | X | **CSS Other Non-FSP 8. Vocational Services** | Vocational services assist consumers and family members in securing and maintaining meaningful employment. Vocational services include job coaching, situational assessment, trainings, and job placement services in the areas of 1) Information Technology 2) Basic Construction 3) Hospitality/Culinary and 4) Behavioral Health Services. | $ 228,252 | * First Impressions is a new (recently approved) INN project. |
| **Housing** | | **CSS Other Non-FSP 9. Emergency Stabilization Housing** (50% FSP) | Emergency stabilization units (ESUs) provide short-term housing stability for clients who are homeless or have been discharged from the hospital or jail. The 25 ESUs are located within three single room occupancy (SRO) hotels in San Francisco. The units are available to clients referred by Full Service Partnership programs, Intensive Case Management programs and Central City Hospitality House. | $ 393,637 | |
| **Housing** | | **CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing)** (25% FSP) | MHSA funding has allowed for Direct Access to Housing to expand capacity to serve MHSA clients with the addition of an Intake Coordinator, focused on placing clients in the setting most appropriate to their needs, and a Nurse Practitioner. | $ 260,508 | |
| **Housing** | | **CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing** (50% FSP) | MHSA ROUTZ TAY Housing Partnership provides 40 housing slots at the Aarti Hotel (located at 391 Leavenworth Street) and 10 additional slots at scattered housing sites. | $ 1,089,465 | |
| **Recovery Oriented Treatment Services** | | **CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity** | In recognition of disparities in access for certain populations, this program expands the staffing capacity at outpatient mental health clinics to better meet the treatment needs of target populations such as older adults and monolingual communities. | $ 338,323 | * Planning to hire a Wellness and Recovery Program Manager to collaborate with providers and stakeholders to develop, implement and evaluate projects promoting wellness and recovery practices across the CBHS Systems of Care. |
| | | **CSS Admin** | The Admin budget includes indirect administrative costs that are 'incurred for a common or joint purpose and cannot be readily identified as benefiting only one MHSA program or project'. These costs typically include salaries and benefits of employees 1) working to administer MHSA funding (e.g. accounting, contracts); 2) working to further the principles of MHSA (e.g. cultural competence); 3) managing program planning and technical assistance activities. Admin expenses also include Community Program Planning expenses as well as MHSA operating expenses not related to direct client services (e.g. rent, utilities) | $ 2,222,592 | |

| SAN FRANCISCO MENTAL HEALTH SERVICES ACT (SFMHSA)<br>INTEGRATED PLAN *At-A-Glance* | | | | | |
|---|---|---|---|---|---|
| S.F. MHSA INTEGRATED Service Categories | RFP likely Summer/Fall 2014 | MHSA Program Name<br>* (by funding component) | MHSA Program Summary | Projected FY 14/15 Budget | Integrated Plan Highlights |
| | | CSS Evaluation | Direct and indirect costs associated with collecting, analyzing, and using information to answer questions about MHSA projects, policies and programs, particularly regarding their effectiveness and efficiency and whether the program goals are appropriate and useful. | $ 661,071 | |
| | | | **Prevention and Early Intervention (PEI)**<br>*20% of MHSA revenue (after INN calculated)*<br>** Plan proposes allocating 2% of PEI funding to CalMHSA for statewide PEI programs* | Total PEI Budget:<br>$7,278,578 | |
| Mental Health Promotion and Early Intervention | X | PEI 1. Stigma Reduction | Sharing Our Lives, Voices and Experiences (SOLVE) is a stigma elimination program. SOLVE trains people in the community who have been living with mental health challenges to share their personal experiences. | $ 201,469 | * Includes funding for 4th Annual MHSA Recovery Award Ceremony and consumer engagement activities and training for MHSA Advisory Committee. |
| Mental Health Promotion and Early Intervention | X | PEI 2. School-Based Mental Health Promotion (K-12) | School-Based Mental Health Promotion – a collaboration of community-based organizations and SF, San Francisco's K-12 campuses – applies school-based best practices that address non-academic barriers to learning. With public schools serving as hubs, this initiative offers a range of supports and opportunities for children, youth and their families to support student success by combining the full spectrum of prevention, early intervention and linkages to behavioral health services. | $ 1,119,589 | |
| Mental Health Promotion and Early Intervention | X | PEI 3. School-Based Mental Health Promotion (Higher Ed) | Student support services are designed to increase university access and enrollment, enhance retention and maximize graduation rates among those at risk for mental illness, particularly members of underserved and underrepresented communities, and their family members who are preparing for careers in the public behavioral health field. | $ 417,226 | |

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| S.F. MHSA INTEGRATED Service Categories | RFP likely Summer/Fall 2014 | MHSA Program Name (by funding component) | MHSA Program Summary | Projected FY 14/15 Budget | Integrated Plan Highlights |
|---|---|---|---|---|---|
| Mental Health Promotion and Early Intervention | X | **PEI 4. Population Focused Mental Health Promotion and Early Intervention** | Population-focused mental health promotion services are typically delivered in community-based settings where mental health services are not traditionally provided. This program supports activities including, outreach and engagement, mental health promotion and psycho-social education, behavioral health screening and assessment, referrals and linkage, and short-term therapeutic services. Target populations include:<br>* African American<br>* Asian and Pacific Islander (API)<br>* Native American<br>* Latino/Mayan<br>* Arab Refugees<br>* Homeless Adults<br>* Homeless or System Involved TAY (18-24)<br>* LGBTQ<br>* Socially Isolated Older Adults | $ 3,597,372 | * Working with providers to develop shared performance objectives for all population-focused mental health promotion programs.<br>* Older Adult Peer-to-Peer program (INN-15) being developed in partnership with Curry Senior Center. |
| Mental Health Promotion and Early Intervention | X | **PEI 5. Mental Health Consultation and Capacity Building** | The Mental Health Consultation and Capacity Building PEI subcategory is comprised of the following two programs: (1) Early Childhood Mental Health Consultation Initiative (ECMHCI) and (2) Youth Agency Mental Health Consultation (YAMHC). The ECMHCI is grounded in the work of mental health professionals who provide support to children, parents, and caregivers of San Francisco's youngest residents between the ages of 0-5. ECMHCI services are delivered in a variety of settings, including center-based and family child care, homeless and domestic violence shelters, permanent supportive housing facilities, family resource centers and substance abuse treatment centers. YAMHC provides consultation services to agencies who serve youth who are involved in the juvenile justice system or at-risk of being involved in the juvenile justice system. | $ 1,131,855 | |
| Mental Health Promotion and Early Intervention | | **PEI 6. Comprehensive Crisis Services** | Comprehensive Crisis Services (CCS) is a multidisciplinary, multi-linguistic program that provides acute mental health and crisis response services to children and adults. In addition to responding to mental health crisis, the team also responds to incidence of gun violence. | $ 526,404 | |
| | | **PEI Admin** | see CSS Admin for description of admin expenses. | $ 141,261 | |
| | | **PEI Evaluation** | See CSS Evaluation for description of evaluation expenses. | $ 143,401 | *Activities include a focused evaluation of K-12 School-Based Programs |

| SAN FRANCISCO MENTAL HEALTH SERVICES ACT (SFMHSA)<br>INTEGRATED PLAN *At-A-Glance* | | | | | |
|---|---|---|---|---|---|
| **S.F. MHSA INTEGRATED Service Categories** | **RFP likely Summer/Fall 2014** | **MHSA Program Name** (by funding component) | **MHSA Program Summary** | **Projected FY 14/15 Budget** | **Integrated Plan Highlights** |
| | | **Innovation (INN)**<br>***5% of total MHSA revenue*** | | Total INN Budget:<br>$2,766,085 | |
| **Peer-to-Peer Support Services** | | **INN 7. Peer Response Team** (part of Peer-to-Peer Support Services) | The Peer Response Team (PRT) was created to provide peer support and assistance navigating the community and systems of care for individuals dealing with hoarding and cluttering challenges. | $ 215,735 | |
| **Mental Health Promotion and Early Intervention** | X | **INN 8. Collaboration with the Faith Community** (part of Population Focused Mental Health Promotion) | Engages faith-based organizations and families in Bayview/Hunter's Point and Visitacion Valley in order to increase mental health awareness, decrease stigma, and provide social support for consumers, community members, and peers. | $ 150,000 | * Partnering with DPH Population Health and Prevention to explore developing a new model of peer support, recruiting peers from the African American churches in the Southeast. |
| | X | **INN 9. Mini Grants** | A community-run grant making program modeled on the funding methodology commonly employed by venture capitalists in the for-profit sector and donor advised funds in a community foundation. Approved through the original INN Plan, this program has yet to be implemented. | $ 500,000 | * Focused on priority populations<br>* Details TBD though CPP. |
| **Workforce & Development** | X | **INN 11 Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS)** (part of Vocational Services) | This pilot program adapted an existing nutrition and exercise protocol into a community mental health setting and integrated shopping and cooking skills training. This program educates consumers on atypical antipsychotics about the connection between diet and health, how to shop based on what is locally available, healthy cooking, and how to exercise to improve fitness and health. | $ 233,903 | |
| **Recovery Oriented Treatment Services** | | **INN 12. Building Bridges Clinic/School of Linking Project** (part of Primary Care and Behavioral Health Integration) | Building Bridges, now in its second year, was designed to test a staffing model to promote interagency collaboration between DPH Community Health Programs for Youth (CHPY) clinics and San Francisco Unified School District to develop a streamlined system for professional linkages and referrals for care. The program aims to better meet the behavioral health needs of youth living in the southeast neighborhoods of San Francisco. Funding supports new mental health staff at Balboa Teen Health Center (BTHC), 3rd Street Youth Center and Clinic, and Hawkins Clinic. | $ 405,361 | |
| **Vocational Services** | X | **INN 14 First Impressions** (part of Vocational Services) | First Impressions (FI) is a basic construction and remodeling vocational program that will assist mental health consumers in learning marketable skills, receive on-the-job training and mentoring, and secure competitive employment in the community. | $ 300,000 | |

| S.F. MHSA INTEGRATED Service Categories | RFP likely Summer/Fall 2014 | MHSA Program Name (by funding component) | MHSA Program Summary | Projected FY 14/15 Budget | Integrated Plan Highlights |
|---|---|---|---|---|---|
| **Mental Health Promotion and Early Intervention** | | **INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults** (part of Population Focused Mental Health Promotion) | This locally approved INN funded pilot program seeks to learn how to develop and implement effective peer-to-peer support services in a network of organizations providing health, nutrition and social supports to seniors. Due to changes to the budget and scope of the project, a revised INN Proposal will be submitted to the MHSOAC (see Plan - Appendix B) | $ 200,000 | * (Updated) INN proposal. |
| **Mental Health Promotion and Early Intervention** | | **INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals** (part of Population Focused Mental Health Promotion) | This locally approved INN funded pilot program seeks to learn how to develop and implement effective peer-to-peer support services across a network of organizations providing health and social supports to Transgender individuals. Due to changes to the budget and scope of the project, a revised INN Proposal will be submitted to the MHSOAC (see plan - Appendix A) | $ 259,807 | * (Updated) INN proposal. |
| **Workforce Development** | X | **INN 17. MH Certificate for Outreach Paraprofessionals** (part of Workforce Development) | This plan includes a proposal for a NEW INN project (see Appendix C). The Mental Health Outreach Workers (MHOW) Training program aims to train San Francisco street outreach workers, exposed to constant community trauma, on how to best meet the mental health needs of the clients that they encounter in the field, and also how to best deal with one's own experience with trauma. Three sub communities of outreach workers have been identified by our local CPP as frontline programs coming in contact with high rates of trauma. These are: Homeless Youth Outreach Workers Programs and Street Violence Outreach workers, and Asian Community Outreach workers. In total, a cohort of 60 outreach workers will be trained (20 per sub community). | $ 300,000 | * New INN proposal. |
| | | **INN Admin** | see CSS Admin for description of admin expenses. | $ 201,279 | |
| **Workforce, Development Education and Training (WDET)** * Plan proposes *$1.6 million per year of CSS funds will be transferred to WDET* | | | | Total WDET Budget: $1,591,151 | |
| **Workforce Development** | X | **WDET 1. Training and TA** | The MHSA supports trainings for health and social service providers to improve their capacity to provide high quality, culturally competent, recovery oriented services. Key components of this work include the implementation of Seeking Safety and Illness Management Recovery (IMR) groups, capacity building for providers serving youth and system-wide (12N) LGBTQ sensitivity training. This program also supports the Trauma Training Institute. | $ 648,653 | * Launched Trauma Training Initiative<br>* Funding evaluation of Wellness Management Recovery groups<br>* New INN proposal for Mental Health Outreach Worker Training Program (see INN #17)<br>* Continues Medicinal Drumming Pilot for another year |

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| SAN FRANCISCO MENTAL HEALTH SERVICES ACT (SFMHSA)<br>INTEGRATED PLAN *At-A-Glance* | | | | | |
|---|---|---|---|---|---|
| S.F. MHSA INTEGRATED Service Categories | RFP likely Summer/Fall 2014 | MHSA Program Name (by funding component) | MHSA Program Summary | Projected FY 14/15 Budget | Integrated Plan Highlights |
| Workforce Development | X | **WDET 2. Career Pathways** | The Mental Health Career Pathways Program focuses on developing a workforce pipeline that will usher in the next generation of mental health and behavioral health practitioners and include members of underserved and underrepresented communities. Funded projects include a 'career exposure' program for high school students and a Community Mental Health Certificate program at City College. | $ 269,365 | * New partnership with SFUSD on pilot promoting behavioral health professions within the Health Academy at John O'Connell High School.<br>* Updated goals from recent workforce disparities assessment. |
| Workforce Development | | **WDET 3. Residency and Internships** | CBHS, in partnership with SFGH and UCSF, established a Public Psychiatry Fellowship Program to enable general psychiatry and child psychiatry fellows to work in CBHS community-based clinics, thereby providing experience and training on how to work in a community-based setting, with the goal of enticing them into future community-based employment. This program also includes funding for a CBHS Intern Coordinator to work collaboratively with CBHS staff, university and college graduate level (Master's level and PhD level) programs and graduate student interns to develop, implement and evaluate a centralized and coordinated public mental health internship/practicum program. | $ 494,033 | * New graduate level Intern Coordinator to be hired |
| | | **WDET Admin** | see CSS Admin for description of admin expenses. | $ 141,949 | |
| | | **WDET Eval** | See CSS Evaluation for description of evaluation expenses. | $ 37,150 | * Evaluating Implementation of Wellness Management and Recovery Groups |
| | | **Capital Facilities/IT**<br>Plan proposes *$500k per year of CSS funds be transferred to CF* | | Total CF/IT Budget: $1,555,312 | |

| S.F. MHSA INTEGRATED Service Categories | RFP likely Summer/Fall 2014 | MHSA Program Name (by funding component) | MHSA Program Summary | Projected FY 14/15 Budget | Integrated Plan Highlights |
|---|---|---|---|---|---|
| Capital Facilities /Information Technology | | IT 1. Consumer Portal | CBHS will provide consumers access to their CBHS EHR records via a new consumer portal. | $ 121,654 | * Not going to implement AVATAR's Consumer Connect as proposed in original IT Plan. DPH-wide consumer portal is under development.<br>* DPH will cover cost of new portal yet other budget implications of implementation for CBHS clients are still TBD. |
| Capital Facilities /Information Technology | X | IT 2. Vocational IT (part of Vocational Services) | Prepares consumers to provide information technology (IT) support services (i.e., desktop, help desk) at the CBHS IT Department through its Vocational Information Technology Training Program. | $ 545,000 | |
| Capital Facilities /Information Technology | | IT 3. System Enhancements | System Enhancements focus on improving the quality and efficiency of behavioral health services and include improving connectivity and IT infrastructure at behavioral health sites, supporting servers that host the Avatar application and other applications related to the delivery of services. System Enhancements also include the expansion of staff capacity to develop reports (clinical productivity, consumer outcomes, etc.) and maintain databases. | $ 225,000 | * Planning currently underway will result in detailed expenditure plan. |
| | | IT Admin | see CSS Admin for description of admin expenses. | $ 163,658 | |
| Capital Facilities /Information Technology | | Cap 1. Southeast Health Center | Renovation will result in a new Southeast Health Campus that will provide integrated services, co-location of five CBHS mental health programs: Child Crisis, Foster Care Mental Health; Family Mosaic Project; Children's System of Care; and the Health and Environment Resource Center (HERC). MHSA is making a $2M contribution of capital facilities funding to this project. The timeline for development and expenditures is still TBD. | TBD | |
| Capital Facilities /Information Technology | | Cap 2. South of Market Mental Health | Renovations at South of Market Mental Health Clinic to better serve MHSA populations and their families. Funds will be allocated to create a peer-run Wellness Center, a more welcoming environment, improve patient flow and increase clinical/staff space. Planning for this project has just begun. | $ 300,000 | * Establish annual allocation of $500K to make capital improvements at mental health clinics.<br>* First new capital project at SOMA MH. |
| Capital Facilities /Information Technology | | Cap 3. TBD through CPP | | $ 200,000 | * Balance of $500K Capital Facility allocation available for project TBD through community planning process. |
| | | | **TOTAL PROJECTED FY 14/15 MHSA Budget *** | **$ 34,618,648** | |

* FY 15/16 and 17/18 expected to be comparable to FY 14/15.
Final budgets for future years will be provided in Annual Updates.

**MENTAL HEALTH SERVICES ACT**
**As amended in 2012**

**SECTION 1.** Title

This Act shall be known and may be cited as the "Mental Health Services Act."

**SECTION 2.** Findings and Declarations

The people of the State of California hereby find and declare all of the following:

(a) Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age. In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.

(b) Failure to provide timely treatment can destroy individuals and families. No parent should have to give up custody of a child and no adult or senior should have to become disabled or homeless to get mental health services as too often happens now. No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. Lives can be devastated and families can be financially ruined by the costs of care. Yet, for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.

(c) Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs.

(d) In a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the streets homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted with untreated severe mental illness. We can and should offer these people the care they need to lead more productive lives.

(e) With effective treatment and support, recovery from mental illness is feasible for most people. The State of California has developed effective models of providing services to children, adults and seniors with serious mental illness. A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President's Commission on Mental Health. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. Other innovations address services to other underserved populations such as traumatized youth and isolated seniors. These successful programs, including prevention, emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system.

(f) By expanding programs that have demonstrated their effectiveness, California can save lives and money. Early diagnosis and adequate treatment provided in an integrated service system is very effective; and by preventing disability, it also saves money. Cutting mental health services wastes lives and costs more. California can do a better job saving lives and saving money by making a firm commitment to providing timely, adequate mental health services.

(g) To provide an equitable way to fund these expanded services while protecting other vital state services from being cut, very high-income individuals should pay an additional one percent of that portion of their annual income that exceeds one million dollars ($1,000,000). About 1/10 of one percent of Californians have incomes in excess of one million dollars ($1,000,000). They have an average pre-tax income of nearly five million dollars ($5,000,000). The additional tax paid pursuant to this represents only a small fraction of the amount of tax reduction they are realizing through recent changes in the federal income tax law and only a small portion of what they save on property taxes by living in California as compared to the property taxes they would be paying on multi-million dollar homes in other states.

**SECTION 3.** Purpose and Intent.

The people of the State of California hereby declare their purpose and intent in enacting this act to be as follows:

(a) To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.

(b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.

(c) To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.

(d) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.

(e) To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

**SECTION 4.** Part 3.6 (commencing with Section 5840) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 3.6 PREVENTION AND EARLY INTERVENTION PROGRAMS

5840. (a) The State Department of Health Care Services, in coordination with counties, shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.

(b) The program shall include the following components:
  (1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.
  (2) Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable.
  (3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.
  (4) Reduction in discrimination against people with mental illness.

(c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.

(d) The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:
  (1) Suicide.
  (2) Incarcerations.
  (3) School failure or dropout.
  (4) Unemployment.
  (5) Prolonged suffering.
  (6) Homelessness.
  (7) Removal of children from their homes.

(e) Prevention and early intervention funds may be used to broaden the provision of community-based mental health services by adding prevention and early intervention services or activities to these services.

(f) In consultation with mental health stakeholders, and consistent with guidelines from the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5846, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors.

5840.2 (a) The department shall contract for the provision of services pursuant to this part with each county mental health program in the manner set forth in Section 5897.

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**SECTION 5.** Article 11 (commencing with Section 5878.1) is added to Chapter 1 of Part 4 of Division 5 of the Welfare and Institutions Code, to read:

Article 11. Services for Children with Severe Mental Illness.

5878.1 (a) It is the intent of this article to establish programs that ensure services will be provided to severely mentally ill children as defined in Section 5878.2 and that they be part of the children's system of care established pursuant to this part. It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and his or her family.

(b) Nothing in this act shall be construed to authorize any services to be provided to a minor without the consent of the child's parent or legal guardian beyond those already authorized by existing statute.

5878.2 For purposes of this article, severely mentally ill children means minors under the age of 18 who meet the criteria set forth in subdivision (a) of Section 5600.3.

5878.3 (a) Subject to the availability of funds as determined pursuant to Part 4.5 (commencing with Section 5890), county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services available pursuant to Medi-Cal, child welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health funds or other entitlement programs.

(b) Funding shall be at sufficient levels to ensure that counties can provide each child served all of the necessary services set forth in the applicable treatment plan developed in accordance with this part, including services where appropriate and necessary to prevent an out of home placement, such as services pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9.

(c) The State Department of Health Care Services shall contract with county mental health programs for the provision of services under this article in the manner set forth in Section 5897.

**SECTION 6.** Section 18257 is added to the Welfare and Institutions Code, to read:

18257. The State Department of Social Services shall seek applicable federal approval to make the maximum number of children being served through such programs eligible for federal financial participation and amend any applicable state regulations to the extent necessary to eliminate any limitations on the numbers of children who can participate in these programs.

**SECTION 7.** Section 5813.5 is added to Part 3 of Division 5 of the Welfare and Institutions Code, to read:

5813.5. Subject to the availability of funds from the Mental Health Services Fund, the state shall distribute funds for the provision of services under Sections 5801, 5802, and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3. For purposes of this act, seniors means older adult persons identified in Part 3 (commencing with Section 5800) of this division.

(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this part with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan.

(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state, and federal funds.

(c) Each county mental health programs plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:
  (1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
  (2) To promote consumer-operated services as a way to support recovery.
  (3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.
  (4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) of this division, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.

(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons.

(g) The department shall contract for services with county mental health programs pursuant to Section 5897. After the effective date of this section the term grants referred to in Sections 5814 and 5814.5 shall refer to such contracts.

**SECTION 8.** Part 3.1 (commencing with Section 5820) is hereby added to Division 5 of the Welfare and Institutions Code, to read:

PART 3.1 HUMAN RESOURCES, EDUCATION, AND TRAINING PROGRAM

5820. (a) It is the intent of this part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

(b) Each county mental health program shall submit to the Office of Statewide Health Planning and Development a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing with section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

(c) The Office of Statewide Health Planning and Development, in coordination with the California Mental Health Planning Council, shall identify the total statewide needs for each professional and other occupational category utilizing county needs assessment information and develop a five-year education and training development plan.

(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years, with the next five-year plan due as of April 1, 2014.
(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

5821. (a) The California Mental Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development.
(b) The Office of Statewide Health Planning and Development shall work with the California Mental Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

5822. The Office of Statewide Health Planning and Development shall include in the five-year plan:
(a) Expansion plans for the capacity of postsecondary education to meet the needs of identified mental health occupational shortages.
(b) Expansion plans for the forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system and make loan forgiveness programs available to current employees of the mental health system who want to obtain Associate of Arts, Bachelor of Arts, masters degrees, or doctoral degrees.
(c) Creation of a stipend program modeled after the federal Title IV-E program for persons enrolled in academic institutions who want to be employed in the mental health system.
(d) Establishment of regional partnerships between the mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce, to reduce the stigma associated with mental illness, and to promote the use of web-based technologies, and distance learning techniques.
(e) Strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation centers and programs, and increasing the number of human service academies.
(f) Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with 5840), and Part 4 (commencing with 5850) of this division.
(g) Promotion of the employment of mental health consumers and family members in the mental health system.
(h) Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs in subdivisions (a) through (f).
(i) Promotion of meaningful inclusion of diverse, racial, and ethnic community members who are underrepresented in the mental health provider network.
(j) Promotion of the inclusion of cultural competency in the training and education programs in subdivisions (a) through (f).

**SECTION 9.** Part 3.2 (commencing with Section 5830) is added to Division 5 of the Welfare and Institutions Code, to read:

Part 3.2 INNOVATIVE PROGRAMS

5830. County mental health programs shall develop plans for innovative programs to be funded pursuant to paragraph (6) of subdivision (a) of Section 5892.

(a) The innovative programs shall have the following purposes:
  (1) To increase access to underserved groups.
  (2) To increase the quality of services, including better outcomes.
  (3) To promote interagency collaboration.
  (4) To increase access to services.

(b) All projects included in the innovative program portion of the county plan shall meet the following requirements:
  (1) Address one of the following purposes as its primary purpose:
    (A) Increase access to underserved groups.
    (B) Increase the quality of services, including measurable outcomes.
    (C) Promote interagency and community collaboration.
    (D) Increase access to services.
  (2) Support innovative approaches by doing one of the following:
    (A) Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.
    (B) Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.
    (C) Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in nonmental health contexts or settings.

(c) An innovative project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, any of the following:
  (1) Administrative, governance, and organizational practices, processes, or procedures.
  (2) Advocacy.
  (3) Education and training for service providers, including nontraditional mental health practitioners.
  (4) Outreach, capacity building, and community development.
  (5) System development.
  (6) Public education efforts.
  (7) Research.
  (8) Services and interventions, including prevention, early intervention, and treatment.

(d) If an innovative project has proven to be successful and a county chooses to continue it, the project work plan shall transition to another category of funding as appropriate.

(e) County mental health programs shall expend funds for their innovation programs upon approval by the Mental Health Services Oversight and Accountability Commission.

**SECTION 10.** Part 3.7 (commencing with Section 5845) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 3.7. OVERSIGHT AND ACCOUNTABILITY

5845. (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830), Innovative Programs; Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs; and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act. The commission shall replace the advisory committee established pursuant to Section 5814. The commission shall consist of 16 voting members as follows:

(1) The Attorney General or his or her designee.

(2) The Superintendent of Public Instruction or his or her designee.

(3) The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.

(4) The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.

(5) Two persons with a severe mental illness, a family member of an adult or senior with a severe mental illness, a family member of a child who has or has had a severe mental illness, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees and a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer, all appointed by the Governor. In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

(b) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(c) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(d) In carrying out its duties and responsibilities, the commission may do all of the following:

(1) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including any clerical, legal, and technical assistance as may appear necessary. The commission shall administer its operations separate and apart from the State Department of Health Care Services.

(3) Establish technical advisory committees such as a committee of consumers and family members.

(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to any officer or employee of state government.

(5) Enter into contracts.

(6) Obtain data and information from the State Department of Health Care Services, the Office of Statewide Health Planning and Development, or

other state or local entities that receive Mental Health Services Act funds, for the commission to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with Mental Health Services Act funds.

(7) Participate in the joint state-county decisionmaking process, as contained in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.

(8) Develop strategies to overcome stigma and discrimination and accomplish all other objectives of Part 3.2 (commencing with Section 5830), 3.6 (commencing with Section 5840), and the other provisions of the act establishing this commission.

(9) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.

(10) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Health Care Services pursuant to Section 5655.

(11) Assist in providing technical assistance to accomplish the purposes of the Mental Health Services Act, Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) in collaboration with the State Department of Health Care Services and in consultation with the California Mental Health Directors Association.

(12) Work in collaboration with the State Department of Health Care Services and the California Mental Health Planning Council, and in consultation with the California Mental Health Directors Association, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.

5846. (a) The commission shall issue guidelines for expenditures pursuant to Part 3.2 (commencing with Section 5830), for innovative programs, and Part 3.6 (commencing with Section 5840), for prevention and early intervention, no later than 180 days before the fiscal year for which the funds will apply.

(b) The commission may provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the commission or when local programs could benefit from technical assistance for improvement of their plans.

(c) The commission shall ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.

5847. Integrated Plans for Prevention, Innovation, and System of Care Services.

(a) Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors to the Mental Health Services Oversight and Accountability Commission within 30 days after adoption.

(b) The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements as required in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).

(2) A program for services to children in accordance with Part 4 (commencing with Section 5850), to include a program pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 or provide substantial evidence that it is not feasible to establish a wraparound program in that county.

(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).

(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).

(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the education and training programs established pursuant to Part 3.1 (commencing with Section 5820).

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act, during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(8) Certification by the county mental health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.

(9) Certification by the county mental health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act.

(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth ages 16 to 25. In

implementing this subdivision, county mental health programs shall consider the needs of transition age foster youth.

(d) Each year, the State Department of Health Care Services shall inform the California Mental Health Directors Association and the Mental Health Services Oversight and Accountability Commission of the methodology used for revenue allocation to the counties.

(e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and Part 4 (commencing with Section 5850) for services for children, and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (6) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (d) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

5848. (a) Each three-year program and expenditure plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30–day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.

(c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840, and Part 4 (commencing with Section 5850) of this division funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the California Mental Health Directors Association.

(d) Mental health services provided pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division, shall be included in the review of program performance by the California Mental Health Planning Council required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.

**SECTION 11.** Section 5771.1 is added to the Welfare and Institutions Code, to read:

5771.1 The members of the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Mental Health Planning Council. They serve in an ex officio capacity when the council is performing its statutory duties pursuant to Section 5772. Such membership shall not affect the composition requirements for the council specified in Section 5771.

**SECTION 12.** Section 17043 is added to the Revenue and Taxation Code, to read:

17043. (a) For each taxable year beginning on or after January 1, 2005, in addition to any other taxes imposed by this part, an additional tax shall be imposed at the rate of 1% on that portion of a taxpayer's taxable income in excess of one million dollars ($1,000,000).

(b) For purposes of applying Part 10.2 (commencing with Section 18401) of Division 2, the tax imposed under this section shall be treated as if imposed under Section 17041.

(c) The following shall not apply to the tax imposed by this section:

(1) The provisions of Section 17039, relating to the allowance of credits.

(2) The provisions of Section 17041, relating to filing status and recomputation of the income tax brackets.

(3) The provisions of Section 17045, relating to joint returns.

**SECTION 13.** Section 19602 of the Revenue and Taxation Code is amended to read:

19602. Except for amounts collected or accrued under Sections 17935, 17941, 17948, 19532, and 19561, revenues deposited pursuant to Section 19602.5, and revenues collected pursuant to Section 17041.1, all moneys and remittances received by the Franchise Tax Board as amounts imposed under Part 10 (commencing with Section 17001), and related penalties, additions to tax, and interest imposed under this part, shall be deposited, after clearance of remittances, in the State Treasury and credited to the Personal Income Tax Fund.

**SECTION 14.** Section 19602.5 is added to the Revenue and Taxation Code to read:

19602.5 (a) There is in the State Treasury the Mental Health Services Fund (MHS Fund). The estimated revenue from the additional tax imposed under Section 17043 for the applicable fiscal year, as determined under subparagraph (B) of paragraph (3) of subdivision (c), shall be deposited to the MHS Fund on a monthly basis, subject to an annual adjustment as described in this section.

(b) (1) Beginning with fiscal year 2004-2005 and for each fiscal year thereafter, the Controller shall deposit on a monthly basis in the MHS Fund an amount equal

to the applicable percentage of net personal income tax receipts as defined in paragraph (4).

(2) (A) Except as provided in subparagraph (B), the applicable percentage referred to in paragraph (1) shall be 1.76 percent.

(B) For fiscal year 2004-2005, the applicable percentage shall be 0.70 percent. (3) Beginning with fiscal year 2006-2007, monthly deposits to the MHS Fund pursuant to this subdivision are subject to suspension pursuant to subdivision (f).

(4) For purposes of this subdivision, "net personal income tax receipts" refers to amounts received by the Franchise Tax Board and the Employment Development Department under the Personal Income Tax Law, as reported by the Franchise Tax Board to the Department of Finance pursuant to law, regulation, procedure, and practice (commonly referred to as the "102 Report") in effect on the effective date of the Act establishing this section.

(c) No later than March 1, 2006, and each March 1 thereafter, the Department of Finance, in consultation with the Franchise Tax Board, shall determine the annual adjustment amount for the following fiscal year.

(1) The "annual adjustment amount" for any fiscal year shall be an amount equal to the amount determined by subtracting the "revenue adjustment amount" for the applicable revenue adjustment fiscal year, as determined by the Franchise Tax Board under paragraph (3), from the "tax liability adjustment amount" for applicable tax liability adjustment tax year, as determined by the Franchise Tax Board under paragraph (2).

(2) (A) (i) The "tax liability adjustment amount" for a tax year is equal to the amount determined by subtracting the estimated tax liability increase from the additional tax imposed under Section 17043 for the applicable year under subparagraph (B) from the amount of the actual tax liability increase from the additional tax imposed under Section 17043 for the applicable tax year, based on the returns filed for that tax year.

(ii) For purposes of the determinations required under this paragraph, actual tax liability increase from the additional tax means the increase in tax liability resulting from the tax of 1% imposed under Section 17043, as reflected on the original returns filed by October 15 of the year after the close of the applicable tax year.

(iii) The applicable tax year referred to in this paragraph means the 12-calendar month taxable year beginning on January 1 of the year that is two years before the beginning of the fiscal year for which an annual adjustment amount is calculated.

(B) (i) The estimated tax liability increase from the additional tax for the following tax years is:

| Tax Year | Estimated Tax Liability Increase from the Additional Tax |
|---|---|
| 2005 | $ 634 million |
| 2006 | $ 672 million |
| 2007 | $ 713 million |
| 2008 | $ 758 million |

(ii) The "estimated tax liability increase from the additional tax" for the tax year beginning in 2009 and each tax year thereafter shall be determined by applying an annual growth rate of 7 percent to the

"estimated tax liability increase from additional tax" of the immediately preceding tax year.

(3) (A) The "revenue adjustment amount" is equal to the amount determined by subtracting the "estimated revenue from the additional tax" for the applicable fiscal year, as determined under subparagraph (B), from the actual amount transferred for the applicable fiscal year.

(B) (i) The "estimated revenue from the additional tax" for the following applicable fiscal years is:

| Applicable Fiscal Year | Estimated Revenue from Additional Tax |
|---|---|
| 2004-05 | $ 254 million |
| 2005-06 | $ 683 million |
| 2006-07 | $ 690 million |
| 2007-08 | $ 733 million |

(ii) The "estimated revenue from the additional tax" for applicable fiscal year 2007-08 and each applicable fiscal year thereafter shall be determined by applying an annual growth rate of 7 percent to the "estimated revenue from the additional tax" of the immediately preceding applicable fiscal year.

(iii) The applicable fiscal year referred to in this paragraph means the fiscal year that is two years before the fiscal year for which an annual adjustment amount is calculated.

(d) The Department of Finance shall notify the Legislature and the Controller of the results of the determinations required under subdivision (c) no later than 10 business days after the determinations are final.

(e) If the annual adjustment amount for a fiscal year is a positive number, the Controller shall transfer that amount from the General Fund to the MHS Fund on July 1 of that fiscal year.

(f) If the annual adjustment amount for a fiscal year is a negative number, the Controller shall suspend monthly transfers to the MHS Fund for that fiscal year, as otherwise required by paragraph (1) of subdivision (b), until the total amount of suspended deposits for that fiscal year equals the amount of the negative annual adjustment amount for that fiscal year.

**SECTION 15.** Part 4.5 (commencing with Section 5890) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 4.5. MENTAL HEALTH SERVICES FUND

5890. (a) The Mental Health Services Fund is hereby created in the State Treasury. The fund shall be administered by the state. Notwithstanding Section 13340 of the Government Code, all moneys in the fund are, except as provided in subdivision (d) of Section 5892, continuously appropriated, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this division:

(1) Part 3 (commencing with Section 5800), the Adult and Older Adult System of Care Act.

(2) Part 3.2 (commencing with Section 5830), Innovative Programs.

(3) Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs.
(4) Part 4 (commencing with Section 5850), the Children's Mental Health Services Act.

(b) Nothing in the establishment of this fund, nor any other provisions of the act establishing it or the programs funded shall be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. Nothing in this act shall be construed to modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing these obligations of plans and insurance policies.

(c) Nothing in this act shall be construed to modify or reduce the existing authority or responsibility of the State Department of Health Care Services.

(d) The State Department of Health Care Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care.

(e) Share of costs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division, shall be determined in accordance with the Uniform Method for Determining Ability to Pay applicable to other publicly funded mental health services, unless this Uniform Method is replaced by another method of determining co-payments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

5891. (a) The funding established pursuant to this act shall be utilized to expand mental health services. Except as provided in subdivision (j) of Section 5892 due to the state's fiscal crisis, these funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund or from the Local Revenue Fund 2011 in the State Treasury, and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Section 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Section 5892.

(b) Notwithstanding subdivision (a), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any such loan shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that

would interfere with the carrying out of the object for which these funds were created.

(c) Commencing July 1, 2012, on or before the 15th day of each month, pursuant to a methodology provided by the State Department of Health Care Services, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Mental Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850).

(d) Counties shall base their expenditures on the county mental health program's three-year program and expenditure plan or annual update, as required by Section 5847. Nothing in this subdivision shall affect subdivision (a) or (b).

5892. (a) In order to promote efficient implementation of this act the county shall use funds distributed from the Mental Health Services Fund as follows:

(1) In 2005-06, 2006-07, and in 2007-08 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005-06, 2006-07 and in 2007-08 10 percent for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association to implement plans developed pursuant to Section 5847.

(3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840) of this division.

(4) The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850), for the children's system of care and Part 3 (commencing with Section 5800), for the adult and older adult system of care.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division, shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.

(b) In any year after 2007-08, programs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

(d) Prior to making the allocations pursuant to subdivisions (a), (b) and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 3.5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. The amount of funds available for the purposes of this subdivision in any fiscal year shall be subject to appropriation in the annual Budget Act.

(e) In 2004-05 funds shall be allocated as follows:
   (1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820) of this division.
   (2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).
   (3) Five percent for local planning in the manner specified in subdivision (c).
   (4) Five percent for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the fund.

(i) If there are still additional revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to

this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the commission's adopted plan which furthers the purposes of this act.

(j) For the 2011-12 fiscal year, General Fund revenues will be insufficient to fully fund many existing mental health programs, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and mental health services provided for special education pupils. In order to adequately fund those programs for the 2011-12 fiscal year and avoid deeper reductions in programs that serve individuals with severe mental illness and the most vulnerable, medically needy citizens of the state, prior to distribution of funds under paragraphs (1) to (6), inclusive, of subdivision (a), effective July 1, 2011, moneys shall be allocated from the Mental Health Services Fund to the counties as follows:

(1) Commencing July 1, 2011, one hundred eighty-three million six hundred thousand dollars ($183,600,000) of the funds available as of July 1, 2011, in the Mental Health Services Fund, shall be allocated in a manner consistent with subdivision (c) of Section 5778 and based on a formula determined by the state in consultation with the California Mental Health Directors Association to meet the fiscal year 2011-12 General Fund obligation for Medi-Cal Specialty Mental Health Managed Care.

(2) Upon completion of the allocation in paragraph (1), the Controller shall distribute to counties ninety-eight million five hundred eighty-six thousand dollars ($98,586,000) from the Mental Health Services Fund for mental health services for special education pupils based on a formula determined by the state in consultation with the California Mental Health Directors Association.

(3) Upon completion of the allocation in paragraph (2), the Controller shall distribute to counties 50 percent of their 2011-12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, not to exceed four hundred eighty-eight million dollars ($488,000,000). This allocation shall commence beginning August 1, 2011.

(4) Upon completion of the allocation in paragraph (3), and as revenues are deposited into the Mental Health Services Fund, the Controller shall distribute five hundred seventy-nine million dollars ($579,000,000) from the Mental Health Services Fund to counties to meet the General Fund obligation for EPSDT for fiscal year 2011-12. These revenues shall be distributed to counties on a quarterly basis and based on a formula determined by the state in consultation with the California Mental Health Directors Association. These funds shall not be subject to reconciliation or cost settlement.

(5) The Controller shall distribute to counties the remaining 2011-12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, beginning no later than April 30, 2012. These remaining allocations shall be made on a monthly basis.

(6) The total one-time allocation from the Mental Health Services Fund for EPSDT, Medi-Cal Specialty Mental Health Managed Care, and mental health services provided to special education pupils as referenced shall not exceed eight hundred sixty-two million dollars ($862,000,000). Any revenues deposited in the Mental Health Services Fund in fiscal year 2011-12 that exceed this obligation shall be distributed to counties for remaining fiscal

year 2011-12 Mental Health Services Act component allocations, consistent with Sections 5847 and 5891.

(k) Subdivision (j) shall not be subject to repayment.

(l) Subdivision (j) shall become inoperative on July 1, 2012.

5893. (a) In any year in which the funds available exceed the amount allocated to counties, such funds shall be carried forward to the next fiscal year to be available for distribution to counties in accordance with Section 5892 in that fiscal year.

(b) All funds deposited into the Mental Health Services Fund shall be invested in the same manner in which other state funds are invested. The fund shall be increased by its share of the amount earned on investments.

5894. In the event that Part 3 (commencing with Section 5800) or Part 4 (commencing with Section 5850) of this division, are restructured by legislation signed into law before the adoption of this measure, the funding provided by this measure shall be distributed in accordance with such legislation; provided, however, that nothing herein shall be construed to reduce the categories of persons entitled to receive services.

5895. In the event any provisions of Part 3 (commencing with Section 5800), or Part 4 (commencing with Section 5850) of this division, are repealed or modified so the purposes of this act cannot be accomplished, the funds in the Mental Health Services Fund shall be administered in accordance with those sections as they read on January 1, 2004.

5897. (a) Notwithstanding any other provision of state law, the State Department of Health Care Services shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. As used herein a county mental health program includes a city receiving funds pursuant to Section 5701.5

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of such mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through the annual county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2 of Division 5.

(d) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific time-line to achieve improvements.

(e) Contracts awarded by the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with 5800), Part 3.1 (commencing with 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890) of this division, may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to such contracts.

(f) For purposes of Section 5775, the allocation of funds pursuant to Section 5892 which are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.

5898. The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission, shall develop regulations, as necessary, for the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, or designated state and local agencies to implement this act. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.

5899. (a) The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the California Mental Health Directors Association, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report. This report shall be submitted electronically to the department and to the Mental Health Services Oversight and Accountability Commission.

(b) The purpose of the Annual Mental Health Services Act Revenue and Expenditure Report is as follows:
(1) Identify the expenditures of the Mental Health Services Act (MHSA) funds that were distributed to each county.
(2) Quantify the amount of additional funds generated for the mental health system as a result of the MHSA.
(3) Identify unexpended funds, and interest earned on MHSA funds.
(4) Determine reversion amounts, if applicable, from prior fiscal year distributions.

(c) This report is intended to provide information that allows for the evaluation of the following:
(1) Children's systems of care.
(2) Prevention and early intervention strategies.
(3) Innovative projects.
(4) Workforce education and training.
(5) Adults and older adults systems of care.
(6) Capital facilities and technology needs.

**SECTION 16**

The provisions of this act shall become effective January 1 of the year following passage of the act, and its provisions shall be applied prospectively.

The provisions of this act are written with the expectation that it will be enacted in November of 2004. In the event that it is approved by the voters at an election other than one which occurs during the 2004-05 fiscal year, the provisions of this act which refer to fiscal year 2005-06 shall be deemed to refer to the first fiscal year which begins after the effective date of this act and the provisions of this act which refer to other fiscal years shall refer to the year that is the same number of years after the first fiscal year as that year is in relationship to 2005-06.

**SECTION 17**

Notwithstanding any other provision of law to the contrary, the department shall begin implementing the provisions of this act immediately upon its effective date and shall have the authority to immediately make any necessary expenditures and to hire staff for that purpose.

**SECTION 18**

This act shall be broadly construed to accomplish its purposes. All of the provisions of this Act may be amended by a 2/3 vote of the Legislature so long as such amendments are consistent with and further the intent of this act. The Legislature may by majority vote add provisions to clarify procedures and terms including the procedures for the collection of the tax surcharge imposed by Section 12 of this act.

**SECTION 19**

If any provision of this act is held to be unconstitutional or invalid for any reason, such unconstitutionality or invalidity shall not affect the validity of any other provision.

**SECTION 1 ( of AB 100)**

(a) The Legislature hereby finds and declares that the statutory changes in this act are consistent with, and further the intent of, the Mental Health Services Act. These specified changes are necessary to adequately fund essential mental health services that would otherwise be significantly and substantially reduced or eliminated absent this temporary funding support.

(b) Further, it is the intent of the Legislature to ensure continued state oversight and accountability of the Mental Health Services Act. In eliminating state approval of county mental health programs, the Legislature expects the state, in consultation with the Mental Health Services Oversight and Accountability Commission, to establish a more effective means of ensuring that county performance complies with the Mental Health Services Act.

California LEGISLATIVE INFORMATION

**AB-1467 Health.** (2011-2012)

## Assembly Bill No. 1467

## CHAPTER 23

An act to amend Sections 7575, 12803.3, and 15438 of, to add Section 15438.10 to, and to repeal Section 7582 of, the Government Code, to amend Sections 137, 138.4, 138.6, 152, 1324.8, 1324.24, 100950, 104150, 104160, 104162.1, 104163, 104314, 104315, 104322, 110050, 113717, 116064.2, 123865, 123870, 123875, 124300, 125130, 125205, 125215, 130060, 130316, 130317, 131051, and 131052 of, to add Sections 1324.9, 131019.5, and 131055.1 to, to repeal Sections 135, 136, 138, 150, 151, 116064.1, and 125145 of, and to repeal and add Section 113718 of, the Health and Safety Code, and to amend Sections 4362, 4362.5, 4364, 4364.5, 4366, 4367.5, 4368.5, 5820, 5821, 5822, 5830, 5840, 5845, 5846, 5847, 5848, 5878.1, 5878.3, 5890, 5891, 5892, 5897, 5898, 14046.7, 14091.3, 14105.22, 14134, 14134.1, 14154, 14165, 14166.8, 14166.12, 14166.14, 14166.17, 14166.19, 14169.7, 14169.7.5, 14169.13, 14169.31, 14169.32, 14169.33, 14169.34, 14169.36, 14169.38, 14171, 14182.4, 14182.45, 14183.6, 14204, 14301.1, 14500.5, 15911, 15916, 24000, and 24001 of, to amend and repeal Sections 14085.6, 14085.7, 14085.8, 14085.81, and 14085.9 of, to add Sections 4024.7, 5899, 14089.08, 14089.09, 14166.151, 14166.152, 14166.153, 14166.154, 14166.155, 14459.6, 14459.8, 15911.1, and 15912.1 to, to add Article 2.82 (commencing with Section 14087.98) to Chapter 7 of Part 3 of Division 9 of, and to add and repeal Section 14105.196 of, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[ Approved by Governor June 27, 2012. Filed with Secretary of State June 27, 2012. ]

## LEGISLATIVE COUNSEL'S DIGEST

AB 1467, Committee on Budget. Health.

(1) Under existing law, the Robert W. Crown California Children's Services Act, the State Department of Health Care Services and each county administer the California Children's Services Program (CCS program) for treatment services for persons under 21 years of age diagnosed with severe chronic disease or severe physical limitations, as specified. Existing law generally limits eligibility for CCS program services to persons in families with an annual adjusted gross income of $40,000 or less. Under existing law, the department, or any designated local agency administering the program, is responsible for providing medically necessary occupational and physical therapy, to eligible children, as specified.

Existing law requires school districts, county offices of education, and special education local plan areas to comply with state laws that conform to the federal Individuals with Disabilities Education Act (IDEA), in order that the state may qualify for federal funds available for the education of individuals with exceptional needs. Existing law requires school districts, county offices of education, and special education local plan areas to identify, locate, and assess individuals with exceptional needs and to provide those pupils with a free appropriate public education in the least restrictive environment, and with special education and related services as reflected in an individualized education program (IEP). Existing law requires the Superintendent of Public Instruction to administer the special education provisions of the Education Code and to be responsible for assuring provision of, and supervising, education and related services to individuals with exceptional needs as required pursuant to the federal IDEA.

This bill would require, when a child has an IEP, that all occupational and physical therapy services assessed and determined to be educationally necessary by the IEP team and included in the IEP shall be provided in accordance with the federal IDEA, and not paid for by the CCS program. The bill would require the parents or estate of a child with an IEP to disclose that IEP to the CCS program at the time of application and on revision of the child's IEP. This bill would make conforming changes to procedures applicable to the CCS program's medical therapy unit conference team, when determining a child's eligibility for those therapy services.

Existing law requires that specified assessments and therapy treatment services rendered to a child referred to a local education agency for an assessment or a disabled child or youth with an IEP be exempt from financial eligibility standards and family repayment requirements.

This bill would delete these provisions.

The bill would require the State Department of Education to review regulations to ensure the appropriate implementation of educationally necessary occupational and physical therapy services required by specified provisions of federal law and specified provisions of the bill. The bill would require that specified provisions of the bill be implemented no later than October 1, 2012, and would require the State Department of Health Care Services to report, as provided, specified data relating to the implementation of the bill's provisions.

(2) Existing law transfers the Systems Integration Division of the California Health and Human Services Data Center to the California Health and Human Services Agency and provides that it shall be known as the Office of Systems Integration. Existing law prohibits the California Health and Human Services Agency from placing or transferring information technology projects in the office without further legislation authorizing these activities.

This bill would delete this prohibition.

(3) The California Health Facilities Financing Authority Act authorizes the California Health Facilities Financing Authority to make loans from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions for financing or refinancing the acquisition, construction, or remodeling of health facilities. The act defines a health facility to include various specified facilities and facilities operated in conjunction with these facilities. It also defines a participating health institution to mean specified entities authorized by state law to provide or operate a health facility and undertake the financing or refinancing of the construction or acquisition of a project or of working capital, as defined. Existing law authorizes the authority to award grants to any eligible health facility, as defined, for purposes of financing defined projects.

This bill would authorize the authority to award one or more grants that, in the aggregate, do not exceed $1,500,000 to one or more projects designed to demonstrate new or enhanced cost-effective methods of delivering health care services, as specified. This bill would authorize the authority to implement a 2nd grant program to award up to $5,000,000 to eligible recipients, if a demonstration project is successful at developing a new method of delivering certain services. This bill would create the California Health Access Model Program Account in the California Health Facilities Financing Authority Fund, and would transfer up to $6,500,000 from the fund to the account for the purposes of the bill. The bill would require that any moneys remaining in the account as of January 1, 2020, revert to the fund. By expanding the purposes for which a continuously appropriated fund may be used, this bill would make an appropriation.

(4) Existing law establishes the Office of Women's Health within the State Department of Health Care Services. Existing law requires the California Health and Human Services Agency to establish an interagency task force on women's health, as specified. Existing law establishes the Office of Multicultural Health within the State Department of Public Health.

This bill would repeal these provisions and other related provisions and instead establish the Office of Health Equity within the State Department of Public Health. The bill would require the office to perform various duties relating to reducing health and mental health disparities in vulnerable communities, as defined. The bill would require that a deputy director be appointed, as specified, and that an advisory committee be established within the office no later than October 1, 2013. The bill would require that an interagency agreement be established between the State Department of Public Health and the State Department of Health Care Services to outline the process by which the departments will jointly work to advance the mission of the office, including responsibilities, scope of work, and necessary resources. This bill would make conforming and related changes.

(5) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law requires that, as a condition of participation in the Medi-Cal program, there be imposed a quality assurance fee on certain

intermediate care facilities. Existing law requires that the fees be deposited into the General Fund and allocated to intermediate care facilities to support their quality improvement efforts, and distributed to each facility based on the number of Medi-Cal patients at the eligible facility. Existing law requires the department to impose a uniform quality assurance fee on each skilled nursing facility, with certain exceptions, in accordance with a prescribed formula and requires that the fees be deposited in the State Treasury. Existing law, the Medi-Cal Long-Term Care Reimbursement Act, requires the department to implement a facility-specific reimbursement ratesetting system for certain skilled nursing facilities. Reimbursement rates for freestanding skilled nursing facilities are funded by a combination of federal funds and moneys collected pursuant to the skilled nursing uniform quality assurance fee.

This bill would instead, beginning August 1, 2013, require the quality assurance fees imposed pursuant to these provisions be deposited into the Long-Term Care Quality Assurance Fund which would be created by this bill.

(6) The State Department of Public Health is required to perform various public health functions, including providing breast and cervical cancer screening and treatment for low-income individuals, providing prostate cancer screening and treatment for low-income and uninsured men, and specified family planning services.

This bill would, commencing July 1, 2012, transfer the duties referenced above to the State Department of Health Care Services.

(7) Existing law, the Sherman Food, Drug, and Cosmetic Law (Sherman Law), requires the department to regulate activities related to food, drugs, devices, and cosmetics and establishes the Food Safety Fund for the deposit of money collected by the department under specified Sherman Law provisions. Money in the Food Safety Fund is available to the department, upon appropriation by the Legislature, to implement specified Sherman Law provisions. The existing California Retail Food Code regulates the health and sanitation standards for retail food facilities and establishes the Retail Food Safety and Defense Fund. Money collected by the department under specified California Retail Food Code provisions is deposited in the fund and used by the department, upon appropriation by the Legislature, to implement the California Retail Food Code.

This bill would eliminate the Retail Food Safety and Defense Fund and require all money deposited into the fund to be transferred to the Food Safety Fund. This bill would expand the purpose of the Food Safety Fund to include carrying out the provisions of the California Retail Food Code.

(8) Existing law requires public swimming pools to be equipped with antientrapment devices or systems that meet ASME/ANSI or ASTM performance standards. Existing law permits the State Department of Public Health to assess an annual fee on public swimming pool owners, collected by the local health department, and deposited into the Recreational Health Fund along with other money collected by the department through enforcement of these provisions. Money in the fund is available to the department, upon appropriation by the Legislature, for the purpose of promoting these public swimming pool provisions.

This bill would instead require public swimming pools to be equipped with antientrapment devices or systems that comply with ANSI/APSP standard 16 and make related changes. This bill would eliminate the Recreational Health Fund and the department's authority to administer or enforce specified public swimming pool provisions.

(9) Existing law requires, after January 1, 2008, that any general acute care hospital building that is determined to be a potential risk of collapse or pose significant loss of life only be used for nonacute care hospital purposes, unless granted an extension as prescribed.

Existing law authorizes, commencing on the date when the State Department of Health Care Services receives specified federal approval for a 2011–12 fiscal year hospital quality assurance fee program that meets a specified condition, the Office of Statewide Health Planning and Development to grant a hospital an additional extension of up to 7 years for a hospital building that it owns or operates if the hospital meets specified milestones. These milestones include a March 31, 2012, deadline for submitting to the office a specified letter of intent and schedule.

This bill would extend until September 30, 2012, the deadline for the above-described milestones for submitting a letter of intent and a schedule.

(10) Existing law requires the Director of Health Care Services to appoint an Advisory Committee on Genetically Handicapped Person's Program. Existing law requires the director to seek advice from the committee when adopting regulations under the Genetically Handicapped Person's Program that would expand the list of genetically handicapping conditions covered by the program and requires approval from the committee when prioritizing funds and services.

This bill would delete the provisions that establish the Advisory Committee on Genetically Handicapped Person's Program. This bill would delete the provisions that authorize the director to expand the list of genetically handicapping conditions covered by the program and that require the director to establish priorities for the use of funds and services. This bill would make conforming changes.

(11) Existing law, the Health Insurance Portability and Accountability Implementation Act of 2001, requires the Office of HIPAA Implementation, established by the Governor's office within the agency, to perform specified activities required for compliance with the federal Health Insurance Portability and Accountability Act. Under existing law, the act will become inoperative and be repealed on January 1, 2013, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date, and all unexpended or unencumbered funds under that act will revert to the General Fund on January 1, 2013.

The bill would extend the act's duration to June 30, 2016, when it would be inoperative and repealed, and all funds under the act that are unexpended or unencumbered as of that date would revert to the General Fund.

(12) Under existing law, the State Department of Mental Health is authorized and required to perform various functions relating to the care and treatment of persons with mental disorders. Existing law requires the Director of Mental Health, with the advice of the Statewide Resources Consultant, as described, to contract with nonprofit community resource agencies to establish regionally based resource centers to provide services for brain-impaired adults.

This bill would transfer the Director of Mental Health's responsibilities with respect to these resource centers to the Director of Health Care Services.

(13) Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. Existing law establishes the Mental Health Services Oversight and Accountability Commission (commission) to oversee the administration of various parts of the Mental Health Services Act. The act provides that it may be amended by the Legislature by a 2/3 vote of each house as long as the amendment is consistent with and furthers the intent of the act, and that the Legislature may also clarify procedures and terms of the act by majority vote.

This bill would authorize the commission to assist in providing technical assistance, as specified, and would authorize the commission to work in collaboration with, and in consultation with, various entities in designing a comprehensive joint plan for coordinated evaluation of client outcomes. This bill would require the California Health and Human Services Agency to lead the comprehensive joint plan effort. This bill would transfer various functions of the State Department of Mental Health under the Mental Health Services Act to the State Department of Health Care Services and the Office of Statewide Health Planning and Development. This bill would make various technical and conforming changes to reflect the transfer of those mental health responsibilities. This bill would require all projects included in the innovative programs portion of the county plan to meet specified requirements.

Existing law requires each county mental health program to prepare and submit a 3-year plan that includes specified components.

This bill, in this regard, would require the plan to be a 3-year program and expenditure plan adopted by the county board of supervisors and submitted to the commission, would require annual updates, and would require plans to be certified by the county mental health director and the county auditor-controller, as specified. This bill would require the State Department of Health Care Services to inform the California Mental Health Directors Association and the commission of the methodology used for revenue allocation to the counties. This bill would require the State Department of Health Care Services, in consultation with the commission and the California Mental Health Directors Association, to develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report, as prescribed.

This bill would declare that it clarifies procedures and terms of the Mental Health Services Act.

This bill would require the Governor or the Director of Health Care Services to appoint, subject to confirmation by the Senate, a Deputy Director of Mental Health and Substance Use Disorder Services of the State Department of Health Care Services.

(14) Existing law requires the State Department of Health Care Services to establish and administer, until July 1, 2021, the Medi-Cal Electronic Health Records Incentive Program, for the purposes of providing federal incentive payments to Medi-Cal providers for the implementation and use of electronic records systems. Existing

law prohibits General Fund moneys from being used for this purpose.

This bill would instead provide that no more than $200,000 from the General Fund may be used annually for state administrative costs associated with implementing these provisions.

(15) Existing law establishes the Emergency Services and Supplemental Payments Fund, the Medi-Cal Education Supplemental Payment Fund, the Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund, and the Small and Rural Hospital Supplemental Payments Fund administered by the department from which the department is required to make supplemental payments to certain hospitals based on specified criteria.

This bill would provide that these provisions shall become inoperative on June 30, 2013, and shall be repealed on January 1, 2014.

(16) Existing law authorizes the department to provide health care services to Medi-Cal beneficiaries through various models of managed care, including though a comprehensive program of managed health care plan services for Medi-Cal recipients residing in clearly defined geographical areas. Existing law provides for a schedule of benefits under the Medi-Cal program, which, with some exceptions, includes certain dental services.

This bill would authorize the Director of Health Care Services to enter into contracts with one or more managed health care plans to provide a comprehensive program of managed health care services to Medi-Cal beneficiaries residing in specified counties. This bill would also make enrollment in Medi-Cal managed health care plans mandatory for beneficiaries residing in these counties.

This bill would require the department to establish a list of performance measures to ensure dental health plans meet quality criteria required by the department to be included in dental health contracts entered into between the department and a dental health plan. This bill would require the department to designate an external quality review organization to conduct quality reviews for any dental health plan contracting with the department, as specified. This bill would require the Director of Health Care Services to establish a beneficiary dental exception (BDE) process for Medi-Cal beneficiaries mandatorily enrolled in dental health plans in the County of Sacramento, and would require the department to amend contracts with dental health plans that provide dental services to Medi-Cal beneficiaries who reside in a specified geographic area to meet these additional requirements.

This bill would require the department, by no later than March 15, 2013, and annually thereafter, to provide designated committees of the Legislature a report on dental managed care in the Counties of Sacramento and Los Angeles, and, for reports on the County of Sacramento, data outcomes and findings from the BDE process. This bill would require the Department of Managed Health Care, by no later than January 1, 2013, to provide designated committees of the Legislature with its final report on specified surveys for the dental health plans participating in the Sacramento Geographic Managed Care Program. This bill would authorize the County of Sacramento to establish a stakeholder advisory committee on the delivery of oral health and dental care services, and would require the State Department of Health Care Services to meet periodically with the committee, as specified.

This bill would also require the department to perform specified functions in connection with the Medi-Cal managed care plan default assignment algorithm.

Existing law requires the department to enter into an interagency agreement with the Department of Managed Health Care to conduct financial audits, medical surveys, and a review of the provider networks of the managed care plans participating in a certain demonstration project.

This bill would additionally require the department to enter into the interagency agreement with the Department of Managed Health Care to conduct financial audits, medical surveys, and a review of the provider networks in connection with the expansion of Medi-Cal managed care into rural counties, and to provide consumer assistance to beneficiaries affected by certain provisions.

This bill would make legislative findings and declarations as to the necessity of a special statute for specified counties.

(17) Existing law requires, until January 1, 2013, a hospital that does not have in effect a contract with a Medi-Cal managed care health plan, as defined, that establishes payment amounts for services furnished to a beneficiary enrolled in that plan to accept as payment in full, from all Medi-Cal managed care plans, specified amounts for outpatient services, emergency inpatient services, and poststabilization services following an

emergency admission.

This bill would modify the payment amount a hospital subject to these provisions is required to accept as payment in full from Medi-Cal managed care health plans for emergency inpatient services, and would provide that the payment amounts for both emergency inpatient services and poststabilization services related to an emergency medical condition shall remain in effect only until the department implements a specified payment methodology based on diagnosis-related groups, at which time, the hospital shall accept the payment amount established by that methodology for those services. This bill would extend the operative date of these provisions to July 1, 2013, and would make related changes.

(18) Existing federal law requires the state to provide payment for primary care services furnished in the 2013 and 2014 calendar years by Medi-Cal providers with specified primary specialty designations at a rate not less than 100% of the payment rate that applies to those services and physicians under the Medicare Program.

This bill would, only to the extent that the federal medical assistance percentage is equal to 100% and only until January 1, 2015, implement this requirement for both Medi-Cal fee-for-service and managed care plans.

(19) Existing law provides that reimbursement for clinical laboratory or laboratory services under the Medi-Cal program, as defined, may not exceed 80% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services.

This bill would, upon federal approval, change the rate methodology for clinical laboratory or laboratory services, as specified. This bill would also require that rates for clinical laboratory or laboratory services be reduced by 10% until federal approval is obtained for this new rate methodology.

(20) Existing law requires Medi-Cal beneficiaries to make set copayments for specified services. Existing law, subject to federal approval, revises these copayment rates, expands the services for which copayments are due, and requires the department to reduce the amount of the payment to the provider by the amount of the copayment. Existing law provides, upon federal approval and with certain exceptions, that a provider has no obligation to provide services to a beneficiary who does not pay the copayment at the point of service.

This bill would modify these provisions as they relate to emergency and nonemergency services.

(21) Existing law provides that it is the intent of the Legislature to provide appropriate funding to the counties for the effective administration of the Medi-Cal program, except for specified fiscal years in regard to any cost-of-doing-business adjustment.

This bill would additionally provide that it is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2012–13 fiscal year.

(22) Existing law establishes the continuously appropriated Private Hospital Supplemental Fund and the continuously appropriated Nondesignated Public Hospital Supplemental Fund administered by the California Medical Assistance Commission for the purposes of funding the nonfederal share of specified payments to private and nondesignated hospitals. Existing law also provides for stabilization funding for certain hospitals through October 31, 2010, and requires specified amounts of that funding to be transferred to the Private Hospital Supplemental Fund and the Nondesignated Public Hospital Supplemental Fund. Existing law requires ~~that the California Medical Assistance Commission be dissolved after June 30, 2012, and requires the~~ department to develop a staff transition plan, as specified, that will be included in the 2012–13 Governor's budget. Existing law requires that, upon dissolution of the commission, all powers, duties, and responsibilities of the commission be transferred to the Director of Health Care Services. Existing law provides that upon a determination by the director that a payment system based on diagnosis-related groups, as described, has been developed and implemented, the powers, duties, and responsibilities conferred on the commission and transferred to the director shall no longer be exercised.

This bill, instead, would provide that the powers, duties, and responsibilities conferred on the commission and transferred to the director shall no longer be exercised upon the director's determination, except for those relating to specified stabilization payments and the ability to negotiate and make payments from the Private Hospital Supplemental Fund and the Nondesignated Public Hospital Supplemental Fund. This bill would also modify the criteria a hospital would have to meet to receive distributions from these funds. This bill would also require, notwithstanding any other law, that stabilization funding payable to nondesignated public hospitals and to project year private DSH hospitals that has not been paid or specifically committed for payment prior to January 1, 2012, be transferred to the General Fund, except as specified, and that funds that would otherwise be drawn from the General Fund for stabilization payments to these hospitals be retained in the General Fund.

This bill would delete the requirement that the department develop a staff transition plan and, instead, would implement the transition of staff positions serving the commission to the department. This bill would provide that after the diagnosis-related groups payment system is implemented, the transferred employees will transfer to civil service classifications within the department, as specified.

(23) Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, which revises hospital supplemental payment methodologies under the Medi-Cal program in order to maximize the use of federal funds consistent with federal Medicaid law and to stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients. Existing law requires the department to seek a successor demonstration project or federal waiver of Medicaid law to implement specified objectives, which may include better care coordination for seniors, persons with disabilities, and children with special health care needs. Existing law provides that to the extent the provisions under the Medi-Cal Hospital/Uninsured Care Demonstration Project Act do not conflict with the provisions of, or the Special Terms and Conditions of, this demonstration project, the provisions of the Medi-Cal Hospital/Uninsured Care Demonstration Project Act shall apply. Existing law establishes the continuously appropriated Health Care Support Fund, which consists of federal safety net care pool funds claimed and received by the department under the demonstration project and the successor demonstration project. Existing law also establishes the continuously appropriated Public Hospital Investment, Improvement, and Incentive Fund, which consists of moneys that a county, other political subdivision of the state, or other governmental entity in the state elects to transfer to the department for use as the nonfederal share of investment, improvement, and incentive payments to participating designated hospitals and the governmental entities with which they are affiliated.

This bill would, subject to federal approval, modify the inpatient fee-for-service reimbursement methodology for nondesignated public hospitals under the successor demonstration project. This bill would, among other things, provide that beginning with the 2012–13 fiscal year, and if specified conditions are met, nondesignated public hospitals, or governmental entities with which they are affiliated, shall be eligible to receive safety net care pool payments for uncompensated care from the Health Care Support Fund. By revising the purposes for which moneys in the Health Care Support Fund may be expended, this bill would make an appropriation. This bill would also provide that beginning with the 2012–13 fiscal year, subject to federal approval and if specified conditions are met, nondesignated public hospitals may receive delivery system reform incentive pool funding, as specified. This bill would make related changes to the Public Hospital Investment, Improvement, and Incentive Fund provisions. By revising the purposes for which moneys in the Public Hospital Investment, Improvement, and Incentive Fund may be used, this bill would make an appropriation. This bill would also require designated public hospitals to report and certify specified information for each successor demonstration year beginning with the 2012–13 fiscal year.

(24) Existing law, subject to federal approval, imposes a quality assurance fee, as specified, on certain general acute care hospitals for the period of July 1, 2011, through December 31, 2013. Existing law creates the Hospital Quality Assurance Revenue Fund in the State Treasury and requires that the money collected from the quality assurance fee be deposited into the fund. Existing law, subject to federal approval, provides that the moneys in the Hospital Quality Assurance Revenue Fund shall, upon appropriation by the Legislature, be available only for certain purposes, including, among other things, paying for health care coverage for children, as specified, making supplemental payments to private hospitals, and making direct grants in support of health care expenditures to designated and nondesignated public hospitals.

This bill would revise the definition of "federal approval" for the purposes of those provisions and would make conforming changes. This bill would increase the amount previously allocated for health care coverage for children for each subject fiscal quarter during the 2012–13 and 2013–14 fiscal years, and would, for the 2013–14 fiscal year, additionally require that the amount of $21,500,000 previously allocated for grants to designated public hospitals be retained by the state to pay for health care coverage of children, as specified.

(25) Existing law requires the department to audit the amounts paid for services provided to Medi-Cal beneficiaries. Existing law requires the Director of Health Care Services to establish administrative appeal processes to review complaints arising from the findings of an audit. Existing law provides that a specified interest rate shall be assessed on amounts when a provider prevails in an appeal of a disallowed payment that was paid and recovered by the department or when an unrecovered overpayment is due to the department, and in other circumstances.

This bill would modify the applicable interest rate.

(26) Existing law requires the department, pursuant to federal approval of a successor demonstration project, to authorize a local Low Income Health Program (LIHP) to provide health care services to eligible low-income

individuals under certain circumstances.

This bill would modify the provisions relating to the application of rates agreed to between the department and the participating entities with respect to the LIHP year ending June 30, 2012.

(27) Existing law authorizes counties meeting certain criteria to elect to participate in the County Medical Services Program (CMSP), for the purpose of providing specified health services to eligible county residents. Counties that elect to participate in the program may establish a CMSP governing board, responsible for the oversight of the participating counties. Existing law permits a CMSP governing board to apply to operate a local LIHP for the purpose of providing health care services, as specified.

This bill would authorize the Director of Finance to require the Controller to draw warrants against General Fund cash to provide cashflow loans of no more than a total of $100,000,000 in the 2012-13 and 2013-14 fiscal years for CMSP governing board expenses that are associated with a Low Income Health Program operated by the governing board, thereby making an appropriation.

(28) Existing law establishes the Office of AIDS in the State Department of Public Health as the lead agency responsible for coordinating state programs, services, and activities relating to the human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS-related conditions (ARC). Existing federal law, under the federal Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White Act), makes financial assistance available to states and other public and nonprofit entities to provide for the delivery of services to families with HIV.

This bill would require the State Department of Health Care Services, in collaboration with the State Department of Public Health, and in consultation with stakeholders, to develop polices and guidance on the transition of persons diagnosed with HIV/AIDS from programs funded under the federal Ryan White Act to the Low Income Health Program.

(29) Existing law provides for the Health Care Coverage Initiative (HCCI), which is a federal waiver demonstration project established to expand health care coverage to low-income uninsured individuals who are not currently eligible for the Medi-Cal program, the Healthy Families Program, or the Access for Infants and Mothers Program. Existing law requires the department to annually seek authority from the federal Centers for Medicare and Medicaid Services under the Special Terms and Conditions of the successor demonstration project to redirect HCCI funds within the safety net care pool, as defined, that are not fully utilized by the end of a demonstration year, as defined, to the category of uncompensated care to be used by designated public hospitals, on a voluntary basis, for allowable certified public expenditures, as specified.

This bill would modify the conditions under which designated public hospitals may utilize the redirected safety net care pool funds and would modify the provisions relating to disallowances or deferrals that relate to certified public expenditures for uncompensated care incurred by the designated public hospitals under these provisions.

(30) This bill would incorporate additional changes in Section 123870 of the Health and Safety Code proposed in AB 1494 and SB 1034, that would become operative only if either AB 1494 or SB 1034 and this bill are both chaptered and become effective on or before January 1, 2013, and this bill is chaptered last.

(31) This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.

Vote: majority Appropriation: yes Fiscal Committee: yes Local Program: no

## THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

**SECTION 1.** Section 7575 of the Government Code is amended to read:

**7575.** (a) Notwithstanding any other provision of law, all services assessed and determined as educationally necessary by the individualized education program (IEP) team contained in the child's IEP or individualized education plan shall be provided in accordance with the federal Individuals with Disabilities Education Act (IDEA; 20 U.S.C. Sec. 1400 et seq.).

(b) If a child applies to the California Children's Services Program pursuant to Section 123865 or 123875 of the Health and Safety Code, the State Department of Health Care Services shall determine whether the child needs medically necessary occupational therapy or physical therapy. A medical referral to the California Children's Services Program shall be based on a written report from a licensed physician and surgeon who has examined

the pupil. The written report shall include the following:

(1) The diagnosed neuromuscular, musculoskeletal, or physical disabling condition prompting the referral.

(2) The referring physician's treatment goals and objectives.

(3) The basis for determining the recommended treatment goals and objectives, including how these will ameliorate or improve the pupil's diagnosed condition.

(4) The relationship of the medical disability to the pupil's need for special education and related services.

(5) Relevant medical records.

(c) If the child has an IEP pursuant to the federal IDEA, the parents or the estate of the child shall disclose that IEP to the California Children's Services Program at the time of application and on revision of the child's IEP.

(d) The department shall provide the service directly or by contracting with another public agency, qualified individual, or a state-certified nonpublic nonsectarian school or agency.

(e) Local education agencies shall provide necessary space and equipment for the provision of occupational therapy and physical therapy in the most efficient and effective manner.

(f) The department shall also be responsible for providing the services of a home health aide when the local education agency considers a less restrictive placement from home to school for a pupil for whom both of the following conditions exist:

(1) The California Medical Assistance Program provides a life-supporting medical service via a home health agency during the time in which the pupil would be in school or traveling between school and home.

(2) The medical service provided requires that the pupil receive the personal assistance or attention of a nurse, home health aide, parent or guardian, or some other specially trained adult in order to be effectively delivered.

**SEC. 2.** Section 7582 of the Government Code is repealed.

**SEC. 3.** Section 12803.3 of the Government Code is amended to read:

**12803.3.** (a) For purposes of this section, the following definitions shall apply:

(1) "Director" means the Director of the Office of Systems Integration.

(2) "Office" means the Office of Systems Integration.

(3) "Services" means all functions, responsibilities, and services deemed to be functions, responsibilities, and services of the Systems Integration Division, also known as Systems Management Services, of the California Health and Human Services Agency Data Center, as determined by the Secretary of California Health and Human Services.

(b) (1) The Systems Integration Division of the California Health and Human Services Agency Data Center is ~~hereby transferred to the California Health and Human Services Agency and shall be known as the Office of~~ Systems Integration. The Office of Systems Integration shall be the successor to, and is vested with, all of the duties, powers, purposes, responsibilities, and jurisdiction of the Systems Integration Division of the California Health and Human Services Agency Data Center.

(2) Notwithstanding any other law, all services of the Systems Integration Division of the California Health and Human Services Agency Data Center shall become the services of the Office of Systems Integration.

(c) The office shall be under the supervision of a director, known as the Director of the Office of Systems Integration, who shall be appointed by, and serve at the pleasure of, the Secretary of California Health and Human Services.

(d) No contract, lease, license, or any other agreement to which the California Health and Human Services Data Center is a party on the date of the transfer as described in paragraph (1) of subdivision (b) shall be void or voidable by reason of this section, but shall continue in full force and effect. The office shall assume from the California Health and Human Services Data Center all of the rights, obligations, and duties of the Systems Integration Division. This assumption of rights, obligations, and duties shall not affect the rights of the parties to the contract, lease, license, or agreement.

(e) All books, documents, records, and property of the Systems Integration Division shall be in the possession and under the control of the office.

(f) All officers and employees of the Systems Integration Division shall be designated as officers and employees of the agency. The status, position, and rights of any officer or employee shall not be affected by this designation and all officers and employees shall be retained by the agency pursuant to the applicable provisions of the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5), except as to any position that is exempt from civil service.

(g) (1) All contracts, leases, licenses, or any other agreements to which the California Health and Human Services Data Center is a party regarding any of the following are hereby assigned from the California Health and Human Services Data Center to the office:

(A) Statewide Automated Welfare System (SAWS).

(B) Child Welfare Services/Case Management System (CWS/CMS).

(C) Electronic Benefit Transfer (EBT).

(D) Statewide Fingerprinting Imaging System (SFIS).

(E) Case Management Information Payrolling System (CMIPS).

(F) Employment Development Department Unemployment Insurance Modernization (UIMOD) Project.

(2) All other contracts, leases, or agreements necessary or related to the operation of the Systems Integration Division of the California Health and Human Services Data Center are hereby assigned from the California Health and Human Services Data Center to the office.

(h) It is the intent of the Legislature that the transfer of the Systems Integration Division of the California Health and Human Services Agency Data Center pursuant to this section shall be retroactive to the passage and enactment of the Budget Act of 2005 and that existing employees of the Systems Integration Division of the California Health and Human Services Agency Data Center and the newly established Office of Systems Integration shall not be negatively impacted by the reorganization and transfer conducted pursuant to this section.

(i) It is the intent of the Legislature to review fully implemented information technology projects managed by the office to assess the viability of placing the management responsibility for those projects in the respective program department.

(j) On or before April 1, 2006, the Department of Finance shall report to the Chairperson of the Joint Legislative Budget Committee the date that the administration shall conduct an assessment for each of the projects managed by the office. The California Health and Human Services Agency, the California Health and Human Services Agency Data Center, or its successor, the State Department of Social Services, and the office shall provide to the Department of Finance all information and analysis the Department of Finance deems necessary to conduct the assessment required by this section. Each assessment shall consider the costs, benefits, and any associated risks of maintaining the project management responsibility in the office and of moving the project management responsibility to its respective program department.

**SEC. 4.** Section 15438 of the Government Code is amended to read:

**15438.** The authority may do any of the following:

(a) Adopt bylaws for the regulation of its affairs and the conduct of its business.

(b) Adopt an official seal.

(c) Sue and be sued in its own name.

(d) Receive and accept from any agency of the United States, any agency of the state, or any municipality, county, or other political subdivision thereof, or from any individual, association, or corporation gifts, grants, or donations of moneys for achieving any of the purposes of this chapter.

(e) Engage the services of private consultants to render professional and technical assistance and advice in carrying out the purposes of this part.

(f) Determine the location and character of any project to be financed under this part, and to acquire, construct, enlarge, remodel, renovate, alter, improve, furnish, equip, fund, finance, own, maintain, manage, repair, operate, lease as lessee or lessor, and regulate the same, to enter into contracts for any or all of those purposes, to enter into contracts for the management and operation of a project or other health facilities owned by the authority, and to designate a participating health institution as its agent to determine the location and character of a project undertaken by that participating health institution under this chapter and as the agent of the authority, to acquire, construct, enlarge, remodel, renovate, alter, improve, furnish, equip, own, maintain, manage, repair, operate, lease as lessee or lessor, and regulate the same, and as the agent of the authority, to enter into contracts for any or all of those purposes, including contracts for the management and operation of that project or other health facilities owned by the authority.

(g) Acquire, directly or by and through a participating health institution as its agent, by purchase solely from funds provided under the authority of this part, or by gift or devise, and to sell, by installment sale or otherwise, any lands, structures, real or personal property, rights, rights-of-way, franchises, easements, and other interests in lands, including lands lying under water and riparian rights, that are located within the state that the authority determines necessary or convenient for the acquisition, construction, or financing of a health facility or the acquisition, construction, financing, or operation of a project, upon the terms and at the prices considered by the authority to be reasonable and that can be agreed upon between the authority and the owner thereof, and to take title thereto in the name of the authority or in the name of a participating health institution as its agent.

(h) Receive and accept from any source loans, contributions, or grants for, or in aid of, the construction, financing, or refinancing of a project or any portion of a project in money, property, labor, or other things of value.

(i) Make secured or unsecured loans to, or purchase secured or unsecured loans of, any participating health institution in connection with the financing of a project or working capital in accordance with an agreement between the authority and the participating health institution. However, no loan to finance a project shall exceed the total cost of the project, as determined by the participating health institution and approved by the authority. Funds for secured loans may be provided from the California Health Facilities Financing Authority Fund pursuant to subdivision (b) of Section 15439 to small or rural health facilities pursuant to authority guidelines.

(j) (1) Make secured or unsecured loans to, or purchase secured or unsecured loans of, any participating health institution in accordance with an agreement between the authority and the participating health institution to refinance indebtedness incurred by that participating health institution or a participating health institution that controls or manages, is controlled or managed by, is under common control or management with, or is affiliated with that participating health institution, in connection with projects undertaken or for health facilities acquired or for working capital.

(2) Make secured or unsecured loans to, or purchase secured or unsecured loans of, any participating health institution in accordance with an agreement between the authority and the participating health institution to refinance indebtedness incurred by that participating health institution or a participating health institution that controls or manages, is controlled or managed by, is under common control or management with, or is affiliated with that participating health institution, payable to the authority or assigned or pledged to authority issued bonds.

(3) Funds for secured loans may be provided from the California Health Facilities Financing Authority Fund pursuant to subdivision (b) of Section 15439 to small or rural health facilities pursuant to authority guidelines.

(k) Mortgage all or any portion of interest of the authority in a project or other health facilities and the property on which that project or other health facilities are located, whether owned or thereafter acquired, including the granting of a security interest in any property, tangible or intangible, and to assign or pledge all or any portion of the interests of the authority in mortgages, deeds of trust, indentures of mortgage or trust, or similar instruments, notes, and security interests in property, tangible or intangible, of participating health institutions to which the authority has made loans, and the revenues therefrom, including payments or income from any thereof owned or held by the authority, for the benefit of the holders of bonds issued to finance the project or health facilities or issued to refund or refinance outstanding indebtedness of participating health institutions as permitted by this part.

(l) Lease to a participating health institution the project being financed or other health facilities conveyed to the authority in connection with that financing, upon the terms and conditions the authority determines proper,

charge and collect rents therefor, terminate the lease upon the failure of the lessee to comply with any of the obligations of the lease, and include in that lease, if desired, provisions granting the lessee options to renew the term of the lease for the period or periods and at the rent, as determined by the authority, purchase any or all of the health facilities or that upon payment of all of the indebtedness incurred by the authority for the financing of that project or health facilities or for refunding outstanding indebtedness of a participating health institution, then the authority may convey any or all of the project or the other health facilities to the lessee or lessees thereof with or without consideration.

(m) Charge and equitably apportion among participating health institutions, the administrative costs and expenses incurred by the authority in the exercise of the powers and duties conferred by this part.

(n) Obtain, or aid in obtaining, from any department or agency of the United States or of the state, any private company, or any insurance or guarantee as to, of, or for the payment or repayment of, interest or principal, or both, or any part thereof, on any loan, lease, or obligation, or any instrument evidencing or securing the loan, lease, or obligation, made or entered into pursuant to this part; and notwithstanding any other provisions of this part, to enter into any agreement, contract, or any other instrument whatsoever with respect to that insurance or guarantee, to accept payment in the manner and form as provided therein in the event of default by a participating health institution, and to assign that insurance or guarantee as security for the authority's bonds.

(o) Enter into any and all agreements or contracts, including agreements for liquidity or credit enhancement, bond exchange agreements, interest rate swaps or hedges, execute any and all instruments, and do and perform any and all acts or things necessary, convenient, or desirable for the purposes of the authority or to carry out any power expressly granted by this part.

(p) Invest any moneys held in reserve or sinking funds or any moneys not required for immediate use or disbursement, at the discretion of the authority, in any obligations authorized by the resolution authorizing the issuance of the bonds secured thereof or authorized by law for the investment of trust funds in the custody of the Treasurer.

(q) Award grants to any eligible clinic pursuant to Section 15438.6.

(r) Award grants to any eligible health facility pursuant to Section 15438.7.

(s) (1) Notwithstanding any other provision of law, provide a working capital loan of up to five million dollars ($5,000,000) to assist in the establishment and operation of the California Health Benefit Exchange (Exchange) established under Section 100500. The authority may require any information it deems necessary and prudent prior to providing a loan to the Exchange and may require any term, condition, security, or repayment provision it deems necessary in the event the authority chooses to provide a loan. Under no circumstances shall the authority be required to provide a loan to the Exchange.

(2) Prior to the authority providing a loan to the Exchange, a majority of the board of the Exchange shall be appointed and shall demonstrate, to the satisfaction of the authority, that the federal planning and establishment grants made available to the Exchange by the United States Secretary of Health and Human Services are insufficient or will not be released in a timely manner to allow the Exchange to meet the necessary requirements of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(3) The Exchange shall repay a loan made under this subdivision no later than June 30, 2016, and shall pay interest at the rate paid on moneys in the Pooled Money Investment Account.

(t) Award grants pursuant to Section 15438.10.

**SEC. 5.** Section 15438.10 is added to the Government Code, to read:

**15438.10.** (a) The Legislature finds and declares the following:

(1) Many Californians face serious obstacles in obtaining needed health care services, including, but not limited to, medical, mental health, dental, and preventive services. The obstacles faced by vulnerable populations and communities include existence of complex medical, physical, or social conditions, disabilities, economic disadvantage, and living in remote or underserved areas that make it difficult to access services.

(2) With the recent passage of national health care reform, there is an increased demand for innovative ways to deliver quality health care, including preventive services, to individuals in a cost-effective manner.

(3) There is a need to develop new methods of delivering health services utilizing innovative models that can be

demonstrated to be effective and then replicated throughout California and that bring community-based health care preventive services to individuals where they live or receive education, social, or general health services.

(4) For more than 30 years, the California Health Facilities Financing Authority has provided financial assistance through tax-exempt bonds, low-interest loans, and grants to health facilities in California, assisting in the expansion of the availability of health services and health care facilities throughout the state.

(b) (1) Following the completion of a competitive selection process, the authority may award one or more grants that, in the aggregate, do not exceed one million five hundred thousand dollars ($1,500,000) to one or more projects designed to demonstrate specified new or enhanced cost-effective methods of delivering quality health care services to improve access to quality health care for vulnerable populations or communities, or both, that are effective at enhancing health outcomes and improving access to quality health care and preventive services. These health care services may include, but are not limited to, medical, mental health, or dental services for the diagnosis, care, prevention, and treatment of human illness, or individuals with physical, mental, or developmental disabilities. More than one demonstration project may receive a grant pursuant to this section. It is the intent of the Legislature for a demonstration project that receives a grant to allow patients to receive screenings, diagnosis, or treatment in community settings, including, but not limited to, school-based health centers, adult day care centers, and residential care facilities for the elderly, or for individuals with mental illness or developmental disabilities.

(2) A grant awarded pursuant to this subdivision may be allocated in increments to a demonstration project over multiple years to ensure the demonstration project's ability to complete its work, as determined by the authority. Prior to the initial allocation of funds pursuant to this subdivision, the administrators of the demonstration project shall provide evidence that the demonstration project has or will have additional funds sufficient to ensure completion of the demonstration project. If the authority allocates a grant in increments, each subsequent year's allocation shall be provided to the demonstration project only upon submission of research that shows that the project is progressing toward the identification of a high-quality and cost-effective delivery model that improves health outcomes and access to quality health care and preventive services for vulnerable populations or communities, and can be replicated throughout the state in community settings.

(3) Except for a health facility that qualifies as a "small and rural hospital" pursuant to Section 124840 of the Health and Safety Code, a health facility that has received tax-exempt bond financing from the authority shall not be eligible to receive funds awarded for a demonstration project. Such a health facility may participate as an uncompensated partner or member of a collaborative effort that is awarded a demonstration project grant. A health facility that participates in a demonstration project that receives funds pursuant to this section may not claim the funding provided by the authority toward meeting its community benefit and charity care obligations.

(4) Funds provided to a demonstration project pursuant to this subdivision may be used to supplement, but not to supplant, existing financial and resource commitments of the grantee or grantees or any other member of a collaborative effort that has been awarded a demonstration project grant.

(c) (1) If a demonstration project that receives a grant pursuant to subdivision (b) is successful at developing a new method of delivering high-quality and cost-effective health care services in community settings that result in increased access to quality health care and preventive services or improved health care outcomes for vulnerable populations or communities, or both, then beginning as early as the second year after the initial allocation of moneys provided pursuant to subdivision (b), the authority may implement a second grant program that awards not more than five million dollars ($5,000,000), in the aggregate, to eligible recipients as defined by the authority, to replicate in additional California communities the model developed by a demonstration project that received a grant pursuant to subdivision (b). Prior to the implementation of this second grant program, the authority shall prepare and provide a report to the Legislature and the Governor on the outcomes of the demonstration project. The report shall be made in accordance with Section 9795.

(2) If the authority implements the second grant program, the authority shall also report annually, beginning with the first year of implementation of the second grant program, to the Legislature and the Governor regarding the program, including, but not limited to, the total amount of grants issued pursuant to this subdivision, the amount of each grant issued, and a description of each project awarded funding for replication of the model.

(3) Grants under this subdivision may be utilized for eligible costs, as defined in subdivision (c) of Section 15432, including equipment, information technology, and working capital, as defined in subdivision (h) of Section 15432.

(4) The authority may adopt regulations relating to the grant program authorized pursuant to this subdivision, including regulations that define eligible recipients, eligible costs, and minimum and maximum grant amounts.

(d) (1) The authority shall prepare and provide a report to the Legislature and the Governor by January 1, 2014, on the outcomes of the demonstration grant program, including, but not limited to, the following:

(A) The total amount of grants issued.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) A description of each project awarded funding.

(E) A description of project outcomes that demonstrate cost-effective delivery of health care services in community settings, that result in improved access to quality health care or improved health care outcomes.

(2) A report submitted pursuant to this subdivision shall be submitted in compliance with Section 9795.

(e) There is hereby created the California Health Access Model Program Account in the California Health Facilities Financing Authority Fund. All moneys in the account are hereby continuously appropriated to the authority for carrying out the purposes of this section. An amount of up to six million five hundred thousand dollars ($6,500,000) shall be transferred from funds in the California Health Facilities Financing Authority Fund that are not impressed with a trust for other purposes into the California Health Access Model Program Account for the purpose of issuing grants pursuant to this section. Any moneys remaining in the California Health Access Model Program Account on January 1, 2020, shall revert as of that date to the California Health Facilities Financing Authority Fund.

(f) Any recipient of a grant provided pursuant to subdivision (b) shall adhere to all applicable laws relating to scope of practice, licensure, staffing, and building codes.

**SEC. 6.** Section 135 of the Health and Safety Code is repealed.

**SEC. 7.** Section 136 of the Health and Safety Code is repealed.

**SEC. 8.** Section 137 of the Health and Safety Code is amended to read:

**137.** (a) The State Department of Public Health shall develop a coordinated state strategy for addressing the health-related needs of women, including implementation of goals and objectives for women's health.

(b) The approved programmatic costs associated with this strategy shall be the responsibility of the State Department of Public Health unless otherwise provided by law.

**SEC. 9.** Section 138 of the Health and Safety Code is repealed.

**SEC. 10.** Section 138.4 of the Health and Safety Code is amended to read:

**138.4.** (a) The State Department of Public Health shall place priority on providing information to consumers, patients, and health care providers regarding women's gynecological cancers, including signs and symptoms, risk factors, the benefits of early detection through appropriate diagnostic testing, and treatment options.

(b) In exercising the powers under this section, the State Department of Public Health shall consult with appropriate health care professionals and providers, consumers, and patients, or organizations representing them.

(c) The duties of the State Department of Public Health pursuant to this section are contingent upon the receipt of funds appropriated for this purpose.

(d) The State Department of Public Health may adopt any regulations necessary and appropriate for the implementation of this section.

**SEC. 11.** Section 138.6 of the Health and Safety Code is amended to read:

**138.6.** (a) The State Department of Public Health shall include in any literature that it produces regarding breast cancer information that shall include, but not be limited to, all of the following:

(1) Summarized information on risk factors for breast cancer in younger women, including, but not limited to, information on the increased risk associated with a family history of the disease.

(2) Summarized information regarding detection alternatives to mammography that may be available and more effective for at-risk women between the ages of 25 and 40 years.

(3) Information on Internet Web sites of relevant organizations, government agencies, and research institutions where information on mammography alternatives may be obtained.

(b) The information required by subdivision (a) shall be produced consistent with the department's protocols and procedures regarding the production and dissemination of information on breast cancer, including, but not limited to, the following factors:

(1) Restrictions imposed by space limitation on materials currently produced and distributed by the department.

(2) Future regular production and replacement schedules.

(3) Translation standards governing the number of languages and literacy levels.

(4) The nature, content, and purpose of the material into which this new information will be incorporated.

(c) It is the intent of the Legislature that subdivisions (a) and (b) apply to information that is distributed by any branch of the department, including, but not limited to, the Cancer Detection Section and the Office of Health Equity.

**SEC. 12.** Section 150 of the Health and Safety Code is repealed.

**SEC. 13.** Section 151 of the Health and Safety Code is repealed.

**SEC. 14.** Section 152 of the Health and Safety Code is amended to read:

**152.** (a) The State Department of Public Health Office of Health Equity shall do all of the following:

(1) Perform strategic planning to develop departmentwide plans for implementation of goals and objectives to close the gaps in health status and access to care among the state's diverse racial and ethnic communities, women, persons with disabilities, and the lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) communities.

(2) Conduct departmental policy analysis on specific issues related to multicultural health.

(3) Coordinate projects funded by the state that are related to improving the effectiveness of services to ethnic and racial communities, women, and the LGBTQQ communities.

(4) Identify the unnecessary duplication of services and future service needs.

(5) Communicate and disseminate information and perform a liaison function within the department and to providers of health, social, educational, and support services to racial and ethnic communities, women, persons with disabilities, and the LGBTQQ communities. The department shall consult regularly with representatives from diverse racial and ethnic communities, women, persons with disabilities, and the LGBTQQ communities, including health providers, advocates, and consumers.

(6) Perform internal staff training, an internal assessment of cultural competency, and training of health care professionals to ensure more linguistically and culturally competent care.

(7) Serve as a resource for ensuring that programs collect and keep data and information regarding ethnic and racial health statistics, including those statistics described in reports released by Healthy People 2020, and information based on sexual orientation, gender identity, and gender expression, strategies and programs that address multicultural health issues, including, but not limited to, infant and maternal mortality, cancer, cardiovascular disease, diabetes, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), child and adult immunization, osteoporosis, menopause, and full reproductive health, asthma, unintentional and intentional injury, and obesity, as well as issues that impact the health of racial and ethnic communities, women, and the LGBTQQ communities, including substance abuse, mental health, housing, teenage pregnancy, environmental disparities, immigrant and migrant health, and health insurance and delivery systems.

(8) Encourage innovative responses by public and private entities that are attempting to address multicultural health issues.

(9) Provide technical assistance to counties, other public entities, and private entities seeking to obtain funds for initiatives in multicultural health, including identification of funding sources and assistance with writing grants.

(b) Notwithstanding Section 10231.5 of the Government Code, the State Department of Public Health shall biennially prepare and submit a report to the Legislature on the status of the activities required by this chapter. This report shall be included in the report required under paragraph (1) of subdivision (d) of Section 131019.5.

**SEC. 15.** Section 1324.8 of the Health and Safety Code is amended to read:

**1324.8.** (a) The quality assurance fee assessed and collected pursuant to this article shall be deposited in the General Fund.

(b) Notwithstanding subdivision (a), commencing August 1, 2013, the quality assurance fee assessed and collected pursuant to this article shall be deposited in the Long-Term Care Quality Assurance Fund established pursuant to Section 1324.9.

**SEC. 16.** Section 1324.9 is added to the Health and Safety Code, to read:

**1324.9.** (a) The Long-Term Care Quality Assurance Fund is hereby created in the State Treasury. Moneys in the fund shall be available, upon appropriation by the Legislature, for expenditure by the State Department of Health Care Services for the purposes of this article and Article 7.6 (commencing with Section 1324.20). Notwithstanding Section 16305.7 of the Government Code, the fund shall contain all interest and dividends earned on moneys in the fund.

(b) Notwithstanding any other law, beginning August 1, 2013, all revenues received by the State Department of Health Care Services categorized by the State Department of Health Care Services as long-term care quality assurance fees shall be deposited into the Long-Term Care Quality Assurance Fund. Revenue that shall be deposited into this fund shall include quality assurance fees imposed pursuant to this article and quality assurance fees imposed pursuant to Article 7.6 (commencing with Section 1324.20).

**SEC. 17.** Section 1324.24 of the Health and Safety Code is amended to read:

**1324.24.** (a) The quality assurance fee assessed and collected pursuant to this article shall be deposited in the State Treasury.

(b) Notwithstanding subdivision (a), commencing August 1, 2013, the quality assurance fee assessed and collected pursuant to this article shall be deposited in the Long-Term Care Quality Assurance Fund established pursuant to Section 1324.9.

**SEC. 18.** Section 100950 of the Health and Safety Code is amended to read:

**100950.** The department shall administer this part, Section 100295, and Chapter 3 (commencing with Section 101175) of Part 3 and shall adopt necessary regulations. These regulations shall be adopted only after consultation with and approval by the California Conference of Local Health Officers. Approval of these regulations shall be by majority vote of those present at an official session.

**SEC. 19.** Section 104150 of the Health and Safety Code is amended to read:

**104150.** (a) A provider or entity that participates in the grant made to the department by the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program established under Title XV of the federal Public Health Service Act (42 U.S.C. Sec. 300k et seq.) in accordance with requirements of Section 1504 of that act (42 U.S.C. Sec. 300n) may only render screening services under the grant to an individual if the provider or entity determines that the individual's family income does not exceed 200 percent of the federal poverty level.

(b) The department shall provide for breast cancer and cervical cancer screening services under the grant at the level of funding budgeted from state and other resources during the fiscal year in which the Legislature has appropriated funds to the department for this purpose. These screening services shall not be deemed to be an

entitlement.

(c) To implement the federal breast and cervical cancer early detection program specified in this section, the department may contract, to the extent permitted by Section 19130 of the Government Code, with public and private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary. However, the Medi-Cal program's fiscal intermediary shall only be utilized if services provided under the program are specifically identified and reimbursed in a manner that does not claim federal financial reimbursement. Any contracts with, and the utilization of, the Medi-Cal program's fiscal intermediary shall not be subject to Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code. Contracts to implement the federal breast and cervical cancer early detection program entered into by the department with entities other than the Medi-Cal program's fiscal intermediary shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(d) The department shall enter into an interagency agreement with the State Department of Health Care Services to transfer that portion of the grant made to the department by the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program established under Title XV of the federal Public Health Service Act (42 U.S.C. Sec. 300k et seq.) to the State Department of Health Care Services. The department shall have no other liability to the State Department of Health Care Services under this article.

**SEC. 20.** Section 104160 of the Health and Safety Code is amended to read:

**104160.** (a) The State Department of Health Care Services shall develop and maintain the Breast and Cervical Cancer Treatment Program to expand and ensure quality breast and cervical cancer treatment for low-income uninsured and underinsured individuals who are diagnosed with breast or cervical cancer.

(b) To implement the program, the State Department of Health Care Services may contract with public or private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary, only if services provided under the program are specifically identified and reimbursed in a manner that does not claim federal financial reimbursement. The utilization of the Medi-Cal program's fiscal intermediary shall not be subject to Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code. Contracts to implement the program entered into by the State Department of Health Care Services with entities other than the Medi-Cal program's fiscal intermediary shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

**SEC. 21.** Section 104162.1 of the Health and Safety Code is amended to read:

**104162.1.** When an individual is underinsured, as defined in subdivision (g) of Section 104161, the State Department of Health Care Services shall be the payer of second resort for treatment services. To the extent necessary for the individual to obtain treatment services under any health care insurance listed in paragraph (2), (3), or (4) of subdivision (f) of Section 104161, the State Department of Health Care Services may do the following:

(a) Pay for the individual's breast or cervical cancer copayments, premiums, and deductible.

(b) Provide only treatment services not otherwise covered by any health care insurance listed in paragraph (2), (3), or (4) of subdivision (f) of Section 104161.

**SEC. 22.** Section 104163 of the Health and Safety Code is amended to read:

**104163.** The State Department of Health Care Services shall provide for breast cancer and cervical cancer treatment services pursuant to this article at the level of funding budgeted from state and other resources during the fiscal year in which the Legislature has appropriated funds to the department for this purpose. These treatment services shall not be deemed to be an entitlement.

**SEC. 23.** Section 104314 of the Health and Safety Code is amended to read:

**104314.** (a) The Prostate Cancer Fund is hereby established in the State Treasury. It is the intent of the Legislature that the fund be funded by an annual appropriation, when funds are available, in the Budget Act.

(b) The moneys in the Prostate Cancer Fund shall be expended by the State Department of Health Care Services, upon appropriation by the Legislature, for the purpose of the Prostate Cancer Screening Program

established by Section 104315.

(c) For the purposes of this chapter, "department" means the State Department of Health Care Services.

**SEC. 24.** Section 104315 of the Health and Safety Code is amended to read:

**104315.** (a) The Prostate Cancer Screening Program shall be established in the State Department of Health Care Services.

(b) The program shall apply to both of the following:

(1) Uninsured men 50 years of age and older.

(2) Uninsured men between 40 and 50 years of age who are at high risk for prostate cancer, upon the advice of a physician or upon the request of the patient.

(c) For purposes of this chapter, "uninsured" means not covered by any of the following:

(1) Medi-Cal.

(2) Medicare.

(3) A health care service plan contract or policy of disability insurance that covers screening for prostate cancer for men 50 years of age and older, and for men between 40 and 50 years of age who are at high risk for prostate cancer upon the advice of a physician or upon the request of the patient.

(4) Any other form of health care coverage that covers screening for prostate cancer for men 50 years of age and older, and for men between 40 and 50 years of age who are at high risk for prostate cancer upon the advice of a physician or upon the request of the patient.

(d) The program shall include all of the following:

(1) Screening of men for prostate cancer as an early detection health care measure.

(2) After screening, medical referral of screened men and services necessary for definitive diagnosis.

(3) If a positive diagnosis is made, then assistance and advocacy shall be provided to help the person obtain necessary treatment.

(4) Outreach and health education activities to ensure that uninsured men are aware of and appropriately utilize the services provided by the program.

(e) Any entity funded by the program shall coordinate with other local providers of prostate cancer screening, diagnostic, followup, education, and advocacy services to avoid duplication of effort. Any entity funded by the program shall comply with any applicable state and federal standards regarding prostate cancer screening.

(f) Administrative costs of the department shall not exceed 10 percent of the funds allocated to the program. Indirect costs of the entities funded by this program shall not exceed 12 percent. The department shall define "indirect costs" in accordance with applicable state and federal law.

(g) Any entity funded by the program shall collect data and maintain records that are determined by the department to be necessary to facilitate the state department's ability to monitor and evaluate the effectiveness of the entities and the program. Commencing with the program's second year of operation, and notwithstanding Section 10231.5 of the Government Code, the department shall submit an annual report to the Legislature and any other appropriate entity. The report shall describe the activities and effectiveness of the program and shall include, but not be limited to, the following types of information regarding those served by the program:

(1) The number.

(2) The ethnic, geographic, and age breakdown.

(3) The stages of presentation.

(4) The diagnostic and treatment status.

(h) The department or any entity funded by the program shall collect personal and medical information necessary to administer the program from any individual applying for services under the program. The

information shall be confidential and shall not be disclosed other than for purposes directly connected with the administration of the program or except as otherwise provided by law or pursuant to prior written consent of the subject of the information.

(i) The department or any entity funded by the program may disclose the confidential information to medical personnel and fiscal intermediaries of the state to the extent necessary to administer the program, and to other state public health agencies or medical researchers if the confidential information is necessary to carry out the duties of those agencies or researchers in the investigation, control, or surveillance of prostate cancer.

(j) The department shall adopt regulations to implement the Prostate Cancer Screening Program in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(k) This section shall not be implemented unless and until funds are appropriated for this purpose in the annual Budget Act.

(l) To implement the Prostate Cancer Screening Program, the department may contract, to the extent permitted by Section 19130 of the Government Code, with public and private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary. However, the Medi-Cal program's fiscal intermediary shall only be utilized if services provided under the program are specifically identified and reimbursed in a manner that does not claim federal financial reimbursement. Any contracts with, and the utilization of, the Medi-Cal program's fiscal intermediary shall not be subject to Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code. Contracts to implement the Prostate Cancer Screening Program entered into by the department with entities other than the Medi-Cal program's fiscal intermediary shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

**SEC. 25.** Section 104322 of the Health and Safety Code is amended to read:

**104322.** (a) (1) The State Department of Health Care Services shall develop and implement a program to provide quality prostate cancer treatment for low-income and uninsured men.

(2) The State Department of Health Care Services shall award one or more contracts to provide prostate cancer treatment through private or public nonprofit organizations, including, but not limited to, community-based organizations, local health care providers, the University of California medical centers, and the Charles R. Drew University of Medicine and Science, an affiliate of the David Geffen School of Medicine at the University of California at Los Angeles. Contracts awarded, subsequent to the effective date of the amendments to this section made during the 2005 portion of the 2005–06 Regular Session, pursuant to this paragraph shall be consistent with both of the following:

(A) Eighty-seven percent of the total contract funding shall be used for direct patient care.

(B) No less than 70 percent of the total contract funding shall be expended on direct patient care treatment costs, which shall be defined as funding to fee-for-service providers for Medi-Cal eligible services.

(3) The contracts described in paragraph (2) shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code. Commencing July 1, 2006, those contracts shall be entered into on a competitive bid basis.

(4) It is the intent of the Legislature to support the prostate cancer treatment program provided for pursuant to this section, and that the program be cost-effective and maximize the number of men served for the amount of funds appropriated. It is further the intent of the Legislature to ensure that the program has an adequate health care provider network to facilitate reasonable access to treatment.

(b) Treatment provided under this chapter shall be provided to uninsured and underinsured men with incomes at or below 200 percent of the federal poverty level. Covered services shall be limited to prostate cancer treatment and prostate cancer-related services. Eligible men shall be enrolled in a 12-month treatment regimen.

(c) The State Department of Health Care Services shall contract for prostate cancer treatment services only at the level of funding budgeted from state and other sources during a fiscal year in which the Legislature has appropriated funds to the department for this purpose.

(d) Notwithstanding subdivision (a) of Section 2.00 of the Budget Act of 2003 and any other provision of law, commencing with the 2003–04 fiscal year and for each fiscal year thereafter, any amount appropriated to the

State Department of Health Care Services for the prostate cancer treatment program implemented pursuant to this chapter shall be made available, for purposes of that program, for encumbrance for one fiscal year beyond the year of appropriation and for expenditure for two fiscal years beyond the year of encumbrance.

**SEC. 26.** Section 110050 of the Health and Safety Code is amended to read:

**110050.** The Food Safety Fund is hereby created as a special fund in the State Treasury. All moneys collected by the department under subdivision (c) of Section 110466 and Sections 110470, 110471, 110485, 111130, and 113717, and under Article 7 (commencing with Section 110810) of Chapter 5 shall be deposited in the fund, for use by the department, upon appropriation by the Legislature, for the purposes of providing funds necessary to carry out and implement the inspection provisions of this part relating to food, licensing, inspection, enforcement, and other provisions of Article 12 (commencing with Section 111070) relating to water, the provisions relating to education and training in the prevention of microbial contamination pursuant to Section 110485, and the registration provisions of Article 7 (commencing with Section 110810) of Chapter 5, and to carry out and implement the provisions of the California Retail Food Code (Part 7 (commencing with Section 113700) of Division 104).

**SEC. 27.** Section 113717 of the Health and Safety Code is amended to read:

**113717.** (a) Any person requesting the department to undertake any activity pursuant to paragraph (5) of subdivision (c) of Section 113871, Section 114417, paragraph (2) of subdivision (b) of Section 114419, and Section 114419.3 shall pay the department's costs incurred in undertaking the activity. The department's services shall be assessed at the current hourly cost-recovery rate, and it shall be entitled to recover any other costs reasonably and actually incurred in performing those activities, including, but not limited to, the costs of additional inspection and laboratory testing. For purposes of this section, the department's hourly rate shall be adjusted annually in accordance with Section 100425.

(b) The department shall provide to the person paying the required fee a statement, invoice, or similar document that describes in reasonable detail the costs paid.

(c) For purposes of this section only, the term "person" does not include any city, county, city and county, or other political subdivision of the state or local government.

**SEC. 28.** Section 113718 of the Health and Safety Code is repealed.

**SEC. 29.** Section 113718 is added to the Health and Safety Code, to read:

**113718.** Notwithstanding Section 16350 of the Government Code, all moneys deposited in the Retail Food Safety and Defense Fund shall be transferred to the Food Safety Fund for appropriation and expenditure as specified by Section 110050.

**SEC. 30.** Section 116064.1 of the Health and Safety Code is repealed.

**SEC. 31.** Section 116064.2 of the Health and Safety Code is amended to read:

**116064.2.** (a) As used in this section, the following words have the following meanings:

(1) "ASME/ANSI performance standard" means a standard that is accredited by the American National Standards Institute and published by the American Society of Mechanical Engineers.

(2) "ASTM performance standard" means a standard that is developed and published by ASTM International.

(3) "Main drain" means a submerged suction outlet typically located at the bottom of a swimming pool that conducts water to a recirculating pump.

(4) "Public swimming pool" means an outdoor or indoor structure, whether in-ground or above-ground, intended for swimming or recreational bathing, including a swimming pool, hot tub, spa, or nonportable wading pool, that is any of the following:

(A) Open to the public generally, whether for a fee or free of charge.

(B) Open exclusively to members of an organization and their guests, residents of a multiunit apartment building, apartment complex, residential real estate development, or other multifamily residential area, or

patrons of a hotel or other public accommodations facility.

(C) Located on the premises of an athletic club, or public or private school.

(5) "Qualified individual" means a contractor who holds a current valid license issued by the State of California or a professional engineer licensed in the State of California who has experience working on public swimming pools.

(6) "Safety vacuum release system" means a vacuum release system that ceases operation of the pump, reverses the circulation flow, or otherwise provides a vacuum release at a suction outlet when a blockage is detected.

(7) "Skimmer equalizer line" means a suction outlet located below the waterline and connected to the body of a skimmer that prevents air from being drawn into the pump if the water level drops below the skimmer weir. However, a skimmer equalizer line is not a main drain.

(8) "Unblockable drain" means a drain of any size and shape that a human body cannot sufficiently block to create a suction entrapment hazard.

(b) Subject to subdivision (e), every public swimming pool shall be equipped with antientrapment devices or systems that comply with the ANSI/APSP-16 2011 standard as in effect on December 31, 2011.

(c) Subject to subdivisions (d) and (e), every public swimming pool with a single main drain that is not an unblockable drain shall be equipped with at least one or more of the following devices or systems that are designed to prevent physical entrapment by pool drains:

(1) A safety vacuum release system that has been tested by a nationally recognized testing laboratory and found to conform to ASME/ANSI performance standard A112.19.17, as in effect on December 31, 2009, or ASTM performance standard F2387, as in effect on December 31, 2009.

(2) A suction-limiting vent system with a tamper-resistant atmospheric opening, provided that it conforms to any applicable ASME/ANSI or ASTM performance standard.

(3) A gravity drainage system that utilizes a collector tank, provided that it conforms to any applicable ASME/ANSI or ASTM performance standard.

(4) An automatic pump shut-off system tested by a department-approved independent third party and found to conform to any applicable ASME/ANSI or ASTM performance standard.

(5) Any other system that is deemed, in accordance with federal law, to be equally effective as, or more effective than, the systems described in paragraph (1) at preventing or eliminating the risk of injury or death associated with pool drainage systems.

(d) Every public swimming pool constructed on or after January 1, 2010, shall have at least two main drains per pump that are hydraulically balanced and symmetrically plumbed through one or more "T" fittings, and that are separated by a distance of at least three feet in any dimension between the drains. A public swimming pool constructed on or after January 1, 2010, that meets the requirements of this subdivision, shall be exempt from the requirements of subdivision (c).

(e) A public swimming pool constructed prior to January 1, 2010, shall be retrofitted to comply with subdivisions (b) and (c) by no later than July 1, 2010, except that no further retrofitting is required for a public swimming pool that completed a retrofit between December 19, 2007, and January 1, 2010, that complied with the Virginia Graeme Baker Pool and Spa Safety Act (15 U.S.C. Sec. 8001 et seq.) as in effect on the date of issue of the construction permit, or for a nonportable wading pool that completed a retrofit prior to January 1, 2010, that complied with state law on the date of issue of the construction permit. A public swimming pool owner who meets the exception described in this subdivision shall do one of the following prior to September 30, 2010:

(1) File the form issued by the department pursuant to subdivision (f), as otherwise provided in subdivision (h).

(2) (A) File a signed statement attesting that the required work has been completed.

(B) Provide a document containing the name and license number of the qualified individual who completed the required work.

(C) Provide either a copy of the final building permit, if required by the local agency, or a copy of one of the

following documents if no permit was required:

(i) A document that describes the modification in a manner that provides sufficient information to document the work that was done to comply with federal law.

(ii) A copy of the final paid invoice. The amount paid for the services may be omitted or redacted from the final invoice prior to submission.

(f) Prior to March 31, 2010, the department shall issue a form for use by an owner of a public swimming pool to indicate compliance with this section. The department shall consult with county health officers and directors of departments of environmental health in developing the form and shall post the form on the department's Internet Web site. The form shall be completed by the owner of a public swimming pool prior to filing the form with the appropriate city, county, or city and county department of environmental health. The form shall include, but not be limited to, the following information:

(1) A statement of whether the pool operates with a single or split main drain.

(2) Identification of the type of antientrapment devices or systems that have been installed pursuant to subdivision (b) and the date or dates of installation.

(3) Identification of the type of devices or systems designed to prevent physical entrapment that have been installed pursuant to subdivision (c) in a public swimming pool with a single main drain that is not an unblockable drain and the date or dates of installation or the reason why the requirement is not applicable.

(4) A signature and license number of a qualified individual who certifies that the factual information provided on the form in response to paragraphs (1) to (3), inclusive, is true to the best of his or her knowledge.

(g) A qualified individual who improperly certifies information pursuant to paragraph (4) of subdivision (f) shall be subject to potential disciplinary action at the discretion of the licensing authority.

(h) Except as provided in subdivision (e), each public swimming pool owner shall file a completed copy of the form issued by the department pursuant to this section with the city, county, or city and county department of environmental health in the city, county, or city and county in which the swimming pool is located. The form shall be filed within 30 days following the completion of the swimming pool construction or installation required pursuant to this section or, if the construction or installation is completed prior to the date that the department issues the form pursuant to this section, within 30 days of the date that the department issues the form. The public swimming pool owner or operator shall not make a false statement, representation, certification, record, report, or otherwise falsify information that he or she is required to file or maintain pursuant to this section.

(i) In enforcing this section, health officers and directors of city, county, or city and county departments of environmental health shall consider documentation filed on or with the form issued pursuant to this section by the owner of a public swimming pool as evidence of compliance with this section. A city, county, or city and county department of environmental health may verify the accuracy of the information filed on or with the form.

(j) To the extent that the requirements for public wading pools imposed by Section 116064 conflict with this section, the requirements of this section shall prevail.

(k) The department shall have no authority to take any enforcement action against any person for violation of this section and has no responsibility to administer or enforce the provisions of this section.

**SEC. 32.** Section 123865 of the Health and Safety Code is amended to read:

**123865.** (a) Whenever the parents or estate of a handicapped child is wholly or partly unable to furnish for the child necessary services, the parents or guardian may apply to the agency of the county that has been designated by the board of supervisors of the county of residence under the terms of Section 123850 to administer the provisions for handicapped children. Residence shall be determined in accordance with Sections 243 and 244 of the Government Code.

(b) If the child has an individualized education program (IEP) pursuant to the federal Individuals with Disabilities Education Act (IDEA; 20 U.S.C. Sec. 1400 et seq.), that IEP shall be disclosed to the California Children's Services Program by the parents or the estate of the handicapped child at the time of application provided for in subdivision (a) and on revision of the child's IEP.

**SEC. 33.** Section 123870 of the Health and Safety Code is amended to read:

**123870.** (a) The State Department of Health Care Services shall establish standards of financial eligibility for treatment services under the California Children's Services Program (CCS program).

(1) Financial eligibility for treatment services under this program shall be limited to persons in families with an adjusted gross income of forty thousand dollars ($40,000) or less in the most recent tax year, as calculated for California state income tax purposes. If a person is enrolled in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the financial documentation required for that program in Section 2699.6600 of Title 10 of the California Code of Regulations may be used instead of the person's California state income tax return. However, the director may authorize treatment services for persons in families with higher incomes if the estimated cost of care to the family in one year is expected to exceed 20 percent of the family's adjusted gross income.

(2) Children enrolled in the Healthy Families Program who have a CCS program eligible medical condition under Section 123830, and whose families do not meet the financial eligibility requirements of paragraph (1), shall be deemed financially eligible for CCS program benefits.

(b) Necessary medical therapy treatment services under the CCS program rendered in the public schools shall be exempt from financial eligibility standards and enrollment fee requirements for the services when rendered to any handicapped child whose physical development would be impeded without the services. All occupational and physical therapy services assessed and determined to be educationally necessary by the individualized education program (IEP) team and included in the child's IEP developed pursuant to the provisions of the federal Individuals with Disabilities Education Act (IDEA; 20 U.S.C. Sec. 1400 et seq.), shall be provided in accordance with the provisions of that federal act and shall not be paid for by the CCS program.

(c) All counties shall use the uniform standards for financial eligibility and enrollment fees established by the department. All enrollment fees shall be used in support of the CCS program.

(d) Annually, every family with a child eligible to receive services under this article shall pay a fee of twenty dollars ($20), that shall be in addition to any other program fees for which the family is liable. This assessment shall not apply to any child who is eligible for full scope Medi-Cal benefits without a share of cost, for children receiving therapy in accordance with the federal IDEA as a related service in their individualized education plans, for children from families having incomes of less than 100 percent of the federal poverty level, or for children covered under the Healthy Families Program.

**SEC. 33.5.** Section 123870 of the Health and Safety Code is amended to read:

**123870.** (a) The State Department of Health Care Services shall establish standards of financial eligibility for treatment services under the California Children's Services Program (CCS program).

(1) Financial eligibility for treatment services under this program shall be limited to persons in families with an adjusted gross income of forty thousand dollars ($40,000) or less in the most recent tax year, as calculated for California state income tax purposes. If a person is enrolled in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the financial documentation required for that program in Section 2699.6600 of Title 10 of the California Code of Regulations may be used instead of the person's California state income tax return. If a person is enrolled in the Medi-Cal program pursuant to Section 14005.26 of the Welfare and Institutions Code, the financial documentation required to establish eligibility for the Medi-Cal program may be used instead of the person's California state income tax return. However, the director may authorize treatment services for persons in families with higher incomes if the estimated cost of care to the family in one year is expected to exceed 20 percent of the family's adjusted gross income.

(2) Children enrolled in the Healthy Families Program, or enrolled in the Medi-Cal program pursuant to Section 14005.26 of the Welfare and Institutions Code, who have a CCS program eligible medical condition under Section 123830, and whose families do not meet the financial eligibility requirements of paragraph (1), shall be deemed financially eligible for CCS program benefits.

(b) Necessary medical therapy treatment services under the CCS program rendered in the public schools shall be exempt from financial eligibility standards and enrollment fee requirements for the services when rendered to any handicapped child whose physical development would be impeded without the services. All occupational and physical therapy services assessed and determined to be educationally necessary by the individualized education program (IEP) team and included in the child's IEP developed pursuant to the provisions of the federal Individuals with Disabilities Education Act (IDEA; 20 U.S.C. Sec. 1400 et seq.), shall be provided in accordance with the provisions of that federal act and shall not be paid for by the CCS program.

(c) All counties shall use the uniform standards for financial eligibility and enrollment fees established by the department. All enrollment fees shall be used in support of the CCS program.

(d) Annually, every family with a child eligible to receive services under this article shall pay a fee of twenty dollars ($20), that shall be in addition to any other program fees for which the family is liable. This assessment shall not apply to any child who is eligible for full scope Medi-Cal benefits without a share of cost, for children receiving therapy in accordance with the federal IDEA as a related service in their individualized education plans, for children from families having incomes of less than 100 percent of the federal poverty level, or for children covered under the Healthy Families Program.

**SEC. 34.** Section 123875 of the Health and Safety Code is amended to read:

**123875.** A handicapped child, as defined in Section 123830, who applies to the California Children's Services Program in accordance with Section 123865, shall be determined to be eligible for therapy services when the California Children's Services Program's medical therapy unit conference team finds that the child needs medically necessary occupational or physical therapy. If the California Children's Services medical consultant disagrees with the determination of eligibility by the California Children's Services medical therapy unit conference team, the medical consultant shall communicate with the conference team to ask for further justification of its determination, and shall weigh the conference team's arguments in support of its decision in reaching his or her own determination.

This section shall not change eligibility criteria for the California Children's Services programs as described in Sections 123830 and 123860.

This section shall not apply to children diagnosed as specific learning disabled, unless they otherwise meet the eligibility criteria of the California Children's Services.

**SEC. 35.** Section 124300 of the Health and Safety Code is amended to read:

**124300.** Within any county where 10 percent or more of the population, as determined by the Population Research Unit of the Department of Finance, speaks any one language other than English as its native language, every local health department shall make copies of circulars and pamphlets relating to family planning that are made available to the public also available in the other language.

The State Department of Health Care Services, upon request, shall make a translation available in other than English those family planning informational materials normally distributed to the general public.

**SEC. 36.** Section 125130 of the Health and Safety Code is amended to read:

**125130.** The Director of Health Care Services shall establish and administer a program for the medical care of persons with genetically handicapping conditions, including cystic fibrosis, hemophilia, sickle cell disease, Huntington's disease, Friedreich's Ataxia, Joseph's disease, Von Hippel-Landau syndrome, and the following hereditary metabolic disorders: phenylketonuria, homocystinuria, branched chain amino acidurias, disorders of propionate and methylmalonate metabolism, urea cycle disorders, hereditary orotic aciduria, Wilson's Disease, galactosemia, disorders of lactate and pyruvate metabolism, tyrosinemia, hyperornithinemia, and other genetic organic acidemias that require specialized treatment or service available from only a limited number of program-approved sources.

The program shall also provide access to social support services, that may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions, in order that the genetically handicapped person may function at an optimal level commensurate with the degree of impairment.

The medical and social support services may be obtained through physicians and surgeons, genetically handicapped person's program specialized centers, and other providers that qualify pursuant to the regulations of the department to provide the services. "Medical care," as used in this section, is limited to noncustodial medical and support services.

The director shall adopt regulations that are necessary for the implementation of this article.

**SEC. 37.** Section 125145 of the Health and Safety Code is repealed.

**SEC. 38.** Section 125205 of the Health and Safety Code is amended to read:

**125205.** The department and the State Department of Social Services shall, after consultation with the Genetically Handicapped Persons Program of the department and consumer organizations representing persons with chronic and degenerative conditions, as defined in Section 125210, compile a list of long-term care resources that serve adults with chronic and degenerative conditions, as defined. The list of resources shall include those that have already been identified by the Genetically Handicapped Persons Program as serving persons with Huntington's disease, Joseph's disease, and Friedrich's ataxia, and shall include those that have already been identified by consumer organizations representing persons with chronic and degenerative conditions. The list of resources shall include, but not be limited to, the following:

(a) Public and private skilled nursing facilities and intermediate care facilities.

(b) Public and private community residential care facilities.

(c) Public and private out-of-home long-term care resources such as day activity programs, and in-home support service programs. Nothing in this section shall require the State Department of Health Care Services to undertake a survey of long-term care facilities or programs in the state for the purposes of carrying out the requirements of this section.

The information shall be made available to the public, upon request, through the Genetically Handicapped Persons Program of the department.

**SEC. 39.** Section 125215 of the Health and Safety Code is amended to read:

**125215.** The department and the State Department of Social Services shall review regulations that currently provide disincentives to providers of in-home and out-of-home long-term care resources, as defined in Section 125205, to accept and serve persons with chronic and degenerative disorders. The review shall be conducted with assistance and input from the Genetically Handicapped Persons Program of the department. These departments shall provide a list of those regulations to the Legislature by September 1, 1982. The regulations subject to review shall be those regulations that do the following:

(a) Affect the admission of patients to state-licensed skilled nursing facilities, intermediate care facilities, and community residential care facilities.

(b) Affect the staffing ratios necessary to care for persons with chronic and degenerative conditions, as defined, within those facilities.

(c) Affect the likelihood of facilities, or of day care programs and in-home support service programs, to refuse the admission of persons with chronic and degenerative conditions, solely on the basis of anticipated jeopardy to their licensing, or on the basis of anticipated liability to the facilities arising from instances where a person's degenerative condition, by its own clinical merits, results in medical complications that are, in fact, entirely unrelated to the quality of care provided by the facility or program.

**SEC. 40.** Section 130060 of the Health and Safety Code is amended to read:

**130060.** (a) (1) After January 1, 2008, any general acute care hospital building that is determined to be a potential risk of collapse or pose significant loss of life shall only be used for nonacute care hospital purposes. A delay in this deadline may be granted by the office upon a demonstration by the owner that compliance will result in a loss of health care capacity that may not be provided by other general acute care hospitals within a reasonable proximity. In its request for an extension of the deadline, a hospital shall state why the hospital is unable to comply with the January 1, 2008, deadline requirement.

(2) Prior to granting an extension of the January 1, 2008, deadline pursuant to this section, the office shall do all of the following:

(A) Provide public notice of a hospital's request for an extension of the deadline. The notice, at a minimum, shall be posted on the office's Internet Web site, and shall include the facility's name and identification number, the status of the request, and the beginning and ending dates of the comment period, and shall advise the public of the opportunity to submit public comments pursuant to subparagraph (C). The office shall also provide notice of all requests for the deadline extension directly to interested parties upon request of the interested parties.

(B) Provide copies of extension requests to interested parties within 10 working days to allow interested parties to review and provide comment within the 45-day comment period. The copies shall include those records that are available to the public pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section

6250) of Division 7 of Title 1 of the Government Code).

(C) Allow the public to submit written comments on the extension proposal for a period of not less than 45 days from the date of the public notice.

(b) (1) It is the intent of the Legislature, in enacting this subdivision, to facilitate the process of having more hospital buildings in substantial compliance with this chapter and to take nonconforming general acute care hospital inpatient buildings out of service more quickly.

(2) The functional contiguous grouping of hospital buildings of a general acute care hospital, each of which provides, as the primary source, one or more of the hospital's eight basic services as specified in subdivision (a) of Section 1250, may receive a five-year extension of the January 1, 2008, deadline specified in subdivision (a) of this section pursuant to this subdivision for both structural and nonstructural requirements. A functional contiguous grouping refers to buildings containing one or more basic hospital services that are either attached or connected in a way that is acceptable to the State Department of Health Care Services. These buildings may be either on the existing site or a new site.

(3) To receive the five-year extension, a single building containing all of the basic services or at least one building within the contiguous grouping of hospital buildings shall have obtained a building permit prior to 1973 and this building shall be evaluated and classified as a nonconforming, Structural Performance Category-1 (SPC-1) building. The classification shall be submitted to and accepted by the Office of Statewide Health Planning and Development. The identified hospital building shall be exempt from the requirement in subdivision (a) until January 1, 2013, if the hospital agrees that the basic service or services that were provided in that building shall be provided, on or before January 1, 2013, as follows:

(A) Moved into an existing conforming Structural Performance Category-3 (SPC-3), Structural Performance Category-4 (SPC-4), or Structural Performance Category-5 (SPC-5) and Non-Structural Performance Category-4 (NPC-4) or Non-Structural Performance Category-5 (NPC-5) building.

(B) Relocated to a newly built compliant SPC-5 and NPC-4 or NPC-5 building.

(C) Continued in the building if the building is retrofitted to a SPC-5 and NPC-4 or NPC-5 building.

(4) A five-year extension is also provided to a post-1973 building if the hospital owner informs the Office of Statewide Health Planning and Development that the building is classified as SPC-1, SPC-3, or SPC-4 and will be closed to general acute care inpatient service use by January 1, 2013. The basic services in the building shall be relocated into a SPC-5 and NPC-4 or NPC-5 building by January 1, 2013.

(5) SPC-1 buildings, other than the building identified in paragraph (3) or (4), in the contiguous grouping of hospital buildings shall also be exempt from the requirement in subdivision (a) until January 1, 2013. However, on or before January 1, 2013, at a minimum, each of these buildings shall be retrofitted to a SPC-2 and NPC-3 building, or no longer be used for general acute care hospital inpatient services.

(c) On or before March 1, 2001, the office shall establish a schedule of interim work progress deadlines that hospitals shall be required to meet to be eligible for the extension specified in subdivision (b). To receive this extension, the hospital building or buildings shall meet the year 2002 nonstructural requirements.

(d) A hospital building that is eligible for an extension pursuant to this section shall meet the January 1, 2030, nonstructural and structural deadline requirements if the building is to be used for general acute care inpatient services after January 1, 2030.

(e) Upon compliance with subdivision (b), the hospital shall be issued a written notice of compliance by the office. The office shall send a written notice of violation to hospital owners that fail to comply with this section. The office shall make copies of these notices available on its Internet Web site.

(f) (1) A hospital that has received an extension of the January 1, 2008, deadline pursuant to subdivision (a) or (b) may request an additional extension of up to two years for a hospital building that it owns or operates and that meets the criteria specified in paragraph (2), (3), or (5).

(2) The office may grant the additional extension if the hospital building subject to the extension meets all of the following criteria:

(A) The hospital building is under construction at the time of the request for extension under this subdivision and the purpose of the construction is to meet the requirements of subdivision (a) to allow the use of the

building as a general acute care hospital building after the extension deadline granted by the office pursuant to subdivision (a) or (b).

(B) The hospital building plans were submitted to the office and were deemed ready for review by the office at least four years prior to the applicable deadline for the building. The hospital shall indicate, upon submission of its plans, the SPC-1 building or buildings that will be retrofitted or replaced to meet the requirements of this section as a result of the project.

(C) The hospital received a building permit for the construction described in subparagraph (A) at least two years prior to the applicable deadline for the building.

(D) The hospital submitted a construction timeline at least two years prior to the applicable deadline for the building demonstrating the hospital's intent to meet the applicable deadline. The timeline shall include all of the following:

(i) The projected construction start date.

(ii) The projected construction completion date.

(iii) Identification of the contractor.

(E) The hospital is making reasonable progress toward meeting the timeline set forth in subparagraph (D), but factors beyond the hospital's control make it impossible for the hospital to meet the deadline.

(3) The office may grant the additional extension if the hospital building subject to the extension meets all of the following criteria:

(A) The hospital building is owned by a health care district that has, as owner, received the extension of the January 1, 2008, deadline, but where the hospital is operated by an unaffiliated third-party lessee pursuant to a facility lease that extends at least through December 31, 2009. The district shall file a declaration with the office with a request for an extension stating that, as of the date of the filing, the district has lacked, and continues to lack, unrestricted access to the subject hospital building for seismic planning purposes during the term of the lease, and that the district is under contract with the county to maintain hospital services when the hospital comes under district control. The office shall not grant the extension if an unaffiliated third-party lessee will operate the hospital beyond December 31, 2010.

(B) The hospital building plans were submitted to the office and were deemed ready for review by the office at least four years prior to the applicable deadline for the building. The hospital shall indicate, upon submission of its plans, the SPC-1 building or buildings that will be retrofitted or replaced to meet the requirements of this section as a result of the project.

(C) The hospital received a building permit for the construction described in subparagraph (B) by December 31, 2011.

(D) The hospital submitted, by December 31, 2011, a construction timeline for the building demonstrating the hospital's intent and ability to meet the deadline of December 31, 2014. The timeline shall include all of the following:

(i) The projected construction start date.

(ii) The projected construction completion date.

(iii) Identification of the contractor.

(E) The hospital building is under construction at the time of the request for the extension, the purpose of the construction is to meet the requirements of subdivision (a) to allow the use of the building as a general acute care hospital building after the extension deadline granted by the office pursuant to subdivision (a) or (b), and the hospital is making reasonable progress toward meeting the timeline set forth in subparagraph (D).

(F) The hospital granted an extension pursuant to this paragraph shall submit an additional status report to the office, equivalent to that required by subdivision (c) of Section 130061, no later than June 30, 2013.

(4) An extension granted pursuant to paragraph (3) shall be applicable only to the health care district applicant and its affiliated hospital while the hospital is operated by the district or an entity under the control of the district.

(5) The office may grant the additional extension if the hospital building subject to the extension meets all of the following criteria:

(A) The hospital owner submitted to the office, prior to June 30, 2009, a request for review using current computer modeling utilized by the office and based upon software developed by the Federal Emergency Management Agency, referred to as Hazards US, and the building was deemed SPC-1 after that review.

(B) The hospital building plans for the building are submitted to the office and deemed ready for review by the office prior to July 1, 2010. The hospital shall indicate, upon submission of its plans, the SPC-1 building or buildings that shall be retrofitted or replaced to meet the requirements of this section as a result of the project.

(C) The hospital receives a building permit from the office for the construction described in subparagraph (B) prior to January 1, 2012.

(D) The hospital submits, prior to January 1, 2012, a construction timeline for the building demonstrating the hospital's intent and ability to meet the applicable deadline. The timeline shall include all of the following:

(i) The projected construction start date.

(ii) The projected construction completion date.

(iii) Identification of the contractor.

(E) The hospital building is under construction at the time of the request for the extension, the purpose of the construction is to meet the requirements of subdivision (a) to allow the use of the building as a general acute care hospital building after the extension deadline granted by the office pursuant to subdivision (a) or (b), and the hospital is making reasonable progress toward meeting the timeline set forth in subparagraph (D).

(F) The hospital owner completes construction such that the hospital meets all criteria to enable the office to issue a certificate of occupancy by the applicable deadline for the building.

(6) A hospital denied an extension pursuant to this subdivision may appeal the denial to the Hospital Building Safety Board.

(7) The office may revoke an extension granted pursuant to this subdivision for any hospital building where the work of construction is abandoned or suspended for a period of at least one year, unless the hospital demonstrates in a public document that the abandonment or suspension was caused by factors beyond its control.

(g) (1) Notwithstanding subdivisions (a), (b), (c), and (f), and Sections 130061.5 and 130064, a hospital that has received an extension of the January 1, 2008, deadline pursuant to subdivision (a) or (b) also may request an additional extension of up to seven years for a hospital building that it owns or operates. The office may grant the extension subject to the hospital meeting the milestones set forth in paragraph (2).

(2) The hospital building subject to the extension shall meet all of the following milestones, unless the hospital building is reclassified as SPC-2 or higher as a result of its Hazards US score:

(A) The hospital owner submits to the office, no later than September 30, 2012, a letter of intent stating whether it intends to rebuild, replace, or retrofit the building, or remove all general acute care beds and services from the building, and the amount of time necessary to complete the construction.

(B) The hospital owner submits to the office, no later than September 30, 2012, a schedule detailing why the requested extension is necessary, and specifically how the hospital intends to meet the requested deadline.

(C) The hospital owner submits to the office, no later than September 30, 2012, an application ready for review seeking structural reassessment of each of its SPC-1 buildings using current computer modeling based upon software developed by FEMA, referred to as Hazards US.

(D) The hospital owner submits to the office, no later than January 1, 2015, plans ready for review consistent with the letter of intent submitted pursuant to subparagraph (A) and the schedule submitted pursuant to subparagraph (B).

(E) The hospital owner submits a financial report to the office at the time the plans are submitted pursuant to subparagraph (D). The report shall demonstrate the hospital owner's financial capacity to implement the construction plans submitted pursuant to subparagraph (D).

(F) The hospital owner receives a building permit consistent with the letter of intent submitted pursuant to subparagraph (A) and the schedule submitted pursuant to subparagraph (B), no later than July 1, 2018.

(3) To evaluate public safety and determine whether to grant an extension of the deadline, the office shall consider the structural integrity of the hospital's SPC-1 buildings based on its Hazards US scores, community access to essential hospital services, and the hospital owner's financial capacity to meet the deadline as determined by either a bond rating of BBB or below or the financial report on the hospital owner's financial capacity submitted pursuant to subparagraph (E) of paragraph (2). The criteria contained in this paragraph shall be considered by the office in its determination of the length of an extension or whether an extension should be granted.

(4) The extension or subsequent adjustments granted pursuant to this subdivision may not exceed the amount of time that is reasonably necessary to complete the construction specified in paragraph (2).

(5) If the circumstances underlying the request for extension submitted to the office pursuant to paragraph (2) change, the hospital owner shall notify the office as soon as practicable, but in no event later than six months after the hospital owner discovered the change of circumstances. The office may adjust the length of the extension granted pursuant to paragraphs (2) and (3) as necessary, but in no event longer than the period specified in paragraph (1).

(6) A hospital denied an extension pursuant to this subdivision may appeal the denial to the Hospital Building Safety Board.

(7) The office may revoke an extension granted pursuant to this subdivision for any hospital building when it is determined that any information submitted pursuant to this section was falsified, or if the hospital failed to meet a milestone set forth in paragraph (2), or where the work of construction is abandoned or suspended for a period of at least six months, unless the hospital demonstrates in a publicly available document that the abandonment or suspension was caused by factors beyond its control.

(8) Regulatory submissions made by the office to the California Building Standards Commission to implement this section shall be deemed to be emergency regulations and shall be adopted as emergency regulations.

(9) The hospital owner that applies for an extension pursuant to this subdivision shall pay the office an additional fee, to be determined by the office, sufficient to cover the additional reasonable costs incurred by the office for maintaining the additional reporting requirements established under this section, including, but not limited to, the costs of reviewing and verifying the extension documentation submitted pursuant to this subdivision. This additional fee shall not include any cost for review of the plans or other duties related to receiving a building or occupancy permit.

(10) This subdivision shall become operative on the date that the State Department of Health Care Services receives all necessary federal approvals for a 2011-12 fiscal year hospital quality assurance fee program that includes three hundred twenty million dollars ($320,000,000) in fee revenue to pay for health care coverage for children, which is made available as a result of the legislative enactment of a 2011-12 fiscal year hospital quality assurance fee program.

**SEC. 41.** Section 130316 of the Health and Safety Code is amended to read:

**130316.** Any funds appropriated for the purpose of this division that remain unexpended or unencumbered on June 30, 2016, shall revert to the General Fund on that date unless a statute that is enacted before June 30, 2016, extends the provisions of this division.

**SEC. 42.** Section 130317 of the Health and Safety Code is amended to read:

**130317.** This division shall become inoperative on June 30, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before June 30, 2016, deletes or extends the dates on which it becomes inoperative and is repealed.

**SEC. 43.** Section 131019.5 is added to the Health and Safety Code, to read:

**131019.5.** (a) For purposes of this section, the following definitions shall apply:

(1) "Determinants of equity" means social, economic, geographic, political, and physical environmental

conditions that lead to the creation of a fair and just society.

(2) "Health equity" means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

(3) "Health and mental health disparities" means differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors.

(4) "Health and mental health inequities" means disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair.

(5) "Vulnerable communities" include, but are not limited to, women, racial or ethnic groups, low-income individuals and families, individuals who are incarcerated and those who have been incarcerated, individuals with disabilities, individuals with mental health conditions, children, youth and young adults, seniors, immigrants and refugees, individuals who are limited-English proficient (LEP), and lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) communities, or combinations of these populations.

(6) "Vulnerable places" means places or communities with inequities in the social, economic, educational, or physical environment or environmental health and that have insufficient resources or capacity to protect and promote the health and well-being of their residents.

(b) The State Department of Public Health shall establish an Office of Health Equity for the purposes of aligning state resources, decisionmaking, and programs to accomplish all of the following:

(1) Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically isolated communities.

(2) Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health.

(3) Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services.

(4) Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities.

(c) The duties of the Office of Health Equity shall include all of the following:

(1) Conducting policy analysis and developing strategic policies and plans regarding specific issues affecting vulnerable communities and vulnerable places to increase positive health and mental health outcomes for vulnerable communities and decrease health and mental health disparities and inequities. The policies and plans shall also include strategies to address social and environmental inequities and improve health and mental health. The office shall assist other departments in their missions to increase access to services and supports and improve quality of care for vulnerable communities.

(2) Establishing a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities. The strategies and recommendations developed shall take into account the needs of vulnerable communities to ensure strategies are developed throughout the state to eliminate health and mental health disparities and inequities. This plan shall be developed in collaboration with the Health in All Policies Task Force. This plan shall establish goals and benchmarks for specific strategies in order to measure and track disparities and the effectiveness of these strategies. This plan shall be updated periodically, but not less than every two years, to keep abreast of data trends, best practices, promising practices, and to more effectively focus and direct necessary resources to mitigate and eliminate disparities and inequities. This plan shall be included in the report required under paragraph (1) of subdivision (d). The Office of Health Equity shall seek input from the public on the plan through an inclusive public stakeholder process.

(3) Building upon and informing the work of the Health in All Policies Task Force in working with state agencies and departments to consider health in appropriate and relevant aspects of public policy development to ensure the implementation of goals and objectives that close the gap in health status. The Office of Health Equity shall work collaboratively with the Health in All Policies Task Force to assist state agencies and departments in developing policies, systems, programs, and environmental change strategies that have population health

impacts in all of the following ways, within the resources made available:

(A) Develop intervention programs with targeted approaches to address health and mental health inequities and disparities.

(B) Prioritize building cross-sectoral partnerships within and across departments and agencies to change policies and practices to advance health equity.

(C) Work with the advisory committee established pursuant to subdivision (f) and through stakeholder meetings to provide a forum to identify and address the complexities of health and mental health inequities and disparities and the need for multiple, interrelated, and multisectoral strategies.

(D) Provide technical assistance to state and local agencies and departments with regard to building organizational capacity, staff training, and facilitating communication to facilitate strategies to reduce health and mental health disparities.

(E) Highlight and share evidence-based, evidence-informed, and community-based practices for reducing health and mental health disparities and inequities.

(F) Work with local public health departments, county mental health or behavioral health departments, local social services, and mental health agencies, and other local agencies that address key health determinants, including, but not limited to, housing, transportation, planning, education, parks, and economic development. The Office of Health Equity shall seek to link local efforts with statewide efforts.

(4) Consult with community-based organizations and local governmental agencies to ensure that community perspectives and input are included in policies and any strategic plans, recommendations, and implementation activities.

(5) Assist in coordinating projects funded by the state that pertain to increasing the health and mental health status of vulnerable communities.

(6) Provide consultation and technical assistance to state departments and other state and local agencies charged with providing or purchasing state-funded health and mental health care, in their respective missions to identify, analyze, and report disparities and to identify strategies to address health and mental health disparities.

(7) Provide information and assistance to state and local departments in coordinating projects within and across state departments that improve the effectiveness of public health and mental health services to vulnerable communities and that address community environments to promote health. This information shall identify unnecessary duplication of services.

(8) Communicate and disseminate information within the department and with other state departments to assist in developing strategies to improve the health and mental health status of persons in vulnerable communities and to share strategies that address the social and environmental determinants of health.

(9) Provide consultation and assistance to public and private entities that are attempting to create innovative responses to improve the health and mental health status of vulnerable communities.

(10) Seek additional resources, including in-kind assistance, federal funding, and foundation support.

(d) In identifying and developing recommendations for strategic plans, the Office of Health Equity shall, at a minimum, do all of the following:

(1) Conduct demographic analyses on health and mental health disparities and inequities. The report shall include, to the extent feasible, an analysis of the underlying conditions that contribute to health and well-being. The first report shall be due July 1, 2014. This information shall be updated periodically, but not less than every two years, and made available through public dissemination, including posting on the department's Internet Web site. The report shall be developed using primary and secondary sources of demographic information available to the office, including the work and data collected by the Health in All Policies Task Force. Primary sources of demographic information shall be collected contingent on the receipt of state, federal, or private funds for this purpose.

(2) Based on the availability of data, including valid data made available from secondary sources, the report described in paragraph (1) shall address the following key factors as they relate to health and mental health disparities and inequities:

(A) Income security such as living wage, earned income tax credit, and paid leave.

(B) Food security and nutrition such as food stamp eligibility and enrollment, assessments of food access, and rates of access to unhealthy food and beverages.

(C) Child development, education, and literacy rates, including opportunities for early childhood development and parenting support, rates of graduation compared to dropout rates, college attainment, and adult literacy.

(D) Housing, including access to affordable, safe, and healthy housing, housing near parks and with access to healthy foods, and housing that incorporates universal design and visitability features.

(E) Environmental quality, including exposure to toxins in the air, water, and soil.

(F) Accessible built environments that promote health and safety, including mixed-used land, active transportation such as improved pedestrian, bicycle, and automobile safety, parks and green space, and healthy school siting.

(G) Health care, including accessible disease management programs, access to affordable, quality health and behavioral health care, assessment of the health care workforce, and workforce diversity.

(H) Prevention efforts, including community-based education and availability of preventive services.

(I) Assessing ongoing discrimination and minority stressors against individuals and groups in vulnerable communities based upon race, gender, gender identity, gender expression, ethnicity, marital status, language, sexual orientation, disability, and other factors, such as discrimination that is based upon bias and negative attitudes of health professionals and providers.

(J) Neighborhood safety and collective efficacy, including rates of violence, increases or decreases in community cohesion, and collaborative efforts to improve the health and well-being of the community.

(K) The efforts of the Health in All Policies Task Force, including monitoring and identifying efforts to include health and equity in all sectors.

(L) Culturally appropriate and competent services and training in all sectors, including training to eliminate bias, discrimination, and mistreatment of persons in vulnerable communities.

(M) Linguistically appropriate and competent services and training in all sectors, including the availability of information in alternative formats such as large font, braille, and American Sign Language.

(N) Accessible, affordable, and appropriate mental health services.

(3) Consult regularly with representatives of vulnerable communities, including diverse racial, ethnic, cultural, and LGBTQQ communities, women's health advocates, mental health advocates, health and mental health providers, community-based organizations and advocates, academic institutions, local public health departments, local government entities, and low-income and vulnerable consumers.

(4) Consult regularly with the advisory committee established by subdivision (f) for input and updates on the policy recommendations, strategic plans, and status of cross-sectoral work.

(e) The Office of Health Equity shall be organized as follows:

(1) A Deputy Director shall be appointed by the Governor or the State Public Health Officer, and is subject to confirmation by the Senate. The salary for the Deputy Director shall be fixed in accordance with state law.

(2) The Deputy Director of the Office of Health Equity shall report to the State Public Health Officer and shall work closely with the Director of Health Care Services to ensure compliance with the requirements of the office's strategic plans, policies, and implementation activities.

(f) The Office of Health Equity shall establish an advisory committee to advance the goals of the office and to actively participate in decisionmaking. The advisory committee shall be composed of representatives from applicable state agencies and departments, local health departments, community-based organizations working to advance health and mental health equity, vulnerable communities, and stakeholder communities that represent the diverse demographics of the state. The chair of the advisory committee shall be a representative from a nonstate entity. The advisory committee shall be established by no later than October 1, 2013, and shall meet, at a minimum, on a quarterly basis. Subcommittees of this advisory committee may be formed as determined by the chair.

(g) An interagency agreement shall be established between the State Department of Public Health and the State Department of Health Care Services to outline the process by which the departments will jointly work to advance the mission of the Office of Health Equity, including responsibilities, scope of work, and necessary resources.

**SEC. 44.** Section 131051 of the Health and Safety Code is amended to read:

**131051.** The duties, powers, functions, jurisdiction, and responsibilities transferred to the State Department of Public Health shall, pursuant to the act that added this section, include all of the following previously performed by the former State Department of Health Services:

(a) Under the jurisdiction of the Deputy Director for Prevention Services:

(1) The Office of AIDS, including but not limited to:

(A) The AIDS Drug Assistance Program (Chapter 6 (commencing with Section 120950) of Part 4 of Division 105).

(B) The AIDS Early Intervention Program (Chapter 4 (commencing with Section 120900) of Part 4 of Division 105).

(C) The CARE Services Program, provided for pursuant to the federal Ryan White CARE Act, 42 U.S.C. Section 300ff.

(D) The CARE/Health Insurance Premium Payment Program (federal Ryan White CARE Act, 42 U.S.C. Sec. 300ff).

(E) The Housing Opportunities for Persons with AIDS Program (Section 100119).

(F) The Residential AIDS Licensed Facilities Program (former Section 100119; Chapter 2 (commencing with Section 120815) of Part 4 of Division 105).

(G) The AIDS Case Management Program (federal Ryan White CARE Act, 42 U.S.C. Sec. 300ff; Chapter 2 (commencing with Section 120815) of Part 4 of Division 105).

(H) The AIDS Medi-Cal Waiver Program (former Section 100119; 42 U.S.C. Sec. 1396n(c)).

(I) The Bridge Project (former Section 100119).

(J) The HIV Therapeutic Monitoring Program (Chapter 16 (commencing with Section 121345) of Part 4 of Division 105).

(K) The Learning Immune Function Enhancement program (former Section 100119).

(L) The San Ysidro Prevention Project (Section 113019).

(M) The California Statewide Treatment Education Program (former Section 100119).

(N) The HIV Counseling and Testing Program (Section 113019).

(O) The Neighborhood Intervention Geared Toward High-Risk Testing program (former Section 100119).

(P) The Perinatal Transmission Prevention Project (Section 113019).

(Q) The California AIDS Clearinghouse (Section 113019).

(R) The California Disclosure Assistance and Partner Services/Partner Counseling and Referral Services (Section 113019).

(S) The African-American HIV Initiative (Section 113019; Chapter 13.7 (commencing with Section 120290) of Part 4 of Division 105).

(T) The Injection Drug User HIV Testing Utilizing Hepatitis C Testing High-Risk Initiative (Section 113019).

(U) The Prevention with Positives High-Risk Initiative (Section 113019).

(V) The Statewide Technical Assistance Initiatives (Section 113019).

(W) The HIV/AIDS Case Registry (Sections 113019, 120125, and 120130).

(2) The Office of Binational Border Health, including, but not limited to, all of the following:

(A) The California-Mexico Health Initiative (Part 3 (commencing with Section 475) of Division 1).

(B) The Early Warning Infectious Disease Surveillance Program (Chapter 2 (commencing with Section 1250) of Division 2; Chapter 2 (commencing with Section 120130) of Part 1 of Division 105).

(3) The Division of Communicable Disease Control, including, but not limited to, all of the following:

(A) The Infant Botulism Treatment and Prevention Program (Article 2.5 (commencing with Section 123700) of Chapter 3 of Part 2 of Division 106).

(B) The Sexually Transmitted Disease Control Program (Part 3 (commencing with Section 120500) of Division 105).

(C) The Infectious Disease Program (Chapter 2 (commencing with Section 120130) of Part 1 of Division 105).

(D) The Bioterrorism Epidemiology Program.

(E) The Vector Borne Disease (Part 11 (commencing with Section 116100) of Division 104).

(F) The Tuberculosis Control Program (Part 5 (commencing with Section 121350) of Division 105).

(G) The Microbial Diseases Laboratory (Chapter 2 (commencing with Section 100250) of Division 101).

(H) The Viral and Rickettsial Disease Laboratory (Chapter 2 (commencing with Section 100250) of Division 101).

(I) The West Nile Human Surveillance Program (Chapter 2 (commencing with Section 116110) of Part 11 of Division 104).

(J) The Immunization Program (Part 2 (commencing with Section 120325) of Division 105).

(K) The Vaccines for Children Program (Part 2 (commencing with Section 120325) of Division 105).

(4) The Division of Chronic Disease and Injury Control, including, but not limited to, all of the following:

(A) The IMPACT Prostate Cancer Treatment Program (Chapter 7 (commencing with Section 104322) of Part 1 of Division 103), until June 30, 2012. Commencing July 1, 2012, the duties, powers, functions, jurisdiction, and responsibilities of the State Department of Public Health regarding this program are hereby with the State Department of Health Care Services.

(B) The Every Woman Counts program (Breast and Cervical Cancer Screening Program) (Article 1.3 (commencing with Section 104150) of Chapter 2 of Part 1 of Division 103; Section 30461.6 of the Revenue and Taxation Code), until June 30, 2012. Commencing July 1, 2012, the duties, powers, functions, jurisdiction, and responsibilities of the State Department of Public Health regarding this program are hereby with the State Department of Health Care Services.

(C) The Well-Integrated Screening and Evaluation for Women Across the Nation Demonstration Project (Article 1.3 (commencing with Section 104150) of Chapter 2 of Part 1 of Division 103).

(D) The California Nutrition Network (Chapter 2 (commencing with Section 104575) of Part 3 of Division 103).

(E) The Cancer Research Program (Article 2 (commencing with Section 104175) of Chapter 2 of Part 1 of Division 103).

(F) The Translational Cancer Research and Technology Transfer Program (Article 2 (commencing with Section 104175) of Chapter 2 of Part 1 of Division 103).

(G) The Ken Maddy California Cancer Registry (Chapter 2 (commencing with Section 103875) of Part 2 of Division 102).

(H) The California Osteoporosis Prevention and Education Program (Chapter 1 (commencing with Section 125700) of Part 8 of Division 106).

(I) The Preventive Health Care for the Aging Program (Part 4 (commencing with Section 104900) of Division

103).

(J) The California Arthritis Prevention Program (former Section 100185).

(K) The Office of Oral Health (Chapter 3 (commencing with Section 104750) of Part 3 of Division 103).

(L) The Children's Dental Disease Prevention Program (Article 3 (commencing with Section 104770) of Chapter 3 of Part 3 of Division 103).

(M) The Community Water Fluoridation Program (Article 3.5 (commencing with Section 116409) of Chapter 4 of Part 12 of Division 104).

(N) The California Asthma Public Health Initiative (Chapter 6.5 (commencing with Section 104316) of Part 1 of Division 103).

(O) The California Obesity Prevention Initiative (Chapter 2 (commencing with Section 104575) of Part 3 of Division 103).

(P) The School Health Connections program (Chapter 2 (commencing with Section 104575) of Part 3 of Division 103).

(Q) The California Project LEAN (Chapter 2 (commencing with Section 104575) of Part 3 of Division 103).

(R) The California Center for Physical Activity (Section 131085).

(S) The California Diabetes Program (Section 131085).

(T) The Preventive Medicine Residency Program (Section 131090).

(U) The California Epidemiologic Investigation Service (Article 4 (commencing with Section 100325) of Chapter 2 of Part 1 of Division 101).

(V) The Continuing Professional Education Program (Section 131090).

(W) The Injury Surveillance and Epidemiology Program (Part 2 (commencing with Section 104325) of Division 103).

(X) The State and Local Injury Control Program (Chapter 1 (commencing with Section 104325) of Part 2 of Division 103).

(Y) The Office on Disability and Health (former Section 100185).

(Z) The Alzheimer's Disease Program (Article 4 (commencing with Section 125275) of Chapter 2 of Part 5 of Division 106).

(AA) The California Tobacco Control Program (Chapter 1 (commencing with Section 104350) of Part 3 of Division 103).

(5) The Division of Drinking Water and Environmental Management, including, but not limited to, all of the following:

(A) The Medical Waste Management Program (Part 14 (commencing with Section 117600) of Division 104).

(B) The Department of Defense Oversight Program (Radiologic Guidance and Approvals) (Part 9 (commencing with Section 114650) of Division 104).

(C) The Nuclear Emergency Response Program (Part 9 (commencing with Section 114650) of Division 104).

(D) The Institutions Program (Environmental Surveys) (Article 5 (commencing with Section 116025) of Chapter 5 of Part 10 of Division 104).

(E) The Drinking Water Field Management program (Chapter 4 (commencing with Section 116270) of Part 12 of Division 104).

(F) The Environmental Health Specialist Registration Program (Article 1 (commencing with Section 106600) of Chapter 4 of Part 1 of Division 104).

(G) The Sanitation and Radiation Laboratory (Article 2 (commencing with Section 100250) of Chapter 2 of Part

1 of Division 101); Chapter 4 (commencing with Section 116270) of Part 12 of Division 104).

(H) The Radon Program (Chapter 7 (commencing with Section 105400) of Part 5 of Division 103; Chapter 4 (commencing with Section 116270) of Part 12, and Article 2 (commencing with Section 106750) of Chapter 4 of Part 1, of Division 104).

(I) The Shellfish Sanitation Program (Chapter 5 (commencing with Section 112150) of Part 6 of Division 104).

(J) The Ocean Beach Safety Programs (Article 2 (commencing with Section 115875) of Chapter 5 of Part 10 of Division 104).

(K) The Bioterrorism Planning and Response for Drinking Water, Medical Waste, and Environmental Health program (Article 6 (commencing with Section 101315) of Chapter 3 of Part 3 of Division 101).

(L) The Safe Drinking Water State Revolving Fund (Chapter 4.5 (commencing with Section 116760) of Part 12 of Division 104).

(M) The Drinking Water Technical Programs (Chapter 4 (commencing with Section 16270) of Part 12 of Division 104; Chapter 4.5 (commencing with Section 116760) of Part 12 of Division 104; Article 3 (commencing with Section 106875) of Chapter 4 of Part 1 of Division 104; Chapter 5 (commencing with Section 116775) of Part 12 of Division 104; Chapter 5 (commencing with Section 115825) of Part 10 of Division 104; Chapter 7 (commencing with Section 13500) of Division 7 of the Water Code; Section 13411 of the Water Code).

(N) The Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002 (Proposition 50) (Division 26.5 (commencing with Section 79500) of the Water Code).

(6) The Division of Environmental and Occupational Disease Control, including, but not limited to, all of the following:

(A) The California Birth Defect Monitoring Program (Chapter 1 (commencing with Section 103825) of Part 2 of Division 102).

(B) The Childhood Lead Poisoning Prevention Program (Chapter 5 (commencing with Section 105275) of Part 5 of Division 103; Article 7 (commencing with Section 124125) of Chapter 3 of Part 2 of Division 106).

(C) The Lead Related Construction Program (Chapter 4 (commencing with Section 105250) of Part 5 of Division 103).

(D) The Epidemiology Studies Laboratory (Sections 25416, former Section 100170, Section 100325, and Section 104324.25).

(E) The Center for Autism and Developmental Disabilities Research and Epidemiology (former Section 100170).

(F) The Cancer Cluster/Environmental Investigations (former Section 100170).

(G) The Toxic Mold Program (Chapter 18 (commencing with Section 26100) of Division 20).

(H) The Federal Agency for Toxic Substances and Disease Registry Health Assessments, Education and Investigations program (former Section 100170).

(I) The Fish Contamination Outreach and Education program (former Section 100170).

(J) The Air Pollution and Cardiovascular Disease in the California Teachers Study Cohort Project (former Section 100170).

(K) The Delta Watershed Fish Project (outreach, education, and training to reduce exposures to mercury in fish) (former Section 100170).

(L) The Environmental Health Laboratory (former Section 100170; Article 2 (commencing with Section 100250) of Chapter 2 of Part 1 of Division 101).

(M) The Indoor Air Quality program (Chapter 7 (commencing with Section 105400) of Part 5 of Division 103).

(N) The Outdoor Air Quality program (Section 60.9 of the Labor Code).

(O) The Laboratory Response Network for Chemical Terrorism program (former Section 100170; Article 2 (commencing with Section 100250) of Chapter 2 of Part 1 of Division 101).

(P) The Air Quality and Human Monitoring Support Program (former Section 100170).

(Q) The Hazard Evaluation System and Information Service Program (Article 1 (commencing with Section 105175) of Chapter 2 of Part 5 of Division 103; Section 147.2 of the Labor Code).

(R) The Occupational Health Surveillance and Evaluation Program (Article 1 (commencing with Section 105175) of Chapter 2 of Part 5 of Division 103).

(S) The Occupational Lead Poisoning Prevention Program (Article 2 (commencing with Section 105185) of Chapter 2 of Part 5 of Division 103).

(T) The Occupational Blood Lead Registry (Article 2 (commencing with Section 105185) of Chapter 2 of Part 5 of Division 103).

(7) The Division of Food, Drug and Radiation Safety, including, but not limited to, all of the following:

(A) The Drug Licensing Program (Article 6 (commencing with Section 111615) of Chapter 6 of Part 5 of Division 104).

(B) The Consumer Product Safety Program (Part 3 (commencing with Section 108100) of Division 104).

(C) The Export Program (Article 2 (commencing with Section 110190) of Chapter 2 of Part 5 of Division 104).

(D) The Food Safety Inspection Program (Part 5 (commencing with Section 109875) and Part 6 (commencing with Section 111940) of Division 104).

(E) The Foodborne Illness and Tampering Emergency Response Program (Part 5 (commencing with Section 109875) of Division 104).

(F) The Retail Food Safety Program (Part 7 (commencing with Section 113700) of Division 104).

(G) The Food Safety Industry Education and Training Program (pursuant to Section 110485).

(H) The Medical Device Licensing Program (Article 6 (commencing with Section 111615) of Chapter 6 of Part 5 of Division 104).

(I) The Medical Device Safety Program (Part 5 (commencing with Section 109875) of Division 104).

(J) The Stop Tobacco Access to Kids Enforcement Program (STAKE) (Division 8.5 (commencing with Section 22950) of the Business and Professions Code).

(K) The Food and Drug Laboratory (Chapter 2 (commencing with Section 100250) of Division 101).

(L) The Drug Safety Program (Part 4 (commencing with Section 109250) and Part 5 (commencing with Section 109875) of Division 104).

(M) The General Food Safety Program (Part 5 (commencing with Section 109875) and Part 6 (commencing with Section 111940) of Division 104).

(N) The Food Testing Program (Chapter 2 (commencing with Section 100250) of Division 101).

(O) The Forensic Alcohol Testing Program (Article 2 (commencing with Section 100700) of Chapter 4 of Part 1 of Division 101).

(P) The Methadone Laboratory Regulating Program (Article 2 (commencing with Section 11839.23) of Chapter 10 of Part 2 of Division 10.5).

(Q) The Radiologic Health Program (Part 9 (commencing with Section 114650) of Division 104).

(R) The Mammography Program (Chapter 6 (commencing with Section 114840) of Part 9 of Division 104).

(S) The Radioactive Materials Licensing and Inspection Program (Chapter 8 (commencing with Section 114960) of Part 9 of Division 104).

(T) The Radiological Technologist Certification Program (Article 5 (commencing with Section 106955) of Part 1, and Article 3 (commencing with Section 114855) of Chapter 6 of Part 9 of Division 104).

(U) The Radioactive Waste Tracking Program (Chapter 8 (commencing with Section 114960) of Part 9 of

Division 104).

(V) The Radioactive Waste Minimization Program (Chapter 8 (commencing with Section 114960) of Part 9 of Division 104).

(W) The Low Level Radioactive Waste Management, Treatment and Disposal Program (Chapter 8 (commencing with Section 114960) of Part 9 of Division 104).

(X) The Statewide Environmental Radiation Monitoring Program (pursuant to Section 114755).

(Y) The Department of Energy Oversight Program (Part 9 (commencing with Section 114650) of Division 104).

(Z) The X-Ray Machine Inspection and Registration and Mammography Quality Standards Act Inspection Program (Article 5 (commencing with Section 106955) of Part 1, and Article 3 (commencing with Section 114855) of Chapter 6 of Part 9 of Division 104).

(8) The Deputy Director for Laboratory Science, including, but not limited to, all of the following:

(A) The Environmental Laboratory Accreditation Program (Article 3 (commencing with Section 100825) of Chapter 4 of Part 1 of Division 101).

(B) The Laboratory Central Services Program (Article 2 (commencing with Section 100250) of Chapter 2 of Part 1 of Division 101).

(C) The National Laboratory Training Network (Section 131085).

(D) The Laboratory Field Services program (Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code).

(b) Under the jurisdiction of the Deputy Director for Licensing and Certification:

(1) The General Acute Care Hospitals Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(2) The Acute Psychiatric Hospitals Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(3) The Special Hospitals Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(4) The Chemical Dependency Recovery Hospitals Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(5) The Skilled Nursing Facilities Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(6) The Intermediate Care Facilities Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(7) The Intermediate Care Facilities-Developmentally Disabled Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(8) The Intermediate Care Facilities-Developmentally Disabled-Habilitative Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(9) The Intermediate Care Facility-Developmentally Disabled-Nursing Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(10) The Home Health Agencies Licensing Program (Chapter 8 (commencing with Section 1725) of Division 2).

(11) The Referral Agencies Licensing Program (Chapter 2.3 (commencing with Section 1400) of Division 2).

(12) The Adult Day Health Centers Licensing Program (Chapter 3.3 (commencing with Section 1570) of Division 2).

(13) The Congregate Living Health Facilities (Chapter 2 (commencing with Section 1250) of Division 2).

(14) The Psychology Clinics Licensing Program (Chapter 1 (commencing with Section 1200) of Division 2).

(15) The Primary Clinics—Community and Free Licensing Program (Chapter 1 (commencing with Section 1200)

of Division 2).

(16) The Specialty Clinics—Rehab Clinics Licensing Program (Chapter 1 (commencing with Section 1200) of Division 2).

(17) The Dialysis Clinics Licensing Program (Chapter 1 (commencing with Section 1200) of Division 2).

(18) The Pediatric Day Health/Respite Care Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(19) The Alternative Birthing Centers Licensing Program (Chapter 1 (commencing with Section 1200) of Division 2).

(20) The Hospice Licensing Program (Chapter 2 (commencing with Section 1339.30) of Division 2).

(21) The Correctional Treatment Centers Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(22) The Medicare/Medi-Cal Certification Program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(23) The Nursing Home Administrator Professional Certification Program (Chapter 2.35 (commencing with Section 1416) of Division 2).

(24) The Certified Nursing Assistants Professional Certification Program (Chapter 2 (commencing with Section 1337) of Division 2).

(25) The Home Health Aides Professional Certification Program (Chapter 8 (commencing with Section 1725) of Division 2).

(26) The Hemodialysis Technicians Professional Certification Program (Chapter 3 (commencing with Section 1247) of Division 2 of the Business and Professions Code; Chapter 10 (commencing with Section 1794) of Division 2).

(27) The Criminal Background Clearance Program (Chapter 2 (commencing with Section 1337), Chapter 3 (commencing with Section 1520), Chapter 3.01 (commencing with Section 1569.15), Chapter 3.4 (commencing with Section 1496.80) of Division 2, and Chapter 4 (commencing with Section 11150) of Division 8).

(c) Under the jurisdiction of the Deputy Director for Health Information and Strategic Planning:

(1) The Refugee Health Program (Subpart G of Part 400 of Title 45 of the Code of Federal Regulations).

(2) The Office of County Health Services (Article 5 (commencing with Section 101300) of Chapter 3 of Part 3 of Division 101; Part 4.7 (commencing with Section 16900) of Division 9 of the Welfare and Institutions Code).

(3) The Medically Indigent Services Program (Article 5 (commencing with Section 101300) of Chapter 3 of Part 3 of Division 101).

(4) The Office of Vital Records (Part 1 (commencing with Section 102100) of Division 102).

(5) The Office of Health Information and Research (Article 1 (commencing with Section 102175) of Chapter 2 of Part 1 of Division 102; Section 128730).

(6) The Local Public Health Services Program (Article 5 (commencing with Section 101300) of Chapter 3 of Part 3 of Division 101).

(7) The Center for Health Statistics (Part 1 (commencing with Section 102100) of Division 102; Section 128730).

(8) The Medical Marijuana Program (Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of the Health and Safety Code).

(d) Under the jurisdiction of the Deputy Director for Primary Care and Family Health:

(1) The Maternal, Child and Adolescent Health program (Part 2 (commencing with Section 123225) of Division 106).

(2) The Adolescent Family Life Program (Article 1 (commencing with Section 124175) of Chapter 4 of Part 2 of Division 106).

(3) The Advanced Practice Nurse Training program (Part 2 (commencing with Section 123225) of Division 106).

(4) The Black Infant Health Program (Part 2 (commencing with Section 123225) of Division 106).

(5) The Breastfeeding Program (Article 3 (commencing with Section 123360) of Chapter 1 of Part 2 of Division 6).

(6) The California Diabetes and Pregnancy Program (Part 2 (commencing with Section 123225) of Division 106).

(7) The California Initiative to Improve Adolescent Health (Part 2 (commencing with Section 123225) of Division 106).

(8) The Childhood Injury Prevention Program (Article 4 (commencing with Section 100325) of Chapter 2 of Division 101).

(9) The Comprehensive Perinatal Services Program (Article 3 (commencing with Section 123475) of Chapter 2 of Part 2; Section 14134.5 of the Welfare and Institutions Code).

(10) The Fetal and Infant Mortality Review Program (Article 1 (commencing with Section 123650) of Chapter 3 of Part 2 of Division 106).

(11) The Human Stem Cell Research Program (Chapter 3 (commencing with Section 125290.10) of Part 5 of Division 106; Chapter 1 (commencing with Section 125300) of Part 5.5 of Division 106).

(12) The Local Health Department Maternal, Child and Adolescent Health Program (Section 123255).

(13) The Maternal Mortality Review Program (Article 4 (commencing with Section 100325) of Chapter 2 of Division 101).

(14) The Oral Health Program (Part 2 (commencing with Section 123225) of Division 106).

(15) The Preconception Health and Health Care Initiative (Part 2 (commencing with Section 123225) of Division 106).

(16) The Regional Perinatal Programs of California (Article 4 (commencing with Section 123550) of Chapter 2 of Part 2 of Division 106).

(17) The Perinatal Dispatch Centers Outreach and Education Program (Article 4 (commencing with Section 123750) of Chapter 3 of Part 2 of Division 106).

(18) The State Early Childhood Comprehensive Services program (Part 2 (commencing with Section 123225) of Division 106).

(19) The Sudden Infant Death Syndrome Program (Article 3 (commencing with Section 123725) of Chapter 3 of Part 2 of Division 106).

(20) The Youth Pilot Program (Chapter 12.85 (commencing with Section 18987) of Part 6 of Division 9 of the Welfare and Institutions Code).

(21) The Office of Family Planning (Chapter 8.5 (commencing with Section 14500) of Part 3 of Division 9 of the Welfare and Institutions Code; Division 24 (commencing with Section 24000) of the Welfare and Institutions Code), until June 30, 2012. Commencing July 1, 2012, the duties, powers, functions, jurisdiction, and responsibilities of the State Department of Public Health regarding this office are hereby with the State Department of Health Care Services.

(22) The Community Challenge Grant Program (Section 14504.1 of the Welfare and Institutions Code, and Chapter 14 (commencing with Section 18993) of Part 6 of Division 9 of the Welfare and Institutions Code).

(23) The Information and Education Program (Section 14504.3 of the Welfare and Institutions Code).

(24) The Family PACT Program (subdivision (aa) of Section 14132 and Section 24005 of the Welfare and Institutions Code), until June 30, 2012. Commencing July 1, 2012, the duties, powers, functions, jurisdiction, and responsibilities of the State Department of Public Health regarding this program are hereby with the State Department of Health Care Services.

(25) The Male Involvement Program (Section 14504 of the Welfare and Institutions Code).

(26) The TeenSMART Outreach Program (Section 14504.2 of the Welfare and Institutions Code).

(27) The Battered Women Shelter Program (Chapter 6 (commencing with Section 124250) of Part 2 of Division 106).

(28) The Women, Infants and Children Program (Article 1 (commencing with Section 123275) of Chapter 1 of Part 2 of Division 106).

(29) The WIC Supplemental Nutrition Program (Article 1 (commencing with Section 123275) of Chapter 1 of Part 2 of Division 106).

(30) The Farmers Market Nutrition Program (Section 123279).

(31) Genetic Disease Program (Chapter 1 (commencing with Section 124975) of Part 5 of Division 106).

(32) The Newborn Screening Program (Chapter 1 (commencing with Section 124975) of Part 5 of Division 106).

(33) The Prenatal Screening Program (Chapter 1 (commencing with Section 124975) of Part 5 of Division 106).

**SEC. 45.** Section 131052 of the Health and Safety Code is amended to read:

**131052.** In implementing the transfer of jurisdiction pursuant to this article, the State Department of Public Health succeeds to and is vested with all the statutory duties, powers, purposes, responsibilities, and jurisdiction of the former State Department of Health Services as they relate to public health as provided for or referred to in all of the following provisions of law:

(1) Sections 550, 555, 650, 680, 1241, 1658, 2221.1, 2248.5, 2249, 2259, 2259.5, 2541.3, 2585, 2728, 3527, 4017, 4027, 4037, 4191, 19059.5, 19120, 22950, 22973.2, and 22974.8 of the Business and Professions Code.

(2) Sections 56.17, 1812.508, and 1812.543 of the Civil Code.

(3) Sections 8286, 8803, 17613, 32064, 32065, 32066, 32241, 49030, 49405, 49414, 49423.5, 49452.6, 49460, 49464, 49565, 49565.8, 49531.1, 56836.165, and 76403 of the Education Code.

(4) Sections 405, 6021, 6026, 18963, 30852, 41302, and 78486 of the Food and Agricultural Code.

(5) Sections 307, 355, 422, 7572, 7574, 8706, 8817, and 8909 of the Family Code.

(6) Sections 217.6, 1507, 1786, 4011, 5671, 5674, 5700, 5701, 5701.5, 7715, and 15700 of the Fish and Game Code.

(7) Sections 855, 51010, and 551017.1 of the Government Code. For purposes of subdivision (s) of Section 6254 of the Government Code, the term "State Department of Health Services" is hereby deemed to refer to the State Department of Public Health.

(8) (A) Sections 475, 1180.6, 1418.1, 1422.1, 1428.2, 1457, 1505, 1507.1, 1507.5, 1570.7, 1599.2, 1599.60, 1599.75, 1599.87, 2002, 2804, 11362.7, 11776, 11839.21, 11839.23, 11839.24, 11839.25, 11839.26, 11839.27, 11839.28, 11839.29, 11839.30, 11839.31, 11839.32, 11839.33, 11839.34, 17920.10, 17961, 18897.2, 24185, 24186, 24187, 24275, 26101, 26122, 26134, 26155, 26200, and 26203.

(B) Chapters 1, 2, 2.05, 2.3, 2.35, 2.4, 3.3, 3.9, 3.93, 3.95, 4, 4.1, 4.5, 5, 6, 6.5, 8, 8.3, 8.5, 8.6, 9, and 11 of Division 2.

(C) Articles 2 and 4 of Chapter 2, Chapter 3, and Chapter 4 of Part 1, Part 2 and Part 3 of Division 101.

(D) Division 102, including Sections 102230 and 102231.

(E) Division 103, including Sections 104145, 104181, 104182, 104182.5, 104187, 104191, 104192, 104193, 104316, 104317, 104318, 104319, 104320, 104321, 104324.2, 104324.25, 104350, 105191, 105251, 105255, 105280, 105340, and 105430.

(F) Division 104, including Sections 106615, 106675, 106770, 108115, 108855, 109282, 109910, 109915, 112155, 112500, 112650, 113355, 114460, 114475, 114650, 114710, 114850, 114855, 114985, 115061, 115261, 115340, 115736, 115880, 115885, 115915, 116064, 116183, 116270, 116365.5, 116366, 116375,

116610, 116751, 116760.20, 116825, 117100, 117924, and 119300.

(G) Division 105, including Sections 120262, 120381, 120395, 120440, 120480, 120956, 120966, 121155, 121285, 121340, 121349.1, 121480, 122410, and 122420.

(H) Part 1, Part 2 excluding Articles 5, 5.5, 6, and 6.5 of Chapter 3, Part 3 and Part 5 excluding Articles 1 and 2 of Chapter 2, Part 7, and Part 8 of Division 106.

(9) Sections 799.03, 10123.35, 10123.5, 10123.55, 10123.10, 10123.184, and 11520 of the Insurance Code.

(10) Sections 50.8, 142.3, 144.5, 144.7, 147.2, 4600.6, 6307.1, 6359, 6712, 9009, and 9022 of the Labor Code.

(11) Sections 4018.1, 5008.1, 7501, 7502, 7510, 7511, 7515, 7518, 7530, 7550, 7553, 7575, 7576, 11010, 11174.34, and 13990 of the Penal Code.

(12) Section 4806 of the Probate Code.

(13) Sections 15027, 25912, 28004, 30950, 41781.1, 42830, 43210, 43308, 44103, and 71081 of the Public Resources Code.

(14) Section 10405 of the Public Contract Code.

(15) Sections 883, 1507, and 7718 of the Public Utilities Code.

(16) Sections 18833, 18838, 18845.2, 18846.2, 18847.2, 18863, 30461.6, 43010.1, and 43011.1 of the Revenue and Taxation Code.

(17) Section 11020 of the Unemployment Insurance Code.

(18) Sections 22511.55, 23158, 27366, and 33000 of the Vehicle Code.

(19) Sections 5326.9, 5328, 5328.15, 14132, 16902, and 16909, and Division 24 of the Welfare and Institutions Code. Payment for services provided under the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program pursuant to subdivision (aa) of Section 14132 and Division 24 shall be made through the State Department of Health Care Services. The State Department of Public Health and the State Department of Health Care Services may enter into an interagency agreement for the administration of those payments. This paragraph, to the extent that it applies to the Family PACT Waiver Program, shall become inoperative on June 30, 2012.

(20) Sections 13176, 13177.5, 13178, 13193, 13390, 13392, 13392.5, 13393.5, 13395.5, 13396.7, 13521, 13522, 13523, 13528, 13529, 13529.2, 13550, 13552.4, 13552.8, 13553, 13553.1, 13554, 13554.2, 13816, 13819, 13820, 13823, 13824, 13825, 13827, 13830, 13834, 13835, 13836, 13837, 13858, 13861, 13862, 13864, 13868, 13868.1, 13868.3, 13868.5, 13882, 13885, 13886, 13887, 13891, 13892, 13895.1, 13895.6, 13895.9, 13896, 13896.3, 13896.4, 13896.5, 13897, 13897.4, 13897.5, 13897.6, 13898, 14011, 14012, 14015, 14016, 14017, 14019, 14022, 14025, 14026, 14027, and 14029 of the Water Code.

**SEC. 46.** Section 131055.1 is added to the Health and Safety Code, to read:

**131055.1.** (a) Notwithstanding Section 131050, commencing on July 1, 2012, the State Department of Health Care Services shall succeed to and be vested with all the duties, powers, purposes, functions, responsibilities, and jurisdiction of the State Department of Public Health as they relate to the Breast and Cervical Cancer Screening Program pursuant to Article 1.3 (commencing with Section 104150) of Chapter 1, the Breast and Cervical Cancer Treatment Program pursuant to Article 1.5 (commencing with Section 104160) of Chapter 1, the Prostate Cancer Screening Program pursuant to Chapter 6 (commencing with Section 104310), the IMPACT Prostate Cancer Treatment Program pursuant to Chapter 7 (commencing with Section 104322) of Part 1 of Division 103, translation services pursuant to Part 3 (commencing with Section 124300) of Division 106, the Office of Family Planning pursuant to Chapter 8.5 (commencing with Section 14500) of Part 3 of Division 9 of the Welfare and Institutions Code, excluding the Personal Responsibility Education Federal Grant Program, the Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132, and the State-Only Family Planning Program pursuant to Division 24 (commencing with Section 24000) of the Welfare and Institutions Code.

(b) Commencing July 1, 2012, any reference to the State Department of Public Health with regard to the Breast

and Cervical Cancer Screening Program pursuant to Article 1.3 (commencing with Section 104150) of Chapter 1, the Breast and Cervical Cancer Treatment Program pursuant to Article 1.5 (commencing with Section 104160) of Chapter 1, the Prostate Cancer Screening Program pursuant to Chapter 6 (commencing with Section 104310), the IMPACT Prostate Cancer Treatment Program pursuant to Chapter 7 (commencing with Section 104322) of Part 1 of Division 103, translation services pursuant to Part 3 (commencing with Section 124300) of Division 106, the Office of Family Planning pursuant to Chapter 8.5 (commencing with Section 14500) of Part 3 of Division 9 of the Welfare and Institutions Code, excluding the Personal Responsibility Education Federal Grant Program, the Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132, or the State-Only Family Planning Program pursuant to Division 24 (commencing with Section 24000) of the Welfare and Institutions Code, shall refer to the State Department of Health Care Services.

(c) All regulations and orders adopted by the State Department of Public Health and any of its predecessors in effect prior to July 1, 2012, shall remain in effect and shall be fully enforceable unless and until readopted, amended, or repealed, or until they expire by their own terms. Any action by or against the State Department of Public Health and any of its predecessors pertaining to matters vested in the State Department of Health Care Services by this act shall not abate but shall continue in the name of the State Department of Health Care Services, and the State Department of Health Care Services shall be substituted for the State Department of Public Health and any of its predecessors by the court wherein the action is pending. The substitution shall not in any way affect the rights of the parties to the action.

(d) Commencing July 1, 2012, the unexpended balance of all funds available for use by the State Department of Public Health or any of its predecessors in carrying out any functions transferred to the State Department of Health Care Services shall be available for use by the State Department of Health Care Services.

(e) Commencing July 1, 2012, all books, documents, records, and property of the State Department of Public Health pertaining to functions transferred to the State Department of Health Care Services shall be transferred to the State Department of Health Care Services.

(f) Commencing July 1, 2012, positions filled by appointment by the Governor in the State Department of Public Health whose principal assignment was to perform functions transferred to the State Department of Health Care Services shall be transferred to the State Department of Health Care Services. Individuals in positions transferred pursuant to this subdivision shall serve at the pleasure of the Governor. Salaries of positions transferred shall remain at the level established pursuant to law unless otherwise provided.

(g) Commencing July 1, 2012, every officer and employee of the State Department of Public Health who is performing a function transferred to the State Department of Health Care Services and who is serving in the state civil service, other than as a temporary employee, shall be transferred to the State Department of Health Care Services pursuant to the provisions of Section 19050.9 of the Government Code. The status, position, and rights of any officer or employee of the State Department of Public Health shall not be affected by the transfer and shall be retained by the person as an officer or employee of the State Department of Health Care Services, as applicable, pursuant to the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code), except for a position that is exempt from civil service.

(h) No contract, lease, license, or any other agreement to which the State Department of Public Health is a party shall be void or voidable by reason of this act, but shall continue in full force and effect, with State Department of Health Care Services assuming all of the rights, obligations, liabilities, and duties of the State Department of Public Health as relates to the duties, powers, purposes, responsibilities, and jurisdiction vested by this section in the State Department of Health Care Services. The assumption by the State Department of Health Care Services shall not in any way affect the rights of the parties to any contract, lease, license, or agreement.

**SEC. 47.** Section 4024.7 is added to the Welfare and Institutions Code, to read:

**4024.7.** The Governor or the Director of Health Care Services shall appoint, subject to confirmation by the Senate, a Deputy Director of Mental Health and Substance Use Disorder Services of the State Department of Health Care Services. The salary for the deputy director shall be fixed in accordance with law.

**SEC. 48.** Section 4362 of the Welfare and Institutions Code is amended to read:

**4362.** The Legislature finds all of the following:

(a) That state public policy discriminates against adults with brain damage or degenerative brain disease, such

as Alzheimer's disease. This damage or disease is referred to as "brain impairments" in this chapter.

(b) That the Legislature has declared state public policy and accepted responsibility to ensure that persons under the age of 18 years who are developmentally disabled pursuant to Division 4.5 (commencing with Section 4500), receive services necessary to meet their needs, which are often similar to those of persons who suffer from brain impairments.

(c) That persons over the age of 18 who sustain brain impairment have a variety of program and service needs for which there is no clearly defined, ultimate responsibility vested in any single state agency and for which there are currently a number of different programs attempting to meet their needs.

(d) That the lack of clearly defined ultimate responsibility has resulted in severe financial liability and physical and mental strain on brain-impaired persons, their families, and caregivers.

(e) That terminology and nomenclature used to describe brain impairments are varied and confusing, in part because of different medical diagnoses and professional opinions, as well as differences in terminology used by the various funding sources for programs and services. Uniformity is required in order to ensure that appropriate programs and services are available throughout the state to serve these persons.

(f) That the term "brain damage" covers a wide range of organic and neurological disorders, and that these disorders, as identified below, are not necessarily to be construed as mental illnesses. These disorders include, but are not limited to, all of the following:

(1) Progressive, degenerative, and dementing illnesses, including, but not limited to, presenile and senile dementias, Alzheimer's disease, multiinfarct disease, Pick's disease, and Kreutzfeldt-Jakob's disease.

(2) Degenerative diseases of the central nervous system that can lead to dementia or severe brain impairment, including, but not limited to, epilepsy, multiple sclerosis, Parkinson's disease, amyotrophic lateral sclerosis (ALS), and hereditary diseases such as Huntington's disease.

(3) Permanent damage caused by cerebrovascular accidents more commonly referred to as "strokes," including, but not limited to, cerebral hemorrhage, aneurysm, and embolism.

(4) Posttraumatic, postanoxic, and postinfectious damage caused by incidents, including, but not limited to, coma, accidental skull and closed head injuries, loss of oxygen (anoxia), and infections such as encephalitis, herpes simplex, and tuberculosis.

(5) Permanent brain damage or temporary or progressive dementia as a result of tumors (neoplasm), hydrocephalus, abscesses, seizures, substance toxicity, and other disorders.

(g) That brain damage frequently results in functional impairments that adversely affect personality, behavior, and ability to perform daily activities. These impairments cause dependency on others for care and decisionmaking. The manifestations of brain damage include impairments of memory, cognitive ability, orientation, judgment, emotional response, and social inhibition. Brain damage can strike anyone regardless of age, race, sex, occupation, or economic status.

(h) That Family Survival Project for Brain-Damaged Adults of San Francisco, a three-year pilot project established pursuant to former Chapter 4 (commencing with Section 4330), has demonstrated that the most successful, cost-effective service model is one which allows a nonprofit community agency to provide a full array of support services to families that have a member who suffers from a brain impairment. This agency provides direct services, coordinates existing resources, and assists in the development of new programs and services on a regional basis.

(i) That respite care services provide a combination of time-limited, in-home, and out-of-home services that significantly decrease the stress of family members and increase their ability to maintain a brain-impaired person at home at less cost than other alternatives. This ability is further increased when complemented by case planning, care training, and other support services for family members.

(j) That providing services to brain-impaired adults, and to their families and caregivers, requires the coordinated services of many state departments and community agencies to ensure that no gaps occur in communication, in the availability of programs, or in the provision of services.

**SEC. 49.** Section 4362.5 of the Welfare and Institutions Code is amended to read:

**4362.5.** As used in this chapter:

(a) "Brain damage," "degenerative brain diseases," and "brain impairment" mean significant destruction of brain tissue with resultant loss of brain function. Examples of causes of the impairments are Alzheimer's disease, stroke, traumatic brain injury, and other impairments described in subdivision (f) of Section 4330.

(b) "Brain-impaired adult" means a person whose brain impairment has occurred after the age of 18.

(c) "Respite care" means substitute care or supervision in support of the caregiver for the purposes of providing relief from the stresses of constant care provision and so as to enable the caregiver to pursue a normal routine and responsibilities. Respite care may be provided in the home or in an out-of-home setting, such as day care centers or short-term placements in inpatient facilities.

(d) "Family member" means any relative or court-appointed guardian or conservator who is responsible for the care of a brain-impaired adult.

(e) "Caregiver" means any unpaid family member or individual who assumes responsibility for the care of a brain-impaired adult.

(f) "Director" means the Director of Health Care Services.

**SEC. 50.** Section 4364 of the Welfare and Institutions Code is amended to read:

**4364.** The Statewide Resources Consultant shall do all of the following:

(a) Serve as the centralized information and technical assistance clearinghouse for brain-impaired adults, their families, caregivers, service professionals and agencies, and volunteer organizations, and in this capacity may assist organizations that serve families with adults with Huntington's disease and Alzheimer's disease by reviewing data collected by those organizations in their efforts to determine the means of providing high-quality appropriate care in health facilities and other out-of-home placements; and shall disseminate information, including, but not limited to, the results of research and activities conducted pursuant to its responsibilities set forth in this chapter as determined by the director, and which may include forwarding quality of care and related information to appropriate state departments for consideration.

(b) Work closely and coordinate with organizations serving brain-impaired adults, their families, and caregivers in order to ensure, consistent with requirements for quality of services as may be established by the director, that the greatest number of persons are served and that the optimal number of organizations participate.

(c) Develop and conduct training that is appropriate for a variety of persons, including, but not limited to, all of the following:

(1) Families.

(2) Caregivers and service professionals involved with brain-impaired adults.

(3) Advocacy and self-help family and caregiver support organizations.

(4) Educational institutions.

(d) Provide other training services, including, but not limited to, reviewing proposed training curricula regarding the health, psychological, and caregiving aspects of individuals with brain damage as defined in subdivision (f) of Section 4362. The proposed curricula may be submitted by providers or statewide associations representing individuals with brain damage, their families, or caregivers.

(e) Provide service and program development consultation to resource centers and to identify funding sources that are available.

(f) Assist the appropriate state agencies in identifying and securing increased federal financial participation and third-party reimbursement, including, but not limited to, Title XVIII (42 U.S.C. Sec. 1395 and following) and Title XIX (42 U.S.C. Sec. 1396 and following) of the federal Social Security Act.

(g) Conduct public social policy research based upon the recommendations of the director.

(h) Assist the director, as the director may require, in conducting directly, or through contract, research in brain damage epidemiology and data collection, and in developing a uniform terminology and nomenclature.

(i) Assist the director in establishing criteria for, and in selecting resource centers and in designing a methodology for, the consistent assessment of resources and needs within the geographic areas to be serviced by the resource centers.

(j) Conduct conferences, as required by the director, for families, caregivers, service providers, advocacy organizations, educational institutions, business associations, community groups, and the general public, in order to enhance the quality and availability of high-quality, low-cost care and treatment of brain-impaired adults.

(k) Make recommendations, after consultation with appropriate state department representatives, to the director and the Secretary of California Health and Human Services for a comprehensive statewide policy to support and strengthen family caregivers, including the provision of respite and other support services, in order to implement more fully this chapter. The Statewide Resources Consultant shall coordinate its recommendations to assist the California Health and Human Services Agency to prepare its report on long-term care programs pursuant to Chapter 1.5 (commencing with Section 100145) of Part 1 of Division 101 of the Health and Safety Code.

(l) Conduct an inventory and submit an analysis of California's publicly funded programs serving family caregivers of older persons and functionally impaired adults.

**SEC. 51.** Section 4364.5 of the Welfare and Institutions Code is amended to read:

**4364.5.** The Statewide Resources Consultant, pursuant to Section 4364, shall do the following:

(a) Develop respite care training materials, with consultation by other appropriate organizations including the California Association of Homes for the Aging, and under the direction of the director, for distribution to all resource centers established under this chapter.

(b) Provide the respite care training materials described in subdivision (a) to other appropriate state entities for distribution to their respective services and programs.

(c) Pursuant to the requirements of Section 4365.5, report on the utilization of the respite care training materials, developed pursuant to subdivision (a), by all the resource centers for the period ending December 31, 1990, only, and make recommendations for the future use of these materials.

**SEC. 52.** Section 4366 of the Welfare and Institutions Code is amended to read:

**4366.** Resource centers shall serve all of the following functions:

(a) Provide directly or assist families in securing information, advice, and referral services, legal services and financial consultation, planning and problem-solving consultation, family support services, and respite care services, as specified in Section 4338.

(b) Provide centralized access to information about, and referrals to, local, state, and federal services and programs in order to assure a comprehensive approach for brain-impaired adults, their families, and caregivers. Nothing in this chapter shall prohibit access to services through other organizations which provide similar programs and services to brain-impaired adults and their families, nor shall other organizations be prevented from providing these programs and services.

(c) Assist in the identification and documentation of service needs and the development of necessary programs and services to meet the needs of brain-impaired adults in the geographic area.

(d) Cooperate with the Statewide Resources Consultant and the director in any activities which they deem necessary for the proper implementation of this chapter.

(e) Work closely and coordinate with organizations serving brain-impaired adults, their families, and caregivers in order to ensure, consistent with requirements for quality of services as may be established by the director, that the greatest number of persons are served and that the optimal number of organizations participate.

**SEC. 53.** Section 4367.5 of the Welfare and Institutions Code is amended to read:

**4367.5.** The director shall establish criteria for client eligibility, including financial liability, pursuant to Section 4368. However, persons eligible for services provided by regional centers or the State Department of

Developmental Services are not eligible for services provided under this chapter. Income shall not be the sole basis for client eligibility. The director shall assume responsibility for the coordination of existing funds and services for brain-impaired adults, and for the purchase of respite care, as defined in subdivision (c) of Section 4362.5, with other departments that may serve brain-impaired adults, including the Department of Rehabilitation, the State Department of Social Services, the State Department of Developmental Services, the Department of Aging, the Office of Statewide Health Planning and Development, and the State Department of Alcohol and Drug Programs.

**SEC. 54.** Section 4368.5 of the Welfare and Institutions Code is amended to read:

**4368.5.** In considering total service funds available for the project, the director shall utilize funding available from appropriate state departments, including, but not limited to: the State Department of Social Services, the Department of Rehabilitation, the California Department of Aging, and the State Department of Alcohol and Drug Programs. The director in conjunction with the Statewide Resources Consultant shall coordinate his or her activities with the implementation of the Torres-Felando Long-Term Care Reform Act (Chapter 1453, Statutes of 1982) in order to further the goal of obtaining comprehensive, coordinated public policy and to maximize the availability of funding for programs and services for persons with brain impairments.

**SEC. 55.** Section 5820 of the Welfare and Institutions Code is amended to read:

**5820.** (a) It is the intent of this part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

(b) Each county mental health program shall submit to the Office of Statewide Health Planning and Development a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

(c) The Office of Statewide Health Planning and Development, in coordination with the California Mental Health Planning Council, shall identify the total statewide needs for each professional and other occupational category utilizing county needs assessment information and develop a five-year education and training development plan.

(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years, with the next five-year plan due as of April 1, 2014.

(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

**SEC. 56.** Section 5821 of the Welfare and Institutions Code is amended to read:

**5821.** (a) The California Mental Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development.

(b) The Office of Statewide Health Planning and Development shall work with the California Mental Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

**SEC. 57.** Section 5822 of the Welfare and Institutions Code is amended to read:

**5822.** The Office of Statewide Health Planning and Development shall include in the five-year plan:

(a) Expansion plans for the capacity of postsecondary education to meet the needs of identified mental health occupational shortages.

(b) Expansion plans for the forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system and make loan forgiveness programs available to current employees of the mental health system who want to obtain Associate of Arts, Bachelor of Arts, master's

degrees, or doctoral degrees.

(c) Creation of a stipend program modeled after the federal Title IV-E program for persons enrolled in academic institutions who want to be employed in the mental health system.

(d) Establishment of regional partnerships between the mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce, to reduce the stigma associated with mental illness, and to promote the use of web-based technologies, and distance learning techniques.

(e) Strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation centers and programs, and increasing the number of human service academies.

(f) Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division.

(g) Promotion of the employment of mental health consumers and family members in the mental health system.

(h) Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs in subdivisions (a) through (f).

(i) Promotion of meaningful inclusion of diverse, racial, and ethnic community members who are underrepresented in the mental health provider network.

(j) Promotion of the inclusion of cultural competency in the training and education programs in subdivisions (a) through (f).

**SEC. 58.** Section 5830 of the Welfare and Institutions Code is amended to read:

**5830.** County mental health programs shall develop plans for innovative programs to be funded pursuant to paragraph (6) of subdivision (a) of Section 5892.

(a) The innovative programs shall have the following purposes:

(1) To increase access to underserved groups.

(2) To increase the quality of services, including better outcomes.

(3) To promote interagency collaboration.

(4) To increase access to services.

(b) All projects included in the innovative program portion of the county plan shall meet the following requirements:

(1) Address one of the following purposes as its primary purpose:

(A) Increase access to underserved groups.

(B) Increase the quality of services, including measurable outcomes.

(C) Promote interagency and community collaboration.

(D) Increase access to services.

(2) Support innovative approaches by doing one of the following:

(A) Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.

(B) Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.

(C) Introducing a new application to the mental health system of a promising community-driven practice or an

approach that has been successful in nonmental health contexts or settings.

(c) An innovative project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, any of the following:

(1) Administrative, governance, and organizational practices, processes, or procedures.

(2) Advocacy.

(3) Education and training for service providers, including nontraditional mental health practitioners.

(4) Outreach, capacity building, and community development.

(5) System development.

(6) Public education efforts.

(7) Research.

(8) Services and interventions, including prevention, early intervention, and treatment.

(d) If an innovative project has proven to be successful and a county chooses to continue it, the project workplan shall transition to another category of funding as appropriate.

(e) County mental health programs shall expend funds for their innovation programs upon approval by the Mental Health Services Oversight and Accountability Commission.

**SEC. 59.** Section 5840 of the Welfare and Institutions Code is amended to read:

**5840.** (a) The State Department of Health Care Services, in coordination with counties, shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.

(b) The program shall include the following components:

(1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

(2) Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable.

(3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.

(4) Reduction in discrimination against people with mental illness.

(c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.

(d) The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

(1) Suicide.

(2) Incarcerations.

(3) School failure or dropout.

(4) Unemployment.

(5) Prolonged suffering.

(6) Homelessness.

(7) Removal of children from their homes.

(e) Prevention and early intervention funds may be used to broaden the provision of community-based mental health services by adding prevention and early intervention services or activities to these services.

(f) In consultation with mental health stakeholders, and consistent with guidelines from the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5846, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors.

**SEC. 60.** Section 5845 of the Welfare and Institutions Code is amended to read:

**5845.** (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830), Innovative Programs; Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs; and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act. The commission shall replace the advisory committee established pursuant to Section 5814. The commission shall consist of 16 voting members as follows:

(1) The Attorney General or his or her designee.

(2) The Superintendent of Public Instruction or his or her designee.

(3) The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.

(4) The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.

(5) Two persons with a severe mental illness, a family member of an adult or senior with a severe mental illness, a family member of a child who has or has had a severe mental illness, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees and a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer, all appointed by the Governor. In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

(b) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(c) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(d) In carrying out its duties and responsibilities, the commission may do all of the following:

(1) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including any clerical, legal, and technical assistance as may appear necessary. The commission shall administer its operations separate and apart from the State Department of Health Care Services.

(3) Establish technical advisory committees such as a committee of consumers and family members.

(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to any officer or employee of state government.

(5) Enter into contracts.

(6) Obtain data and information from the State Department of Health Care Services, the Office of Statewide Health Planning and Development, or other state or local entities that receive Mental Health Services Act funds, for the commission to utilize in its oversight, review, training and technical assistance, accountability, and

evaluation capacity regarding projects and programs supported with Mental Health Services Act funds.

(7) Participate in the joint state-county decisionmaking process, as contained in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.

(8) Develop strategies to overcome stigma and discrimination, and accomplish all other objectives of Part 3.2 (commencing with Section 5830), 3.6 (commencing with Section 5840), and the other provisions of the act establishing this commission.

(9) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.

(10) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Health Care Services pursuant to Section 5655.

(11) Assist in providing technical assistance to accomplish the purposes of the Mental Health Services Act, Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) in collaboration with the State Department of Health Care Services and in consultation with the California Mental Health Directors Association.

(12) Work in collaboration with the State Department of Health Care Services and the California Mental Health Planning Council, and in consultation with the California Mental Health Directors Association, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.

**SEC. 61.** Section 5846 of the Welfare and Institutions Code is amended to read:

**5846.** (a) The commission shall issue guidelines for expenditures pursuant to Part 3.2 (commencing with Section 5830), for innovative programs, and Part 3.6 (commencing with Section 5840), for prevention and early intervention, no later than 180 days before the fiscal year for which the funds will apply.

(b) The commission may provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the commission or when local programs could benefit from technical assistance for improvement of their plans.

(c) The commission shall ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.

**SEC. 62.** Section 5847 of the Welfare and Institutions Code is amended to read:

**5847.** Integrated Plans for Prevention, Innovation, and System of Care Services.

(a) Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Mental Health Services Oversight and Accountability Commission within 30 days after adoption.

(b) The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements as required in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).

(2) A program for services to children in accordance with Part 4 (commencing with Section 5850), to include a program pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 or provide substantial evidence that it is not feasible to establish a wraparound program in that county.

(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).

(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).

(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the education and training programs established pursuant to Part 3.1 (commencing with Section 5820).

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act, during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(8) Certification by the county mental health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.

(9) Certification by the county mental health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act.

(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth ages 16 to 25. In implementing this subdivision, county mental health programs shall consider the needs of transition age foster youth.

(d) Each year, the State Department of Health Care Services shall inform the California Mental Health Directors Association and the Mental Health Services Oversight and Accountability Commission of the methodology used for revenue allocation to the counties.

(e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (7) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (e) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

**SEC. 63.** Section 5848 of the Welfare and Institutions Code is amended to read:

**5848.** (a) Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan

or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.

(c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the California Mental Health Directors Association.

(d) Mental health services provided pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), shall be included in the review of program performance by the California Mental Health Planning Council required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.

**SEC. 64.** Section 5878.1 of the Welfare and Institutions Code is amended to read:

**5878.1.** (a) It is the intent of this article to establish programs that ensure services will be provided to severely mentally ill children as defined in Section 5878.2 and that they be part of the children's system of care established pursuant to this part. It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and his or her family.

(b) Nothing in this act shall be construed to authorize any services to be provided to a minor without the consent of the child's parent or legal guardian beyond those already authorized by existing statute.

**SEC. 65.** Section 5878.3 of the Welfare and Institutions Code is amended to read:

**5878.3.** (a) Subject to the availability of funds as determined pursuant to Part 4.5 (commencing with Section 5890) of this division, county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services available pursuant to Medi-Cal, child welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health funds or other entitlement programs.

(b) Funding shall be at sufficient levels to ensure that counties can provide each child served all of the necessary services set forth in the applicable treatment plan developed in accordance with this part, including services where appropriate and necessary to prevent an out of home placement, such as services pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9.

(c) The State Department of Health Care Services shall contract with county mental health programs for the provision of services under this article in the manner set forth in Section 5897.

**SEC. 66.** Section 5890 of the Welfare and Institutions Code is amended to read:

**5890.** (a) The Mental Health Services Fund is hereby created in the State Treasury. The fund shall be administered by the state. Notwithstanding Section 13340 of the Government Code, all moneys in the fund are, except as provided in subdivision (d) of Section 5892, continuously appropriated, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this division:

(1) Part 3 (commencing with Section 5800), the Adult and Older Adult System of Care Act.

(2) Part 3.2 (commencing with Section 5830), Innovative Programs.

(3) Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs.

(4) Part 4 (commencing with Section 5850), the Children's Mental Health Services Act.

(b) Nothing in the establishment of this fund, nor any other provisions of the act establishing it or the programs funded shall be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the

Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. Nothing in this act shall be construed to modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing these obligations of plans and insurance policies.

(c) Nothing in this act shall be construed to modify or reduce the existing authority or responsibility of the State Department of Health Care Services.

(d) The State Department of Health Care Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care.

(e) Share of costs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division, shall be determined in accordance with the Uniform Method for Determining Ability to Pay applicable to other publicly funded mental health services, unless this Uniform Method is replaced by another method of determining co-payments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

**SEC. 67.** Section 5891 of the Welfare and Institutions Code is amended to read:

**5891.** (a) The funding established pursuant to this act shall be utilized to expand mental health services. Except as provided in subdivision (j) of Section 5892 due to the state's fiscal crisis, these funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund or from the Local Revenue Fund 2011 in the State Treasury, and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Section 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Section 5892.

(b) Notwithstanding subdivision (a), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any such loan shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that would interfere with the carrying out of the object for which these funds were created.

(c) Commencing July 1, 2012, on or before the 15th day of each month, pursuant to a methodology provided by the State Department of Health Care Services, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Mental Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850).

(d) Counties shall base their expenditures on the county mental health program's three-year program and expenditure plan or annual update, as required by Section 5847. Nothing in this subdivision shall affect subdivision (a) or (b).

**SEC. 68.** Section 5892 of the Welfare and Institutions Code is amended to read:

**5892.** (a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:

(1) In 2005–06, 2006–07, and in 2007–08 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005–06, 2006–07 and in 2007–08 10 percent for capital facilities and technological needs distributed to

counties in accordance with a formula developed in consultation with the California Mental Health Directors Association to implement plans developed pursuant to Section 5847.

(3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840) of this division.

(4) The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850), for the children's system of care and Part 3 (commencing with Section 5800), for the adult and older adult system of care.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division, shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.

(b) In any year after 2007-08, programs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

(d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 3.5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. The amount of funds available for the purposes of this subdivision in any fiscal year shall be subject to appropriation in the annual Budget Act.

(e) In 2004-05 funds shall be allocated as follows:

(1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820) of this division.

(2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).

(3) Five percent for local planning in the manner specified in subdivision (c).

(4) Five percent for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the fund.

(i) If there are still additional revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the commission's adopted plan which furthers the purposes of this act.

(j) For the 2011–12 fiscal year, General Fund revenues will be insufficient to fully fund many existing mental health programs, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and mental health services provided for special education pupils. In order to adequately fund those programs for the 2011–12 fiscal year and avoid deeper reductions in programs that serve individuals with severe mental illness and the most vulnerable, medically needy citizens of the state, prior to distribution of funds under paragraphs (1) to (6), inclusive, of subdivision (a), effective July 1, 2011, moneys shall be allocated from the Mental Health Services Fund to the counties as follows:

(1) Commencing July 1, 2011, one hundred eighty-three million six hundred thousand dollars ($183,600,000) of the funds available as of July 1, 2011, in the Mental Health Services Fund, shall be allocated in a manner consistent with subdivision (c) of Section 5778 and based on a formula determined by the state in consultation with the California Mental Health Directors Association to meet the fiscal year 2011–12 General Fund obligation for Medi-Cal Specialty Mental Health Managed Care.

(2) Upon completion of the allocation in paragraph (1), the Controller shall distribute to counties ninety-eight million five hundred eighty-six thousand dollars ($98,586,000) from the Mental Health Services Fund for mental health services for special education pupils based on a formula determined by the state in consultation with the California Mental Health Directors Association.

(3) Upon completion of the allocation in paragraph (2), the Controller shall distribute to counties 50 percent of their 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, not to exceed four hundred eighty-eight million dollars ($488,000,000). This allocation shall commence beginning August 1, 2011.

(4) Upon completion of the allocation in paragraph (3), and as revenues are deposited into the Mental Health Services Fund, the Controller shall distribute five hundred seventy-nine million dollars ($579,000,000) from the Mental Health Services Fund to counties to meet the General Fund obligation for EPSDT for fiscal year 2011–12. These revenues shall be distributed to counties on a quarterly basis and based on a formula determined by the state in consultation with the California Mental Health Directors Association. These funds shall not be subject to reconciliation or cost settlement.

(5) The Controller shall distribute to counties the remaining 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, beginning no later than April 30, 2012. These remaining allocations shall be made on a monthly basis.

(6) The total one-time allocation from the Mental Health Services Fund for EPSDT, Medi-Cal Specialty Mental Health Managed Care, and mental health services provided to special education pupils as referenced shall not exceed eight hundred sixty-two million dollars ($862,000,000). Any revenues deposited in the Mental Health Services Fund in fiscal year 2011–12 that exceed this obligation shall be distributed to counties for remaining fiscal year 2011–12 Mental Health Services Act component allocations, consistent with Sections 5847 and 5891.

(k) Subdivision (j) shall not be subject to repayment.

(l) Subdivision (j) shall become inoperative on July 1, 2012.

**SEC. 69.** Section 5897 of the Welfare and Institutions Code is amended to read:

**5897.** (a) Notwithstanding any other provision of state law, the State Department of Health Care Services shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. As used herein a county mental health program includes a city receiving funds pursuant to Section 5701.5.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of such mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through the annual county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2 of Division 5.

(d) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements.

(e) Contracts awarded by the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with Section 5800), Part 3.1 (commencing with Section 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890) of this division, may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to such contracts.

(f) For purposes of Section 5775, the allocation of funds pursuant to Section 5892 which are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.

**SEC. 70.** Section 5898 of the Welfare and Institutions Code is amended to read:

**5898.** The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission, shall develop regulations, as necessary, for the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, or designated state and local agencies to implement this act. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.

**SEC. 71.** Section 5899 is added to the Welfare and Institutions Code, to read:

**5899.** (a) The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the California Mental Health Directors Association, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report. This report shall be submitted electronically to the department and to the Mental Health Services Oversight and Accountability Commission.

(b) The purpose of the Annual Mental Health Services Act Revenue and Expenditure Report is as follows:

(1) Identify the expenditures of Mental Health Services Act (MHSA) funds that were distributed to each county.

(2) Quantify the amount of additional funds generated for the mental health system as a result of the MHSA.

(3) Identify unexpended funds, and interest earned on MHSA funds.

(4) Determine reversion amounts, if applicable, from prior fiscal year distributions.

(c) This report is intended to provide information that allows for the evaluation of all of the following:

(1) Children's systems of care.

(2) Prevention and early intervention strategies.

(3) Innovative projects.

(4) Workforce education and training.

(5) Adults and older adults systems of care.

(6) Capital facilities and technology needs.

**SEC. 72.** Section 14046.7 of the Welfare and Institutions Code is amended to read:

**14046.7.** (a) General Fund moneys shall not be used for the purposes of this article.

(b) Notwithstanding subdivision (a), no more than two hundred thousand dollars ($200,000) from the General Fund may be used annually for state administrative costs associated with implementing this article.

**SEC. 73.** Section 14085.6 of the Welfare and Institutions Code is amended to read:

**14085.6.** (a) Except as stated in subdivision (g), each hospital contracting to provide services under this article that meets the criteria contained in the state Medicaid plan for disproportionate share hospital status shall be eligible to negotiate with the commission for distributions from the Emergency Services and Supplemental Payments Fund, which is hereby created. All distributions from the fund shall be pursuant to this section.

(b) (1) To the extent permitted by federal law, the department shall administer the fund in accordance with this section.

(2) The money in this fund shall be available for expenditure by the department for the purposes of this section, subject to approval through the regular budget process.

(c) The fund shall include all of the following:

(1) Subject to subdivision (l), all public funds transferred by public agencies to the department for deposit in the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws. These transfers shall constitute local government financial participation in Medi-Cal as permitted under Section 1902(a)(2) of the federal Social Security Act (Title 42 U.S.C. Sec. 1396a(a)(2)) and other applicable federal Medicaid laws.

(2) Subject to subdivision (l), all private donated funds transferred by private individuals or entities for deposit in the fund as permitted under applicable federal Medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Interest that accrues on amounts in the fund.

(5) Moneys appropriated to the fund, or appropriated for poison control center grants and transferred to the fund, pursuant to the annual Budget Act.

(d) Amounts in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section.

(e) Distributions from the fund shall be supplemental to any and all other amounts that hospitals would have received under the contracting program, and under the state Medicaid plan, including contract rate increases and supplemental payments and payment adjustments under distribution programs relating to disproportionate share hospitals.

(f) Distributions from the fund shall not serve as the state's payment adjustment program under Section 1923 of the federal Social Security Act (42 U.S.C. Sec. 1396r-4). To the extent permitted by federal law, and except as otherwise provided in this section, distributions from the fund shall not be subject to requirements contained in or related to Section 1923 of the federal Social Security Act (42 U.S.C. Sec. 1396r-4). Distributions from the fund shall be supplemental contract payments and may be structured on any federally permissible basis, as negotiated between the commission and the hospital.

(g) In order to qualify for distributions from the fund, a hospital shall meet all of the following criteria:

(1) Be a contracting hospital under this article.

(2) Satisfy the state Medicaid plan criteria referred to in subdivision (a).

(3) Be one of the following:

(A) A licensed provider of basic emergency services as described in Sections 70411 and following of Title 22 of the California Code of Regulations.

(B) A licensed provider of comprehensive emergency medical services as defined in Sections 70451 and following of Title 22 of the California Code of Regulations.

(C) A children's hospital as defined in Section 14087.21 that satisfies subparagraph (A) or (B) or that jointly provides basic or comprehensive emergency services in conjunction with another licensed hospital.

(D) A hospital owned and operated by a public agency that operates two or more hospitals that qualify under subparagraph (A) or (B) with respect to the particular state fiscal year.

(E) A hospital designated by the National Cancer Institute as a comprehensive or clinical cancer research center that primarily treats acutely ill cancer patients and that is exempt from the federal Medicare prospective payment system pursuant to Section 1886(d)(1)(B)(v) of the federal Social Security Act (42 U.S.C. Sec. 1395ww(d)(1)(B)(v)).

(4) Be able to demonstrate a purpose for additional funding under the selective provider contracting program including proposals relating to emergency services and other health care services, including infrequent yet high-cost services, such as anti-AB human antitoxin treatment for infant botulism (human botulinum immune globulin (HBIG), commonly referred to as "Baby-BIG"), that are made available, or will be made available, to Medi-Cal beneficiaries.

(h) (1) The department shall seek federal financial participation for expenditures made from the fund to the full extent permitted by federal law.

(2) The department shall promptly seek any necessary federal approvals regarding this section.

(i) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in following fiscal years.

(j) For purposes of this section, "fund" means the Emergency Services and Supplemental Payments Fund.

(k) (1) Any public agency transferring amounts to the fund, as specified in paragraph (1) of subdivision (c), may for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public funds or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(2) Notwithstanding paragraph (1), a public agency may transfer to the fund only those moneys that have a source that will qualify for federal financial participation under the provisions of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or other applicable federal Medicaid laws.

(l) Public funds transferred pursuant to paragraph (1) of subdivision (c), and private donated funds transferred pursuant to paragraph (2) of subdivision (c), shall be deposited into the fund, and expended pursuant to this section. The director may accept only those funds that are certified by the transferring entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contributions and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and may return any funds transferred in error.

(m) The department may adopt emergency regulations, if necessary, for the purposes of this section.

(n) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section with respect to that hospital. The state may recoup that federal disallowance from the hospital in any manner authorized by law or contract.

(o) This section shall become inoperative on June 30, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

**SEC. 74.** Section 14085.7 of the Welfare and Institutions Code is amended to read:

**14085.7.** (a) The Medi-Cal Medical Education Supplemental Payment Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in this section. Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) All public moneys transferred by public agencies to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(2) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal Medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Any interest that accrues on amounts in the fund.

(b) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(c) The department shall have the discretion to accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by law. The department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable, and may return any funds transferred or donated in error.

(d) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under subdivision (e). Distributions from the fund shall be supplemental to any other amounts that hospitals receive under the contracting program.

(e) For purposes of recognizing medical education costs incurred for services rendered to Medi-Cal beneficiaries, payments from this fund shall be negotiated between the California Medical Assistance Commission and hospitals contracting under this article that meet the definition of university teaching hospitals or major (nonuniversity) teaching hospitals as set forth on page 51 and as listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping." Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(f) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section with respect to that hospital. The state may recoup any federal disallowance from the hospital.

(g) This section shall become inoperative on June 30, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

**SEC. 75.** Section 14085.8 of the Welfare and Institutions Code is amended to read:

**14085.8.** (a) The Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund is hereby created in the State Treasury.

(b) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in this section.

(c) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) All public moneys transferred by public agencies to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(2) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal Medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Any interest that accrues on amounts in the fund.

(d) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(e) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by law. The department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable, and may return any funds transferred or donated in error.

(f) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under subdivision (g). Distributions from the fund shall be supplemental to any other amounts that hospitals receive under the contracting program.

(g) (1) For purposes of recognizing medical education costs incurred for services rendered to Medi-Cal beneficiaries, contracts for payments from the fund may, at the discretion of the California Medical Assistance Commission, be negotiated between the commission and hospitals contracting under this article that are defined as either of the following:

(A) A large teaching emphasis hospital, as set forth on page 51 and listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," and meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(B) A children's hospital pursuant to Section 10727 and meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(2) Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(h) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section with respect to that hospital. The state may recoup any federal disallowance from the hospital.

(i) This section shall become inoperative on June 30, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

**SEC. 76.** Section 14085.81 of the Welfare and Institutions Code is amended to read:

**14085.81.** (a) Notwithstanding the requirement in subparagraph (A) of paragraph (1) of subdivision (g) of Section 14085.8 that a hospital must be listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," any hospital whose license pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code was consolidated during the 1999 calendar year with a large teaching emphasis hospital that is listed on page 57 of the above described report shall be eligible to negotiate payments pursuant to paragraph (1) of subdivision (g) of Section 14085.8. All other requirements of Section 14085.8 shall continue to apply.

(b) This section shall become inoperative on June 30, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

**SEC. 77.** Section 14085.9 of the Welfare and Institutions Code is amended to read:

**14085.9.** (a) Except as provided in subdivision (g), each hospital contracting to provide services under this article that meets the criteria contained in the state Medicaid plan for disproportionate share hospital status shall be eligible to negotiate with the commission for distributions from the Small and Rural Hospital Supplemental Payments Fund, which is hereby created and, notwithstanding Section 13340 of the Government Code, is continuously appropriated for the purposes specified in this section. All distributions from the fund shall be pursuant to this section.

(b) (1) To the extent permitted by federal law, the department shall administer the fund in accordance with this section.

(2) The money in this fund shall be available for expenditure by the department for the purposes of this section, subject to approval through the regular budget process.

(c) The fund shall include all of the following:

(1) Subject to subdivision (l), all public funds transferred by public agencies to the department for deposit in the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws. These transfers shall constitute local government financial participation in Medi-Cal as permitted under Section 1902(a)(2) of the federal Social Security Act (Title 42 U.S.C. Sec. 1396a(a)(2)) and other applicable federal Medicaid laws.

(2) Subject to subdivision (l), all private donated funds transferred by private individuals or entities for deposit in the fund as permitted under applicable federal Medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Interest that accrues on amounts in the fund.

(d) Amounts in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section.

(e) Distributions from the fund shall be supplemental to any and all other amounts that hospitals would have received under the contracting program, and under the state Medicaid plan, including contract rate increases and supplemental payments and payment adjustments under distribution programs relating to disproportionate share hospitals.

(f) Distributions from the fund shall not serve as the state's payment adjustment program under Section 1923 of the federal Social Security Act (42 U.S.C. Sec. 1396r-4). To the extent permitted by federal law, and except as otherwise provided in this section, distributions from the fund shall not be subject to requirements contained in or related to Section 1923 of the federal Social Security Act (42 U.S.C. Sec. 1396r-4). Distributions from the fund shall be supplemental contract payments and may be structured on any federally permissible basis, as negotiated between the commission and the hospital.

(g) In order to qualify for distributions from the fund, a hospital shall meet all of the following criteria:

(1) Be a contracting hospital under this article.

(2) Satisfy the state Medicaid plan criteria referred to in subdivision (a).

(3) Be a small and rural hospital as defined in Section 124840 of the Health and Safety Code.

(4) Be a licensed provider of standby emergency services as described in Section 70649 and following of Title 22 of the California Code of Regulations.

(5) Be able to demonstrate a purpose for additional funding under the selective provider contracting program with proposals relating to health care services that are made available, or will be made available, to Medi-Cal beneficiaries.

(6) Be determined by the California Medical Assistance Commission to be a hospital that provides an important community service that otherwise would not be provided in the community.

(h) (1) The department shall seek federal financial participation for expenditures made from the fund to the full extent permitted by federal law.

(2) The department shall promptly seek any necessary federal approvals regarding this section.

(i) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in following fiscal years.

(j) For purposes of this section, "fund" means the Small and Rural Hospital Supplemental Payments Fund.

(k) (1) Any public agency transferring amounts to the fund, as specified in paragraph (1) of subdivision (c), may for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public funds or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(2) Notwithstanding paragraph (1), a public agency may transfer to the fund only those moneys that have a source that will qualify for federal financial participation under the provisions of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or other applicable federal Medicaid laws.

(l) Public funds transferred pursuant to paragraph (1) of subdivision (c), and private donated funds transferred pursuant to paragraph (2) of subdivision (c), shall be deposited into the fund, and expended pursuant to this section. The director may accept only those funds that are certified by the transferring entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contributions and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and may return any funds transferred in error.

(m) The department may adopt emergency regulations for the purposes of this section.

(n) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section with respect to that hospital. The state may recoup that federal disallowance from the hospital in any manner authorized by law or contract.

(o) This section shall become inoperative on June 30, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

**SEC. 78.** Article 2.82 (commencing with Section 14087.98) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

**Article 2.82. Managed Health Care Expansion into Rural Counties**

**14087.98.** (a) The purpose of this article is to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in the following counties that currently receive Medi-Cal services on a fee-for-service basis: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Nevada, Mono, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

(b) The director may enter into exclusive or nonexclusive contracts on a bid or negotiated basis with one or more managed health care plans to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in the counties described in subdivision (a). The director shall give special consideration to managed health care plans that meet all of the following:

(1) Have demonstrated experience in effectively serving Medi-Cal beneficiaries, including diverse populations.

(2) Have demonstrated experience in effectively partnering with public and traditional safety net health care providers.

(3) Have demonstrated experience in working with local stakeholders, including consumers, providers, advocates, and county officials, in plan oversight and in delivery of care.

(4) Have the lowest administrative costs.

(5) Show support from local county officials as demonstrated by an action of the county board of supervisors.

(6) Show recent successful experience with expansion of managed care to a rural area.

(7) Offer a quality improvement program for primary care providers.

(c) Contracts entered into or amended pursuant to this section shall be exempt from the provisions of Chapter 2

(commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code.

(d) The managed health care plans that the department contracts with under this article shall comply with the requirements of Section 14087.48 and meet all of the following:

(1) Have Medi-Cal managed health care plan contract experience, or evidence of the ability to meet these contracting requirements.

(2) Be in good financial standing and meet licensure requirements under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), if applicable.

(3) Meet quality measures, which may include Medi-Cal and Medicare Healthcare Effectiveness Data and Information Set measures and other quality measures determined or developed by the department and the federal Centers for Medicare and Medicaid Services.

(e) The managed health care plans that the department contracts with under this article shall provide Medi-Cal beneficiaries with information about enrollment rights and options, plan benefits and rules, and care plan elements so that beneficiaries have the ability to make informed choices. This information shall be delivered in a format and language accessible to beneficiaries. The managed health care plans shall provide access to providers in compliance with applicable state and federal laws, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.

(f) The department shall conduct a stakeholder process including relevant stakeholders to ensure that beneficiaries, health care providers, and managed health care plans have an opportunity to provide input into the delivery model for these counties and to help ensure smooth care transitions for beneficiaries.

(g) Enrollment in a Medi-Cal managed health care plan or plans under this article shall be mandatory in order to receive services under Medi-Cal, except as otherwise provided by law.

(h) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship if his or her treating provider is a primary care provider or clinic contracting with the managed health care plan, has the available capacity, and agrees to continue to treat that beneficiary or eligible applicant. The managed health care plans shall comply with continuity of care requirements in Section 1373.96 of the Health and Safety Code.

(i) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section and amend regulations and orders adopted by the department by means of plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action, until the time regulations are adopted. It is the intent of the Legislature that the department have temporary authority as necessary to implement program changes until completion of the regulatory process.

(2) The department shall adopt emergency regulations no later than July 1, 2014. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted pursuant to this section. The initial adoption of emergency regulations implementing this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law.

(3) The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(j) The cost of any program established under this section shall not exceed the total amount that the department estimates it would pay for all services and requirements within the same geographic area under the fee-for-service Medi-Cal program.

(k) The department shall have exclusive authority to set the rates, terms, and conditions of managed health care plan contracts and contract amendments under this article. The director may include in the contract a provision for quality assurance withholding from the plan payment, to be paid only if quality measures identified in the plan contract are met.

(l) The department shall provide the fiscal and appropriate policy committees of the Legislature with quarterly updates, commencing January 1, 2014, and ending January 1, 2016, regarding the expansion of Medi-Cal managed care into the new counties authorized pursuant to this section. These updates shall include, but not be limited to, continuity of care requests, grievance and appeal rates, and utilization reports for the new counties.

(m) The department shall seek all necessary federal approvals to allow for federal financial participation in expenditures under this article. This article shall not be implemented until all necessary federal approvals have been obtained.

(n) This section shall be implemented only to the extent federal financial participation or funding is available.

(o) Notwithstanding subdivision (q) of Section 6254 of the Government Code, a contract or contract amendments executed by both parties after the effective date of the act adding this subdivision shall be considered a public record for purposes of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and shall be disclosed upon request. This subdivision applies to contracts that reveal the department's rates of payment for health care services, the rates themselves, and rate manuals.

(p) To implement this section, the department may contract with public or private entities. Contracts or amendments entered into under this section may be on an exclusive or nonexclusive basis and a noncompetitive bid basis and shall be exempt from the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.

(3) Review or approval of contracts by the Department of General Services.

**SEC. 79.** Section 14089.08 is added to the Welfare and Institutions Code, to read:

**14089.08.** (a) Sacramento County may establish a stakeholder advisory committee to provide input on the delivery of oral health and dental care services, including prevention and education services, dental managed care, and fee-for-service Denti-Cal. The advisory committee shall include, but not be limited to, local nonprofit organizations, representatives from the First Five Sacramento Commission, representatives and members of the local dental society, local health and human services representatives, representatives of Medi-Cal dental managed care plans, Medi-Cal enrollees, and other interested individuals. The advisory committee may meet on a monthly basis.

(b) The advisory committee may submit written input to the State Department of Health Care Services or the Sacramento County Board of Supervisors, as applicable, regarding policies that improve the delivery of oral health and dental services in Sacramento under the Medi-Cal program or county-administered health care system.

(c) The State Department of Health Care Services shall meet periodically, but at least on a quarterly basis, with the advisory committee to facilitate communication, dissemination of information, and improvements in the provision of oral health and dental care services under the Medi-Cal program in the County of Sacramento. The dissemination of information shall include data reported from performance measures and benchmarks used by the department.

(d) The advisory committee may meet periodically, but at least twice annually, with the Sacramento County Department of Health and Human Services advisory committee established pursuant to Section 14089.07.

(e) No state General Fund moneys shall be used to fund advisory committee costs or to fund any related administrative costs incurred by the county.

**SEC. 80.** Section 14089.09 is added to the Welfare and Institutions Code, to read:

**14089.09.** (a) It is the intent of the Legislature to improve access to oral health and dental care services provided to Medi-Cal beneficiaries enrolled in dental health managed care plans in the Counties of Sacramento and Los Angeles through implementation of performance contracting to ensure dental health plans meet quality criteria and timely access to dental care, as contained in Section 14459.6, and implementation of a beneficiary dental

exception process for Medi-Cal beneficiaries in the County of Sacramento to access dental care through fee-for-service Denti-Cal when applicable.

(b) (1) The Director of Health Care Services shall exercise his or her authority under Section 14131.15 to establish a beneficiary dental exception (BDE) process, as described in paragraph (2), for Medi-Cal beneficiaries mandatorily enrolled in dental health plans in the County of Sacramento. The BDE process shall be implemented no later than July 1, 2012, and shall be in effect for as long as mandatory enrollment for dental care is in effect in the County of Sacramento. The department shall consult with the advisory committee established pursuant to Section 14089.08 regarding potential modifications to the BDE process. For purposes of emergency access to dental care issues, the department shall establish specific processes under the BDE to accommodate for these issues.

(2) The BDE shall be available to Medi-Cal dental managed care beneficiaries in the County of Sacramento who are unable to secure access to services through their managed care plan, in accordance with applicable contractual timeframes and in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). The BDE shall allow a beneficiary to opt-out of Medi-Cal dental managed care and move into fee-for-service Denti-Cal where the beneficiary may select his or her own dental provider on an ongoing basis. The beneficiary shall remain in fee-for-service Denti-Cal until the time he or she chooses to opt in to a dental managed care arrangement.

(3) Beneficiaries shall be notified of the BDE option, which shall include the process for access to emergency visits, through a letter from the department detailing the process, directions on how to fill out the BDE form, and where to access the BDE form. A hard copy of the BDE form shall accompany the letter from the department. The BDE form, directions on how to fill out the BDE form, and a description of the process shall also be posted on the department's Internet Web site for easy access by beneficiaries and the public. The department shall also notify and inform dental managed care plans of the BDE process and its operation.

(4) Upon receipt of the BDE form, the department shall have no more than three business days to contact the beneficiary. The department shall, within five business days from the date of contact with the beneficiary, work with the beneficiary and the dental plan to schedule an appointment within the applicable contractual timeframes and in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(A) If an appointment is not available, the department shall approve and process the BDE and move the beneficiary into fee-for-service Denti-Cal.

(B) If an appointment is available, the beneficiary shall receive from the department a followup telephone call after the appointment to assess how the visit went and to determine if there is a need for any additional followup.

(5) Based on the followup as identified in subparagraph (B) of paragraph (4), to the extent no additional access issues to contractually required services are identified, the BDE shall be closed and the beneficiary shall remain in the selected dental plan.

(c) The department shall take all necessary steps to implement the BDE process as described in this section and shall, monthly, publicly report on the department's Internet Web site the number of individuals requesting the BDE and the specific outcome of each request, including, but not limited to, summary data on the types of visits subject to the BDE process, the services provided, description of timely access to care, the delivery system in which services were provided, beneficiary satisfaction, and the department's perspective of the outcome. The information provided on the department's Internet Web site shall be deidentified in accordance with the Health Insurance Portability and Availability Act of 1996 (HIPAA), including Section 164.514 of Title 45 of the Code of Federal Regulations, and shall not contain any personally indentifiable information according to the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code).

(d) The department shall consult with stakeholders in the development of the BDE form and related materials.

**SEC. 81.** Section 14091.3 of the Welfare and Institutions Code is amended to read:

**14091.3.** (a) For purposes of this section, the following definitions shall apply:

(1) "Medi-Cal managed care plan contracts" means those contracts entered into with the department by any individual, organization, or entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8

(commencing with Section 14087.5), or Article 2.91 (commencing with Section 14089) of this chapter, or Article 1 (commencing with Section 14200) or Article 7 (commencing with Section 14490) of Chapter 8, or Chapter 8.75 (commencing with Section 14591).

(2) "Medi-Cal managed care health plan" means an individual, organization, or entity operating under a Medi-Cal managed care plan contract with the department under this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591).

(b) The department shall take all appropriate steps to amend the Medicaid State Plan, if necessary, to carry out this section. This section shall be implemented only to the extent that federal financial participation is available.

(c) (1) Any hospital that does not have in effect a contract with a Medi-Cal managed care health plan, as defined in paragraph (2) of subdivision (a), that establishes payment amounts for services furnished to a beneficiary enrolled in that plan shall accept as payment in full, from all these plans, the following amounts:

(A) For outpatient services, the Medi-Cal fee-for-service (FFS) payment amounts.

(B) For emergency inpatient services, the average per diem contract rate specified in paragraph (2) of subdivision (b) of Section 14166.245, except that the payment amount shall not be reduced by 5 percent, until July 1, 2013, and thereafter, the average contract rate specified in Section 1396u-2(b)(2) of Title 42 of the United States Code. For the purposes of this subparagraph, this payment amount shall apply to all hospitals, including hospitals that contract with the department under the Medi-Cal Selective Provider Contracting Program described in Article 2.6 (commencing with Section 14081), and small and rural hospitals specified in Section 124840 of the Health and Safety Code.

(C) For poststabilization services following an emergency admission, payment amounts shall be consistent with Section 438.114(e) of Title 42 of the Code of Federal Regulations. This paragraph shall only be implemented to the extent that contract amendment language providing for these payments is approved by CMS. For purposes of this subparagraph, this payment amount shall apply to all hospitals, including hospitals that contract with the department under the Medi-Cal Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081).

(2) The rates established in paragraph (1) for emergency inpatient services and poststabilization services shall remain in effect only until the department implements the payment methodology based on diagnosis-related groups pursuant to Section 14105.28.

(3) Upon implementation of the payment methodology based on diagnosis-related groups pursuant to Section 14105.28, any hospital described in paragraph (1) shall accept as payment in full for inpatient hospital services, including both emergency inpatient services and poststabilization services related to an emergency medical condition, the payment amount established pursuant to the methodology developed under Section 14105.28.

(d) Medi-Cal managed care health plans that, pursuant to the department's encouragement in All Plan Letter 07003, have been paying out-of-network hospitals the most recent California Medical Assistance Commission regional average per diem rate as a temporary rate for purposes of Section 1932(b)(2)(D) of the federal Social Security Act (SSA), which became effective January 1, 2007, shall make reconciliations and adjustments for all hospital payments made since January 1, 2007, based upon rates published by the department pursuant to Section 1932(b)(2)(D) of the SSA and effective January 1, 2007, to June 30, 2008, inclusive, and, if applicable, provide supplemental payments to hospitals as necessary to make payments that conform with Section 1932(b)(2)(D) of the SSA. In order to provide managed care health plans with 60 working days to make any necessary supplemental payments to hospitals prior to these payments becoming subject to the payment of interest, Section 1300.71 of Title 28 of the California Code of Regulations shall not apply to these supplemental payments until 30 working days following the publication by the department of the rates.

(e) (1) The department shall provide a written report to the policy and fiscal committees of the Legislature on October 1, 2009, and May 1, 2010, on the implementation and impact made by this section, including the impact of these changes on access to hospitals by managed care enrollees and on contracting between hospitals and managed care health plans, including the increase or decrease in the number of these contracts.

(2) Not later than August 1, 2010, the department shall report to the Legislature on the implementation of this section. The report shall include, but not be limited to, information and analyses addressing managed care enrollee access to hospital services, the impact of this section on managed care health plan capitation rates, the impact of this section on the extent of contracting between managed care health plans and hospitals, and fiscal impact on the state.

(3) For the purposes of preparing the status reports and the final evaluation report required pursuant to this subdivision, Medi-Cal managed care health plans shall provide the department with all data and documentation, including contracts with providers, including hospitals, as deemed necessary by the department to evaluate the impact of the implementation of this section. In order to ensure the confidentiality of managed care health plan proprietary information, and thereby enable the department to have access to all of the data necessary to provide the Legislature with accurate and meaningful information regarding the impact of this section, all information and documentation provided to the department pursuant to this section shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(f) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement, interpret, or make specific this section and applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries.

(g) This section shall become inoperative on July 1, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

**SEC. 82.** Section 14105.196 is added to the Welfare and Institutions Code, to read:

**14105.196.** (a) It is the intent of the Legislature to comply with the provisions of the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and temporarily increase reimbursement to certain primary care providers at the same levels as Medicare rates for the 2013 and 2014 calendar years for specified services.

(b) (1) Notwithstanding any other law, to the extent required by federal law and regulations, beginning January 1, 2013, through and including December 31, 2014, payments for primary care services provided by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine shall not be less than 100 percent of the payment rate that applies to those services and physicians as established by the Medicare Program, for both fee-for-service and managed care plans.

(2) Notwithstanding any other law, to the extent required by federal law and regulations, beginning January 1, 2013, through and including December 31, 2014, the payments for primary care services implemented pursuant to this section shall be exempt from the payment reductions under Sections 14105.191 and 14105.192.

(c) For purposes of this section, "primary care services" and "primary specialty" means the services and primary specialties defined in Section 1202 of the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152; 42 U.S.C. Sec. 1396a(a)(13)(C)) and related federal regulations.

(d) Notwithstanding any other law, effective on or after January 1, 2013, the payment increase implemented pursuant to this section shall apply to managed care health plans that contract with the department pursuant to Chapter 8.75 (commencing with Section 14591) and to contracts with the Senior Care Action Network and the AIDS Healthcare Foundation, and to the extent that the services are provided through any of these contracts, payments shall be increased by the actuarial equivalent amount of the payment increases pursuant to contract amendments or change orders effective on or after January 1, 2013.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, clarify, make specific, and define the provisions of this section by means of provider bulletins or similar instructions, without taking regulatory action.

(f) Notwithstanding paragraph (1) of subdivision (b), if a final judicial determination is made by any state or federal court that is not appealed, in any action by any party, or a final determination is made by the administrator of the federal Centers for Medicare and Medicaid Services, that any payments pursuant to this section are invalid, unlawful, or contrary to any provision of federal law or regulations, or of state law, this section shall become inoperative.

(g) (1) The director shall implement the increased payments for primary care services and primary specialties provided for in this section only to the extent that the federal medical assistance percentage is equal to 100

percent.

(2) In assessing whether federal financial participation is available, the director shall determine whether the payments comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(3) To the extent that the director determines that the payments do not comply with applicable federal Medicaid requirements, the director shall retain the discretion not to implement the changes and may revise the payments as necessary to comply with the federal Medicaid requirements.

(h) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

**SEC. 83.** Section 14105.22 of the Welfare and Institutions Code is amended to read:

**14105.22.** (a) (1) Reimbursement for clinical laboratory or laboratory services, as defined in Section 51137.2 of Title 22 of the California Code of Regulations, may not exceed 80 percent of the lowest maximum allowance established by the federal Medicare Program for the same or similar services.

(2) This subdivision shall be implemented only until the new rate methodology under subdivision (b) is approved by the federal Centers for Medicare and Medicaid Services (CMS).

(b) (1) It is the intent of the Legislature that the department develop payment rates for clinical laboratory or laboratory services that are comparable to the payment amounts received from other payers for laboratory services. Development of these rates will enable the department to reimburse clinical laboratory or laboratory service providers in compliance with state and federal law.

(2) (A) The provisions of Section 51501(a) of Title 22 of the California Code of Regulations shall not apply to the rate methodology developed for clinical laboratories or laboratory services pursuant to this subdivision.

(B) In addition to subparagraph (a), any payment reductions implemented pursuant to this section shall not be subject to the provisions of Section 51501(a) of Title 22 of the California Code of Regulations for 12 months following the date of implementation of this reduction.

(3) Reimbursement to providers for clinical laboratory or laboratory services shall not exceed the lowest of the following:

(A) The amount billed.

(B) The charge to the general public.

(C) Eighty percent of the lowest maximum allowance established by the federal Medicare Program for the same or similar services.

(D) A reimbursement rate based on an average of the lowest amount that other payers and other state Medicaid programs are paying for similar clinical laboratory services.

(4) In addition to the payment reductions implemented pursuant to Section 14105.192, payments shall be reduced by up to 10 percent for clinical laboratory or laboratory services, as defined in Section 51137.2 of Title 22 of the California Code of Regulations, for dates of service on and after July 1, 2012. The payment reductions pursuant to this paragraph shall continue until the new rate methodology under this subdivision has been approved by CMS.

(5) (A) For purposes of establishing reimbursement rates for clinical laboratory or laboratory services based on the lowest amounts other payers are paying providers for similar laboratory services, laboratory service providers shall submit data reports within six months of the date the act that added this paragraph becomes effective and annually thereafter. The data provided shall be based on the previous calendar year and shall specify the provider's usual and customary payments, reflecting Medi-Cal, other state Medicaid programs, private insurance, and Medicare payment data, minus discounts and rebates.

(B) The data submitted pursuant to subparagraph (A) may be used to determine reimbursement rates by procedure code based on an average of the lowest amount other payers are paying providers for similar laboratory services, excluding significant deviations of cost or volume factors and with consideration to geographical areas.

(C) For purposes of subparagraph (B), the department may contract with a vendor for the purposes of collecting payment data reports from clinical laboratories, analyzing payment information, and calculating a proposed rate.

(D) The proposed rates calculated by the vendor described in subparagraph (C) may be used in determining the lowest reimbursement rate for clinical laboratories or laboratory services in accordance with paragraph (3).

(E) Data reports submitted to the department shall be certified by the provider's certified financial officer or an authorized individual.

(F) Clinical laboratory providers that fail to submit data reports within 30 working days from the time requested by the department shall be subject to the suspension provisions of subdivisions (a) and (c) of Section 14123.

(6) Data reports provided to the department pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(7) The department shall seek stakeholder input on the rate setting methodology.

(8) (A) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any further regulatory action, implement, interpret, or make specific this section by means of provider bulletins or similar instructions until regulations are adopted. It is the intent of the Legislature that the department have temporary authority as necessary to implement program changes until completion of the regulatory process.

(B) The department shall adopt emergency regulations no later than July 1, 2014. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted pursuant to this section. The initial adoption of emergency regulations implementing the amendments to this section and the one readoption of emergency regulations authorized by this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law.

(C) The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(9) To the extent that the director determines that the new methodology or payment reductions are not consistent with the requirements of Section 1396a(a)(30)(A) of Title 42 of the United States Code, the department may revert to the methodology under subdivision (a) to ensure access to care is not compromised.

(10) (A) The department shall implement this section in a manner that is consistent with federal Medicaid law and regulations. The director shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only to the extent that federal approval is obtained.

(B) In determining whether federal financial participation is available, the director shall determine whether the rates and payments comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(C) To the extent that the director determines that the rates and payments do not comply with applicable federal Medicaid requirements or that federal financial participation is not available with respect to any reimbursement rate, the director retains the discretion not to implement that rate or payment and may revise the rate or payment as necessary to comply with federal Medicaid requirements. The department shall notify the Joint Legislative Budget Committee 10 days prior to revising the rate or payment to comply with federal Medicaid requirements.

**SEC. 84.** Section 14134 of the Welfare and Institutions Code, as amended by Chapter 3 of the Statutes of 2011, is amended to read:

**14134.** (a) Except for any prescription, refill, visit, service, device, or item for which the program's payment is ten dollars ($10) or less, in which case no copayment shall be required, a recipient of services under this chapter shall be required to make copayments not to exceed the maximum permitted under federal regulations or federal waivers as follows:

(1) Copayment of five dollars ($5) shall be made for nonemergency services received in an emergency department or emergency room when the services do not result in the treatment of an emergency medical condition or inpatient admittance. For the purposes of this section, "nonemergency services" means services not required to, as appropriate, medically screen, examine, evaluate, or stabilize an emergency medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(A) Placing the individual's health, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(B) Serious impairment to bodily functions.

(C) Serious dysfunction of any bodily organ or part.

(2) Copayment of one dollar ($1) shall be made for each drug prescription or refill.

(3) Copayment of one dollar ($1) shall be made for each visit for services under subdivisions (a) and (h) of Section 14132.

(4) The copayment amounts set forth in paragraphs (1), (2), and (3) may be collected and retained or waived by the provider.

(5) The department shall not reduce the reimbursement otherwise due to providers as a result of the copayment. The copayment amounts shall be in addition to any reimbursement otherwise due the provider for services rendered under this program.

(6) This section does not apply to emergency services, family planning services, or to any services received by:

(A) Any child in AFDC-Foster Care, as defined in Section 11400.

(B) Any person who is an inpatient in a health facility, as defined in Section 1250 of the Health and Safety Code.

(C) Any person 18 years of age or under.

(D) Any woman receiving perinatal care.

(7) Paragraph (2) does not apply to any person 65 years of age or over.

(8) A provider of service shall not deny care or services to an individual solely because of that person's inability to copay under this section. An individual shall, however, remain liable to the provider for any copayment amount owed.

(9) The department shall seek any federal waivers necessary to implement this section. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented, but provisions for which waivers are either obtained or found to be unnecessary shall be unaffected by the inability to obtain federal waivers for the other provisions.

(10) The director shall adopt any regulations necessary to implement this section as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The director shall transmit these emergency regulations directly to the Secretary of State for filing and the regulations shall become effective immediately upon filing. Upon completion of the formal regulation adoption process and prior to the expiration of the 120 day duration period of emergency regulations, the director shall transmit directly to the Secretary of State for filing the adopted regulations, the rulemaking file, and the certification of compliance as required by subdivision (e) of Section 11346.1 of the Government Code.

(b) This section, or subdivisions thereof, if applicable, shall become inoperative on the implementation date for copayments stated in the declaration executed by the director pursuant to Section 14134 as added by Section 101.5 of the act that added this subdivision.

**SEC. 85.** Section 14134 of the Welfare and Institutions Code, as added by Chapter 3 of the Statutes of 2011, is amended to read:

**14134.** (a) The Legislature finds and declares all of the following:

(1) Costs within the Medi-Cal program continue to grow due to the rising cost of providing health care throughout the state and also due to increases in enrollment, which are more pronounced during difficult economic times.

(2) In order to minimize the need for drastically cutting enrollment standards or benefits or imposing further reductions on Medi-Cal providers during times of economic crisis, it is crucial to find areas within the program where beneficiaries can share responsibility for utilization of health care, whether they are participating in the fee-for-service or the managed care model of service delivery.

(3) The establishment of cost-sharing obligations within the Medi-Cal program is complex and is subject to close supervision by the United States Department of Health and Human Services.

(4) As the single state agency for Medicaid in California, the State Department of Health Care Services has unique expertise that can inform decisions that set or adjust cost-sharing responsibilities for Medi-Cal beneficiaries receiving health care services.

(b) Therefore, it is the intent of the Legislature for the department to obtain federal approval to implement cost-sharing for Medi-Cal beneficiaries and permit providers to require that individuals meet their cost-sharing obligation prior to receiving care or services.

(c) A Medi-Cal beneficiary shall be required to make copayments as described in this section. These copayments represent a contribution toward the rate of payment made to providers of Medi-Cal services and shall be as follows:

(1) Copayment of up to fifty dollars ($50) shall be made for nonemergency services received in an emergency department or emergency room when the services do not result in the treatment of an emergency condition or inpatient admittance. For the purposes of this section, "nonemergency services" means services not required to, as appropriate, medically screen, examine, evaluate, or stabilize an emergency medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(A) Placing the individual's health, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(B) Serious impairment to bodily functions.

(C) Serious dysfunction of any bodily organ or part.

(2) Copayment of up to fifty dollars ($50) shall be made for emergency services received in an emergency department or emergency room when the services result in the treatment of an emergency medical condition or inpatient admittance. For purposes of this section, "emergency services" means services required to, as appropriate, medically screen, examine, evaluate, or stabilize an emergency medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(A) Placing the individual's health, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(B) Serious impairment to bodily functions.

(C) Serious dysfunction of any bodily organ or part.

(3) Copayment of up to one hundred dollars ($100) shall be made for each hospital inpatient day, up to a maximum of two hundred dollars ($200) per admission.

(4) Copayment of up to three dollars ($3) shall be made for each preferred drug prescription or refill. A copayment of up to five dollars ($5) shall be made for each nonpreferred drug prescription or refill. Except as provided in subdivision (g), "preferred drug" shall have the same meaning as in Section 1916A of the Social Security Act (42 U.S.C. Sec. 1396o-1).

(5) Copayment of up to five dollars ($5) shall be made for each visit for services under subdivision (a) of Section 14132 and for dental services received on an outpatient basis provided as a Medi-Cal benefit pursuant to this chapter or Chapter 8 (commencing with Section 14200), as applicable.

(6) This section does not apply to services provided pursuant to subdivision (aa) of Section 14132.

(d) The copayments established pursuant to subdivision (c) shall be set by the department, at the maximum amount provided for in the applicable paragraph, except that each copayment amount shall not exceed the maximum amount allowable pursuant to the state plan amendments or other federal approvals.

(e) The copayment amounts set forth in subdivision (c) may be collected and retained or waived by the provider. The department shall deduct the amount of the copayment from the payment the department makes to the provider whether retained, waived, or not collected by the provider.

(f) Notwithstanding any other provision of law, and only to the extent allowed pursuant to federal law, a provider of service has no obligation to provide services to a Medi-Cal beneficiary who does not, at the point of service, pay the copayment assessed pursuant to this section. If the provider provides services without collecting the copayment, and has not waived the copayment, the provider may hold the beneficiary liable for the copayment amount owed.

(g) (1) Notwithstanding any other provision of law, except as described in paragraph (2), this section shall apply to Medi-Cal beneficiaries enrolled in a health plan contracting with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except for the Senior Care Action Network or AIDS Healthcare Foundation. To the extent permitted by federal law and pursuant to any federal waivers or state plan adjustments obtained, a managed care health plan may establish a lower copayment or no copayment.

(2) For the purpose of paragraph (4) of subdivision (c), copayments assessed against a beneficiary who receives Medi-Cal services through a health plan described in paragraph (1) shall be based on the plan's designation of a drug as preferred or nonpreferred.

(3) To the extent provided by federal law, capitation payments shall be calculated on an actuarial basis as if copayments described in this section were collected.

(h) This section shall be implemented only to the extent that federal financial participation is available. The department shall seek and obtain any federal waivers or state plan amendments necessary to implement this section. The provisions for which appropriate federal waivers or state plan amendments cannot be obtained shall not be implemented, but provisions for which waivers or state plan amendments are either obtained or found to be unnecessary shall be unaffected by the inability to obtain federal waivers or state plan amendments for the other provisions.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, all-plan letters, provider bulletins, or similar instructions, without taking further regulatory actions.

(j) (1) This section shall become operative on the date that the act adding this section is effective, but shall not be implemented until the date in the declaration executed by the director pursuant to paragraph (2). In no event shall the director set an implementation date prior to the date federal approval is received.

(2) The director shall execute a declaration that states the date that implementation of the copayments described in this section or subdivisions thereof, if applicable, will commence and shall post the declaration on the department's Internet Web site and provide a copy of the declaration to the Chair of the Joint Legislative Budget Committee, the Chief Clerk of the Assembly, the Secretary of the Senate, the Office of the Legislative Counsel, and the Secretary of State.

**SEC. 86.** Section 14134.1 of the Welfare and Institutions Code is amended to read:

**14134.1.** (a) Except as provided in paragraph (2) of subdivision (a) of Section 14134, no provider under this chapter may deny care or services to an individual eligible for care or services under this chapter because of the individual's inability to pay a copayment, as defined in Section 14134. The requirements of this section shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the copayment.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, provider bulletins, or similar instructions, without taking further regulatory action.

(c) This section shall become inoperative to the extent, and on the implementation date for, copayments as stated in the declaration executed by the director pursuant to Section 14134 as added by Section 101.5 of the

act that added this subdivision.

**SEC. 87.** Section 14154 of the Welfare and Institutions Code is amended to read:

**14154.** (a) (1) The department shall establish and maintain a plan whereby costs for county administration of the determination of eligibility for benefits under this chapter will be effectively controlled within the amounts annually appropriated for that administration. The plan, to be known as the County Administrative Cost Control Plan, shall establish standards and performance criteria, including workload, productivity, and support services standards, to which counties shall adhere. The plan shall include standards for controlling eligibility determination costs that are incurred by performing eligibility determinations at county hospitals, or that are incurred due to the outstationing of any other eligibility function. Except as provided in Section 14154.15, reimbursement to a county for outstationed eligibility functions shall be based solely on productivity standards applied to that county's welfare department office.

(2) (A) The plan shall delineate both of the following:

(i) The process for determining county administration base costs, which include salaries and benefits, support costs, and staff development.

(ii) The process for determining funding for caseload changes, cost-of-living adjustments, and program and other changes.

(B) The annual county budget survey document utilized under the plan shall be constructed to enable the counties to provide sufficient detail to the department to support their budget requests.

(3) The plan shall be part of a single state plan, jointly developed by the department and the State Department of Social Services, in conjunction with the counties, for administrative cost control for the California Work Opportunity and Responsibility to Kids (CalWORKs), CalFresh, and Medical Assistance (Medi-Cal) programs. Allocations shall be made to each county and shall be limited by and determined based upon the County Administrative Cost Control Plan. In administering the plan to control county administrative costs, the department shall not allocate state funds to cover county cost overruns that result from county failure to meet requirements of the plan. The department and the State Department of Social Services shall budget, administer, and allocate state funds for county administration in a uniform and consistent manner.

(4) The department and county welfare departments shall develop procedures to ensure the data clarity, consistency, and reliability of information contained in the county budget survey document submitted by counties to the department. These procedures shall include the format of the county budget survey document and process, data submittal and its documentation, and the use of the county budget survey documents for the development of determining county administration costs. Communication between the department and the county welfare departments shall be ongoing as needed regarding the content of the county budget surveys and any potential issues to ensure the information is complete and well understood by involved parties. Any changes developed pursuant to this section shall be incorporated within the state's annual budget process by no later than the 2011–12 fiscal year.

(5) The department shall provide a clear narrative description along with fiscal detail in the Medi-Cal estimate package, submitted to the Legislature in January and May of each year, of each component of the county administrative funding for the Medi-Cal program. This shall describe how the information obtained from the county budget survey documents was utilized and, where applicable, modified and the rationale for the changes.

(6) Notwithstanding any other provision of law, the department shall develop and implement, in consultation with county program and fiscal representatives, a new budgeting methodology for Medi-Cal county administrative costs. The new budgeting methodology shall be used to reimburse counties for eligibility determinations for applicants and beneficiaries, including one-time eligibility processing and ongoing case maintenance.

(A) The budgeting methodology shall include, but is not limited to, identification of the costs of eligibility determinations for applicants, and the costs of eligibility redeterminations and case maintenance activities for recipients, for different groupings of cases. The groupings of cases shall be based on variations in time and resources needed to conduct eligibility determinations. The calculation of time and resources shall be based on the following factors: complexity of eligibility rules, ongoing eligibility requirements, and other factors as determined appropriate by the department.

(B) The new budgeting methodology shall be clearly described, state the necessary data elements to be

collected from the counties, and establish the timeframes for counties to provide the data to the state.

(C) The department may develop a process for counties to phase in the requirements of the new budgeting methodology.

(D) To the extent a county does not submit the requested data pursuant to subparagraph (B), the new budgeting methodology may include a process to use peer-based proxy costs in developing the county budget.

(E) The department shall provide the new budgeting methodology to the legislative fiscal committees by March 1, 2012, and may include the methodology in the May Medi-Cal Local Assistance Estimate, beginning with the May 2012 estimate, for the 2012–13 fiscal year and each fiscal year thereafter.

(F) To the extent that the funding for the county budgets developed pursuant to the new budget methodology is not fully appropriated in any given fiscal year, the department, with input from the counties, shall identify and consider options to align funding and workload responsibilities.

(b) Nothing in this section, Section 15204.5, or Section 18906 shall be construed so as to limit the administrative or budgetary responsibilities of the department in a manner that would violate Section 14100.1, and thereby jeopardize federal financial participation under the Medi-Cal program.

(c) (1) The Legislature finds and declares that in order for counties to do the work that is expected of them, it is necessary that they receive adequate funding, including adjustments for reasonable annual cost-of-doing-business increases. The Legislature further finds and declares that linking appropriate funding for county Medi-Cal administrative operations, including annual cost-of-doing-business adjustments, with performance standards will give counties the incentive to meet the performance standards and enable them to continue to do the work they do on behalf of the state. It is therefore the Legislature's intent to provide appropriate funding to the counties for the effective administration of the Medi-Cal program at the local level to ensure that counties can reasonably meet the purposes of the performance measures as contained in this section.

(2) It is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2008–09, 2009–10, 2010–11, 2011–12, and 2012–13 fiscal years.

(d) The department is responsible for the Medi-Cal program in accordance with state and federal law. A county shall determine Medi-Cal eligibility in accordance with state and federal law. If in the course of its duties the department becomes aware of accuracy problems in any county, the department shall, within available resources, provide training and technical assistance as appropriate. Nothing in this section shall be interpreted to eliminate any remedy otherwise available to the department to enforce accurate county administration of the program. In administering the Medi-Cal eligibility process, each county shall meet the following performance standards each fiscal year:

(1) Complete eligibility determinations as follows:

(A) Ninety percent of the general applications without applicant errors and are complete shall be completed within 45 days.

(B) Ninety percent of the applications for Medi-Cal based on disability shall be completed within 90 days, excluding delays by the state.

(2) (A) The department shall establish best-practice guidelines for expedited enrollment of newborns into the Medi-Cal program, preferably with the goal of enrolling newborns within 10 days after the county is informed of the birth. The department, in consultation with counties and other stakeholders, shall work to develop a process for expediting enrollment for all newborns, including those born to mothers receiving CalWORKs assistance.

(B) Upon the development and implementation of the best-practice guidelines and expedited processes, the department and the counties may develop an expedited enrollment timeframe for newborns that is separate from the standards for all other applications, to the extent that the timeframe is consistent with these guidelines and processes.

(3) Perform timely annual redeterminations, as follows:

(A) Ninety percent of the annual redetermination forms shall be mailed to the recipient by the anniversary date.

(B) Ninety percent of the annual redeterminations shall be completed within 60 days of the recipient's annual redetermination date for those redeterminations based on forms that are complete and have been returned to the county by the recipient in a timely manner.

(C) Ninety percent of those annual redeterminations where the redetermination form has not been returned to the county by the recipient shall be completed by sending a notice of action to the recipient within 45 days after the date the form was due to the county.

(D) When a child is determined by the county to change from no share of cost to a share of cost and the child meets the eligibility criteria for the Healthy Families Program established under Section 12693.98 of the Insurance Code, the child shall be placed in the Medi-Cal-to-Healthy Families Bridge Benefits Program, and these cases shall be processed as follows:

(i) Ninety percent of the families of these children shall be sent a notice informing them of the Healthy Families Program within five working days from the determination of a share of cost.

(ii) Ninety percent of all annual redetermination forms for these children shall be sent to the Healthy Families Program within five working days from the determination of a share of cost if the parent has given consent to send this information to the Healthy Families Program.

(iii) Ninety percent of the families of these children placed in the Medi-Cal-to-Healthy Families Bridge Benefits Program who have not consented to sending the child's annual redetermination form to the Healthy Families Program shall be sent a request, within five working days of the determination of a share of cost, to consent to send the information to the Healthy Families Program.

(E) Subparagraph (D) shall not be implemented until 60 days after the Medi-Cal and Joint Medi-Cal and Healthy Families applications and the Medi-Cal redetermination forms are revised to allow the parent of a child to consent to forward the child's information to the Healthy Families Program.

(e) The department shall develop procedures in collaboration with the counties and stakeholder groups for determining county review cycles, sampling methodology and procedures, and data reporting.

(f) On January 1 of each year, each applicable county, as determined by the department, shall report to the department on the county's results in meeting the performance standards specified in this section. The report shall be subject to verification by the department. County reports shall be provided to the public upon written request.

(g) If the department finds that a county is not in compliance with one or more of the standards set forth in this section, the county shall, within 60 days, submit a corrective action plan to the department for approval. The corrective action plan shall, at a minimum, include steps that the county shall take to improve its performance on the standard or standards with which the county is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the county in order to avoid a sanction.

(h) (1) If a county does not meet the performance standards for completing eligibility determinations and redeterminations as specified in this section, the department may, at its sole discretion, reduce the allocation of funds to that county in the following year by 2 percent. Any funds so reduced may be restored by the department if, in the determination of the department, sufficient improvement has been made by the county in meeting the performance standards during the year for which the funds were reduced. If the county continues not to meet the performance standards, the department may reduce the allocation by an additional 2 percent for each year thereafter in which sufficient improvement has not been made to meet the performance standards.

(2) No reduction of the allocation of funds to a county shall be imposed pursuant to this subdivision for failure to meet performance standards during any period of time in which the cost-of-doing-business increase is suspended.

(i) The department shall develop procedures, in collaboration with the counties and stakeholders, for developing instructions for the performance standards established under subparagraph (D) of paragraph (3) of subdivision (d), no later than September 1, 2005.

(j) No later than September 1, 2005, the department shall issue a revised annual redetermination form to allow a parent to indicate parental consent to forward the annual redetermination form to the Healthy Families Program if the child is determined to have a share of cost.

(k) The department, in coordination with the Managed Risk Medical Insurance Board, shall streamline the method of providing the Healthy Families Program with information necessary to determine Healthy Families eligibility for a child who is receiving services under the Medi-Cal-to-Healthy Families Bridge Benefits Program.

(l) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any further regulatory action, implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters or similar instructions.

**SEC. 88.** Section 14165 of the Welfare and Institutions Code is amended to read:

**14165.** (a) There is hereby created in the Governor's office the California Medical Assistance Commission, for the purpose of contracting with health care delivery systems for the provision of health care services to recipients under the California Medical Assistance program.

(b) Notwithstanding any other provision of law, the commission created pursuant to subdivision (a) shall continue through June 30, 2012, after which, it shall be dissolved and the term of any commissioner serving at that time shall end.

(1) Upon dissolution of the commission, all powers, duties, and responsibilities of the commission shall be transferred to the Director of Health Care Services. These powers, duties, and responsibilities shall include, but are not limited to, those exercised in the operation of the selective provider contracting program pursuant to Article 2.6 (commencing with Section 14081).

(2) (A) On July 1, 2012, notwithstanding any other law, employees of the California Medical Assistance Commission as of June 30, 2012, excluding commissioners, shall transfer to the State Department of Health Care Services.

(B) Employees who transfer pursuant to subparagraph (A) shall be subject to the same conditions of employment under the department as they were under the California Medical Assistance Commission, including retention of their exempt status, until the diagnosis-related groups payment system described in Section 14105.28 replaces the contract-based payment system described in this article.

(C) (i) Notwithstanding any other law or rule, persons employed by the department who transferred to the department pursuant to subparagraph (A) shall be eligible to apply for civil service examinations. Persons receiving passing scores shall have their names placed on lists resulting from these examinations, or otherwise gain eligibility for appointment. In evaluating minimum qualifications, related California Medical Assistance Commission experience shall be considered state civil service experience in a class deemed comparable by the State Personnel Board, based on the duties and responsibilities assigned.

(ii) On the date the diagnosis-related groups payment system described in Section 14105.28 replaces the contract-based system described in this article, employees who transferred to the department pursuant to subparagraph (A) shall transfer to civil service classifications within the department for which they are eligible.

(3) Upon a determination by the Director of Health Care Services that a payment system based on diagnosis-related groups as described in Section 14105.28 that is sufficient to replace the contract-based payment system described in this article has been developed and implemented, the powers, duties, and responsibilities conferred on the commission and transferred to the Director of Health Care Services shall no longer be exercised, excluding both of the following:

(A) Stabilization payments made or committed from Sections 14166.14 and 14166.19 for services rendered prior to the director's determination pursuant to this paragraph.

(B) The ability to negotiate and make payments from the Private Hospital Supplemental Fund, established pursuant to Section 14166.12, and the Nondesignated Public Hospital Supplemental Fund, established pursuant to Section 14166.17.

(4) Protections afforded to the negotiations and contracts of the commission by the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) shall be applicable to the negotiations and contracts conducted or entered into pursuant to this section by the State Department of Health Care Services.

(c) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, or any other provision of law, the State Department of Health Care Services may implement and administer this section by means of provider bulletins or other similar instructions, without taking regulatory action. The authority to implement this section as set forth in this subdivision shall include the authority to give notice by provider bulletin or other similar instruction of a

determination made pursuant to paragraph (3) of subdivision (b) and to modify or supersede existing regulations in Title 22 of the California Code of Regulations that conflict with implementation of this section.

**SEC. 89.** Section 14166.8 of the Welfare and Institutions Code is amended to read:

**14166.8.** (a) Within five months after the end of each project year or successor demonstration year, each of the designated public hospitals shall submit to the department all of the following reports:

(1) The hospital's Medicare cost report for the project year or successor demonstration year.

(2) Other cost reporting and statistical data necessary for the determination of amounts due the hospital under the demonstration project or successor demonstration project, as requested by the department.

(b) For each project year or successor demonstration year, the reports shall identify all of the following:

(1) The costs incurred in providing inpatient hospital services to Medi-Cal beneficiaries on a fee-for-service basis and physician and nonphysician practitioner services costs, as identified in subdivision (e) of Section 14166.4.

(2) The amount of uncompensated costs incurred in providing hospital services to Medi-Cal beneficiaries, including managed care enrollees.

(3) The costs incurred in providing hospital services to uninsured individuals.

(4) (A) Discharge data, commencing with successor demonstration year 6, and retrospectively for prior periods as necessary to establish interim payment determinations, for the following patient categories:

(i) Uninsured patients.

(ii) Low Income Health Program patients.

(iii) Medi-Cal patients, excluding discharges for which Medicare payments were received.

(B) The department shall consult with the designated public hospitals regarding a methodology for adjusting prior period discharge data to reflect the projected number of discharges relating to Low Income Health Program patients for the period at issue.

(c) (1) Each designated public hospital, or governmental entity with which it is affiliated, that operates nonhospital clinics or provides physician, nonphysician practitioner, or other health care services that are not identified as hospital services under the Special Terms and Conditions for the demonstration project and successor demonstration project, may report and certify all, or a portion, of the uncompensated Medi-Cal and uninsured costs of the services furnished.

(2) Notwithstanding paragraph (1), beginning with the 2012–13 fiscal year, and for each successor demonstration year thereafter, each designated public hospital, or governmental entity with which it is affiliated, that operates nonhospital clinics or provides physician, nonphysician practitioner, or other health care services that are not identified as hospital services under the Special Terms and Conditions for the successor demonstration project, shall report and certify all of the uncompensated uninsured costs of the services furnished that meet the requirements of subdivisions (d) and (e).

(3) The amount of these uncompensated costs to be claimed by the department shall be determined by the department in consultation with the governmental entity so as to optimize the level of claimable federal Medicaid funding.

(d) Reports submitted under this section shall include all allowable costs.

(e) The appropriate public official shall certify to all of the following:

(1) The accuracy of the reports required under this section.

(2) That the expenditures to meet the reported costs comply with Section 433.51 of Title 42 of the Code of Federal Regulations.

(3) That the sources of funds used to make the expenditures certified under this section do not include impermissible provider taxes or donations as defined under Section 1396b(w) of Title 42 of the United States Code or other federal funds. For this purpose, federal funds do not include delivery system reform incentive pool payments, patient care revenue received as payment for services rendered under programs such as designated

state health programs, the Low Income Health Program, Medicare, or Medicaid.

(f) The certification of public expenditures made pursuant to this section shall be based on a schedule established by the department. The director may require the designated public hospitals to submit quarterly estimates of anticipated expenditures, if these estimates are necessary to obtain interim payments of federal Medicaid funds. All reported expenditures shall be subject to reconciliation to allowable costs, as determined in accordance with applicable implementing documents for the demonstration project and successor demonstration project.

(g) Subject to the determination made under paragraph (3) of subdivision (c), the director shall seek Medicaid federal financial participation for all certified public expenditures reported by the designated public hospitals and recognized under the demonstration project and successor demonstration project, to the extent consistent with Section 14166.9.

(h) Governmental or public entities other than those that operate a designated public hospital may, at the request of a governmental or public entity, certify uncompensated Medi-Cal and uninsured costs in accordance with this section, subject to the department's discretion and prior approval of the federal Centers for Medicare and Medicaid Services.

(i) The timeframes for data submission and reporting periods may be adjusted as necessary with respect to the 2010–11 project year through October 31, 2010, and successor demonstration years 6 and 10.

**SEC. 90.** Section 14166.12 of the Welfare and Institutions Code is amended to read:

**14166.12.** (a) The California Medical Assistance Commission shall negotiate payment amounts, in accordance with the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081), from the Private Hospital Supplemental Fund established pursuant to subdivision (b) for distribution to private hospitals that satisfy the criteria of subdivision (s). Pursuant to Section 14165, on and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission.

(b) The Private Hospital Supplemental Fund is hereby established in the State Treasury. For purposes of this section, "fund" means the Private Hospital Supplemental Fund.

(c) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this section.

(d) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) One hundred eighteen million four hundred thousand dollars ($118,400,000), which shall be transferred annually from General Fund amounts appropriated in the annual Budget Act for the Medi-Cal program, except as follows:

(A) For the 2008–09 fiscal year, this amount shall be reduced by thirteen million six hundred thousand dollars ($13,600,000) and by an amount equal to one-half of the difference between eighteen million three hundred thousand dollars ($18,300,000) and the amount of any reduction in the additional payments for distressed hospitals calculated pursuant to subparagraph (B) of paragraph (3) of subdivision (b) of Section 14166.20.

(B) For the 2012–13 fiscal year, this amount shall be reduced by seventeen million five hundred thousand dollars ($17,500,000).

(C) For the 2013–14 fiscal year, this amount shall be reduced by eight million seven hundred fifty thousand dollars ($8,750,000).

(2) Any additional moneys appropriated to the fund.

(3) All stabilization funding transferred to the fund pursuant to paragraph (2) of subdivision (a) of Section 14166.14.

(4) Any moneys that any county, other political subdivision of the state, or other governmental entity in the state may elect to transfer to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(5) All private moneys donated by private individuals or entities to the department for deposit in the fund as

permitted under applicable federal Medicaid laws.

(6) Any interest that accrues on amounts in the fund.

(e) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(f) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal financial participation to the full extent permitted by law. With respect to funds transferred or donated from private individuals or entities, the department shall accept only those funds that are certified by the transferring or donating entity that qualify for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable. The department may return any funds transferred or donated in error.

(g) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section.

(h) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in the following fiscal year.

(i) Moneys shall be allocated from the fund by the department and shall be applied to obtain federal financial participation in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section. Distributions from the fund shall be supplemental to any other Medi-Cal reimbursement received by the hospitals, including amounts that hospitals receive under the selective provider contracting program (Article 2.6 (commencing with Section 14081)), and shall not affect provider rates paid under the selective provider contracting program.

(j) Each private hospital that was a private hospital during the 2002–03 fiscal year, received payments for the 2002–03 fiscal year from any of the prior supplemental funds, and, during the project year, satisfies the criteria in subdivision (s) to be eligible to negotiate for distributions under any of those sections, shall receive no less from the Private Hospital Supplemental Fund for the project year than 100 percent of the amount the hospital received from the prior supplemental funds for the 2002–03 fiscal year. Each private hospital described in this subdivision shall be eligible for additional payments from the fund pursuant to subdivision (k).

(k) All amounts that are in the fund for a project year in excess of the amount necessary to make the payments under subdivision (j) shall be available for negotiation by the California Medical Assistance Commission, along with corresponding federal financial participation, for supplemental payments to private hospitals, which for the project year satisfy the criteria under subdivision (s) to be eligible to negotiate for distributions under any of those sections, and paid for services rendered during the project year pursuant to the selective provider contracting program established under Article 2.6 (commencing with Section 14081).

(l) The amount of any stabilization funding transferred to the fund, or the amount of intergovernmental transfers deposited to the fund pursuant to subdivision (o), together with the associated federal reimbursement, with respect to a particular project year, may, in the discretion of the California Medical Assistance Commission, until its dissolution on June 30, 2012, be paid for services furnished in the same project year regardless of when the stabilization funds or intergovernmental transfer funds, and the associated federal reimbursement, become available, provided the payment is consistent with other applicable federal or state law requirements and does not result in a hospital exceeding any applicable reimbursement limitations. On and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission by this subdivision.

(m) The department shall pay amounts due to a private hospital from the fund for a project year, with the exception of stabilization funding, in up to four installment payments, unless otherwise provided in the hospital's contract negotiated with the California Medical Assistance Commission, except that hospitals that are not described in subdivision (j) shall not receive the first installment payment. The first payment shall be made as soon as practicable after the issuance of the tentative disproportionate share hospital list for the project year, and in no event later than January 1 of the project year. The second and subsequent payments shall be made after the issuance of the final disproportionate hospital list for the project year, and shall be made only to hospitals that are on the final disproportionate share hospital list for the project year. The second payment shall be made by February 1 of the project year or as soon as practicable after the issuance of the final

disproportionate share hospital list for the project year. The third payment, if scheduled, shall be made by April 1 of the project year. The fourth payment, if scheduled, shall be made by June 30 of the project year. This subdivision does not apply to hospitals that are scheduled to receive payments from the fund because they meet the criteria under paragraph (2) of subdivision (s) and do not meet the criteria under paragraph (1), (3), or (4) of subdivision (s), which shall be paid in accordance with the applicable contract or contract amendment negotiated by the California Medical Assistance Commission.

(n) The department shall pay stabilization funding transferred to the fund in amounts negotiated by the California Medical Assistance Commission and shall pay the scheduled payments in accordance with the applicable contract or contract amendment.

(o) Payments to private hospitals that are eligible to receive payments pursuant to subdivision (s) may be made using funds transferred from governmental entities to the state, at the option of the governmental entity. Any payments funded by intergovernmental transfers shall remain with the private hospital and shall not be transferred back to any unit of government. An amount equal to 25 percent of the amount of any intergovernmental transfer made in the project year that results in a supplemental payment made for the same project year to a project year private DSH hospital designated by the governmental entity that made the intergovernmental transfer shall be deposited in the fund for distribution as determined by the California Medical Assistance Commission. An amount equal to 75 percent shall be deposited in the fund and distributed to the private hospitals designated by the governmental entity.

(p) A private hospital that receives payment pursuant to this section for a particular project year shall not submit a notice for the termination of its participation in the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081) until the later of the following dates:

(1) On or after December 31 of the next project year.

(2) The date specified in the hospital's contract, if applicable.

(q) (1) For the 2007–08, 2008–09, and 2009–10 project years, the County of Los Angeles shall make intergovernmental transfers to the state to fund the nonfederal share of increased Medi-Cal payments to those private hospitals that serve the South Los Angeles population formerly served by Los Angeles County Martin Luther King, Jr.-Harbor Hospital. The intergovernmental transfers required under this subdivision shall be funded by county tax revenues and shall total five million dollars ($5,000,000) per project year, except that, in the event that the director determines that any amount is due to the County of Los Angeles under the demonstration project for services rendered during the portion of a project year during which Los Angeles County Martin Luther King, Jr.-Harbor Hospital was operational, the amount of intergovernmental transfers required under this subdivision shall be reduced by a percentage determined by reducing 100 percent by the percentage reduction in Los Angeles County Martin Luther King, Jr.-Harbor Hospital's baseline, as determined under subdivision (c) of Section 14166.5 for that project year.

(2) Notwithstanding subdivision (o), an amount equal to 100 percent of the county's intergovernmental transfers under this subdivision shall be deposited in the fund and, within 30 days after receipt of the intergovernmental transfer, shall be distributed, together with related federal financial participation, to the private hospitals designated by the county in the amounts designated by the county. The director shall disregard amounts received pursuant to this subdivision in calculating the OBRA 1993 payment limitation, as defined in paragraph (24) of subdivision (a) of Section 14105.98, for purposes of determining the amount of disproportionate share hospital replacement payments due a private hospital under Section 14166.11.

(r) (1) The reductions in supplemental payments under this section that result from the reductions in the amounts transferred from the General Fund to the Private Hospital Supplemental Fund for the 2012–13 and 2013–14 fiscal years under subparagraphs (B) and (C) of paragraph (1) of subdivision (d) shall be allocated equally in the aggregate between children's hospitals eligible for supplemental payments under this section and other hospitals eligible for supplemental payments under this section. When negotiating payment amounts to a hospital under this section for the 2012–13 and 2013–14 fiscal years, the California Medical Assistance Commission, or its successor agency, shall identify both a payment amount that would have been made absent the funding reductions in subparagraphs (B) and (C) of paragraph (1) of subdivision (d) and the payment amount that will be made taking into account the funding reductions under subparagraphs (B) and (C) of paragraph (1) of subdivision (d). For purposes of this subdivision, "children's hospital" shall have the meaning set forth in paragraph (13) of subdivision (a) of Section 14105.98.

(2) This subdivision shall not preclude the department from including some or all of the reductions under this

section within the payments made under a new diagnosis-related group payment methodology for the 2012-13 fiscal year or the 2013-14 fiscal year. In the event the department includes some or all of the amounts, including reductions, within the payments made under a new diagnosis-related group payment methodology for the 2012-13 fiscal year or the 2013-14 fiscal year, the department, in implementing the reductions in paragraph (1) of subdivision (d), shall, to the extent feasible, utilize the allocation specified in paragraph (1).

(s) In order for a hospital to receive distributions pursuant to this section, the hospital shall satisfy the eligibility criteria in paragraph (1), (2), (3), or (4) of this subdivision.

(1) The hospital meets all of the following criteria:

(A) The hospital is contracting under this article.

(B) The hospital meets the criteria contained in the Medicaid State Plan for disproportionate share hospital status.

(C) The hospital is one of the following:

(i) A licensed provider of basic emergency services as described in Section 70411 of Title 22 of the California Code of Regulations.

(ii) A licensed provider of comprehensive emergency medical services as defined in Section 70451 of Title 22 of the California Code of Regulations.

(iii) A children's hospital, as defined in Section 14087.21, that satisfies clause (i) or (ii), or that jointly provides basic or comprehensive emergency services in conjunction with another licensed hospital.

(iv) A hospital owned and operated by a public agency that operates two or more hospitals that qualify under subparagraph (A) or (B) with respect to the particular state fiscal year.

(v) A hospital designated by the National Cancer Institute as a comprehensive or clinical cancer research center that primarily treats acutely ill cancer patients and that is exempt from the federal Medicare prospective payment system pursuant to Section 1886(d)(1)(B)(v) of the federal Social Security Act (42 U.S.C. Sec. 1395ww(d)(1)(B)(v)).

(D) The hospital is able to demonstrate a purpose for additional funding under the selective provider contracting program including proposals relating to emergency services and other health care services, including infrequent yet high-cost services, such as anti-AB human antitoxin treatment for infant botulism (human botulinum immune globulin (HBIG), commonly referred to as "Baby-BIG"), that are made available, or will be made available, to Medi-Cal beneficiaries.

(2) The hospital is contracting under this article and meets the definition of a university teaching hospital or major, nonuniversity, teaching hospital as set forth on page 51 and as listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping." Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(3) The hospital is contracting under this article, and meets the definition of any of the following:

(A) A large teaching emphasis hospital, as set forth on page 51 and listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," and also meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(B) A children's hospital pursuant to Section 10727, and also meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(C) Notwithstanding the requirement in subparagraph (A) that a hospital must be listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," any hospital whose license pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code was consolidated during the 1999 calendar year with a large teaching emphasis hospital that is listed on page 57 of the above-described report shall be eligible. All other requirements of paragraph (3) shall continue to apply.

(4) The hospital meets all of the following criteria:

(A) The hospital is contracting under this article.

(B) The hospital satisfies the Medicaid State Plan criteria for disproportionate share hospital status.

(C) The hospital is a small and rural hospital as defined in Section 124840 of the Health and Safety Code.

(D) The hospital is a licensed provider of standby emergency services as described in Section 70649 of Title 22 of the California Code of Regulations.

(E) The hospital is able to demonstrate a purpose for additional funding under the selective provider contracting program with proposals relating to health care services that are made available, or will be made available, to Medi-Cal beneficiaries.

(F) The hospital is determined by the California Medical Assistance Commission to be a hospital that provides an important community service that otherwise would not be provided in the community.

**SEC. 91.** Section 14166.14 of the Welfare and Institutions Code is amended to read:

**14166.14.** The amount of any stabilization funding payable to the project year private DSH hospitals under Section 14166.20 for a project year, which amount shall not include the amount of stabilization funding paid or payable to hospitals prior to the computation of the stabilization funding under Section 14166.20, plus any amount payable to project year private DSH hospitals under paragraph (1) of subdivision (b) of Section 14166.21, shall be allocated as follows:

(a) (1) To fund any shortfall due under Section 14166.11.

(2) An amount shall be transferred to the Private Hospital Supplemental Fund established pursuant to Section 14166.12, as may be necessary so that the amount for the Private Hospital Supplemental Fund for the project year, including all funds previously transferred to, or deposited in, the Private Hospital Supplemental Fund for the project year, is not less than the Private Hospital Supplemental Fund base amount determined pursuant to subdivision (j) of Section 14166.12.

(3) The amounts paid or transferred under paragraphs (1) and (2) shall be reduced pro rata if there is not sufficient funding described under paragraphs (1) and (2).

(b) Of the stabilization funding remaining, after allocations pursuant to subdivision (a), that are payable to project year private DSH hospitals, 66.4 percent shall be allocated and distributed among those hospitals pro rata based on the amounts determined in accordance with Section 14166.11, and 33.6 percent shall be transferred to the Private Hospital Supplemental Fund.

(c) (1) Notwithstanding any other law, the stabilization funding payable to project year private DSH hospitals under Section 14166.20 for a project year as determined under this section that has not been paid, or specifically committed for payment, to hospitals prior to January 1, 2012, may be utilized by the director to make payments to hospitals that received underpayments pursuant to Section 14166.11 due to improper peer group classifications for the 2005–06 and 2006–07 payment adjustment years.

(2) The balance after payments made pursuant to paragraph (1), if any, of the stabilization funding payable to project year private DSH hospitals under Section 14166.20 shall not be paid to the project year private DSH hospitals pursuant to Section 14166.20. The funds that would otherwise be paid from the Private Hospital Supplemental Fund shall be transferred to the General Fund, and funds that would otherwise be drawn from the General Fund for payments to the private DSH hospitals pursuant to Section 14166.20 shall be retained in the General Fund.

**SEC. 92.** Section 14166.151 is added to the Welfare and Institutions Code, to read:

**14166.151.** (a) It is the intent of the Legislature to reform the inpatient fee-for-service reimbursement methodology for nondesignated public hospitals based on their public structure in order to provide new opportunities for nondesignated public hospitals to receive reimbursement under the successor demonstration project for care provided to the uninsured and to receive new incentive payments for achievement related to delivery system reform.

(b) Subject to subdivision (c), beginning with services provided on or after July 1, 2012, fee-for-service payments to nondesignated public hospitals for inpatient services shall be governed by this subdivision. Each nondesignated public hospital shall receive as payment for inpatient hospital services provided to Medi-Cal beneficiaries during any successor demonstration year, the federal financial participation claimed by the department based on the hospital's allowable costs incurred in providing those services, subject to all of the following:

(1) Nondesignated public hospitals shall comply with the requirements of Section 14166.152. The payments authorized in this section shall be subject to audit and a final reconciliation where an overpayment to the nondesignated public hospital shall result in a collection of the overpayment and an underpayment to the nondesignated public hospital shall result in a corrective payment.

(2) (A) Nondesignated public hospitals shall be eligible to receive safety net care pool payments for uncompensated care costs to the extent that additional federal funding is made available pursuant to the Special Terms and Conditions for the safety net care pool uncompensated care limit of the successor demonstration project and if they comply with the requirements set forth in Section 14166.154.

(B) The amount of funds that may be claimed pursuant to subparagraph (A) shall not exceed the additional federal funding made available under the safety net care pool for nondesignated public hospital uncompensated care costs, and shall not reduce the amounts of federal funding for safety net care pool uncompensated care costs that would otherwise be made available to designated public hospitals in the absence of this paragraph, including the amounts available under the Special Terms and Conditions in effect as of April 1, 2012, and amounts available pursuant to Section 15916.

(C) (i) Notwithstanding subparagraph (B), if the designated public hospitals do not have sufficient certified public expenditures to claim the full amount of federal funding made available to the designated public hospitals as referenced in subparagraph (B), including consideration of the potential for the designated public hospitals to have sufficient certified public expenditures in a subsequent year, the department may authorize the funding to be claimed by the nondesignated public hospitals.

(ii) The department may determine whether designated public hospitals do not have sufficient certified public expenditures to claim the full amount of federal funding pursuant to clause (i) no sooner than after the submission of the cost reporting information required pursuant to Section 14166.8 for the applicable successor demonstration year.

(iii) If the department makes the determination identified in clause (ii) based on as-filed cost reporting information submitted prior to a final audit, the department shall make the determination in consultation with the designated public hospitals and shall apply an audit cushion of at least 5 percent to the as-filed cost information. If the department makes the determination identified in clause (ii) based on audited cost reporting information, no audit cushion shall be applied.

(3) (A) Nondesignated public hospitals shall be eligible to receive delivery system reform incentive pool payments to the extent additional federal funding is made available for this purpose under the delivery system reform incentive pool in the successor demonstration project and if the nondesignated public hospitals comply with the delivery system reform incentive pool funding requirements set forth in Section 14166.155.

(B) The amount of funds that may be received shall not exceed the additional federal funding made available for delivery system reform incentive pool payments to nondesignated public hospitals, and shall not reduce the amounts that would otherwise be made available to designated public hospitals in the absence of this paragraph, including the amounts that designated public hospitals would be eligible to receive under their delivery system reform incentive pool plans approved as of January 1, 2012.

(C) Notwithstanding subparagraph (B), if the designated public hospitals are unable to claim the full amount of federal funding made available to the designated public hospitals pursuant to Section 14166.77 and the Special Terms and Conditions, including through reallocations made pursuant to paragraph (3) of subdivision (a) of Section 14166.77 as authorized by the Special Terms and Conditions, and the unused amount of federal funding made available to the designated public hospitals cannot be used in a later demonstration year, the department may authorize such unused funding to be made available to the nondesignated public hospitals.

(c) (1) (A) The reimbursement methodology developed pursuant to subdivision (b) shall be effective beginning July 1, 2012. If all necessary federal approvals have not been received by July 1, 2012, then the effective date shall be retroactive to July 1, 2012. Between July 1, 2012, and when all necessary federal approvals have been received, any payments made pursuant to any methodology replaced by subdivision (b) shall be deemed as interim payments subject to offsetting and recoupment against payments made under subdivision (b) pursuant to Section 51047 of Title 22 of the California Code of Regulations.

(B) Subject to paragraph (2), beginning January 1, 2014, the reimbursement methodology developed pursuant to subdivision (b), which shall be in effect July 1, 2012, through and including December 31, 2013, shall continue for those nondesignated public hospitals that certify voluntary participation as described in clause (i), if the director executes a declaration on or before December 31, 2013, certifying all of the following:

(i) The governmental entities that own or operate a nondesignated public hospital, or hospitals, have provided certifications of voluntary participation in the reimbursement methodology pursuant to subdivision (b).

(ii) Any necessary federal approvals have been obtained.

(iii) Continuation of the reimbursement methodology for those nondesignated public hospitals certifying voluntary participation would be cost beneficial to the state.

(2) On December 31, 2013, if one or more of the nondesignated public hospitals subject to the reimbursement methodology described in subdivision (b) have not provided written certification of voluntariness described in clause (i) of subparagraph (B) of paragraph (1), or if the director determines, for any reason, that the reimbursement methodology described in subdivision (b) cannot be implemented on or after January 1, 2014, then the director shall execute a declaration certifying that the reimbursement methodology described in subdivision (b) cannot continue to be implemented for all or one or more of the nondesignated public hospitals, in which case subdivision (e) shall be implemented on January 1, 2014.

(d) Upon implementation of subparagraph (A) of paragraph (1) of subdivision (c), implementation of the laws and regulations listed in paragraphs (1) to (4), inclusive, shall be suspended with respect to fee-for-service payments to all nondesignated public hospitals for inpatient services through and including December 31, 2013. Implementation of the laws and regulations listed in paragraphs (1) to (4), inclusive, shall also be suspended with respect to fee-for-service payments to nondesignated public hospitals that certify voluntary participation if a declaration is executed pursuant to subparagraph (B) of paragraph (1) of subdivision (c), beginning on January 1, 2014, and until the expiration of the successor demonstration project.

(1) The Nondesignated Public Hospital Medi-Cal Rate Stabilization Act in Article 5.17 (commencing with Section 14165.55).

(2) The inpatient fee-for-service per diem rate authorized in Article 2.6 (commencing with Section 14081).

(3) The reimbursement methodology for fee-for-service inpatient services in Sections 14105 and 14105.15, and Article 7.5 (commencing with Section 51536) of Title 22 of the California Code of Regulations.

(4) Section 14166.17.

(e) Subject to the conditions in paragraph (2) of subdivision (c), on January 1, 2014, the percentage of each intergovernmental transfer amount retained pursuant to subdivision (j) of Section 14165.57 shall be increased to 20 percent to reimburse the department, or transferred to the General Fund, for the administrative costs of operating the Nondesignated Public Hospital Intergovernmental Transfer Program and for the benefit of the Medi-Cal program.

(f) This section and Sections 14166.152, 14166.153, 14166.154, and 14166.155 shall become operative on the date all necessary federal approvals have been obtained to implement all of these sections.

**SEC. 93.** Section 14166.152 is added to the Welfare and Institutions Code, to read:

**14166.152.** (a) Pursuant to subdivision (b) of Section 14166.151, and notwithstanding any other law, fee-for-service payments to nondesignated public hospitals for inpatient services to Medi-Cal beneficiaries shall be governed by this section. The hospitals' allowable costs shall be determined, certified, and claimed in accordance with Section 14166.153. The Medicaid federal financial participation received by the state for the certified public expenditures of the hospital, or the governmental entity with which the hospital is affiliated, for inpatient hospital services rendered to Medi-Cal beneficiaries shall be paid to the hospital.

(b) With respect to each successor demonstration year, each of the nondesignated public hospitals shall receive an interim payment for each day of inpatient hospital services rendered to Medi-Cal beneficiaries based upon claims filed by the hospital in accordance with the claiming process set forth in Division 3 (commencing with Section 50000) of Title 22 of the California Code of Regulations. The interim per diem payment amount shall be based on estimated costs, which shall be derived from statistical data from the following sources and which shall be multiplied by the federal medical assistance percentage:

(1) For allowable costs reflected in the Medicare cost report, the cost report most recently audited by the hospital's Medicare fiscal intermediary adjusted by a trend factor to reflect increased costs, as approved by the federal Centers for Medicare and Medicaid Services for the successor demonstration project.

(2) For allowable costs not reflected in the Medicare cost report, each hospital shall provide hospital-specific

cost data requested by the department. The department shall adjust the data by a trend factor as necessary to reflect project year allowable costs.

(c) Until the department commences making payments pursuant to subdivision (b), the department may continue to make fee-for-service per diem payments to the nondesignated public hospitals pursuant to the selective provider contracting program in accordance with Article 2.6 (commencing with Section 14081), for services rendered on and after July 1, 2012. Per diem payments shall be adjusted retroactively to the amounts determined under the payment methodology prescribed in this section.

(d) No later than April 1 following the end of the relevant reporting period for the successor demonstration year, the department shall undertake an interim reconciliation of payments made pursuant to subdivisions (a) to (c), inclusive, based on Medicare and other cost and statistical data submitted by the hospital for the year and shall adjust payments to the hospital accordingly.

(e) (1) The nondesignated public hospitals shall receive supplemental reimbursement for the costs incurred for physician and nonphysician practitioner services provided to Medi-Cal beneficiaries who are patients of the hospital, to the extent that those services are not claimed as inpatient hospital services by the hospital and the costs of those services are not otherwise recognized under subdivision (a).

(2) Expenditures made by the nondesignated public hospital, or a governmental entity with which it is affiliated, for the services identified in paragraph (1) shall be reduced by any payments received pursuant to Article 7 (commencing with Section 51501) of Title 22 of the California Code of Regulations. The remainder shall be certified by the appropriate public official and claimed by the department in accordance with Section 14166.153. These expenditures may include any of the following:

(A) Compensation to physicians or nonphysician practitioners pursuant to contracts with the nondesignated public hospital.

(B) Salaries and related costs for employed physicians and nonphysician practitioners.

(C) The costs of interns, residents, and related teaching physician and supervision costs.

(D) Administrative costs associated with the services described in subparagraphs (A) to (C), inclusive, including billing costs.

(3) Nondesignated public hospitals shall receive federal financial participation based on the expenditures identified and certified in paragraph (2).

(4) The federal financial participation received by the department for the certified public expenditures identified in paragraph (2) shall be paid to the nondesignated public hospital, or a governmental entity with which it is affiliated.

(5) Supplemental reimbursement under this subdivision may be distributed as part of the interim payments under subdivision (b), on a per-visit basis, on a per-procedure basis, or on any other federally permissible basis.

(6) The department shall submit for federal approval, by September 30, 2012, a proposed amendment to the Medi-Cal state plan to implement this subdivision, retroactive to July 1, 2012, to the extent permitted by the federal Centers for Medicare and Medicaid Services. If necessary to obtain federal approval, the department may limit the application of this subdivision to costs determined allowable by the federal Centers for Medicare and Medicaid Services. If federal approval is not obtained, this subdivision shall not be implemented.

(f) This section shall become operative as provided in subdivision (f) of Section 14166.151.

**SEC. 94.** Section 14166.153 is added to the Welfare and Institutions Code, to read:

**14166.153.** (a) Beginning in the 2012–13 fiscal year, within five months after the end of a successor demonstration year, each of the nondesignated public hospitals shall submit to the department all of the following reports:

(1) The hospital's Medicare cost report for the project year or successor demonstration year.

(2) Other cost reporting and statistical data necessary for the determination of amounts due the hospital under the demonstration project or successor demonstration project, as requested by the department.

(b) For each project year or successor demonstration year, the reports shall identify all of the following:

(1) To the extent applicable, the costs incurred in providing inpatient hospital services to Medi-Cal beneficiaries on a fee-for-service basis and physician and nonphysician practitioner services costs, as identified in subdivision (e) of Section 14166.152.

(2) The costs incurred in providing hospital services to uninsured individuals.

(c) Each nondesignated public hospital, or governmental entity with which it is affiliated, that operates nonhospital clinics or provides physician, nonphysician practitioner, or other health care services that are not identified as hospital services under the Special Terms and Conditions for the demonstration project and successor demonstration project, shall report and certify all of the uncompensated Medi-Cal and uninsured costs of the services furnished. The amount of these uncompensated costs to be claimed by the department shall be determined by the department in consultation with the governmental entity so as to optimize the level of claimable federal Medicaid reimbursement.

(d) Reports submitted under this section shall include all allowable costs.

(e) The appropriate public official shall certify to all of the following:

(1) The accuracy of the reports required under this section.

(2) That the expenditures to meet the reported costs comply with Section 433.51 of Title 42 of the Code of Federal Regulations.

(3) That the sources of funds used to make the expenditures certified under this section do not include impermissible provider taxes or donations as defined under Section 1396b(w) of Title 42 of the United States Code or other federal funds. For this purpose, federal funds do not include delivery system reform incentive pool payments or patient care revenue received as payment for services rendered under programs such as nondesignated state health programs, the Low Income Health Program, Medicare, or Medicaid.

(f) The certification of public expenditures made pursuant to this section shall be based on a schedule established by the department in accordance with federal requirements.

(1) The director may require the nondesignated public hospitals to submit quarterly estimates of anticipated expenditures, if these estimates are necessary to obtain interim payments of federal Medicaid funds.

(2) All reported expenditures shall be subject to reconciliation to allowable costs, as determined in accordance with applicable implementing documents for the demonstration project and successor demonstration project.

(g) The director shall seek Medicaid federal financial participation for all certified public expenditures reported by the nondesignated public hospitals and recognized under the successor demonstration project.

(h) The timeframes for data submission and reporting periods may be adjusted as necessary in accordance with federal requirements.

(i) This section shall become operative as provided in subdivision (f) of Section 14166.151.

**SEC. 95.** Section 14166.154 is added to the Welfare and Institutions Code, to read:

**14166.154.** (a) (1) Beginning in the 2012-13 fiscal year, if the reimbursement methodology in subdivision (b) of Section 14166.151 is in effect and federal approval is obtained for an amendment to the successor demonstration project that was submitted pursuant to subdivision (d), then, with respect to each successor demonstration year, nondesignated public hospitals, or governmental entities with which they are affiliated, shall be eligible to receive safety net care pool payments for uncompensated care from the Health Care Support Fund established pursuant to Section 14166.21. Safety net care pool payments for uncompensated care shall be allocated to nondesignated public hospitals as follows:

(A) The department shall determine the maximum amount of safety net care pool payments for uncompensated care that is available to nondesignated public hospitals for the successor demonstration year pursuant to paragraph (2) of subdivision (b) of Section 14166.151. This determination shall be made solely with respect to allowable uncompensated care costs incurred by nondesignated public hospitals and reported pursuant to Section 14166.153.

(B) The department shall establish, in consultation with the nondesignated public hospitals, an allocation methodology to determine the amount of safety net care pool payments to be made to each hospital. The

allocation methodology shall be implemented when the director issues a declaration stating that the methodology complies with all applicable federal requirements for federal financial participation.

(2) A safety net care pool payment amount may be paid to a nondesignated public hospital, or governmental entity with which it is affiliated, pursuant to this section independent of the amount of uncompensated Medi-Cal and uninsured costs that is certified as public expenditures pursuant to Section 14166.153, provided that, in accordance with the Special Terms and Conditions for the successor demonstration project, the recipient hospital does not return any portion of the funds received to any unit of government, excluding amounts recovered by the state or federal government.

(3) In establishing the amount to be paid to each nondesignated public hospital under this subdivision, the department shall minimize to the extent possible the redistribution of federal funds that are based on certified public expenditures as described in paragraph (2).

(b) Each nondesignated public hospital, or governmental entity with which it is affiliated, shall receive the amount established pursuant to subdivision (a) in quarterly interim payments during the successor demonstration year. The determination of the interim payments shall be made on an interim basis prior to the start of each successor demonstration year. The department shall use the same cost and statistical data that is used in determining the interim payments for Medi-Cal inpatient hospital services under Section 14166.152.

(c) (1) No later than April 1 following the end of the relevant reporting period for the successor demonstration year, the department shall undertake an interim reconciliation of the payment amount established pursuant to subdivision (a) for each nondesignated public hospital using Medicare and other cost, payment, and statistical data submitted by the hospital for the successor demonstration year, and shall adjust payments to the hospital accordingly.

(2) The final payment to a nondesignated public hospital, for purposes of subdivision (b) and paragraph (1) of this subdivision, shall be subject to final audits of all applicable Medicare and other cost, payment, discharge, and statistical data for the successor demonstration year.

(d) The department shall submit for federal approval a proposed amendment to the successor demonstration project to implement this section.

(e) This section shall become operative as provided in subdivision (f) of Section 14166.151.

**SEC. 96.** Section 14166.155 is added to the Welfare and Institutions Code, to read:

**14166.155.** (a) (1) Beginning in the 2012–13 fiscal year, if the reimbursement methodology in subdivision (b) of Section 14166.151 is in effect and federal approval is obtained for an amendment to the successor demonstration project that was submitted pursuant to subdivision (c), then nondesignated public hospitals may receive payments pursuant to this section. The amount of delivery system reform incentive pool funding, consisting of both the federal and nonfederal share of payments, that is made available to each nondesignated public hospital system in the aggregate for the term of the successor demonstration project shall be based initially on the delivery system reform proposals that are submitted by the nondesignated public hospitals to the department for review and submission to the federal Centers for Medicare and Medicaid Services for final approval. The initial percentages of delivery system reform incentive pool funding among the nondesignated public hospitals for each successor demonstration year shall be determined based on the annual components as contained in the approved proposals.

(2) The actual receipt of funds shall be conditioned on the nondesignated public hospital's progress toward, and achievement of, the specified milestones and other metrics established in its approved delivery system reform incentive pool proposal. A nondesignated public hospital may carry forward available incentive pool funding associated with milestones and metrics from one year to a subsequent period as authorized by the Special Terms and Conditions and the final delivery system reform incentive pool protocol.

(3) The department may reallocate the incentive pool funding available under this section pursuant to conditions specified, and as authorized by, the Special Terms and Conditions and the final delivery system reform incentive pool protocol.

(b) Each nondesignated public hospital shall be individually responsible for progress toward, and achievement of, milestones and other metrics in its proposal, as well as other applicable requirements specified in the Special Terms and Conditions and the final delivery system reform incentive pool protocol, in order to receive its specified allocation of incentive pool funding under this section.

(1) The nondesignated public hospital shall submit semiannual reports and requests for payment to the department by March 31 and the September 30 following the end of the second and fourth quarters of the successor demonstration year, or comply with any other process as approved by the federal Centers for Medicare and Medicaid Services.

(2) Within 14 days after the semiannual report due date, the nondesignated public hospital system or its affiliated governmental entity shall make an intergovernmental transfer of funds equal to the nonfederal share that is necessary to claim the federal funding for the pool payment related to the achievement or progress metric that is certified. The intergovernmental transfers shall be deposited into the Public Hospital Investment, Improvement, and Incentive Fund, established pursuant to Section 14182.4.

(3) The department shall claim the federal funding and pay both the nonfederal and federal shares of the incentive payment to the nondesignated public hospital system or other affiliated governmental provider, as applicable. If the intergovernmental transfer is made within the appropriate 14-day timeframe, the incentive payment shall be disbursed within seven days with the expedited payment process as approved by the federal Centers for Medicare and Medicaid Services, otherwise the payment shall be disbursed within 20 days of when the transfer is made.

(4) The nondesignated public hospital system or other affiliated governmental provider is responsible for any fee or cost required to implement the expedited payment process in accordance with Section 8422.1 of the State Administrative Manual.

(c) The department shall submit for federal approval an amendment to the successor demonstration project to implement this section.

(d) In the event of a conflict between any provision of this section and the Special Terms and Conditions for the successor demonstration project and the final delivery system reform incentive pool protocol, the Special Terms and Conditions and the final delivery system reform incentive pool protocol shall control.

(e) This section shall become operative as provided in subdivision (f) of Section 14166.151.

**SEC. 97.** Section 14166.17 of the Welfare and Institutions Code is amended to read:

**14166.17.** (a) The California Medical Assistance Commission shall negotiate payment amounts in accordance with the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081) from the Nondesignated Public Hospital Supplemental Fund established pursuant to subdivision (b) for distribution to nondesignated public hospitals that satisfy the criteria of subdivision (o). Pursuant to Section 14165, on and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission.

(b) The Nondesignated Public Hospital Supplemental Fund is hereby established in the State Treasury. For purposes of this section, "fund" means the Nondesignated Public Hospital Supplemental Fund.

(c) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this section.

(d) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) One million nine hundred thousand dollars ($1,900,000), which shall be transferred annually from General Fund amounts appropriated in the annual Budget Act for the fund.

(2) Any additional moneys appropriated to the fund.

(3) All stabilization funding transferred to the fund.

(4) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal Medicaid laws.

(5) Any interest that accrues on amounts in the fund.

(e) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal financial participation to the full extent permitted by law. With respect to funds transferred or donated from private individuals or entities, the department shall accept only those funds that are certified by the transferring or donating entity as

qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable. The department may return any funds transferred or donated in error.

(f) Moneys in the funds shall be used as the source for the nonfederal share of payments to hospitals under this section.

(g) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in the following fiscal year.

(h) Moneys shall be allocated from the fund by the department and shall be applied to obtain federal financial participation in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section. Distributions from the fund shall be supplemental to any other Medi-Cal reimbursement received by the hospitals, including amounts that hospitals receive under the selective provider contracts negotiated under Article 2.6 (commencing with Section 14081), and shall not affect provider rates paid under the selective provider contracting program.

(i) Each nondesignated public hospital that was a nondesignated public hospital during the 2002–03 fiscal year, received payments for the 2002–03 fiscal year from any of the prior supplemental funds, and, during the project year satisfies the criteria in subdivision (o) to be eligible to negotiate for distributions under any of those sections shall receive no less from the Nondesignated Public Hospital Supplemental Fund for the project year than 100 percent of the amount the hospital received from the prior supplemental funds for the 2002–03 fiscal year, minus the total amount of intergovernmental transfers made by or on behalf of the hospital pursuant to subdivision (o) for the same fiscal year. Each hospital described in this subdivision shall be eligible for additional payments from the fund pursuant to subdivision (j).

(j) All amounts that are in the fund for a project year in excess of the amount necessary to make the payments under subdivision (i) shall be available for negotiation by the California Medical Assistance Commission, along with corresponding federal financial participation, for supplemental payments to nondesignated public hospitals that for the project year satisfy the criteria under subdivision (o) to be eligible to negotiate for distributions under any of those sections, and paid for services rendered during the project year pursuant to the selective provider contracting program under Article 2.6 (commencing with Section 14081).

(k) The amount of any stabilization funding transferred to the fund with respect to a project year may in the discretion of the California Medical Assistance Commission, until its dissolution on June 30, 2012, to be paid for services furnished in the same project year regardless of when the stabilization funds become available, provided the payment is consistent with other applicable federal or state legal requirements and does not result in a hospital exceeding any applicable reimbursement limitations. On and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission by this subdivision.

(l) The department shall pay amounts due to a nondesignated hospital from the fund for a project year, with the exception of stabilization funding, in up to four installment payments, unless otherwise provided in the hospital's contract negotiated with the California Medical Assistance Commission, except that hospitals that are not described in subdivision (i) shall not receive the first installment payment. The first payment shall be made as soon as practicable after the issuance of the tentative disproportionate share hospital list for the project year, and in no event later than January 1 of the project year. The second and subsequent payments shall be made after the issuance of the final disproportionate hospital list for the project year, and shall be made only to hospitals that are on the final disproportionate share hospital list for the project year. The second payment shall be made by February 1 of the project year or as soon as practicable after the issuance of the final disproportionate share hospital list for the project year. The third payment, if scheduled, shall be made by April 1 of the project year. The fourth payment, if scheduled, shall be made by June 30 of the project year. This subdivision does not apply to hospitals that are scheduled to receive payments from the fund because they meet the criteria under paragraph (2) of subdivision (o) but do not meet the criteria under paragraph (1), (3), or (4) of subdivision (o).

(m) The department shall pay stabilization funding transferred to the fund in amounts negotiated by the California Medical Assistance Commission and paid in accordance with the applicable contract or contract amendment.

(n) A nondesignated public hospital that receives payment pursuant to this section for a particular project year shall not submit a notice for the termination of its participation in the selective provider contracting program

established pursuant to Article 2.6 (commencing with Section 14081) until the later of the following dates:

(1) On or after December 31 of the next project year.

(2) The date specified in the hospital's contract, if applicable.

(o) In order for a hospital to receive distributions pursuant to this section, the hospital shall satisfy the eligibility criteria in paragraph (1), (2), (3), or (4) of this subdivision.

(1) The hospital meets all of the following criteria:

(A) The hospital is contracting under this article.

(B) The hospital meets the criteria contained in the Medicaid State Plan for disproportionate share hospital status.

(C) The hospital is one of the following:

(i) A licensed provider of basic emergency services as described in Section 70411 of Title 22 of the California Code of Regulations.

(ii) A licensed provider of comprehensive emergency medical services as defined in Section 70451 of Title 22 of the California Code of Regulations.

(iii) A children's hospital, as defined in Section 14087.21, that satisfies clause (i) or (ii), or that jointly provides basic or comprehensive emergency services in conjunction with another licensed hospital.

(iv) A hospital owned and operated by a public agency that operates two or more hospitals that qualify under subparagraph (A) or (B) with respect to the particular state fiscal year.

(v) A hospital designated by the National Cancer Institute as a comprehensive or clinical cancer research center that primarily treats acutely ill cancer patients and that is exempt from the federal Medicare prospective payment system pursuant to Section 1886(d)(1)(B)(v) of the federal Social Security Act (42 U.S.C. Sec. 1395ww(d)(1)(B)(v)).

(D) (1) The hospital is able to demonstrate a purpose for additional funding under the selective provider contracting program including proposals relating to emergency services and other health care services, including infrequent yet high-cost services, such as anti-AB human antitoxin treatment for infant botulism (human botulinum immune globulin (HBIG), commonly referred to as "Baby-BIG"), that are made available, or will be made available, to Medi-Cal beneficiaries.

(2) The hospital is contracting under this article and meets the definition of a university teaching hospital or major, nonuniversity, teaching hospital as set forth on page 51 and as listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping." Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(3) The hospital is contracting under this article and meets the definition of any of the following:

(A) A large teaching emphasis hospital, as set forth on page 51 and listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," and also meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(B) A children's hospital pursuant to Section 10727, and also meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(C) Notwithstanding the requirement in subparagraph (A) of paragraph (3) that a hospital must be listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," any hospital whose license pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code was consolidated during the 1999 calendar year with a large teaching emphasis hospital that is listed on page 57 of the above-described report shall be eligible. All other requirements of paragraph (3) shall continue to apply.

(4) The hospital meets all of the following criteria:

(A) The hospital is contracting under this article.

(B) The hospital satisfies the Medicaid State Plan criteria for disproportionate share hospital status.

(C) The hospital is a small and rural hospital as defined in Section 124840 of the Health and Safety Code.

(D) The hospital is a licensed provider of standby emergency services as described in Section 70649 of Title 22 of the California Code of Regulations.

(E) The hospital is able to demonstrate a purpose for additional funding under the selective provider contracting program with proposals relating to health care services that are made available, or will be made available, to Medi-Cal beneficiaries.

(F) The hospital is determined by the California Medical Assistance Commission to be a hospital that provides an important community service that otherwise would not be provided in the community.

**SEC. 98.** Section 14166.19 of the Welfare and Institutions Code is amended to read:

**14166.19.** The amount of any stabilization funding payable to the nondesignated public hospitals under paragraph (4) of subdivision (b) of Section 14166.20 for a project year, which amount shall not include the amount of stabilization funding paid or payable to hospitals prior to the computation of the stabilization funding under Section 14166.20, shall be allocated in the following priority:

(a) An amount shall be transferred to the Nondesignated Public Hospital Supplemental Fund, as may be necessary so that the amount for the Nondesignated Public Hospital Supplemental Fund for the project year, including all funds previously transferred to, or deposited in, the Nondesignated Public Hospital Supplemental Fund for the project year, is not less than one million nine hundred thousand dollars ($1,900,000).

(b) Of the remaining stabilization funding payable to nondesignated public hospitals, 75 percent shall be allocated, distributed, and paid in accordance with Section 14166.16, and 25 percent shall be transferred to the Nondesignated Public Hospital Supplemental Fund.

(c) Notwithstanding any other law, the amount of any stabilization funding payable to nondesignated public hospitals under Section 14166.20 for a project year as determined under this section that has not been paid, or specifically committed for payment, to nondesignated public hospitals before January 1, 2012, shall not be paid pursuant to Section 14166.20. The funds that would otherwise be paid from the Nondesignated Public Hospital Supplemental Fund shall be transferred to the General Fund, and funds that would otherwise be drawn from the General Fund for payments to the nondesignated public hospitals pursuant to Section 14166.20 shall be retained in the General Fund.

**SEC. 99.** Section 14169.7 of the Welfare and Institutions Code is amended to read:

**14169.7.** (a) (1) Designated public hospitals shall be paid direct grants in support of health care expenditures, which shall not constitute Medi-Cal payments, and which shall be funded by the quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31). The aggregate amount of the grants to designated public hospitals shall be fifty million dollars ($50,000,000) for the 2011–12 fiscal year, forty-three million dollars ($43,000,000) for the 2012–13 fiscal year, and twenty-one million five hundred thousand dollars ($21,500,000) for the 2013–14 fiscal year. The director shall allocate the amounts specified in this paragraph pursuant to paragraph (2).

(2) For the 2011–12 fiscal year, the director shall allocate the fifty million dollars ($50,000,000) identified in paragraph (1) among the designated public hospitals pursuant to a methodology developed in consultation with the designated public hospitals. For the 2012–13 fiscal year, the director shall allocate the forty-three million dollars ($43,000,000) identified in paragraph (1) among the designated public hospitals pursuant to a methodology developed in consultation with the designated public hospitals. For the 2013–14 fiscal year, the state shall retain the twenty-one million five hundred thousand dollars ($21,500,000) identified in paragraph (1) to pay for health care coverage for children in addition to the amounts identified in Section 14169.33.

(b) Nondesignated public hospitals shall be paid direct grants in support of health care expenditures, and shall be funded by the quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31). The aggregate amount of the grants to nondesignated public hospitals for each subject fiscal year shall be ten million dollars ($10,000,000), except that for the 2013–14 subject fiscal year, the aggregate amount of the grants shall be five million dollars ($5,000,000). The director shall allocate the amounts specified in this subdivision among the nondesignated public hospitals pursuant to a methodology developed in consultation with the nondesignated public hospitals.

**SEC. 100.** Section 14169.7.5 of the Welfare and Institutions Code is amended to read:

**14169.7.5.** (a) The Low Income Health Program MCE Out-of-Network Emergency Care Services Fund is hereby established in the State Treasury. The moneys in the fund shall, upon appropriation by the Legislature to the department, be used solely for the purposes specified in this section. Notwithstanding Section 16305.7 of the Government Code, any and all interest and dividends earned on money in the fund shall be used exclusively for the purposes of this section.

(b) The fund shall consist of the following:

(1) Funds transferred from governmental entities, at the option of the governmental entity, to the state for deposit into the fund in an aggregate amount of twenty million dollars ($20,000,000) per subject fiscal year, except that for the 2013–14 subject fiscal year, the aggregate amount of the transfer shall be ten million dollars ($10,000,000).

(2) Proceeds of the quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31) that, subject to paragraph (1) of subdivision (a) of Section 14169.36, are transferred from the Hospital Quality Assurance Revenue Fund and deposited into the fund in an aggregate amount of seventy-five million dollars ($75,000,000) per subject fiscal year, except that for the 2013–14 subject fiscal year, the aggregate amount of the proceeds of the quality assurance fee deposited into the fund shall be thirty-seven million five hundred thousand dollars ($37,500,000).

(c) Any amounts of the quality assurance fee deposited to the fund in excess of the funds required to implement this section shall be returned to the Hospital Quality Assurance Revenue Fund.

(d) Any amounts deposited to the fund as described in paragraph (1) of subdivision (b) that are in excess of the funds required to implement this section shall be returned to the transferring entity.

(e) Consistent with the Special Terms and Conditions for the California's Bridge to Reform Section 1115(a) Medicaid Demonstration (11-W-00193/9), moneys in the fund shall be used with respect to Low Income Health Programs (LIHPs) operating pursuant to Part 3.6 (commencing with Section 15909) as the source for the nonfederal share of expenditures for coverage for the Medi-Cal coverage expansion (MCE) population of medically necessary hospital emergency services for emergency medical conditions and required poststabilization care furnished by private hospitals and nondesignated public hospitals that are outside the LIHP coverage network, subject to the following:

(1) Moneys in the fund shall only be used to fund the nonfederal share of supplemental payments made to private hospital and nondesignated public hospital out-of-network emergency care services providers by the LIHP for the MCE population in accordance with this section.

(2) Supplemental payments under this section shall supplement but shall not supplant amounts that would have been paid absent the provisions of this section.

(f) Moneys in the fund shall be allocated with respect to each subject fiscal year as follows:

(1) Within 60 days after the last day of each subject fiscal year, each LIHP shall report utilization data to the department on approved hospital emergency services for emergency medical conditions and required poststabilization care, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration (11-W-00193/9), provided to MCE enrollees by out-of-network private hospitals and nondesignated public hospitals during that year. The reported data shall be as specified by the department, and shall include the number of emergency room encounters and the number of inpatient hospital days.

(2) The department shall, in consultation with the hospital community, determine the amount of funding for the nonfederal share of supplemental payments available for each reported emergency room encounter or inpatient day by dividing the total funds available by the total number of inpatient days or emergency visits in accordance with subparagraphs (A) and (B).

(A) Seventy percent of the moneys in the fund shall be allocated for the nonfederal share of supplemental payments to private hospitals and nondesignated public hospitals for approved out-of-network inpatient hospital emergency and poststabilization care, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration (11-W-00193/9).

(B) Thirty percent of the available funds shall be allocated for the nonfederal share of supplemental payments to

private hospitals and nondesignated public hospitals for approved out-of-network hospital emergency room services (excluding emergency room visits, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration (11-W-00193/9), that resulted in an approved out-of-network inpatient hospital stay), provided that for any emergency room visit that results in a hospital stay for which a supplemental payment is available under subparagraph (A), no supplemental payment shall be available under this subparagraph.

(C) The allocations and total available fund amount shall be adjusted as necessary so as to be consistent with the requirement in paragraph (1) of subdivision (g).

(g) (1) The department shall obtain federal financial participation for moneys in the fund to the full extent permitted by federal law. Moneys shall be allocated from the fund by the department to be matched by federal funds in accordance with the Special Terms and Conditions for the Medicaid Demonstration, or pursuant to other federal approvals or waivers as necessary.

(2) The department shall disburse moneys from the fund to the LIHPs in accordance with the calculations in subdivision (f) within 60 days after completing the calculations. The moneys shall be distributed to the LIHPs solely for purposes of funding the nonfederal portion of the supplemental out-of-network amounts determined for each service in subdivision (f) to out-of-network hospital emergency care services providers.

(3) The LIHPs shall make the supplemental payments described in paragraph (2) within 30 days of receiving the nonfederal share from the department.

(h) It is the intent of the Legislature that for each subject fiscal year, the first twenty million dollars ($20,000,000), or, for subject fiscal year 2013–14, the first ten million dollars ($10,000,000), of the nonfederal share for the emergency hospital services payments are funded with intergovernmental transfers described in paragraph (1) of subdivision (b).

(i) This section shall be implemented only if, and to the extent that, both of the following conditions exist:

(1) All necessary federal approvals have been obtained for the implementation of this section and federal financial participation is available.

(2) The ability of the department to maximize federal funding is not jeopardized.

(j) In designing and implementing the program for supplemental payments created under this section, the director shall have discretion, after consultation with the hospital community and the LIHPs, to modify timelines and to make modifications to the operational requirements of this section, but only to the extent necessary to secure federal approval or to ensure successful operation of the program and to effectuate the intent of this section.

(k) Notwithstanding any other provision of this article or Article 5.229 (commencing with Section 14169.31), federal disapproval of the program developed pursuant to the requirements of this section shall not affect the implementation of the remainder of this article or Article 5.229 (commencing with Section 14169.31).

**SEC. 101.** Section 14169.13 of the Welfare and Institutions Code is amended to read:

**14169.13.** (a) The director shall do all of the following:

(1) Promptly submit any state plan amendment or waiver request that may be necessary to implement this article.

(2) Promptly seek federal approvals or waivers as may be necessary to implement this article and to obtain federal financial participation to the maximum extent possible for the payments under this article.

(3) Amend the contracts between the managed health care plans and the department as necessary to incorporate the provisions of Sections 14169.5 and 14169.6 and promptly seek all necessary federal approvals of those amendments. The department shall pursue amendments to the contracts as soon as possible after the effective date of this article and Article 5.229 (commencing with Section 14169.31), and shall not wait for federal approval of this article or Article 5.229 (commencing with Section 14169.31) prior to pursuing amendments to the contracts. The amendments to the contracts shall, among other provisions, set forth an agreement to increase capitation payments to managed health care plans under Section 14169.5 and increase payments to hospitals under Section 14169.6 in a manner that relates back to July 1, 2011, or as soon thereafter as possible, conditioned on obtaining all federal approvals necessary for federal financial participation

for the increased capitation payments to the managed health care plans.

(b) In implementing this article, the department may utilize the services of the Medi-Cal fiscal intermediary through a change order to the fiscal intermediary contract to administer this program, consistent with the requirements of Sections 14104.6, 14104.7, 14104.8, and 14104.9. Contracts entered into for purposes of implementing this article or Article 5.229 (commencing with Section 14169.31) shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(c) This article shall become inoperative if either of the following occurs:

(1) In the event, and on the effective date, of a final judicial determination made by any court of appellate jurisdiction or a final determination by the federal Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that Section 14169.2, Section 14169.3, or any provision of Section 14166.115 cannot be implemented.

(2) In the event both of the following conditions exist:

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2013, the implementation of Section 14169.2, Section 14169.3, or the quality assurance fee established pursuant to Article 5.229 (commencing with Section 14169.31).

(B) Section 14169.2, Section 14169.3, or Article 5.229 (commencing with Section 14169.31) cannot be modified by the department pursuant to subdivision (e) of Section 14169.33 in order to meet the requirements of federal law or to obtain federal approval.

(d) If this article becomes inoperative pursuant to paragraph (1) of subdivision (c) and the determination applies to any period or periods of time prior to the effective date of the determination, the department shall have authority to recoup all payments made pursuant to this article during that period or those periods of time.

(e) In the event any hospital, or any party on behalf of a hospital, shall initiate a case or proceeding in any state or federal court in which the hospital seeks any relief of any sort whatsoever, including, but not limited to, monetary relief, injunctive relief, declaratory relief, or a writ, based in whole or in part on a contention that any or all of this article or Article 5.229 (commencing with Section 14169.31) is unlawful and may not be lawfully implemented, both of the following shall apply:

(1) Payments shall not be made to the hospital pursuant to this article until the case or proceeding is finally resolved, including the final disposition of all appeals.

(2) Any amount computed to be payable to the hospital pursuant to this section for a project year shall be withheld by the department and shall be paid to the hospital only after the case or proceeding is finally resolved, including the final disposition of all appeals.

(f) Subject to Section 14169.34, no payment shall be made under this article until all necessary federal approvals for the payment and for the fee provisions in Article 5.229 (commencing with Section 14169.31) have been obtained and the fee has been imposed and collected. Notwithstanding any other provision of law, payments under this article shall be made only to the extent that the fee established in Article 5.229 (commencing with Section 14169.31) is collected and available to cover the nonfederal share of the payments.

(g) A hospital's receipt of payments under this article for services rendered prior to the effective date of this article is conditioned on the hospital's continued participation in Medi-Cal for at least 30 days after the effective date of this article.

(h) All payments made by the department to hospitals, managed health care plans, and mental health plans under this article shall be made only from the following:

(1) The quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31) and due and payable on or before December 31, 2013, along with any interest or other investment income thereon.

(2) Federal reimbursement and any other related federal funds.

**SEC. 102.** Section 14169.31 of the Welfare and Institutions Code is amended to read:

**14169.31.** For the purposes of this article, the following definitions shall apply:

(a) (1) "Aggregate quality assurance fee" means, with respect to a hospital that is not a prepaid health plan

hospital, the sum of all of the following:

(A) The annual fee-for-service days for an individual hospital multiplied by the fee-for-service per diem quality assurance fee rate.

(B) The annual managed care days for an individual hospital multiplied by the managed care per diem quality assurance fee rate.

(C) The annual Medi-Cal days for an individual hospital multiplied by the Medi-Cal per diem quality assurance fee rate.

(2) "Aggregate quality assurance fee" means, with respect to a hospital that is a prepaid health plan hospital, the sum of all of the following:

(A) The annual fee-for-service days for an individual hospital multiplied by the fee-for-service per diem quality assurance fee rate.

(B) The annual managed care days for an individual hospital multiplied by the prepaid health plan hospital managed care per diem quality assurance fee rate.

(C) The annual Medi-Cal managed care days for an individual hospital multiplied by the prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate.

(D) The annual Medi-Cal fee-for-service days for an individual hospital multiplied by the Medi-Cal per diem quality assurance fee rate.

(3) "Aggregate quality assurance fee after the application of the fee percentage" means the aggregate quality assurance fee multiplied by the fee percentage for each subject fiscal year.

(b) "Annual fee-for-service days" means the number of fee-for-service days of each hospital subject to the quality assurance fee, as reported on the days data source.

(c) "Annual managed care days" means the number of managed care days of each hospital subject to the quality assurance fee, as reported on the days data source.

(d) "Annual Medi-Cal days" means the number of Medi-Cal days of each hospital subject to the quality assurance fee, as reported on the days data source.

(e) "Converted hospital" shall mean a hospital described in subdivision (b) of Section 14169.1.

(f) "Days data source" means the hospital's Annual Financial Disclosure Report filed with the Office of Statewide Health Planning and Development as of May 5, 2011, for its fiscal year ending during 2009.

(g) "Designated public hospital" shall have the meaning given in subdivision (d) of Section 14166.1 as of January 1, 2011.

(h) "Exempt facility" means any of the following:

(1) A public hospital, which shall include either of the following:

(A) A hospital, as defined in paragraph (25) of subdivision (a) of Section 14105.98.

(B) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code and operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(2) With the exception of a hospital that is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, a hospital that is a hospital designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report for the hospital's fiscal year ending in the 2009 calendar year.

(3) A hospital that satisfies the Medicare criteria to be a long-term care hospital.

(4) A small and rural hospital as specified in Section 124840 of the Health and Safety Code designated as that in the hospital's Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report for the hospital's fiscal year ending in the 2009 calendar year.

(i) "Federal approval" means the approval by the federal government of both the quality assurance fee established pursuant to this article and the supplemental payments to private hospitals described in Sections 14169.2 and 14169.3.

(j) (1) "Fee-for-service per diem quality assurance fee rate" means a fixed daily fee on fee-for-service days.

(2) The fee-for-service per diem quality assurance fee rate shall be three hundred nine dollars and eighty-six cents ($309.86) per day.

(3) Upon federal approval or conditional federal approval described in Section 14169.34, the director shall determine the fee-for-service per diem quality assurance fee rate based on the funds required to make the payments specified in Article 5.228 (commencing with Section 14169.1), in consultation with the hospital community.

(k) "Fee-for-service days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medicare traditional," "county indigent programs-traditional," "other third parties-traditional," "other indigent," and "other payers," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(l) "Fee percentage" means a fraction, expressed as a percentage, the numerator of which is the amount of payments for each subject fiscal year under Sections 14169.2, 14169.3, 14169.5, and 14169.7.5, for which federal financial participation is available and the denominator of which is four billion eight hundred ninety-seven million eight hundred sixty-six thousand nine hundred thirty-seven dollars ($4,897,866,937).

(m) "General acute care hospital" means any hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(n) "Hospital community" means any hospital industry organization or system that represents hospitals.

(o) "Managed care days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medicare managed care," "county indigent programs-managed care," and "other third parties-managed care," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(p) "Managed care per diem quality assurance fee rate" means a fixed fee on managed care days of eighty-six dollars and forty cents ($86.40) per day.

(q) "Medi-Cal days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medi-Cal traditional" and "Medi-Cal managed care," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(r) "Medi-Cal fee-for-service days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medi-Cal traditional" for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(s) "Medi-Cal managed care days" means inpatient hospital days as reported on the days data source where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medi-Cal managed care" for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(t) "Medi-Cal per diem quality assurance fee rate" means a fixed fee on Medi-Cal days of three hundred eighty-three dollars and twenty cents ($383.20) per day.

(u) "New hospital" means a hospital operation, business, or facility functioning under current or prior ownership as a private hospital that does not have a days data source or a hospital that has a days data source in whole, or in part, from a previous operator where there is an outstanding monetary liability owed to the state in connection with the Medi-Cal program and the new operator did not assume liability for the outstanding monetary obligation.

(v) "Nondesignated public hospital" means either of the following:

(1) A public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not

designated as a specialty hospital in the hospital's Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2009, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2009, is operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(w) "Prepaid health plan hospital" means a hospital owned by a nonprofit public benefit corporation that shares a common board of directors with a nonprofit health care service plan.

(x) "Prepaid health plan hospital managed care per diem quality assurance fee rate" means a fixed fee on non-Medi-Cal managed care days for prepaid health plan hospitals of forty-eight dollars and thirty-eight cents ($48.38) per day.

(y) "Prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate" means a fixed fee on Medi-Cal managed care days for prepaid health plan hospitals of two hundred fourteen dollars and fifty-nine cents ($214.59) per day.

(z) "Prior fiscal year data" means any data taken from sources that the department determines are the most accurate and reliable at the time the determination is made, or may be calculated from the most recent audited data using appropriate update factors. The data may be from prior fiscal years, current fiscal years, or projections of future fiscal years.

(aa) "Private hospital" means a hospital that meets all of the following conditions:

(1) Is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2009.

(3) Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

(4) Is a nonpublic hospital, nonpublic converted hospital, or converted hospital as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

(ab) "Program period" means the period from July 1, 2011, to December 31, 2013, inclusive.

(ac) "Subject fiscal quarter" means a state fiscal quarter during the program period.

(ad) "Subject fiscal year" means a state fiscal year that ends after July 1, 2011, and begins before January 1, 2014.

(ae) "Upper payment limit" means a federal upper payment limit on the amount of the Medicaid payment for which federal financial participation is available for a class of service and a class of health care providers, as specified in Part 447 of Title 42 of the Code of Federal Regulations. The applicable upper payment limit shall be separately calculated for inpatient and outpatient hospital services.

**SEC. 103.** Section 14169.32 of the Welfare and Institutions Code is amended to read:

**14169.32.** (a) There shall be imposed on each general acute care hospital that is not an exempt facility a quality assurance fee, provided that a quality assurance fee under this article shall not be imposed on a converted hospital.

(b) The quality assurance fee shall be computed starting on July 1, 2011, and continue through and including December 31, 2013.

(c) Subject to Section 14169.34, upon receipt of federal approval, the following shall become operative:

(1) Within 10 business days following receipt of the notice of federal approval from the federal government, the department shall send notice to each hospital subject to the quality assurance fee, and publish on its Internet

Web site, the following information:

(A) The date that the state received notice of federal approval.

(B) The fee percentage for each subject fiscal year.

(2) The notice to each hospital subject to the quality assurance fee shall also state the following:

(A) The aggregate quality assurance fee after the application of the fee percentage for each subject fiscal year.

(B) The aggregate quality assurance fee.

(C) The amount of each payment due from the hospital with respect to the aggregate quality assurance fee.

(D) The date on which each payment is due.

(3) The hospitals shall pay the aggregate quality assurance fee in 10 equal installments. The department shall establish the date that each installment is due, provided that the first installment shall be due no earlier than 20 days following the department sending the notice pursuant to paragraph (1), and the installments shall be paid at least one month apart, but if possible, the installments shall be paid on a quarterly basis.

(4) Notwithstanding paragraph (3), the amount of each hospital's aggregate quality assurance fee after the application of the fee percentage that has not been paid by the hospital before December 15, 2013, pursuant to paragraph (3), shall be paid by the hospital no later than December 15, 2013.

(d) The quality assurance fee, as paid pursuant to this section, shall be paid by each hospital subject to the fee to the department for deposit in the Hospital Quality Assurance Revenue Fund. Deposits may be accepted at any time and will be credited toward the program period.

(e) This section shall become inoperative if the federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before July 1, 2014, the implementation of the quality assurance fee pursuant to this article or the supplemental payments to private hospitals described in Sections 14169.2 and 14169.3, and either or both provisions cannot be modified by the department pursuant to subdivision (d) of Section 14169.33 in order to meet the requirements of federal law or to obtain federal approval.

(f) In no case shall the aggregate fees collected in a federal fiscal year pursuant to this section, Section 14167.32, and Section 14168.32 exceed the maximum percentage of the annual aggregate net patient revenue for hospitals subject to the fee that is prescribed pursuant to federal law and regulations as necessary to preclude a finding that an indirect guarantee has been created.

(g) (1) Interest shall be assessed on quality assurance fees not paid on the date due at the greater of 10 percent per annum or the rate at which the department assesses interest on Medi-Cal program overpayments to hospitals that are not repaid when due. Interest shall begin to accrue the day after the date the payment was due and shall be deposited in the Hospital Quality Assurance Revenue Fund.

(2) In the event that any fee payment is more than 60 days overdue, a penalty equal to the interest charge described in paragraph (1) shall be assessed and due for each month for which the payment is not received after 60 days.

(h) When a hospital fails to pay all or part of the quality assurance fee on or before the date that payment is due, the department may immediately begin to deduct the unpaid assessment and interest from any Medi-Cal payments owed to the hospital, or, in accordance with Section 12419.5 of the Government Code, from any other state payments owed to the hospital until the full amount is recovered. All amounts, except penalties, deducted by the department under this subdivision shall be deposited in the Hospital Quality Assurance Revenue Fund. The remedy provided to the department by this section is in addition to other remedies available under law.

(i) The payment of the quality assurance fee shall not be considered as an allowable cost for Medi-Cal cost reporting and reimbursement purposes.

(j) The department shall work in consultation with the hospital community to implement this article and Article 5.228 (commencing with Section 14169.1).

(k) This subdivision creates a contractually enforceable promise on behalf of the state to use the proceeds of the quality assurance fee, including any federal matching funds, solely and exclusively for the purposes set forth in

this article as they existed on the effective date of this article, to limit the amount of the proceeds of the quality assurance fee to be used to pay for the health care coverage of children to the amounts specified in this article, to limit any payments for the department's costs of administration to the amounts set forth in this article on the effective date of this article, to maintain and continue prior reimbursement levels as set forth in Section 14169.12 on the effective date of that article, and to otherwise comply with all its obligations set forth in Article 5.228 (commencing with Section 14169.1) and this article provided that amendments that arise from, or have as a basis, a decision, advice, or determination by the federal Centers for Medicare and Medicaid Services relating to federal approval of the quality assurance fee or the payments set forth in this article or Article 5.228 (commencing with Section 14169.1) shall control for the purposes of this subdivision.

(l) (1) Effective January 1, 2014, the rates payable to hospitals and managed health care plans under Medi-Cal shall be the rates then payable without the supplemental and increased capitation payments set forth in Article 5.228 (commencing with Section 14169.1).

(2) The supplemental payments and other payments under Article 5.228 (commencing with Section 14169.1) shall be regarded as quality assurance payments, the implementation or suspension of which does not affect a determination of the adequacy of any rates under federal law.

(m) (1) Subject to paragraph (2), the director may waive any or all interest and penalties assessed under this article in the event that the director determines, in his or her sole discretion, that the hospital has demonstrated that imposition of the full quality assurance fee on the timelines applicable under this article has a high likelihood of creating a financial hardship for the hospital or a significant danger of reducing the provision of needed health care services.

(2) Waiver of some or all of the interest or penalties under this subdivision shall be conditioned on the hospital's agreement to make fee payments, or to have the payments withheld from payments otherwise due from the Medi-Cal program to the hospital, on a schedule developed by the department that takes into account the financial situation of the hospital and the potential impact on services.

(3) A decision by the director under this subdivision shall not be subject to judicial review.

(4) If fee payments are remitted to the department after the date determined by the department to be the final date for calculating the final supplemental payments under this article and Article 5.228 (commencing with Section 14169.1), the fee payments shall be retained in the fund for purposes of funding supplemental payments supported by a hospital quality assurance fee program implemented under subsequent legislation, provided, however, that if supplemental payments are not implemented under subsequent legislation, then those fee payments shall be deposited in the Distressed Hospital Fund.

(5) If during the implementation of this article, fee payments that were due under Article 5.21 (commencing with Section 14167.1) and Article 5.22 (commencing with Section 14167.31), or Article 5.226 (commencing with Section 14168.1) and Article 5.227 (commencing with Section 14168.31), are remitted to the department under a payment plan or for any other reason, and the final date for calculating the final supplemental payments under those articles has passed, then those fee payments shall be deposited in the fund to support the uses established by this article.

**SEC. 104.** Section 14169.33 of the Welfare and Institutions Code is amended to read:

**14169.33.** (a) (1) All fees required to be paid to the state pursuant to this article shall be paid in the form of remittances payable to the department.

(2) The department shall directly transmit the fee payments to the Treasurer to be deposited in the Hospital Quality Assurance Revenue Fund, created pursuant to Section 14167.35. Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on deposits in the fund from the proceeds of the fee assessed pursuant to this article shall be retained in the fund for purposes specified in subdivision (b).

(b) Notwithstanding subdivision (c) of Section 14167.35 and subdivision (b) of Section 14168.33, all funds from the proceeds of the fee assessed pursuant to this article in the Hospital Quality Assurance Revenue Fund, together with any interest and dividends earned on money in the fund, shall, upon appropriation by the Legislature, continue to be used exclusively to enhance federal financial participation for hospital services under the Medi-Cal program, to provide additional reimbursement to, and to support quality improvement efforts of, hospitals, and to minimize uncompensated care provided by hospitals to uninsured patients, as well as to pay for the state's administrative costs and to provide funding for children's health coverage, in the following order

of priority:

(1) To pay for the department's staffing and administrative costs directly attributable to implementing Article 5.228 (commencing with Section 14169.1) and this article, not to exceed two million five hundred thousand dollars ($2,500,000) for the program period.

(2) To pay for the health care coverage for children in the amount of eighty-five million dollars ($85,000,000) for each subject fiscal quarter during the 2011–12 subject fiscal year, in the amount of one hundred thirty-four million two hundred fifty thousand dollars ($134,250,000) for each subject fiscal quarter during the 2012–13 subject fiscal year, and in the amount of one hundred forty-four million two hundred fifty thousand dollars ($144,250,000) for each subject fiscal quarter during the 2013–14 subject fiscal year.

(3) To make increased capitation payments to managed health care plans pursuant to Article 5.228 (commencing with Section 14169.1).

(4) To reimburse the General Fund for the increase in the overall compensation to a private hospital that is attributable to its change in status from contract hospital to noncontract hospital, pursuant to subdivision (a) of Section 14169.10.

(5) To make increased payments or grants to hospitals pursuant to Article 5.228 (commencing with Section 14169.1).

(6) To make increased payments to mental health plans pursuant to Article 5.228 (commencing with Section 14169.1).

(7) To make supplemental payments for out-of-network emergency and poststabilization services provided by private hospitals and nondesignated public hospitals to Medi-Cal expansion enrollees in the Low Income Health Program in the amount of thirty-seven million five hundred thousand dollars ($37,500,000) for each fiscal quarter pursuant to Section 14169.7.5.

(c) Any amounts of the quality assurance fee collected in excess of the funds required to implement subdivision (b), including any funds recovered under subdivision (d) of Section 14169.13 or subdivision (e) of Section 14169.38, shall be refunded to general acute care hospitals, pro rata with the amount of quality assurance fee paid by the hospital, subject to the limitations of federal law. If federal rules prohibit the refund described in this subdivision, the excess funds shall be deposited in the Distressed Hospital Fund to be used for the purposes described in Section 14166.23, and shall be supplemental to and not supplant existing funds.

(d) Any methodology or other provision specified in Article 5.228 (commencing with Section 14169.1) or this article may be modified by the department, in consultation with the hospital community, to the extent necessary to meet the requirements of federal law or regulations to obtain federal approval or to enhance the probability that federal approval can be obtained, provided the modifications do not violate the spirit and intent of Article 5.228 (commencing with Section 14169.1) or this article and are not inconsistent with the conditions of implementation set forth in Section 14169.40.

(e) The department, in consultation with the hospital community, shall make adjustments, as necessary, to the amounts calculated pursuant to Section 14169.32 in order to ensure compliance with the federal requirements set forth in Section 433.68 of Title 42 of the Code of Federal Regulations or elsewhere in federal law.

(f) The department shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this article. In making this request, the department shall seek specific approval from the federal Centers for Medicare and Medicaid Services to exempt providers identified in this article as exempt from the fees specified, including the submission, as may be necessary, of a request for waiver of the broad-based requirement, waiver of the uniform fee requirement, or both, pursuant to paragraphs (1) and (2) of subdivision (e) of Section 433.68 of Title 42 of the Code of Federal Regulations.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this article or Article 5.228 (commencing with Section 14169.1) by means of provider bulletins, all plan letters, or other similar instruction, without taking regulatory action. The department shall also provide notification to the Joint Legislative Budget Committee and to the appropriate policy and fiscal committees of the Legislature within five working days when the above-described action is taken in order to inform the Legislature that the action is being implemented.

**SEC. 105.** Section 14169.34 of the Welfare and Institutions Code is amended to read:

**14169.34.** (a) Notwithstanding any other provision of this article or Article 5.228 (commencing with Section 14169.1) requiring federal approvals, the department may impose and collect the quality assurance fee and may make payments under this article and Article 5.228 (commencing with Section 14169.1), including increased capitation payments, based upon receiving a letter from the federal Centers for Medicare and Medicaid Services or the United States Department of Health and Human Services that indicates likely federal approval, but only if and to the extent that the letter is sufficient as set forth in subdivision (b).

(b) In order for the letter to be sufficient under this section, the director shall find that the letter meets both of the following requirements:

(1) The letter is in writing and signed by an official of the federal Centers for Medicare and Medicaid Services or an official of the United States Department of Health and Human Services.

(2) The director, after consultation with the hospital community, has determined, in the exercise of his or her sole discretion, that the letter provides a sufficient level of assurance to justify advanced implementation of the fee and payment provisions.

(c) Nothing in this section shall be construed as modifying the requirement under Section 14169.13 that payments shall be made only to the extent a sufficient amount of funds collected as the quality assurance fee are available to cover the nonfederal share of those payments.

(d) Upon notice from the federal government that final federal approval for the fee model under this article or for the supplemental payments to private hospitals under Section 14169.2 or 14169.3 has been denied, any fees collected pursuant to this section shall be refunded and any payments made pursuant to this article or Article 5.228 (commencing with Section 14169.1) shall be recouped, including, but not limited to, supplemental payments, increased capitation payments, payments to hospitals by health care plans resulting from the increased capitation payments, increased payments to mental health plans, and payments for the health care coverage of children. To the extent fees were paid by a hospital that also received payments under this section, the payments may first be recouped from fees that would otherwise be refunded to the hospital prior to the use of any other recoupment method allowed under law.

(e) Any payment made pursuant to this section shall be a conditional payment until final federal approval has been received.

(f) The director shall have broad authority under this section to collect the quality assurance fee for an interim period after receipt of the letter described in subdivision (a) pending receipt of all necessary federal approvals. This authority shall include discretion to determine both of the following:

(1) Whether the quality assurance fee should be collected on a full or pro rata basis during the interim period.

(2) The dates on which payments of the quality assurance fee are due.

(g) The department may draw against the Hospital Quality Assurance Revenue Fund for all administrative costs associated with implementation under this article or Article 5.228 (commencing with Section 14169.1).

(h) This section shall be implemented only to the extent federal financial participation is not jeopardized by implementation prior to the receipt of all necessary final federal approvals.

**SEC. 106.** Section 14169.36 of the Welfare and Institutions Code is amended to read:

**14169.36.** (a) Upon receipt of a letter that indicates likely federal approval that the director determines is sufficient for implementation under Section 14169.34, or upon the receipt of federal approval, the following shall occur:

(1) To the maximum extent possible, and consistent with the availability of funds in the Hospital Quality Assurance Revenue Fund, the department shall make all of the payments under Sections 14169.2, 14169.3, 14169.5, 14169.7, and 14169.7.5, including, but not limited to, supplemental payments and increased capitation payments, prior to January 1, 2014, except that the increased capitation payments under Section 14169.5 shall not be made until federal approval is obtained for these payments.

(2) The department shall make supplemental payments to hospitals under Article 5.228 (commencing with Section 14169.1) consistent with the timeframe described in Section 14169.11 or a modified timeline developed pursuant to Section 14169.35.

(b) Notwithstanding any other provision of this article or Article 5.228 (commencing with Section 14169.1), if the director determines, on or after December 15, 2013, that there are insufficient funds available in the Hospital Quality Assurance Revenue Fund to make all scheduled payments under Article 5.228 (commencing with Section 14169.1) before January 1, 2014, he or she shall consult with representatives of the hospital community to develop an acceptable plan for making additional payments to hospitals and managed health care plans to maximize the use of delinquent fee payments or other deposits or interest projected to become available in the fund after December 15, 2013, but before June 15, 2014.

(c) Nothing in this section shall require the department to continue to make payments under Article 5.228 (commencing with Section 14169.1) if, after the consultation required under subdivision (b), the director determines in the exercise of his or her sole discretion that a workable plan for the continued payments cannot be developed.

(d) Subdivisions (b) and (c) shall be implemented only if and to the extent federal financial participation is available for continued supplemental payments and to providers and continued increased capitation payments to managed health care plans.

(e) If any payment or payments made pursuant to this section are found to be inconsistent with federal law, the department shall recoup the payments by means of withholding or any other available remedy.

(f) Nothing in this section shall be read as affecting the department's ongoing authority to continue, after December 31, 2013, to collect quality assurance fees imposed on or before December 31, 2013.

**SEC. 107.** Section 14169.38 of the Welfare and Institutions Code is amended to read:

**14169.38.** (a) This article shall be implemented only as long as all of the following conditions are met:

(1) Subject to Section 14169.33, the quality assurance fee is established in a manner that is fundamentally consistent with this article.

(2) The quality assurance fee, including any interest on the fee after collection by the department, is deposited in a segregated fund apart from the General Fund.

(3) The proceeds of the quality assurance fee, including any interest and related federal reimbursement, may only be used for the purposes set forth in this article.

(b) No hospital shall be required to pay the quality assurance fee to the department unless and until the state receives and maintains federal approval.

(c) Hospitals shall be required to pay the quality assurance fee to the department as set forth in this article only as long as all of the following conditions are met:

(1) The federal Centers for Medicare and Medicaid Services allows the use of the quality assurance fee as set forth in this article in accordance with federal approval.

(2) Article 5.228 (commencing with Section 14169.1) is enacted and remains in effect and hospitals are reimbursed the increased rates for services during the program period, as defined in Section 14169.1.

(3) The full amount of the quality assurance fee assessed and collected pursuant to this article remains available only for the purposes specified in this article.

(d) This article shall become inoperative if either of the following occurs:

(1) In the event, and on the effective date, of a final judicial determination made by any court of appellate jurisdiction or a final determination by the United States Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that the quality assurance fee established pursuant to this article or any provision of Section 14166.115 cannot be implemented.

(2) In the event both of the following conditions exist:

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2014, the implementation of Sections 14169.2 and 14169.3 or this article.

(B) Section 14169.2, Section 14169.3, or this article cannot be modified by the department pursuant to subdivision (d) of Section 14169.33 in order to meet the requirements of federal law or to obtain federal

approval.

(e) If this article becomes inoperative pursuant to paragraph (1) of subdivision (d) and the determination applies to any period or periods of time prior to the effective date of the determination, the department may recoup all payments made pursuant to Article 5.228 (commencing with Section 14169.1) during that period or those periods of time.

(f) (1) In the event that all necessary final federal approvals are not received as described and anticipated under this article or Article 5.228 (commencing with Section 14169.1), the director shall have the discretion and authority to develop procedures for recoupment from managed health care plans, and from hospitals under contract with managed health care plans, of any amounts received pursuant to this article or Article 5.228 (commencing with Section 14169.1).

(2) Any procedure instituted pursuant to this subdivision shall be developed in consultation with representatives from managed health care plans and representatives of the hospital community.

(3) Any procedure instituted pursuant to this subdivision shall be in addition to all other remedies made available under the law, pursuant to contracts between the department and the managed health care plans, or pursuant to contracts between the managed health care plans and the hospitals.

**SEC. 108.** Section 14171 of the Welfare and Institutions Code is amended to read:

**14171.** (a) The director shall establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination made pursuant to Sections 10722 and 14170 and for final settlements, including, in the case of hospitals, the application of Sections 51536, 51537, and 51539 of Title 22 of the California Code of Regulations. All these processes shall be established by regulation, pursuant to, and consistent with, Section 100171 of the Health and Safety Code.

(b) Different administrative appeal processes may be established by the director for grievances or complaints arising from the determinations of a tentative or final settlement based on audit or examination findings made by or on behalf of the department pursuant to Sections 10722 and 14170. However, consistent with existing practice, no administrative appeal shall be available for tentative settlement of cost reports.

(c) The administrative appeal process established by the director for tentative settlements, including, in the case of hospitals, the application of Sections 51536, 51537, and 51539 of Title 22 of the California Code of Regulations shall be an informal process which, however, guarantees a provider the right to present any grievance or complaint to the department in writing. Any subsequent hearings shall be conducted in an informal manner and shall be held at the discretion of the department.

(d) The time limitations in subdivisions (e) and (f) for the impartial hearing and the final decisions are mandatory. If the department fails to conduct the hearing or to adopt a final decision thereon within the time limitations provided in subdivisions (e) and (f), the amount of any overpayment which is ultimately determined by the department to be due shall be reduced by 10 percent for each 30-day period, or portion thereof, that the hearing or the decision, or both, are delayed beyond the time limitations provided in subdivisions (e) and (f). However, the time period shall be extended by either of the following:

(1) Delay caused by a provider.

(2) Extensions of time granted a provider at its sole request or at the joint request of the provider and the department.

(e) (1) The administrative appeal process established by the director shall commence with an informal conference with the provider, a representative of the department, and the administrative law judge. The informal conference shall be conducted no later than 90 days after the filing of a timely and specific statement of disputed issues by the provider. The administrative law judge, when appropriate, may assign the administrative appeal to an informal level of review where efforts could be made to resolve facts and issues in dispute in a fair and equitable manner, subject to the requirements of state and federal law. The review conducted at this informal level shall be completed no later than 180 days after the filing of a timely and specific statement of disputed issues by the provider.

(2) Nothing in this subdivision shall prohibit the provider from presenting any unresolved grievances or complaints at an impartial hearing pursuant to subdivision (a). The impartial hearing shall be conducted no later than 300 days after the filing of a timely and specific statement of disputed issues by the provider.

(3) (A) Subject to subdivision (f), a final decision in a noninstitutional provider appeal shall be adopted within 180 days after the closure of the record of the impartial hearing, and a final decision in an institutional provider appeal shall be adopted within 300 days after the closure of the record of the impartial hearing.

(B) The department shall mail a copy of the adopted decision to all parties within 30 days of the date of adoption of the decision.

(f) In the event the director intends to modify a proposed decision, on or before the 180th day following the closure of the record of the hearing for noninstitutional providers or the 300th day following the closure of the record of the hearing for institutional providers, the director shall provide written notice of his or her intention to the parties and shall afford the parties an opportunity to present written argument. Following this notice, on or before the 240th day following the closure of the record of the hearing for noninstitutional providers or the 420th day following closure of the record of the hearing for institutional providers, or within that additional time period as is granted pursuant to the sole request of a provider or at the joint request of the provider and the department, the director shall issue a final decision.

(g) In the event recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of a disallowed payment shall be entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7 percent per annum, whichever is higher, commencing on the date the appeal is formally accepted by the department or the date payment is received by the department, whichever is later.

(h) Except as provided in subdivision (i), commencing 60 days after issuance of the first statement of account status or demand for repayment resulting from an audit or examination made pursuant to Sections 10722 and 14170, interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund during the month the first statement of account status or demand for repayment was issued, or simple interest at the rate of 7 percent per annum, whichever is higher, shall be assessed against any unrecovered overpayment due to the department.

(i) (1) Commencing on the day following the last day of the period covered by an audit or examination made pursuant to Sections 10722 and 14170, interest at the rate established under Section 19269 of the Revenue and Taxation Code which is in effect on the date of the commencement of that interest shall be assessed against any unrecovered overpayment due to the department by providers of durable medical equipment or incontinence supplies.

(2) Interest which accrues under this subdivision for recoupment of an overpayment based on the lack of medical necessity for a previously approved claim shall commence to accrue on the date of written demand by the department.

(j) The final decision of the director shall be reviewable in accordance with Section 1094.5 of the Code of Civil Procedure within six months of the issuance of the director's final decision.

**SEC. 109.** Section 14182.4 of the Welfare and Institutions Code is amended to read:

**14182.4.** (a) To the extent authorized under a federal waiver or demonstration project described in Section 14180 that is approved by the federal Centers for Medicare and Medicaid Services, the department shall establish a program of investment, improvement, and incentive payments for designated public hospitals and, to the extent federal approval is obtained pursuant to subdivision (c) of Section 14166.155, for nondesignated public hospitals to encourage and incentivize delivery system transformation and innovation in preparation for the implementation of federal health care reform.

(b) The Public Hospital Investment, Improvement, and Incentive Fund is hereby established in the State Treasury. Notwithstanding Section 13340 of the Government Code, moneys in the fund shall be continuously appropriated, without regard to fiscal years, to the department for the purposes specified in this section.

(c) The fund shall consist of any moneys that a county, other political subdivision of the state, or other governmental entity in the state that may elect to transfer to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(d) Moneys in the fund shall be used as the source for the nonfederal share of investment, improvement, and incentive payments as authorized under a federal waiver or demonstration project to participating designated public hospitals and, to the extent federal approval is obtained pursuant to subdivision (c) of Section

14166.155, to nondesignated public hospitals, defined in subdivisions (d) and (f) of Section 14166.1 respectively, and the governmental entities with which they are affiliated, that provide the intergovernmental transfers for deposit into the fund.

(e) The department shall obtain federal financial participation for moneys in the fund to the full extent permitted by law. Moneys shall be allocated from the fund by the department and used as the nonfederal share for claiming federal funds in accordance with the Special Terms and Conditions of the waiver or demonstration project and Sections 14166.77 and 14166.155, to the extent federal approval is obtained pursuant to subdivision (c) of Section 14166.151, as applicable. The moneys disbursed from the fund, and all associated federal financial participation, shall be distributed only to the designated public hospitals and the governmental entities with which they are affiliated, and to the extent federal approval is obtained pursuant to subdivision (c) of Section 14166.155, to nondesignated public hospitals as described in subdivision (a) and the governmental entities with which they are affiliated.

(f) Participation under this section is voluntary on the part of the county or other political subdivision for purposes of all applicable federal laws. As part of its voluntary participation in the nonfederal share of payments under this section, the county or other political subdivision agrees to reimburse the state for the nonfederal share of state staffing or administrative costs directly attributable to implementation of this section. This section shall be implemented only to the extent federal financial participation is not jeopardized.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may clarify, interpret, or implement the provisions of this section by means of provider bulletins or similar instructions. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

**SEC. 110.** Section 14182.45 of the Welfare and Institutions Code is amended to read:

**14182.45.** (a) In consultation with the designated public hospitals, as defined in subdivision (d) of Section 14166.1, and to the extent it does not impede the ability of the designated public hospitals to meet the requirements and conditions for delivery system reform incentive payments authorized under Sections 14166.77 and 14182.4, the state may provide for milestone incentive payments to private disproportionate share hospitals and nondesignated public disproportionate share hospitals to create incentives for improvement activities towards, and achievement of, delivery system transformation. The milestone incentive payments to private disproportionate share hospitals and nondesignated public disproportionate share hospitals shall be structured in accordance with the requirements and conditions for delivery system reform incentive payments set forth in the Special Terms and Conditions and as approved by the federal Centers for Medicare and Medicaid Services. Incentive payments may be funded by voluntary intergovernmental transfers made by the designated public hospitals and nondesignated public hospitals. All incentive pool funding, including any potential private and nondesignated public hospital subpools, shall be limited to the total amount of incentive pool funding allowed for delivery system reform incentive payments as set forth in the Special Terms and Conditions.

(b) Upon federal approval of the reimbursement methodology in subdivision (b) of Section 14166.151, this section shall become inoperative.

**SEC. 111.** Section 14183.6 of the Welfare and Institutions Code is amended to read:

**14183.6.** The department shall enter into an interagency agreement with the Department of Managed Health Care to have the Department of Managed Health Care, on behalf of the department, conduct financial audits, medical surveys, and a review of the provider networks of the managed care health plans participating in the demonstration project and the Medi-Cal managed care expansion into rural counties, and to provide consumer assistance to beneficiaries affected by Sections 14182.16 and 14182.17. The interagency agreement shall be updated, as necessary, on an annual basis in order to maintain functional clarity regarding the roles and responsibilities of these core activities. The department shall not delegate its authority under this division to the Department of Managed Health Care.

**SEC. 112.** Section 14204 of the Welfare and Institutions Code is amended to read:

**14204.** (a) Pursuant to the provisions of this chapter, the department may contract with one or more prepaid health plans in order to provide the benefits authorized under this chapter and Chapter 7 (commencing with Section 14000) of this part. The department may contract with one or more children's hospitals on an exclusive

basis for a specified population in a specified geographic area. Contracts entered into pursuant to this chapter may be awarded on a bid or nonbid basis.

(b) In order to achieve maximum cost savings the Legislature hereby determines that expedited contract process for contracts under this chapter is necessary. Therefore, contracts under this chapter shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(c) The department shall amend contracts with dental health plans in effect on the date the act that added this subdivision and Section 14459.6 become effective to provide Medi-Cal dental services authorized under this chapter and Chapter 7 (commencing with Section 14000) to Medi-Cal beneficiaries who reside in a specified geographic area to meet the requirements of Sections 14089.09 and 14459.6.

**SEC. 113.** Section 14301.1 of the Welfare and Institutions Code is amended to read:

**14301.1.** (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan– and county-specific rates. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health-plan-specific encounter and claims data.

(2) Supplemental utilization and cost data submitted by the health plans.

(3) Fee-for–service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.

(4) Department of Managed Health Care financial statement data specific to Medi-Cal operations.

(5) Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county-specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.

(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.

(g) (1) Prior to finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(2) For contracts entered into between the department and any entity pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, the department, by June 30 of each year, or, if the budget has not passed by that date, no later than five working days after the budget is signed, shall provide preliminary rates for the upcoming fiscal year.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. This data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Division 7 (commencing with

Section 6250) of Title 1 of the Government Code).

(i) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

(j) Prior to October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20 percent of the total capitation rate paid to each Medi-Cal managed care plan.

(k) (1) It is the intent of the Legislature to preserve the policy goal to support and strengthen traditional safety net providers who treat high volumes of uninsured and Medi-Cal patients when Medi-Cal enrollees are defaulted into Medi-Cal managed care plans.

(2) As the department adds additional factors, such as managed care plan costs, to the Medi-Cal managed care plan default assignment algorithm, it shall consult with the Auto Assignment Performance Incentive Program stakeholder workgroup to develop cost factor disregards related to intergovernmental transfers and required wraparound payments that support safety net providers.

**SEC. 114.** Section 14459.6 is added to the Welfare and Institutions Code, to read:

**14459.6.** (a) The department shall establish a list of performance measures to ensure dental health plans meet quality criteria required by the department. The list shall specify the benchmarks used by the department to determine whether and the extent to which a dental health plan meets each performance measure. Commencing January 1, 2013, and quarterly thereafter, the list of performance measures established by the department along with each plan's performance shall be posted on the department's Internet Web site. The Department of Managed Health Care and the advisory committee established pursuant to Section 14089.08 shall have access to all performance measures and benchmarks used by the department as described in this section.

(1) The performance measures established by the department shall include, but not be limited to, all of the following: provider network adequacy, overall utilization of dental services, annual dental visits, use of preventive dental services, use of dental treatment services, use of examinations and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and survey of member satisfaction with plans and providers.

(2) The survey of member satisfaction with plans and providers shall be the same dental version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as used by the Healthy Families Program.

(3) The department shall notify dental health plans at least 30 days prior to the implementation date of these performance measures.

(4) The department shall include the initial list of performance measures and benchmarks in any dental health contracts entered into between the department and a dental health plan pursuant to Section 14204.

(5) The department shall update performance measures and benchmarks and establish additional performance measures and benchmarks in accordance with all of the following:

(A) The department shall consider performance measures and benchmarks established by other states, the federal government, and national organizations developing dental program performance and quality measures.

(B) The department shall notify dental health plans at least 30 days prior to the implementation date of updates or changes to performance measures and benchmarks. The department shall also post these updates or changes on its Internet Web site at least 30 days prior to implementation in order to provide transparency to the public.

(C) To ensure that the dental health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating performance measures and benchmarks for retention on, addition to, or deletion from the list, consider all of the following criteria:

(i) Monthly, quarterly, annual, and multiyear Medi-Cal dental managed care trended data.

(ii) County and statewide Medi-Cal dental fee-for-service performance and quality ratings.

(iii) Other state and national dental program performance and quality measures.

(iv) Other state and national performance ratings.

(b) In establishing and updating the performance measures and benchmarks, the department shall consult the advisory committee established pursuant to Section 14089.08, as well as dental health plan representatives and other stakeholders, including representatives from counties, local dental societies, nonprofit entities, legal aid entities, and other interested parties.

(c) In evaluating a dental health plan's ability to meet the criteria established through the performance measures and benchmarks, the department shall select specific performance measures from those established by the department in subdivision (a) as the basis for establishing financial or other incentives or disincentives, including, but not limited to, bonuses, payment withholds, and adjustments to beneficiary assignment to plan algorithms. These incentives and disincentives shall be included in the dental health plan contracts.

(d) (1) The department shall designate an external quality review organization (EQRO) that shall conduct external quality reviews for any dental health plan contracting with the department pursuant to Section 14204.

(2) As determined by the department, but at least annually, dental health plans shall arrange for an external quality of care review with the EQRO designated by the department that evaluates the dental health plan's performance in meeting the performance measures established in this section. Dental health plans shall cooperate with and assist the EQRO in this review. The Department of Managed Health Care shall have direct access to all external quality of care review information upon request to the department.

(3) An external quality of care review shall include, but not be limited to, all of the following: performance on the selected performance measures and benchmarks established and updated by the department, the CAHPS member or consumer satisfaction survey referenced in paragraph (2) of subdivision (a), reporting systems, and methodologies for calculating performance measures. An external quality of care review that includes all of the above components shall be paid for by the dental health plan and posted online annually, or at any other frequency specified by the department, on the department's Internet Web site.

(e) All marketing methods and activities to be used by dental plans shall comply with subdivision (b) of Section 10850, Sections 14407.1, 14408, 14409, 14410, and 14411, and Title 22 of the California Code of Regulations, including Sections 53880 and 53881. Each dental plan shall submit its marketing plan to the department for review and approval.

(f) Each dental plan shall submit its member services procedures, beneficiary informational materials, and any updates to those procedures or materials to the department for review and approval. The department shall ensure that member services procedures and beneficiary informational materials are clear and provide timely and fair processes for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits.

(g) Each dental plan shall submit its provider compensation agreements to the department for review and approval.

(h) The department shall post to its Internet Web site a copy of all final reports completed by the Department of Managed Health Care regarding dental managed care plans.

**SEC. 115.** Section 14459.8 is added to the Welfare and Institutions Code, to read:

**14459.8.** (a) By no later than March 15, 2013, with annual updates thereafter, the department shall provide the fiscal and appropriate policy committees of the Legislature with either a comprehensive report or separate reports on dental managed care in the Counties of Sacramento and Los Angeles. This report shall articulate specific changes and improvements implemented to increase Medi-Cal beneficiary access to preventive services and dental treatment, the utilization of services, and beneficiary satisfaction. Key measures, outcomes, and department findings pertaining to participating dental managed care plans and provider networks shall also be included.

(b) Any report provided pursuant to subdivision (a) on the County of Sacramento shall also provide data regarding the outcomes and findings from the beneficiary dental exception (BDE) process implemented by the department pursuant to Section 14089.09, including the consideration of voluntary enrollment in the County of Sacramento as compared to the existing mandatory enrollment.

(c) The department may seek foundation funding or federal grant funding to facilitate data analysis and reporting as applicable for this purpose.

**SEC. 116.** Section 14500.5 of the Welfare and Institutions Code is amended to read:

**14500.5.** (a) It is the intent of the Legislature that family planning includes, but is not limited to, an effective means to improve reproductive health by disease prevention and treatment, to reduce the incidence of unintended pregnancies, and to reduce the demand for abortions. It is the intent of the Legislature that no family planning shall be expended other than for the services enumerated in this chapter. It is also the intent of the Legislature that no funds received pursuant to this chapter be used for abortions or services ancillary to abortions.

(b) For purposes of this chapter, the following definitions shall apply:

(1) "Family planning" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, natural family planning, abstinence methods, and the management of infertility. Family planning services include preconceptional counseling, maternal and fetal health counseling, and general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, and other services as described in Section 14503, except for abortions and services ancillary to abortions as prohibited in Section 14509. Family planning does not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care which is not incident to the diagnosis of a pregnancy, except as otherwise provided for in this chapter.

(2) "Abortion as a method of family planning" means the deliberate choice of abortion over other methods to limit the number, gender, and spacing of children, including, but not limited to, contraception, abstinence, and natural family planning methods.

(3) "Department" means the State Department of Health Care Services.

(4) "Director" means the Director of Health Care Services.

(5) "Grantee" means an agency, institution, or organization approved by the department to provide family planning services pursuant to this chapter.

**SEC. 117.** Section 15911 of the Welfare and Institutions Code is amended to read:

**15911.** (a) Funding for each LIHP shall be based on all of the following:

(1) The amount of funding that the participating entity voluntarily provides for the nonfederal share of LIHP expenditures.

(2) For a LIHP that had in operation a Health Care Coverage Initiative program under Part 3.5 (commencing with Section 15900) as of November 1, 2010, and elects to continue funding the program, the amount of funds requested to ensure that eligible enrollees continue to receive health care services for persons enrolled in the Health Care Coverage Initiative program as of November 1, 2010.

(3) Any limitations imposed by the Special Terms and Conditions of the demonstration project.

(4) The total allocations requested by participating entities for Health Care Coverage Initiative eligible individuals.

(5) Whether funding under this part would result in the reduction of other payments under the demonstration project.

(b) Nothing in this part shall be construed to require a political subdivision of the state to participate in a LIHP as set forth in this part, and those local funds expended or transferred for the nonfederal share of LIHP expenditures under this part shall be considered voluntary contributions for purposes of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), as amended by the federal Patient Protection and Affordable Care Act.

(c) No state General Fund moneys shall be used to fund LIHP services, nor to fund any related administrative costs incurred by counties or any other political subdivision of the state.

(d) Subject to the Special Terms and Conditions of the demonstration project, if a participating entity elects to

fund the nonfederal share of a LIHP, the nonfederal funding and payments to the LIHP shall be provided through one of the following mechanisms, at the options of the participating entity:

(1) On a quarterly basis, the participating entity shall transfer to the department for deposit in the LIHP Fund established for the participating counties and pursuant to subparagraph (A), the amount necessary to meet the nonfederal share of estimated payments to the LIHP for the next quarter under subdivision (g) Section 15910.3.

(A) The LIHP Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, all moneys in the fund shall be continuously appropriated to the department for the purposes specified in this part. The fund shall contain all moneys deposited into the fund in accordance with this paragraph.

(B) The department shall obtain the related federal financial participation and pay the rates established under Section 15910.3, provided that the intergovernmental transfer is transferred in accordance with the deadlines imposed under the Medi-Cal Checkwrite Schedule, no later than the next available warrant release date. This payment shall be a nondiscretionary obligation of the department, enforceable under a writ of mandate pursuant to Section 1085 of the Code of Civil Procedure. Participating entities may request expedited processing within seven business days of the transfer as made available by the Controller's office, provided that the participating entity prepay the department for the additional administrative costs associated with the expedited processing.

(C) Total quarterly payment amounts shall be determined in accordance with estimates of the number of enrollees in each rate category, subject to annual reconciliation to final enrollment data.

(2) If a participating entity operates its LIHP through a contract with another entity, the participating entity may pay the operating entity based on the per enrollee rates established under Section 15910.3 on a quarterly basis in accordance with estimates of the number of enrollees in each rate category, subject to annual reconciliation to final enrollment data.

(A) (i) On a quarterly basis, the participating entity shall certify the expenditures made under this paragraph and submit the report of certified public expenditures to the department.

(ii) The department shall report the certified public expenditures of a participating entity under this paragraph on the next available quarterly report as necessary to obtain federal financial participation for the expenditures. The total amount of federal financial participation associated with the participating entity's expenditures under this paragraph shall be reimbursed to the participating entity.

(B) At the option of the participating entity, the LIHP may be reimbursed on a cost basis in accordance with the methodology applied to Health Care Coverage Initiative programs established under Part 3.5 (commencing with Section 15900) including interim quarterly payments.

(e) (1) Notwithstanding Section 15910.3 and subdivision (d) of this section, if the participating entity cannot reach an agreement with the department as to the appropriate rate to be paid under Section 15910.3, at the option of the participating entity, the LIHP shall be reimbursed on a cost basis in accordance with the methodology applied to Health Care Coverage Initiative programs established under Part 3.5 (commencing with Section 15900), including interim quarterly payments. If the participating entity and the department reach an agreement as to the appropriate rate, the rate shall be applied no earlier than the first day of the LIHP year in which the parties agree to the rate, except that for the LIHP year ending June 30, 2012, the rate may apply as early as July 1, 2011, without regard to the date of the agreement between the participating entity and the department.

(2) (A) The department finds and declares all of the following:

(i) The department, in consultation with a number of the LIHPs, has proposed LIHP capitation rates for federal approval.

(ii) There is some concern that federal approval of the proposed rates will not be received, and implementing contracts may not be signed, before June 30, 2012.

(iii) The amendments made to this subdivision by the act that added this clause would allow the federally approved capitation rates to apply to the LIHP year, which is July 1, 2011, to June 30, 2012, inclusive, even if federal approval and the necessary contract amendments are not finalized until after June 30, 2012.

(B) Therefore, it is the intent of the Legislature in amending this subdivision to allow the LIHP capitation rates to apply for the 2011-12 fiscal year even if final agreements on the capitation rates are delayed while awaiting

federal approval and are not finalized until after June 30, 2012.

(f) If authorized under the Special Terms and Conditions of the demonstration project, pending the department's development of rates in accordance with Section 15910.3, the department shall make interim quarterly payments to approved LIHPs for expenditures based on estimated costs submitted for rate setting.

(g) Participating entities that operate a LIHP directly or through contract with another entity shall be entitled to any federal financial participation available for administrative expenditures incurred in the operation of the Medi-Cal program or the demonstration project, including, but not limited to, outreach, screening and enrollment, program development, data collection, reporting and quality monitoring, and contract administration, but only to the extent that the expenditures are allowable under federal law and only to the extent the expenditures are not taken into account in the determination of the per enrollee rates under Section 15910.3.

(h) On and after January 1, 2014, the state shall implement comprehensive health care reform for the populations targeted by the LIHP in compliance with federal health care reform law, regulation, and policy, including the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and subsequent amendments.

(i) Subject to the Special Terms and Conditions of the demonstration project, a participating entity may elect to include, in collaboration with the department, as the nonfederal share of LIHP expenditures, voluntary intergovernmental transfers or certified public expenditures of another governmental entity, as long as the intergovernmental transfer or certified public expenditure is consistent with federal law.

(j) Participation in the LIHP under this part is voluntary on the part of the eligible entity for purposes of all applicable federal laws. As part of its voluntary participation under this article, the participating entity shall agree to reimburse the state for the nonfederal share of state staffing and administrative costs directly attributable to the cost of administering that LIHP, including, but not limited to, the state administrative costs related to certified public expenditures and intergovernmental transfers. This section shall be implemented only to the extent federal financial participation is not jeopardized.

**SEC. 118.** Section 15911.1 is added to the Welfare and Institutions Code, to read:

**15911.1.** Upon the order of the Director of Finance, the Controller shall draw warrants against General Fund cash to provide cashflow loans as follows:

(a) The Director of Finance may approve cashflow loans of no more than a total of one hundred million dollars ($100,000,000) in the 2012–13 and 2013–14 fiscal years for County Medical Services Program governing board expenses that are associated with a Low Income Health Program operated by the governing board pursuant to this part.

(b) The terms and conditions of any cashflow loan provided pursuant to this section shall be subject to approval by the Director of Finance. Interest shall be charged at the rate earned by moneys in the Pooled Money Investment Account.

(c) The Department of Finance shall notify the Legislature within 15 days of authorizing a cashflow loan pursuant to this section, unless prior notification of the cashflow loan was included when the Medi-Cal estimates were submitted pursuant to Section 14100.5.

(d) Any cashflow loans made pursuant to this section shall be short term and shall not constitute General Fund expenditures. These loans and the repayment of these loans shall not affect the General Fund reserve.

**SEC. 119.** Section 15912.1 is added to the Welfare and Institutions Code, to read:

**15912.1.** (a) The department, in collaboration with the State Department of Public Health, shall develop policies and guidance on the transition of persons diagnosed with HIV/AIDS from federal Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White Act) funded programs, pursuant to Section 131019 of the Health and Safety Code, to the Low Income Health Program (LIHP) pursuant to Part 3.6 (commencing with Section 15909). These policies and guidance shall be provided to local LIHPs, federal Ryan White Act providers, and to persons receiving services pursuant to the federal Ryan White Act, as applicable. Guidance shall include, but not be limited to, operational processes and procedures supporting the transition of persons receiving services

pursuant to the federal Ryan White Act in order to minimize disruption of access to and availability of care and services.

(b) The department, in collaboration with the State Department of Public Health, shall consult with stakeholders, including administrators, advocates, providers, and persons receiving services pursuant to the federal Ryan White Act, to obtain advice in forming the policy decisions regarding the transition of persons receiving services pursuant to the federal Ryan White Act to the local LIHPs.

**SEC. 120.** Section 15916 of the Welfare and Institutions Code is amended to read:

**15916.** (a) It is the intent of the Legislature that the State Department of Health Care Services and all other departments take all appropriate steps to fully maximize and claim all available expenditures for Designated State Health Programs listed in the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration under the safety net care pool (SNCP) for an applicable demonstration year.

(b) For the purposes of this section, the following definitions apply:

(1) "California's Bridge to Reform Section 1115(a) Demonstration" means the Section 1115(a) Medicaid demonstration project, No. 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services (CMS), effective for the period of November 1, 2010, through October 31, 2015.

(2) "Demonstration year" means a specific period of time during California's Bridge to Reform Section 1115(a) Wavier as identified in the Special Terms and Conditions. "Demonstration year" may be denominated in yearly increments, which correspond with the yearly increments identified in the Special Terms and Conditions.

(3) "Designated public hospital" has the meaning given in subdivision (d) of Section 14166.1.

(4) "Excess certified public expenditures" means the amount of allowable uncompensated care expenditures reported and certified for the applicable demonstration year under Section 14166.8 by designated public hospitals (DPHs), including the governmental entities with which they are affiliated, that is in excess of the amount necessary to draw the maximum amount of federal funding for DPHs for uncompensated care under the safety net care pool and for disproportionate share hospital payments without regard to subdivision (c) or to the amount authorized pursuant to paragraph (5).

(5) "Reserved SNCP funds for DSHP" means the amount of SNCP uncompensated care funds used to fund expenditures for the Designated State Health Programs, as specified in the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration.

(6) "Redirected SNCP funds" means the amount of federal funding available for a specified demonstration year that would otherwise be restricted for expenditures associated with the Health Care Coverage Initiative (HCCI) program, for which there are insufficient HCCI expenditures to draw the federal funds and which CMS has authorized to be available for uncompensated care expenditures under the safety net care pool in either the demonstration year for which the funds were initially reserved or a subsequent demonstration year.

(7) "Safety net care pool" or "SNCP" means the federal funds available under the Medi-Cal Hospital/Uninsured Care Demonstration Project and the successor demonstration project, California's Bridge to Reform, to ensure continued government support for the provision of health care services to uninsured populations.

(c) Notwithstanding any other provision of law, the state shall annually seek authority from CMS under the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration to redirect to the uncompensated care category within the SNCP the portion of the restricted funds used to fund expenditures under the HCCI that will not be fully utilized by the end of the demonstration year for use in any demonstration year.

(d) Designated public hospitals may utilize the redirected SNCP funds described in subdivision (c) as follows:

(1) Designated public hospitals may opt to utilize excess certified public expenditures to claim the redirected SNCP funds.

(2) As a condition of exercising the option in paragraph (1), DPHs voluntarily agree that, up to the amount of redirected SNCP funds available, the excess certified public expenditures are to be allocated equally between the state and the DPHs, such that for every dollar of excess certified public expenditure used by the DPHs, the DPHs will voluntarily allow the state to use a corresponding excess certified public expenditure amount for claiming purposes.

(3) As a condition of receiving any of the funding in paragraph (2), DPHs voluntarily agree that, to the extent the state is unable to fully claim the maximum annual amount of reserved SNCP funds for DSHP, the excess certified public expenditures will be used to enable the state to receive total SNCP uncompensated care funds, in conjunction with its claims for expenditures for DSHP, to the maximum amount described in paragraph (5) of subdivision (b).

(e) Participation in the utilization of the excess certified public expenditures and redirected SNCP funds under this section is voluntary on the part of the DPHs for the purpose of all applicable federal laws.

(f) The department shall consult with DPH representatives regarding the availability of excess certified public expenditures, how to optimize the level of claimable federal Medicaid funding, and the appropriate allocation of SNCP funds under paragraphs (2) and (3) of subdivision (d). The department may make interim determinations and allocations of such SNCP funds, provided that the interim determinations and allocations take into account adjustments to reported expenditures for possible audit disallowances, consistent with the type of adjustments applied in prior projects years under Article 5.2 (commencing with Section 14166). Any interim determinations and allocations of redirected SNCP funds based on excess certified public expenditures shall be subject to interim and final reconciliations.

(g) Notwithstanding any other provision of law, upon the receipt of a notice of disallowance or deferral from the federal government related to any certified public expenditures for uncompensated care incurred by DPHs that are used for federal claiming under the SNCP pursuant to California's Bridge to Reform Section 1115(a) Demonstration after this section is implemented, and subject to the processes described in subdivisions (a) through (d) of Section 14166.24, the following shall apply with respect to the disallowance or deferral:

(1) The department and the DPH shall each be responsible for half of the repayment of the federal portion of any federal disallowance or deferral for the applicable demonstration year, up to the amount claimed and allocated pursuant to paragraph (2) of subdivision (d) for that particular year.

(2) If there are additional disallowances or deferrals beyond those described in paragraph (1), the department shall be solely responsible for the repayment of the federal portion of any federal disallowance or deferral for the applicable demonstration year, up to the amount claimed and allocated pursuant to paragraph (3) of subdivision (d) for that particular year.

(3) If there are additional disallowances or deferrals beyond those described in paragraphs (1) and (2) for the applicable demonstration year, the DPH shall be solely responsible for the repayment of the federal portion of all remaining federal disallowances or deferrals for that particular year.

(h) The department shall obtain federal approvals or waivers as necessary to implement this section and to obtain federal financial participation to the maximum extent permitted by federal law. This section shall be implemented only to the extent other federal financial participation is not jeopardized.

**SEC. 121.** Section 24000 of the Welfare and Institutions Code is amended to read:

**24000.** There is established in the State Department of Health Care Services the State-Only Family Planning Program to provide comprehensive clinical family planning services to low-income men and women. This division shall be known and may be cited as the State-Only Family Planning Program.

**SEC. 122.** Section 24001 of the Welfare and Institutions Code is amended to read:

**24001.** (a) (1) For purposes of this division, "family planning" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, natural family planning, abstinence methods and basic, limited fertility management. Family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Family planning shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, not including contraceptives, or pregnancy care that is not incident to the diagnosis of pregnancy.

(2) Family planning services for males shall be expanded to include laboratory tests for sexually transmitted

infections and comprehensive physical examinations. Within 60 days of approval of the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program, provided for pursuant to subdivision (aa) of Section 14132, the department shall seek to amend the waiver to add this expansion. The implementation of this paragraph shall be dependent upon federal approval and receipt of federal financial participation.

(b) For purposes of this division, "department" means the State Department of Health Care Services.

**SEC. 123.** (a) It is the intent of the Legislature that the State Department of Education and the State Department of Health Care Services modify or repeal regulations that are no longer supported by statute due to the amendments in Sections 1, 2, 32, 33, 33.5, and 34 of this act.

(b) The State Department of Education shall review regulations to ensure the appropriate implementation of educationally necessary occupational and physical therapy services required by the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and Sections 1, 2, 32, 33, 33.5, and 34 of this act.

(c) The State Department of Education may adopt regulations to implement Sections 1, 2, 32, 33, 33.5, and 34 of this act. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the State Department of Education is hereby exempted, for this purpose, from the requirements of subdivision (a) of Section 11346.1 of the Government Code. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 180-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to one year.

(d) Implementation of Sections 1, 2, 32, 33, 33.5, and 34 of this act shall occur no later than October 1, 2012.

(e) The State Department of Health Care Services shall report in the November 2012 and May 2013 Family Health Estimate on the status of the implementation of the provisions of Sections 1, 2, 32, 33, 33.5, and 34 of this act. The report shall include, but not be limited to, the following:

(1) The number of children enrolled in the California Children's Services by county known to the county California Children's Services Programs to be receiving physical and occupational therapy services from the California Children's Services Medical Therapy Program assessed and determined to be educationally necessary by the individualized education program team and included in a child's individualized education program.

(2) The estimated California Children's Services Program savings from implementation of Sections 1, 2, 32, 33, 33.5, and 34 of this act.

(3) An update on the implementation of Sections 1, 2, 32, 33, 33.5, and 34 of this act, including a description of implementation successes and challenges.

(f) The State Department of Education and the State Department of Health Care Services shall work together to collect the relevant data necessary for the report described in subdivision (e).

**SEC. 124.** By no later than January 1, 2013, the Department of Managed Health Care shall provide the fiscal and appropriate policy committees of the Legislature with its final report on surveys conducted under the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and the department's contractual requirements, for the dental plans participating in the Sacramento Geographic Managed Care Program.

**SEC. 125.** Given the uncertainty within which persons diagnosed with HIV/AIDS from federal Ryan White HIV/AIDS Treatment Extension Act of 2009 funded programs may transition to the Low Income Health Program pursuant to Part 3.6 (commencing with Section 15909) of the Welfare and Institutions Code, the State Department of Public Health shall report to the Joint Legislative Budget Committee by October 1, 2012, on whether any of the projections or assumptions used to develop the AIDS Drug Assistance Program (ADAP) estimated budget for the Budget Act of 2012 may result in an inability of ADAP to provide services to eligible ADAP clients. If this occurs before October 1, 2012, and ADAP is unable to provide services to eligible ADAP clients, the State Department of Public Health shall provide notification to the Joint Legislative Budget Committee within 15 calendar days of this determination.

**SEC. 126.** Notwithstanding the amendments made in Sections 18 to 25, inclusive, and Sections 35, 116, 121, and 122 of this act, if this act becomes effective before July 1, 2012, it is the intent of the Legislature that the transfer of duties, powers, functions, responsibilities, and jurisdiction described in those sections from the State Department of Public Health to the State Department of Health Care Services shall occur in accordance with

Sections 131051, 131052, and 131055.1 of the Health and Safety Code, as amended or added by this act.

**SEC. 127.** The Legislature finds and declares that Sections 55 to 63, inclusive, 66 to 68, inclusive, and 70 and 71 of this act clarify procedures and terms of the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.

**SEC. 128.** The Legislature finds and declares that, for the purposes of Sections 78 and 111 of this act, a special law is necessary and that a general law cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because the counties listed in subdivision (a) of Section 14087.98 of the Welfare and Institutions Code, as added by this act, are Medi-Cal fee-for-service counties and this act would provide expansion of Medi-Cal managed care to these counties.

**SEC. 129.** The Legislature finds and declares that, for the purposes of Sections 79, 80, 112, 114, 115, and 124 of this act, a special law is necessary and that a general law cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because the Counties of Los Angeles and Sacramento are the only counties that have Medi-Cal dental managed care arrangements and the County of Sacramento is the only county with mandatory dental managed care enrollment.

**SEC. 130.** Section 33.5 of this bill incorporates amendments to Section 123870 of the Health and Safety Code proposed by this bill and Assembly Bill 1494 and Senate Bill 1034. It shall only become operative if (1) either Assembly Bill 1494 or Senate Bill 1034 and this bill are enacted and become effective on or before January 1, 2013, (2) each bill amends Section 123870 of the Health and Safety Code, and (3) this bill is enacted after either Assembly Bill 1494 or Senate Bill 1034, in which case Section 33 of this bill shall not become operative.

**SEC. 131.** This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.