CONTRA COSTA
MENTAL HEALTH COMMISSION

CONTRA COSTA
MENTAL HEALTH
COMMISSION
1220 Morello Ave., Suite 100
Martinez, CA 94553
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cchealth.org/mentalhealth/mhc

Mental Health Commission (MHC)
Wednesday, February 5th, 2020 ◊ 4:30pm-6:30pm
At: 550 Ellinwood Way, Pleasant Hill, CA

I. **Call to Order/Introductions**

II. **Public Comments**

III. **Commissioner Comments**

IV. **Chair Comments/Announcements**

V. **APPROVE January 8, 2020 Meeting Minutes**

VI. **DISCUSS Behavior Health Services Director's Report with Dr. Suzanne Tavano**

VII. **RECEIVE an update on PES regarding:**
a. Progress on BHS and CCRMC leadership efforts to respond to Grand Jury Report 1909 by Dr. Suzanne Tavano, Behavioral Health Services Director;
b. Progress on the PES Community Report, Barbara Serwin

VIII. **CONSIDER two motions:**
a. To advocate against the possible use/diversion of MHSA money by State Government to help to resolve the problem of homelessness, Douglas Dunn;
b. To support for IMD (Institute of Mental Diseases) Medi-Cal Reimbursement Demonstration Waiver and Permanent Repeal of IMD, Douglas Dunn

IX. **DISCUSS a proposal to jointly host a Commission/Board meeting(s) with other county Commissions or Boards that have intersecting concerns with mental illness, Supervisor Diane Burgis**

X. **VOTE on two Committees motions:**
a. The Executive Committee will track and monitor progress of data collection for Director's Report on a quarterly basis (motion recommended by Data Committee);
b. The Commission will recommend to the Board of Supervisors to allow qualified members of the same household to serve on the Mental Health Commission

XI. **DISCUSS general Commission goals for 2020**

XII. **Adjourn**

A REPORT BY
THE 2018-2019 CONTRA COSTA COUNTY GRAND JURY
725 Court Street
Martinez, California 94553

Report 1909

Contra Costa County Psychiatric Emergency Services

Improving Care for Children and Adolescents

APPROVED BY THE GRAND JURY

Date MAY 22, 2019

RICHARD S. NAKANO
GRAND JURY FOREPERSON

ACCEPTED FOR FILING

Date MAY 24 2019

ANITA SANTOS
JUDGE OF THE SUPERIOR COURT

Contact: Richard S. Nakano
Foreperson
925-522-6941

Contra Costa County Grand Jury Report 1909

Contra Costa County Psychiatric Emergency Services

Improving Care for Children and Adolescents

TO: Contra Costa County Board of Supervisors
Contra Costa Health Services

SUMMARY

How does the Contra Costa Regional Medical Center's Psychiatric Emergency Services (PES) meet the mental health needs of children and adolescents in Contra Costa County? The PES unit provided care for over 10,000 patients from October 2017 through September 2018. More than 1,600 were children (ages 7 through 12 years) and adolescents (ages 13 through 17 years).

The Grand Jury wanted to understand how PES cares for children and adolescents once they arrive at the Medical Center for psychiatric care. Because this is a Contra Costa County (the County) facility, many do not have health insurance and are brought to PES by family, police, or social worker. The Jury determined that while PES provides the needed mental health services, it lacks suitable facilities necessary to provide psychiatric emergency care for children and adolescents. The PES facility does not separate children and adolescents from adult patients at its entrance, waiting room, triage, or treatment area. They are exposed to adults needing psychiatric help, which PES staff states could cause additional trauma to the children and adolescents. Staff also indicated the crowded conditions at PES may compromise patients' privacy as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The County does not operate a facility for children and adolescents in need of long-term psychiatric care. While waiting for long-term placement, children and adolescents are held in the PES unit until a place is found for them, often outside the County.

The Grand Jury recommends that the County Board of Supervisors (the Board) consider directing Contra Costa Health Services to perform a needs assessment focused on PES services for children and adolescents. In conducting a needs

assessment, the County should consider including a plan to segregate children and adolescents from adult patients in PES. It should also consider identifying space within the Contra Costa County Medical Center (Medical Center) for children and adolescents who are awaiting long-term placement. In addition, the Board should consider locating a long-term-care facility within the County or collaborating with neighboring counties on a regional solution.

METHODOLOGY

In the course of its investigation, the Grand Jury:

- Reviewed Psychiatric Emergency Services Policies and Procedures
- Interviewed mental health professionals, individuals associated with PES, and individuals engaged in providing mental health services in the County
- Toured the PES facility and other areas of the Contra Costa Regional Medical Center
- Reviewed information regarding the number of patients served, reasons for presentation at PES, average patients served per month, and number of staff in PES
- Reviewed Contra Costa County Mental Health Commission meeting minutes
- Reviewed the 2016 Contra Costa County Mental Health Commission White Paper and updates in 2017 and 2018

BACKGROUND

Contra Costa Health Services

The mission of Contra Costa Health Services (Health Services) is to care for and improve the health of all people in the County, with special attention to those who are most vulnerable to health problems. Health Services is organized into eight divisions. Two of the divisions are Behavioral Health Services and the Contra Costa Regional Medical Center, located in Martinez. These two divisions collaborate on mental health care, with the Medical Center's PES unit providing emergency mental health services. The Grand Jury focused on PES in its investigation.

Medical Center Psychiatric Emergency Services

PES provides emergency mental health services for adults and children and adolescents who rely on the County for their mental health care. PES contains 14 beds for adults and four beds for children and adolescents. The Medical Center maintains an inpatient unit providing long-term psychiatric care for persons the age of 18 and over.

However, there is no such inpatient unit in the Medical Center, or other County-operated facilities, for seriously mentally ill children and adolescents in need of hospitalization. Children and adolescents needing hospitalization must stay in the PES unit until they are placed in a facility that provides long-term care.

PES is designated by the County as the receiving center for patients undergoing involuntary holds of up to 72 hours. Involuntary holds are required by Section 5150 of the state Welfare and Institutions Code when patients, including children and adolescents, are a danger to themselves or others.

From October 2017 through September 2018, the PES unit served 10,171 patients. Of these patients, 1,609 were children and adolescents: an average of five per day. Forty-nine children and adolescents were psychiatric holds under Section 5150. An additional 943 were at PES because they were either suicidal, had attempted suicide, or had exhibited suicidal thoughts (ideation). See graph in the following section.

On average, the PES day and evening shifts consist of eight nursing staff, four social workers and two psychiatrists. The night shift consists of eight nursing staff, two social workers and one psychiatrist.

Mental Health Commission White Paper

The Contra Costa County Mental Health Commission (the Commission) is an advisory body of citizens appointed by the Board to serve as the watchdog group for mental health services provided by the County. In April 2016, the Commission submitted a White Paper to the Board regarding what it called, “a crisis in the county public mental health care system and budgetary issues contributing to the crisis.” The White Paper was followed by updates in October 2017 and September 2018.

In addition to the Grand Jury’s independent findings, the White Paper and the updates also recommended changes in PES to improve treatment space for children and adolescents. The Grand Jury did not find any evidence that the Commission’s recommendations had been implemented.

DISCUSSION

Children and Adolescent Patients Presenting to PES

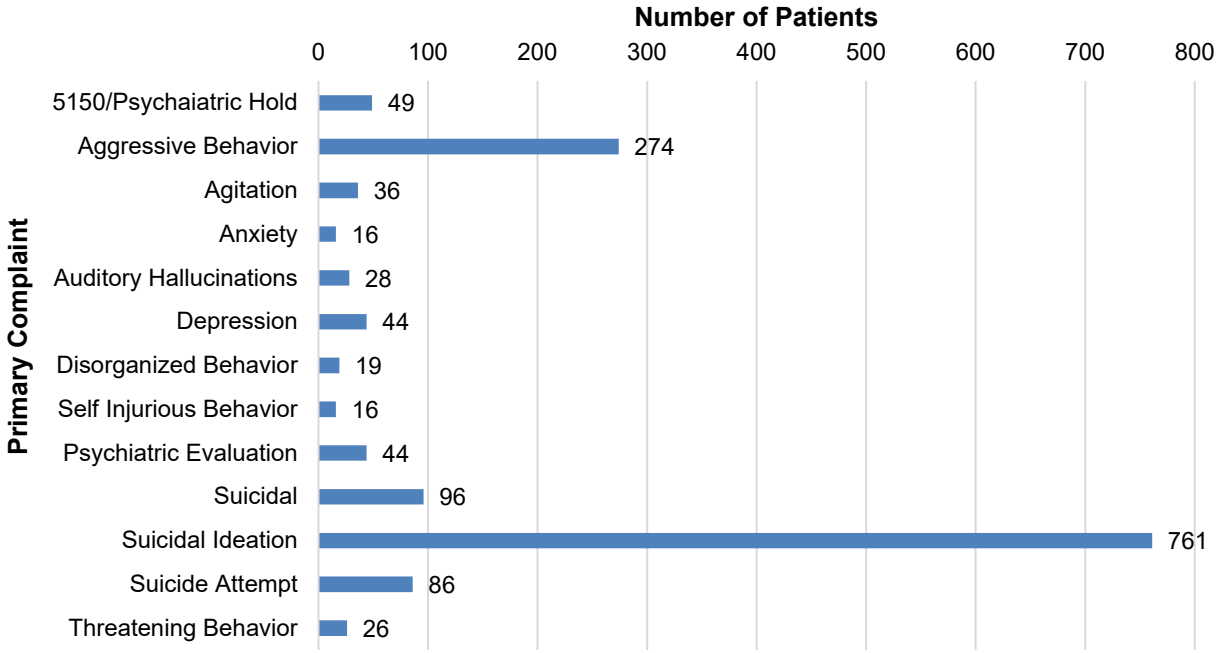
From October 2017 through September 2018, PES saw an average of 848 patients per month. On average, 134 of these were children and adolescents. The facility has four beds for children and adolescents and 14 beds for adults. When children and adolescents in PES exceed the number of beds, they are provided with floor mats until beds become available.

Adults requiring longer-term care are admitted to a separate unit within the Medical

Center which has 23 inpatient beds. The Medical Center does not have a similar long-term-care unit for children and adolescents. These patients must stay in the four-bed PES unit until beds are located in other facilities, many times outside of the County.

The following graph shows the most significant complaints of children and adolescents presenting to PES:

Children and Adolescent PES Patient Primary Complaints
October 2017 through September 2018
(*Source: PES*)



The PES Experience for Children and Adolescents

The PES facility has no separate entrance, waiting room, triage, treatment area, or exit for children and adolescents. They stay in a small section of the PES unit with two designated rooms, one for children (ages 7 through 12 years) and one for adolescents (ages 13 through 17 years). Upon arrival at PES, and when they leave, children and adolescents must pass through the adult area to reach the assessment rooms. Distressed children and adolescents are exposed to adult patients needing psychiatric help. PES staff states this could cause additional trauma to the children and adolescents.

The Grand Jury determined in its investigation, and as noted in the updates to the

Commission's White Paper, there has been no progress made in implementing a new design of PES facilities for children and adolescents.

The Grand Jury observed there is a vacant wing (4D) on the fourth floor of the Medical Center. This space may be an option to serve as a temporary holding unit for children and adolescents awaiting placement in long-term care.

Long-term Care Placement

The PES facility has four beds to accommodate children and adolescents. After patients are assessed and a decision is made that they need inpatient admission, staff must find an appropriate place for them in a long-term-care facility. Inpatient beds are in such high demand that children and adolescents are held in PES an average of four to five days until space is found for them in a long-term-care facility. The facility can be as far away as Sacramento and Fresno.

According to mental health professionals interviewed by the Grand Jury, placing these children and adolescents outside the County can impact their treatment and recovery. These professionals also indicated that children and adolescents need to stay connected with their families.

The Grand Jury recommends that the Board of Supervisors consider directing Health Services to address two issues:

1. The need for improved space for children and adolescents in PES
2. The need for a children and adolescents treatment center in the County, or a regional approach to long-term care in collaboration with neighboring counties.

Additional Concerns

The Grand Jury has other concerns based on our investigation:

- The PES facility is configured so there is a lack of privacy for patients. This could result in HIPAA violations.
- John Muir Health Concord Medical Center is designated by the County as a 5150 receiving center. However, there is no formal contract between it and the County to accept 5150 cases.

FINDINGS

F1. At peak times the PES facility, with four beds and two treatment rooms, is not sufficient to handle its volume of children and adolescent patients.

F2. Children and adolescents could remain in PES four to five days while they wait for long-term placement.

F3. The PES facility is configured so that children and adolescents seeking treatment must pass through the adult patient area.

F4. Contra Costa County does not operate a long-term-care facility for children and adolescents. They are often placed in long-term-care facilities outside the County.

F5. Although the County has authorized John Muir Health Concord Medical Center to accept 5150 patients, there is no formal contract to do so.

F6. The Medical Center's 4D wing is vacant with no plans for its utilization.

F7. The Contra Costa County Mental Health Commission recommended changes in PES to improve treatment space for children and adolescents. The Grand Jury did not find any evidence that the Commission's recommendations had been implemented.

RECOMMENDATIONS

R1. The Board of Supervisors should consider directing Contra Costa Health Services to perform a comprehensive needs assessment that would include a redesign of the PES facility that would separate children and adolescents from adult patients by June 30, 2020.

R2. The Board of Supervisors should consider directing Contra Costa Health Services to investigate the use of the Medical Center's vacant wing (4D) as a temporary holding area for children and adolescents waiting for long-term placement in other facilities by December 31, 2019.

R3. The Board of Supervisors should consider directing Contra Costa Health Services to develop a plan to operate a treatment center for children and adolescents who need long-term psychiatric care by June 30, 2020. The treatment center could either be within the County or in collaboration with neighboring counties.

R4. The Board of Supervisors should consider directing Contra Costa Health Services to explore entering into a contract with John Muir Health Concord Medical Center to accept and treat 5150 patients presently only served by the County by June 30, 2020.

REQUIRED RESPONSES

	Findings	Recommendations
Contra Costa County Board of Supervisors	F1, F2, F3, F4, F5, F6, and F7	R1, R2, R3, and R4
Contra Costa Health Services	F1, F2, F3, F4, F5, F6, and F7	

These responses must be provided in the format and by the date set forth in the cover letter that accompanies this report. An electronic copy of these responses in the form of a Word document should be sent by e-mail to ctadmin@contracosta.courts.ca.gov and a hard (paper) copy should be sent to:

Civil Grand Jury – Foreperson
725 Court Street
P.O. Box 431
Martinez, CA 94553-0091

Contra Costa County

To: Board of Supervisors

From: David Twa, County Administrator

Date: August 6, 2019

Subject: RESPONSE TO CIVIL GRAND JURY REPORT NO. 1909, ENTITLED "CONTRA COSTA COUNTY PSYCHIATRIC EMERGENCY SERVICES"

RECOMMENDATION(S):

ADOPT report as the Board of Supervisors' response to Civil Grand Jury Report No. 1909, entitled "Contra Costa County Psychiatric Emergency Services", and DIRECT the Clerk of the Board to transmit the Board's response to the Superior Court no later than August 22, 2019.

FISCAL IMPACT:

There is no fiscal impact.

BACKGROUND:

The 2018/19 Civil Grand Jury filed the above-referenced report, attached, on May 22, 2019, which was reviewed by the Board of Supervisors and subsequently referred to the County Librarian and County Administrator, who prepared the attached response that clearly specifies:

1. Whether the finding or recommendation is accepted or will be implemented;
2. If a recommendation is accepted, a statement as to who will be responsible for implementation and a definite target date;
3. A delineation of the constraints if a recommendation is accepted but cannot be implemented within a six-month period; and
4. The reason for not accepting or adopting a finding or recommendation.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **08/06/2019** ☑ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYE: John Gioia, District I Supervisor
Candace Andersen, District II Supervisor
Diane Burgis, District III Supervisor
Karen Mitchoff, District IV Supervisor
Federal D. Glover, District V Supervisor

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: August 6, 2019

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: Stephanie Mello, Deputy

Contact: Julia Taylor, 925.335.1043

cc:

BACKGROUND: (CONT'D)

CONSEQUENCE OF NEGATIVE ACTION:

In order to comply with California Penal Code, the Board of Supervisors must forward its response to the Superior Court no later than August 22, 2019 (90 days from receipt).

ATTACHMENTS

Civil Grand Jury Report No. 1909

BOS Response to Grand Jury Report 1909

CONTRA COSTA COUNTY CIVIL GRAND JURY REPORT NO. 1909
"Contra Costa County Psychiatric Emergency Services – Improving Care for Children and Adolescents"

BOARD OF SUPERVISORS' AND HEALTH SERVICE DEPARTMENT RESPONSE

FINDINGS – *California Penal Code Section 933.5(a) requires a response to the designated findings of the Grand Jury.*

F1. At peak times, the Psychiatric Emergency Services (PES) facility, with four beds and two treatment rooms, is not sufficient to handle its volume of children and adolescent patients.

Response: Respondent partially disagrees with this finding.

There are four beds and an additional three treatment rooms available to serve up to 7 youth at any one time. Census data shows that in 2018 there were more than four youth being treated simultaneously at PES 10.7% of the time, but additional rooms designated for family visitation provide increased capacity as needed. Additionally, utilization of PES by youth varies by month with highest census from September through December and prior to the end of the school year. Intervening months and the summer have lower census and shorter lengths of stay.

F2. Children and adolescents could remain in PES four to five days while they wait for long-term placement.

Response: Respondent partially disagrees with this finding.

In 2018, the average length of stay for youth in PES was 11.9 hours with a median length of stay of 11.1 hours. In total, eighteen out of 1,601youth spent more than 72 hours in PES in 2018. The majority of these individuals were not in need of acute hospitalization; rather, they needed other types of placements associated with developmental disabilities (Regional Center) or Child and Family Services. Additionally, 30% to 40% of the youth served in PES have commercial insurance (predominately Kaiser) which requires collaboration and coordination with entities external to the county for discharge planning. While PES is designed to provide crisis stabilization services for up to 24 hours, it occasionally exceeds this time standard in effort to support youth awaiting placement.

F3. The PES facility is configured so that children and adolescents seeking treatment must pass through the adult patient area.

Response: Respondent agrees with this finding.

F4. Contra Costa County does not operate a long-term-care facility for children and adolescents. They are often placed in in long-term-care facilities outside the county.

Response: Respondent partially disagrees with this finding.

Contra Costa contracts with Youth Homes, Inc. to provide long term intensive mental health treatment within the county. These residential programs serve up to 24 youth in a very structured therapeutic residential setting which are an alternative to institutional care. It should be noted that this facility funded by the county is to serve Medi-Cal and low-income uninsured youth, the County's mandated target population. The county recognizes the need for additional capacity of this type of long-term mental health residential program and is conducting a needs assessment to determine if an additional facility is needed within Contra Costa County or additional capacity might best be provided at existing facilities in the Bay Area. Commercial insurers generally do not include this level of care as a covered benefit, so their beneficiaries do not have access to this same type of longer-term residential programs. Consequently, youth with commercial insurance might remain longer in PES while further stabilizing or waiting for authorization and availability of a covered service.

F5. Although the County has authorized John Muir Health Concord Medical Center to accept 5150 patients, there is no formal contract to do so.

Response: Respondent disagrees with this finding.

Contra Costa has contracted with John Muir Behavioral Health Center for approximately 20 years to provide inpatient psychiatric services to youth detained on involuntary psychiatric holds (5150 Welfare and Institutions Code). Contract No. 24-794-8 with John Muir had a payment limit of $3,270,781 for the term July 1, 2018 through June 30, 2019. The most recent amendment for this contract was approved by the Board of Supervisors on June 18, 2019.

F6. The Medical Center's 4D wing is vacant with no plans for its utilization.

Response: Respondent agrees with this finding.

F7. The Contra Costa Mental Health Commission recommended changes to PES to improve treatment space for children and adolescents. The grand Jury did not find any evidence that the Commission's recommendations had been implemented.

Response: Respondent agrees with this finding.

The Mental Health Commission report titled "Mental Health System and Budget Crisis in Contra Costa County, FY16/17" was issued in April, 2016 and later updated in 2017 and 2018. It referenced the negative impact of insufficient availability of outpatient, inpatient and residential services on PES, but did not include specific recommendations to improve treatment space for youth within PES.

However, the County's Behavioral Health Division issued a response report titled "Update on the Grand Jury Report No. 1703 and Referrals 115 & 116 – MHC's White Paper and BH Division White Paper Clarifications," in 2018. Behavioral Health stated that "a separate space for children to enter, exit and reside while present in PES is a priority." It also stated "A re-model is needed for separate entry of

patients arriving via ambulance, voluntary walk-up clients, and children…". Therefore, the Department agrees these are priorities, but are under consideration at this time and have not yet been implemented.

RECOMMENDATIONS - *California Penal Code Section 933.05(b) requires a response to the designated recommendations of the Grand Jury.*

R1. The Board of Supervisors should consider directing Contra Costa Health Services to perform a comprehensive needs assessment that would include a redesign of the PES facility that would separate children and adolescents from adult patients by June 30, 2020.

Response: The recommendation has not yet been implemented, but will be implemented by June, 30, 2020.

R2. The Board of Supervisors should consider directing Contra Costa Health Services to investigate the use of the Medical Center's vacant wing (4D) as a temporary holding area for children and adolescents waiting for long-term placement in other facilities by December 31, 2019.

Response: The recommendation will not be implemented due to regulatory restrictions.

4D cannot serve as an auxiliary crisis stabilization/psychiatric emergency unit due to strict requirements and limitations on this level of care and where it can be located. 4D, if operated as an acute inpatient unit, could not detain youth while waiting for long term placement unless strict medical necessity criteria for acute inpatient care are met. 4D cannot serve as a holding area for either level of care.

R3. The Board of Supervisors should consider directing Contra Costa Health Services to develop a plan to operate a treatment center for children and adolescents who need long-term psychiatric care by June 30, 2020. The treatment center could either be within the County or in collaboration with neighboring counties.

Response: This recommendation has been implemented.

As pointed out in F4, County acknowledges the need for additional treatment capacity and will continue to further analyze this.

R4. The Board of Supervisors should consider directing Contra Costa Health Services to explore entering into a contract with John Muir Health Concord Medical Center to accept and treat 5150 patients presently only served by the County by June 30, 2020.

Response: This recommendation has been implemented.

Feb. 6, 2020 Mental Health Commission—Institute of Mental Diseases (IMD) Medi-Cal Reimbursement Exclusion Waiver and Repeal

Discussion and Motion: Support for IMD Medi-Cal Reimbursement Exclusion Demonstration Waiver and Permanent Repeal of IMD Medi-Cal Reimbursement Exclusion

Motion Part 1: Let the Board of Supervisors and the Behavioral Health Director know we support:

A. The California Department of Health Care Services (DHCS) filing for the up to 30 Day Institute of Mental Diseases (IMD) Medi-Cal Reimbursement Exclusion Waiver since the California Assn. of Counties (CSAC) and the County Behavioral Health Directors Assn. (CBHDA) of California have already publicly done so (see attached letters).
B. Permanent Repeal of the Institute of Mental Diseases (IMD) Medi-Cal Reimbursement Exclusion as requested by the National Assn. of Attorney's General (NAAG) letter to federal congressional leadership (see attached).

Motion Part 2: Ask the Board of Supervisors and the Behavioral Health Director to request that their respective state associations, the California Association of Counties (CSAC) and the County Behavioral Health Director's Assn. (CBHDA) of California continue to actively influence the California Department of Health Care Services (DHCS) to file for the up to 30 Day Institute of Mental Diseases (IMD) Medi-Cal Reimbursement Exclusion Waiver when it reapplies for the Section 1115 Waiver in the fall of this year.

Motion Part 3: Ask the Board of Supervisors and the Behavioral Health Director to request that their respective state associations, the California Association of Counties (CSAC) and the County Behavioral Health Director's Assn. (CBHDA) of California actively support permanent Repeal of the Institute of Mental Diseases (IMD) Medi-Cal Reimbursement Exclusion.

Brief background

IMD Medicaid Reimbursement exclusion included in original Medicare and Medicaid Act of 1965. Federal govt. did not want to pay for persons then consigned to state hospitals (approx...500,000). Legacy of subsequent emptying of state hospitals has changed everything. Approx. 500,000 seriously mentally ill persons now in jail, 35,000 seriously mentally ill persons now in longer-term treatment facilities, 14/1 prison/longer-term treatment facility ratio.

Contra Costa Behavioral Health Financial Impact w/o IMD Waiver

Per Behavioral Health Director's Jan., 2020 presentation, $225M Behavioral Health budget currently "in balance." However:

- Children & Adolescent Budget under by $13M ($56.8M vs. $69.1M because of slow start-up of several new major programs.
- Adult Locked Facilities Budget over by $8M ($54.1M vs. $46.9M) because of explosion in Incompetent to Stand Trial (IST) criminal cases as well as lack of available State Hospital and other IMD facilities beds, and $1,500+/day cost of non-county hospital in-patient psychiatric beds.

Contra Costa Behavioral Health Financial Impact w/ IMD up to 30 days Waiver

- Additional $1.5-$2M. Behavioral Health Director confident of showing overall cost neutrality.

Contra Costa Behavioral Health Financial Impact w/permanent IMD Medi-Cal Reimbursement Exclusion Repeal

- Up to over $25M/yr. freeing up of current existing State Realignment costs for use in other behavioral health areas. Current Realignment funds—Approx. $57M, all "spoken for." $12M-$15M+ for LPS Conserv. (120-150) and State Hospital (20) beds. ?$ in-patient beds?

NAMI California Response To Governor Newsom's 2020-2021 Budget

Governor Gavin Newsom has released his most ambitious budget (http://www.ebudget.ca.gov/budget/2020-21/#/Home) to date, showing that he and his Administration aim to make sweeping improvements to behavioral health across the state.

"We are happy to see a solid priority on mental health that focuses on a multi-pronged approach to solving a complex issue," says CEO Jessica Cruz. "It is clear the Governor and his Administration are prioritizing mental health, from plans to establish a new 'Behavioral Health Task Force' and improve the enforcement of behavioral health parity laws, to investing in state hospitals and establishing a new 'Healthcare Rights and Access Section' at the California Department of Justice."

Several new behavioral health initiatives outlined in the budget include:

- Establishing a new "Behavioral Health Task Force" at the California Health and Human Services Agency
- Establishing a new "Behavioral Health Quality Improvement Program"
- Strengthening and updating the California Department of Managed Health Care enforcement of behavioral health parity laws
- Establishing a new "Healthcare Rights and Access Section" at the California Department of Justice

- Proposing reforms to the Mental Health Services Act (MHSA) to address spending for substance use disorder treatment, people with mental illness who are also experiencing homelessness or are involved in the criminal justice, and early intervention for youth

Also in the works, investments are being made available for:

- State mental health hospitals
- The Medi-Cal "Healthier California for All" Initiative [formerly named the California Advancing and Innovating Medi-Cal initiative (CalAIM)
- New "Access to Housing and Services Fund" to tackle homelessness
- State prison supports for behavioral health
- Early childhood, student well-being, and addressing adverse childhood experiences
- Making health care more affordable
- Increases to the In-Home Supportive Services (IHSS) Program for aged, blind, and disabled individuals to remain safely in their homes rather than institutions
- Nursing home reimbursement reform
- Small increases to Supplemental Security Income (SSI)/State Supplementary Payment (SSP) benefits
- Addressing individuals with both behavioral health and developmental disability needs
- New State Department of Youth and Community Restoration

We are looking forward to continuing to advocate for the family and individual's voice in the development and implementation of these policies. We will work with the legislature, department of finance and state departments, including the Governor's office, on being a part of the solution that is best for families across California.

NAMI CALIFORNIA BUDGET REVIEW

Our more comprehensive summary of the budget is below.

The Big Picture

The Governor's Budget describes California's economy as the strongest in the nation, which has contributed to fueling the nation's economy. Despite the strong economy, low unemployment rate (3.9%) and healthy projected reserves ($18 billion in the Rainy Day Fund in 2020-21), Governor Newsom wants to ensure the state can weather a recession. In the immediate future, the Budget projects state revenue growth will slow over the next four years.

Behavioral Health is Prioritized in New Initiatives

Governor Newsom and his Administration aim to improve behavioral health in California through varying complimentary approaches. The Governor's Budget proposes the following ***new*** behavioral health initiatives:

- Establish a new "Behavioral Health Task Force" at the California Health and Human Services Agency comprised of state agencies, counties, consumers, health plans, providers, and other stakeholders. According to the Governor's Budget, the task force will "review existing policies and programs to improve the quality of care, and coordinate system transformation efforts to better prevent and respond to the impacts of mental illness and substance use disorders in California's communities."
- Establish a new "Behavioral Health Quality Improvement Program" with $45.1 million General Fund in FY 2020-21 and $42 million General Fund in FY 2021-22. This would fund county-operated community mental health and substance use disorder systems to "incentivize system changes and process improvements that will help counties prepare for opportunities through the Medi-Cal Healthier California for All initiative. Improvements include enhanced data-sharing capability for care coordination and establishing the foundational elements of value-based payment such as data collection, performance measurement, and reporting. These core investments build off the $70 million in the 2019 Budget Act to provide value-based provider payments for services and projects focused on behavioral health integration.
- Strengthen and update the California Department of Managed Health Care enforcement of behavioral health parity laws by working with health plans, providers, patient representatives, and others to address timely access to

treatment, network adequacy, benefit design, and plan policies. The May Revise will include updates to this proposal.

- Establish a new "Healthcare Rights and Access Section" at the California Department of Justice to consolidate and centralize and managing the increasing volume of healthcare litigation regarding the opioid crisis, drug price-fixing, antitrust cases, and defenses of the Affordable Care Act.
- Propose reforms to the Mental Health Services Act (MHSA) to address spending for substance use disorder treatment, people with mental illness who are also experiencing homelessness or are involved in the criminal justice, and early intervention for youth. The Budget reports that counties currently have slightly more than $500 million in local MHSA reserves, of which $161 million must be shifted to prevention and community services and supports by June 30, 2020. The May Revise will include a proposal for proposed reforms.

The Medi-Cal "Healthier California for All" Initiative

The Governor's Budget provides new information and announcements about the "Medi-Cal Healthier California for All" initiative (formerly CalAIM, the California Advancing and Innovating Medi-Cal initiative). The Medi-Cal Healthier California for All initiative is intended to improve Medi-Cal beneficiaries' clinical outcomes, assist beneficiaries with navigating the complex health system, and better coordinate between and integrate delivery systems. The initiative also builds upon recent Medi-Cal demonstration programs, including Whole Person Care pilots, the Coordinated Care Initiative, the Health Homes program, and public hospital system delivery transformation.

To implement the Medi-Cal Healthier California for All initiative starting January 1, 2021, the Budget provides $348 million General Fund. The investment would grow to $695 million in FYs 2021-22 and 2022-23. These funds would be used for enhanced care management, in lieu of services, necessary infrastructure to expand whole person care approaches statewide, and to build upon various dental initiatives. Beginning in FY 2023-24, the Administration projects ongoing annual costs of $395 million. For additional information, please see my November 6, 2019 memo describing CalAIM components pertaining to behavioral health.

State Mental Health Hospitals

The Department of State Hospitals (DSH) are proposed to receive $2 billion in 2020-21 and the patient population is expected to reach 6,761 by the end of 2020-21. Select state hospital investments of interest proposed in the Budget include:

- Establish a Community Care Collaborative Pilot Program to address the growing number of incompetent to stand trial (IST) commitments awaiting admission to the state hospital system. The number of ISTs with felony criminal charges awaiting state hospital admission was approximately 800 individuals in December 2019. The pilot program would receive $24.6 million General Fund in FY 2020-21 for a six-year pilot to incentivize three counties to treat and serve individuals deemed IST in the community. Over six years, the cost of the pilot program is estimated to be $364.2 million General Fund;
- Expand the existing Jail-Based Competency Treatment program to eight additional counties with $8.9 million General Fund in 2020-21 and $11.2 million General Fund annually thereafter; and
- Improve clinical care through $32 million General Fund and 80 positions for the first year of a five-year effort to standardize clinician-to-patient ratios, improve patient outcomes, shorten lengths of stay, reduce patient violence and staff injuries, implement trauma-informed care, and develop of a comprehensive discharge planning program.

New "Access to Housing and Services Fund" to Tackle Homelessness

According to the Budget, the Administration proposes a "radical shift in the state's involvement to augment local governments' efforts to shelter the many unsheltered persons living in California, by

launching a new state fund for developing additional affordable housing units, supplementing and augmenting rental and operating subsidies, and stabilizing board and care homes.

The Budget would establish a new "Access to Housing and Services Fund" (administered by the California Department of Social Services) with $750 million General Fund to move individuals and families into stable housing, and to increase

the number of units available as a stable housing option for individuals and families who are homeless or at risk of becoming homeless. The funds would be provided under contract with regional administrators and would be used to:

- Provide short- and long-term rental subsidies;
- Make small and medium-sized contributions to encourage development of new units in exchange for a rental credit;
- Stabilize board and care facilities by funding capital projects and/or operating subsidies;
- Engage with landlords to secure units and negotiate individual client leases;
- Provide tenancy support services;
- Coordinate case management with counties for those receiving rental subsidies to ensure they are enrolled in eligible public assistance programs; and
- Enable regional partners to pool federal, state, local, and private funds to stabilize the housing circumstances of the state's most vulnerable populations.

State Prison Supports for Behavioral Health

The Budget provides resource to the California Department of Corrections and Rehabilitation (CDCR) for a variety of efforts to address behavioral health needs of individuals in its care. The average daily adult inmate population is now projected to be 124,655 in 2019-20, and an average daily adult parolee population of 50,442. Budget proposals of interest include:

- Expand telepsychiatry to increase inmate access to mental health care services ($5.9 million);
- Expand inmate visitation at nine CDCR institutions to establish and maintain a continuum of social support, including parent-child relationships, which are critical for successful reentry ($4.6 million General Fund);
- Retrofit 64 cells for inmates entering segregated housing at institutions around the state to prevent suicide ($3.8 million);
- Maintain mental health, medical, and dental care services programs ($3.6 billion);
- Support an electronic health care data exchange process to transfer health records to counties for inmates who are transitioning to county custody or the community ($720,000)

Early Childhood, Student Well-Being, and Addressing Adverse Childhood Experiences

According to the Budget, "Providing children in California with a healthy start is one of the best investments the state can make. A growing body of research points to the link between early

childhood interventions and improved outcomes years or even decades into the future, including higher education levels, better health, and stronger career opportunities." Specific investments of interest include:

- $10 million for the development of an adverse childhood experiences (ACES) cross-sector training program that will be accredited by the Office of the Surgeon General, as well as a statewide ACES public awareness campaign;
- $300 million for the development of innovative community school models that support student mental health in public schools;
- $350 million to augment Educator Workforce Investment Grants for local educational agencies to train school teachers and paraprofessionals on a host of issues, including multi-tiered systems of support and mental health interventions: social-emotional learning and restorative practices; non-discrimination, anti-bullying, and affirmative supports for LGBTQ and other marginalized students.
- $18 million for the California Collaborative for Educational Excellence to bolster awareness of available services and supports for all local educational agencies in the topics listed above.

Additionally, to improve local educational agencies' ability to effectively support students with

Disabilities and identify best practices, the Administration and Legislature engaged with researchers and collaborated with stakeholders. Among their findings are that "Needs associated with student mental health and social-emotional issues are becoming more prevalent." In response, the Budget proposes a three-phase, multi-year process to improve special education finance, services, and student outcomes. This process will finalize a new special education funding formula to support equity, more inclusive practices, and early intervention services; improve family and student

engagement, including whole-child and family wrap-around services; and refining funding, accountability, and service delivery for specialized services, such as out-of-home placements, non-public school placements.

Making Health Care More Affordable

Governor Newsom reports his Administration will pursue new initiatives this year to make health care more affordable. For example, he proposes to increase transparency in the price for health care, address hospitals' costs on a regional basis, increase use of technology, and expand value-based reimbursements. Additionally, the Budget seeks to reduce prescription drug costs by expanding the state's ability to consider the best prices offered by manufacturers internationally, negotiating additional supplemental rebates, and increasing the state's purchasing program to further consolidate the state's purchasing power. The Governor plans to propose a single market for drug pricing within the state and the state's own generic drug label, as well as to establish a new "Office of Health Care Affordability." Additionally, to strengthen California's public option for health plan selection, the Administration plans to "leverage" Covered California (the health care exchange) and Medi-Cal. The California Health and Human Services Agency plans to identify options that would address enrollment, affordability, and choice through Covered California, as well as utilize existing Medi-Cal managed care plans.

Increases to the In-Home Supportive Services (IHSS) Program

The IHSS program is a Medicaid entitlement that provides domestic and related services to enable aged, blind, and disabled individuals to remain safely in their homes rather than institutions. The Governor's Budget includes $5.2 billion General Fund for IHSS in FY 2020-21, representing a 16% increase from 2019-20. The Budget estimates that over half a million (586,000) Californians will receive IHSS services in FY 2020-21. Additionally, the Budget provides $523.8 million General Fund to provide planned minimum wage increases to IHSS works ($13 per hour on January 1, 2020, $14 per hour on January 1, 2021).

The Budget also provides $1.9 million General Fund in 2020-21 to providing additional training to county social workers and managers in conducting needs assessments for IHSS recipients, with the goal of improving consistency across counties in implementing IHSS program requirements.

Nursing Home Reimbursement Reform

Currently, the state provides annual cost-based increases and quality incentive payments to all skilled nursing facilities (SNFs) that are partly funded by facilities paying a fee of 6% of their revenue. These fees are then used as state match to draw down federal Medicaid reimbursement for SNF services to Medi-Cal beneficiaries. This type of arrangement began in 2004, but sunsets July 31, 2020. The Governor proposes to reform SNF reimbursement to a cost-based methodology that could better incentivize value and quality.

It is important to note that this funding arrangement does not include SNFs that are considered Institutions for Mental Disease (IMDs), as SNF-IMDs are ineligible for federal Medicaid reimbursement. As such, county mental health departments utilize 1991 Realignment Mental Health revenues to cover the full costs of SNF-IMDs. Under current law, counties must pay SNF-IMDs an annual 3.5% rate increase.

Small Increases to Supplemental Security Income (SSI)/State Supplementary Payment (SSP) Benefits Starting Next Year

As described in the Budget, the federal SSI program "provides a monthly cash benefit to eligible aged, blind, and disabled persons who meet the program's income and resource requirements. In California, the SSI payment is augmented with an SSP grant. These cash grants assist recipients with basic needs and living expenses…The state-only Cash Assistance Program for Immigrants (CAPI) provides monthly cash benefits to aged, blind, and disabled legal noncitizens who are ineligible for SSI/SSP due solely to their immigration status." Due to a 1.7% increase in the Consumer Price Index, the maximum SSI/SSP monthly grant levels will increase January 1, 2021 by approximately $13 for individuals and $20 for couples. The Budget provides $2.6 billion General Fund in FY 2020-21 for the SSI/SSP program (a 1.6% decrease from the current year due to lower caseload projections). Current maximum SSI/SSP grant levels are $943 per month for individuals and $1,583 per month for couples.

Addressing Individuals with Both Behavioral Health and Developmental Disability Needs

According to the Budget, the composition of regional center consumers living with developmental disabilities has significantly changed over the past decade. Specifically, behavioral health needs among regional center consumers have grown by 48%. The Budget includes $2.6 million General Fund for "Systemic, Therapeutic, Assessment, Resources and Treatment Training" on person-centered, trauma-informed, and evidence-based support services for individuals with co-occurring developmental disabilities and mental health needs.

New State Department of Youth and Community Restoration

The 2019 Budget transitioned the Division of Juvenile Justice at the Department of Corrections and Rehabilitation (CDCR) to the Health and Human Services Agency as an independent department, effective July 1, 2020. The Governor's 2020-21 Budget includes additional resources to establish the division as a new "Department of Youth and Community Restoration." The new department will consist of over 1,400 personnel and would be supported by $260.8 million General Fund in 2020-21. According to the budget, this transition "aligns with the rehabilitative mission and core values of the Agency by providing trauma-informed and developmentally appropriate services to youth in California's state juvenile justice system. This transition will improve the state's ability to provide youth in the juvenile justice system with the services necessary to return safely to the community and become responsible and successful adults." Funds provided to the new Department of Youth and Community Restoration would be used to establish a new training academy, as well as to continue support for "therapeutic communities" for offenders under age 26 who reside in a campus-style environment. A model program will be established at Valley State Prison in Chowchilla.

Senate Bill No. 389

CHAPTER 209

An act to amend Section 5813.5 of the Welfare and Institutions Code, relating to mental health, and making an appropriation therefor.

[Approved by Governor August 30, 2019. Filed with Secretary of State August 30, 2019.]

LEGISLATIVE COUNSEL'S DIGEST

SB 389, Hertzberg. Mental Health Services Act.

Existing law, the Mental Health Services Act (MHSA), an initiative statute 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 prohibits MHSA moneys from being used to pay for persons incarcerated in state prison or parolees from state prisons.

Existing law authorizes the act to be amended by a ⅔ vote of the Legislature if the amendments are consistent with, and further the intent of, the act. Existing law authorizes the Legislature to add provisions to clarify procedures and terms of the act by majority vote.

This bill would amend the act to authorize the counties to use MHSA moneys to provide services to persons who are participating in a presentencing or postsentencing diversion program or who are on parole, probation, postrelease community supervision, or mandatory supervision. By authorizing a new use of continuously appropriated moneys, this bill would make an appropriation. The bill would state the finding of the Legislature that this act is consistent with, and furthers the intent of, the Mental Health Services Act.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 5813.5 of the Welfare and Institutions Code is amended 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 program's 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. Funds may be used to provide services to persons who are participating in a presentencing or postsentencing diversion program or who are on parole, probation, postrelease community supervision, or mandatory supervision. When included in county plans pursuant to Section 5847, funds may be used for the provision of mental health services under Sections 5347 and 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1).

(g) The department shall contract for services with county mental health programs pursuant to Section 5897. After November 2, 2004, the term "grants," as used in Sections 5814 and 5814.5, shall refer to those contracts.

SEC. 2. The Legislature finds and declares that this act is consistent with, and furthers the intent of, the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.

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February 27, 2019

Ms. Jennifer Kent, Director
California Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Re: Medicaid Institutions for Mental Disease (IMD) Exclusion Waiver – Support

Dear Director Kent:

The California State Association of Counties (CSAC), representing California's 58 counties, writes to urge the Department of Health Care Services (DHCS) to capitalize on the new opportunity to lift the Institutes for Mental Disease (IMD) exclusion offered by the federal government through the Section 1115 Medicaid waiver process.

The Federal IMD exclusion rule prohibits the use of federal Medicaid funds for seriously mentally ill individuals ages 21-64, in a hospital, nursing facility, or other institution with more than 16 beds. The intent of the exclusion, which was developed more than 40 years ago, was to end federal funding for large psychiatric institutions and instead to encourage a community-based mental health care model. This federal policy decision has led to a growing shortage of facilities and beds in California and often requires counties to find other inadequate or adverse placements, including long-term placement facilities, jails, hospitalization, and homelessness. At present, it is difficult for psychiatric facilities to operate and establish sites with fewer than 16 beds, resulting in a severe shortage for inpatient psychiatric placements in California.

California is already taking advantage of the current Section 1115 waiver of the IMD exclusion from the U.S. Centers for Medicare and Medicaid Services (CMS) to use federal funds for short-term inpatient stays in IMDs for substance use disorder (SUD) treatment. While the current SUD waiver has provided some relief and flexibility, additional expansion and flexibility is essential to the behavioral health system.

As California struggles to provide adequate coverage for a significant number of low-income individuals living with chronic and severe mental illness who are in need of short-term psychiatric care, counties view the new IMD waiver as an extraordinary opportunity to address the growing gap in inpatient mental health coverage created by the current IMD exclusion. Counties also remain committed to operating a community behavioral health continuum that seeks to return patients to the lowest level of care in the community as soon as possible.

California counties strongly support state action to pursue the waiver on the IMD exclusion. We appreciate your past leadership on Section 1115 waiver requests, and stand ready to assist the Department in pursuit of a new federal waiver of the IMD exclusion. Thank you for your time in considering our request.

Sincerely,

Farah M. Tiry

Farrah McDaid Ting
Legislative Representative

cc: Richard Pan, Chair, Senate Health Committee
Jim Wood, Chair, Assembly Health Committee
Scott Ogus, Policy Consultant, Senate Committee on Budget and Fiscal Review
Andrea Margolis, Policy Consultant, Assembly Budget Committee
Marjorie Swartz, Office of Pro Tempore Atkins
Agnes Lee, Policy Consultant, Office of Assembly Speaker Rendon
Michael Wilkening, California Health and Human Services Secretary
Tom Renfree, County Behavioral Health Directors Association
County Legislative Coordinators
County Caucus

February 13, 2019

Jennifer Kent
Director
California Department of Health Care Services
1501 Capitol Avenue, MS 0000, P.O. Box 997413
Sacramento, CA 95899-7413

SUBJECT: Institutes for Mental Disease (IMD) Exclusion Waiver—SUPPORT

Dear Director Kent,

The County Behavioral Health Directors Association of California (CBHDA), which represents the public behavioral health authorities in counties throughout the state, is writing to encourage you to pursue California's participation in a waiver of the IMD Exclusion for Medi-Cal mental health services.

The decades old IMD exclusion prohibits the provision of federal Medicaid matching funds for inpatient services provided by states and counties to adults (ages 18 to 65) for stays in hospitals, nursing homes or other inpatient care settings with more than 16 beds. This exclusion was initially designed to ensure states are disincentivized to provide psychiatric care in large hospitals, asylums and institutions. However, it is very difficult for psychiatric nursing facility operators to establish sites of 16 beds or fewer, due to the lack of economies of scale.

In recent years the Centers for Medicare & Medicaid Services (CMS) has softened this exclusion to provide federal Medicaid funding to states and counties for services provided in 16-plus bed IMDs under specified conditions. This has occurred through two mechanisms: the Section 1115 Demonstration Waiver for substance use disorders (SUD), and a new provision in 42 CFR Part 438 (Part 438) that authorizes federal Medicaid payments to capitated managed care entities for stays in IMDs up to 15 days per month.

While California has taken advantage of the new federal flexibility via the Drug Medi-Cal Organized Delivery System Waiver for beneficiaries with SUDs, the state is currently ineligible for the additional flexibility permitted under Part 438 as the regulatory provision is limited to risk-based, capitated systems. CBHDA supports federal statutory or regulatory efforts to extend the flexibility granted under Part 438 to non-capitated systems.

Apart from an extension of Part 438 to non-capitated systems, a federal regulatory opportunity to lift the IMD exclusion was published as a part of State Medicaid Director (SMD) Letter #18—011 on November 12, 2018. This letter lays out a new opportunity for states to utilize Section 1115(a) demonstration waivers to obtain authority to pay for short-term treatment in IMDs and to receive federal Medicaid matching funds for these services.

CBHDA members strongly support action by the state to take advantage of this new opportunity and include an IMD waiver proposal within California's next 1115 waiver. Historically, the absence of federal funding for services delivered in IMDs has contributed to an ongoing, acute shortage of psychiatric beds around the state. This disproportionately impacts low-income and vulnerable communities and creates major financial burdens for consumers and the state through hospitalization and avoidable use of emergency departments for psychiatric care. Waiving the IMD exclusion could help alleviate such shortages of psychiatric care. Further, the IMD exclusion has negatively impacted the availability of other community mental health services. At present, significant portions of counties' 1991 Realignment dollars are utilized to pay for inpatient psychiatric hospital stays that are medically necessary but not federally reimbursable through Medicaid. Waiving the IMD exclusion would allow the state to draw on federal funds to increase the availability of psychiatric beds and to free up state funds for other critical community mental health services.

Thank you for taking our comments under consideration. We look forward to discussing this pursuit of a waiver of the IMD exclusion with you at your convenience. Please do not hesitate to contact me via email or phone (trenfree@cbhda.org or (916) 556-3477).

Sincerely,

Tom Renfree
Interim Executive Director
CBHDA

cc: Brenda Grealish, Department of Health Care Services
Farrah McDaid Ting, California State Association of Counties
Adrienne Shilton, The Steinberg Institute

National Association of Attorneys General

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August 5, 2019

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
H-232, The Capitol
Washington, DC 20515

The Honorable Kevin McCarthy
Minority Leader
U.S. House of Representatives
H-204, The Capitol
Washington, DC 20515

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
S-230, The Capitol
Washington, DC 20510

The Honorable Charles Schumer
Minority Leader
U.S. Senate
S-221, The Capitol
Washington, DC 20510

Dear Speaker Pelosi, Minority Leader McCarthy, Majority Leader McConnell, and Minority Leader Schumer,

The undersigned attorneys general share your concern about the impact of the opioid epidemic on our country. As President Trump has recognized in the National Drug Control Strategy he released earlier this year, the opioid crisis has resulted in more American deaths in just two years than in the course of the entire Vietnam War. In 2017, there were more than 70,200 drug overdose deaths in the United States. More than 47,500 of these deaths involved an opioid, and more than half of these deaths involved a synthetic opioid such as illicit fentanyl or one of its analogues.

The impact of the epidemic has been so pervasive and so severe that life expectancy in the United States has declined for three years in a row for the first time since the influenza pandemic of 1918. The epidemic has contributed to a rise in Hepatitis C and heart valve infections (endocarditis), a rise in the number and rate of hospitalizations associated with drug withdrawal in newborns, and other significant and costly health impacts.

This loss of life and these major health consequences are matched by significant and continuing costs imposed on our criminal justice and social service systems. And the economic cost of the opioid crisis exceeded $500 billion in 2015 – equal to 2.8 percent of the U.S. Gross Domestic Product (GDP) that year – according to the White House Council of Economic Advisers.

We all understand that effective treatment is key to saving lives and helping to stop this epidemic. In particular, research shows that Medication-Assisted Treatment (MAT) – the use of medications, in combination with counseling and behavioral therapies – is a highly effective approach to the treatment of opioid use disorders.

Unfortunately, there are three significant barriers to treating opioid use disorder that we cannot change at the state level and that must be tackled at the federal level. We share these barriers below in the hope that we can work together to remove them and allow more providers to offer treatment for opioid use disorder and other substance use disorders.

1. **Replace the cumbersome, out-of-date, privacy rules contained in 42 CFR Part 2 with the effective and more familiar privacy rules contained in the Health Insurance Portability and Accountability Act (HIPAA).**

42 CFR Part 2 sets forth strict requirements for the use and disclosure of patients' substance use disorder treatment records. The complexities of complying with 42 CFR Part 2 often prevent general practice providers from even attempting to treat patients with substance use disorders through the use of medication-assisted treatment (MAT), because – while providers are familiar with how to comply with the privacy requirements of HIPAA – they may be intimidated by the requirements of 42 CFR Part 2.

This regulatory scheme also sets up a strange situation in which office-based MAT providers do not have to follow the specialized requirements of 42 CFR Part 2 unless they advertise to the public that they provide MAT. So, in an era when we are trying to promote access to MAT, we are encouraging office-based MAT providers to keep secret the fact that they provide this life-saving service so they can avoid the cumbersome 42 CFR Part 2 rules.

These privacy rules were created more than 40 years ago in a time of intense stigma surrounding substance use disorder treatment. They were created to assure patients that they would not face adverse legal or civil consequences when seeking treatment by protecting confidentiality of substance use disorder patient records. Unfortunately, they now serve to perpetuate that stigma, as the principle underlying these rules is that substance use disorder treatment is shameful and records of it should be withheld from other treatment providers in ways that we do not withhold records of treatment of other chronic diseases. While maintaining confidentiality is imperative to encouraging individuals to seek and obtain treatment, the inability to share records among providers can burden coordination of care, potentially resulting in harm to the patient.

To be effective in fighting the opioid epidemic, we must treat substance use disorder as the chronic disease that it is—and that means aligning the rules regarding disclosure of substance use disorder treatment records with the protections against unwanted disclosure of patient records already contained in HIPAA, particularly as it relates to disclosure of substance abuse treatment information to authorized providers.

In seeking needed changes in 42 CFR Part 2, we are joined by Democratic and Republican lawmakers in both houses of Congress. In the House, the Overdose Prevention and Patient Safety Act (OPPS Act) (H.R. 2062) was introduced by Reps. Markwayne Mullin (R-OK) and Earl Blumenauer (D-OR); and in the Senate, the Protecting Jessica Grubb's Legacy Act (Legacy Act) (S. 1012) was introduced by Sens. Joe Manchin (D-WV) and Shelley Moore Capito (R-WV). Both bills will align Part 2 with HIPAA for the purposes of health care treatment, and both are supported by the Partnership to Amend 42 CFR Part 2, a growing coalition of more than

40 national health care organizations that includes the American Hospital Association, the American Psychiatric Association, and the American Society of Addiction Medicine.

2. **Pass H.R. 2482, the Mainstreaming Addiction Treatment (MAT) Act, and eliminate unnecessary burdens on buprenorphine prescribing imposed by the Drug Addiction Treatment Act of 2000 (DATA 2000).**

DATA 2000 was a step forward in substance use disorder treatment because it allowed the treatment of opioid use disorder in an office-based setting. However, it created a cumbersome bureaucratic system whereby providers who wish to prescribe buprenorphine in an office-based setting must prove to the Substance Abuse and Mental Health Services Administration (SAMHSA) that they have taken special trainings and then apply to the Drug Enforcement Administration (DEA) for a special DEA "X" number to indicate when buprenorphine is being prescribed to treat substance use disorder.

This is the only drug on the market for which prescribers have to prove they have received specialized training in order to prescribe the drug. This requirement was put in place well before the rapid rise in opioid use disorder and opioid overdose deaths that have become a national crisis. Just as opioid use disorder and opioid overdose deaths have risen dramatically in recent years, so the need for MAT with buprenorphine has risen just as dramatically. Because the need for MAT is far out-pacing the availability of such treatment, it is time to reconsider the DATA 2000 regulatory framework and other barriers that stand in the way of expanded use of buprenorphine to treat opioid use disorder and help prevent opioid overdose deaths.

The fact is that, as a partial agonist, buprenorphine is a safer drug than opioid agonists such as oxycodone and fentanyl that are readily prescribed without any requirements for training or specialized DEA numbers. So, doctors need not prove any special training to prescribe more addictive opioid pain killers but must follow complicated bureaucratic steps to prescribe a less addictive opioid (buprenorphine) for substance use disorder treatment.

Buprenorphine should not be singled out from all other drugs because it is a treatment for substance use disorder. Providers should be trained to prescribe buprenorphine the same way they are trained to prescribe other drugs – in medical schools, nurse practitioner schools, medical residencies, and continuing medical education. The stigma-based policy is endangering lives by suppressing access to treatment and should be changed.

In our effort to eliminate this antiquated policy that restricts a healthcare provider's ability to prescribe buprenorphine, we are joined by a coalition of 22 states, led by the New York State Department of Health, seeking exactly this change.

H.R. 2482, the Mainstreaming Addiction Treatment (MAT) Act, would address this issue by eliminating the redundant and outdated requirement that practitioners apply for a separate waiver through the DEA to prescribe buprenorphine for the treatment of substance use disorder. We urge Congress to pass – and President Trump to sign – the MAT Act or similar legislation as expeditiously as possible.

3. Fully repeal the Medicaid Institutions for Mental Diseases (IMD) exclusion.

The Institutions for Mental Diseases (IMD) exclusion generally prohibits state Medicaid programs from receiving federal reimbursement for adults between 21 and 65 receiving mental health or substance use disorder treatment in a residential treatment facility with more than 16 beds.

This arcane federal policy, while well intentioned at its inception to encourage treatment in community-based settings, has proven to detrimentally limit states' ability to provide the full continuum of clinically appropriate care for Medicaid enrollees with a substance use disorder. We join the National Governor's Association and a wide range of health care and public health groups in calling on the Administration to continue working with states to expedite approval of IMD waivers, while also recognizing the need for a permanent, statutory solution to resolve this issue for all states.

The recently-enacted Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act took a step in the right direction, but it did not go far enough. The SUPPORT Act partly eliminates the IMD exclusion for a five-year period by allowing states to cover IMD services to people with at least one substance use disorder for up to 30 days over a 12-month period under certain circumstances. Congress needs to go further, by fully repealing the IMD exclusion.

We applaud the federal government for its recent constructive steps to address the opioid epidemic through both legislative and executive action, but we all know that there is more work to be done. By making the changes recommended, Congress would make effective treatment for opioid use disorders more widely and readily available so that we can save more lives and help turn the tide on this crisis.

Thank you for your consideration.

Sincerely,

Josh Stein
North Carolina Attorney General

Mike Hunter
Oklahoma Attorney General

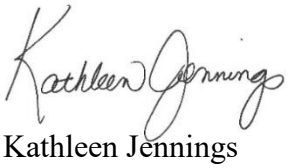
Kevin G. Clarkson
Alaska Attorney General

Leslie Rutledge
Arkansas Attorney General

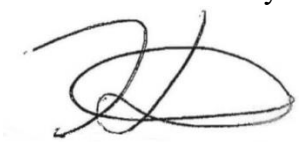
Xavier Becerra
California Attorney General

Phil Weiser
Colorado Attorney General

William Tong
Connecticut Attorney General

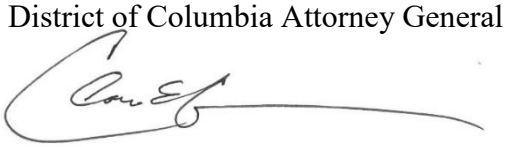


Kathleen Jennings
Delaware Attorney General

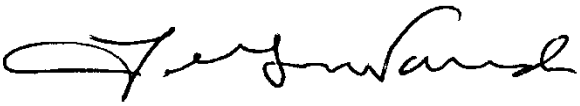


Karl A. Racine
District of Columbia Attorney General

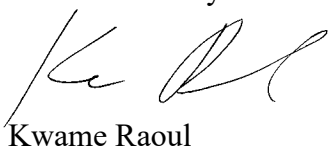
Ashley Moody
Florida Attorney General



Clare E. Connors
Hawaii Attorney General



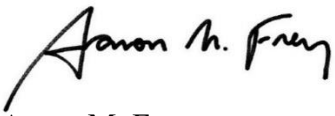
Lawrence Wasden
Idaho Attorney General



Kwame Raoul
Illinois Attorney General

Tom Miller
Iowa Attorney General

Jeff Landry
Louisiana Attorney General

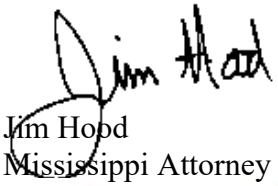


Aaron M. Frey
Maine Attorney General

Maura Healey
Massachusetts Attorney General

Dana Nessel
Michigan Attorney General

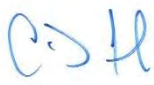
Keith Ellison
Minnesota Attorney General



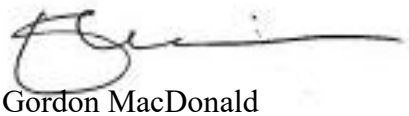
Jim Hood
Mississippi Attorney General

Tim Fox
Montana Attorney General

Douglas Peterson
Nebraska Attorney General



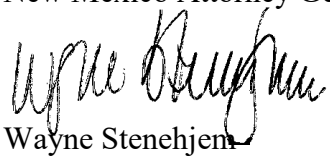
Aaron D. Ford
Nevada Attorney General



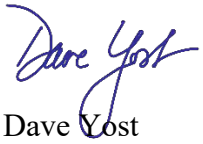
Gordon MacDonald
New Hampshire Attorney General

Hector Balderas
New Mexico Attorney General

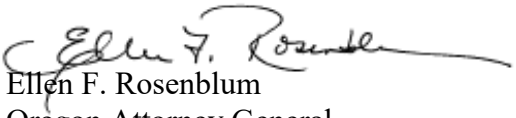
Letitia James
New York Attorney General



Wayne Stenehjem
North Dakota Attorney General



Dave Yost
Ohio Attorney General

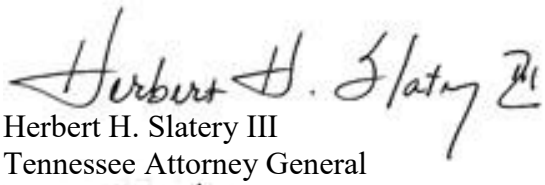


Ellen F. Rosenblum
Oregon Attorney General

Josh Shapiro
Pennsylvania Attorney General

Peter F. Neronha
Rhode Island Attorney General

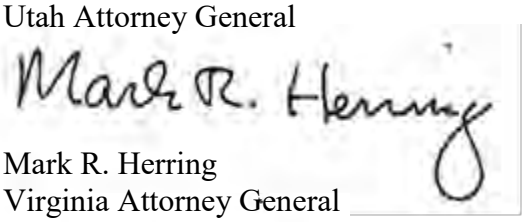
Jason R. Ravnsborg
South Dakota Attorney General



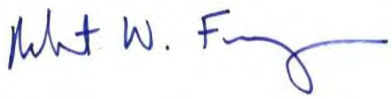
Herbert H. Slatery III
Tennessee Attorney General

Sean Reyes
Utah Attorney General

T.J. Donovan
Vermont Attorney General

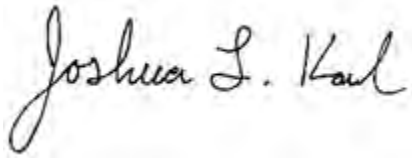


Mark R. Herring
Virginia Attorney General



Robert W. Ferguson
Washington Attorney General

Patrick Morrisey
West Virginia Attorney General



Joshua L. Kaul
Wisconsin Attorney General

Proposed MHC Goals for 2020
Barbara Serwin, MHC Chair

These proposed goals are meant to apply to cooperation and facilitation by all Commissioners. These differ from Committee goals which are driven at the Committee level. They may result in actions that are reviewed and supported by the entire Commission, but their achievement depends on the Committees.

Note that not all of these proposed goals need to be implemented. The Commission needs to decide how many goals it would like to pursue, although no more than three is recommended. The specific framing of the proposed goals and their measurements are open to discussion and changes as well.

Here are proposed goals:

1. Successful implementation of the new MHC orientation and training program as measured by:
- Attendance of the orientation module and / or review of Orientation materials by 100% of new Commissioners.
- Attendance of at least 50% of remaining five training modules by at least 75% of Commissioners – incumbents and new.
- Responsive adjustment of orientation and training model as per feedback by Commissioners and per review by MHC leadership; Alexander Ayzenberg, MHC Executive Assistant; and Warren Hayes, Director of MHSA programs.

2. Successful implementation of the new MHC Site Visit program (target implementation date is August 1, 2020) as measured by TBD number of site visits and Commissioner attendance.

3. A deeper review of the MHSA 2019 three-year plan update, the 2019 EQRO report and the Data Notebook report by each Commissioner as measured by 90% of Commissioner participation as measured by self-reporting.

4. Broadening of MHC community outreach by hosting a minimum of two meetings outside of Pleasant Hill with the agenda including one or more items particularly relevant to the local committee of the target communities and thoroughly advertised by the MHC and its partners.

5. Achieving a quorum for full Commission meetings of the number of scheduled meetings minus one. Achieving a quorum for Committee meetings for the number of scheduled meetings minus one. It's the responsibility of each Commissioner to notify the Executive Assistant of their expected absence at least one day in advance so that the Committee Chair can decide whether or not to cancel the meeting or hold a community discussion instead.

6. Achieving at least 14 out of 15 of Commission seats filled through the effort of Commissioner recruiting efforts, a warm hand-off of individuals who approach Commissioners regarding MHC seats to the appropriate district staff, and active follow up with Supervisors regarding open seats. Also, achieving at least three members and a target of five (five is the maximum per Committee) per each standing Committee (with the exception of the Executive Committee, which also requires membership to one of the three other standing Committees).