CBHDA LEGISLATIVE PLATFORM

Introduction

The purpose of this Legislative Platform is to outline the perspectives of the County Behavioral Health Directors Association of California (CBHDA) on priority issues and legislation that impact mental health and substance use disorder services in communities throughout the state. This document also directs the consideration of additional legislative and budget issues that arise during the Legislative Session. In consultation with the County Directors, the California State Association of Counties (CSAC), and other behavioral health stakeholders, CBHDA has identified the following priorities in order to assist the County Directors in proactively and appropriately addressing legislation that impacts community and individual behavioral health and wellness.

A. Overarching Issues

1. Collaborate with county affiliates, including the: California State Association of Counties (CSAC), County Welfare Directors Association (CWDA), Chief Probation Officers of California (CPOC), California State Sheriffs' Association, County Health Executives Association of California (CHEAC), California State Association of Public Administrators, Public Guardians, and Public Conservators (CAPAPGPC), Urban Counties Caucus (UCC), Rural County Representatives of California (RCRC) and California Association of Public Hospitals and Health Systems (CAPH).

2. Partner with stakeholders such as the: California Council of Community Behavioral Health Agencies, Disability Rights California, Labor, California Hospital Association, Children Now, California Alliance for Children and Family Services, California Consortium of Addiction Programs and Professionals, California Association of Alcohol and Drug Program Executives, California Society for Addiction Medicine, California Opioid Maintenance Providers, Faces and Voices of Recovery, the California Association of Social Rehabilitation Agencies, the California Association of Alcohol and Drug Educators, the California Association of DUI Treatment Programs, National Alliance on Mental Illness, Western Center on Law and Poverty, the California Pan Ethnic Health Network, California Coalition for Mental Health, California Primary Care Association, California Council on Criminal Justice and Behavioral Health, Judicial Council, Racial and Ethnic Mental Health Disparities Coalition, California Association of Mental Health Peer Run Organizations and Steinberg Institute.

3. In conjunction with the CBHDA Legislative Committee, support and oppose legislation in accordance with a variety of principles laid out in this Platform.

4. Support increases in state funding for behavioral health services.

5. Oppose additional reductions in state funding for behavioral health services that will result in the shifting of state or federal costs to counties. These cost shifts result in reduced services available at the local level and disrupt treatment.

6. Evaluate legislation to identify potential significant county fiscal impacts.

7. Leverage the provisions of Proposition 30 with regard to legislative proposals that result in county workload or service increases in 2011 Realignment Behavioral Health programs.

8. Any shift in responsibility or funding must hold counties fiscally harmless and provide the authority and flexibility to tailor behavioral health programs to individual community needs.

9. Support legislation to prioritize patients over paperwork, and to reduce unnecessary documentation and regulatory burdens on counties and providers.

B. Federal Issues that Impact California

While a majority of policy, political and funding activity is driven at the state level in California, the federal government has become much more of a factor in recent years relative to a variety of important issues in which CBHDA will continue to engage.

1. Promote and Operationalize CBHDA Behavioral Health 2020. CBHDA and its members face opportunities and challenges to fundamentally shift the delivery of and payment for public behavioral health services in 2020 and beyond. This is due in part to the expiration of key federal Medicaid waivers and State Plan Amendments (SPAs). The Medicaid Section 1115 Waiver is the California Medi-Cal 2020 Demonstration and includes the Drug Medi-Cal Organized Delivery System (DMC-ODS) and Whole Person Care pilots. This five-year Demonstration Waiver expires at the end of calendar year 2020. The Section 1915(b) Specialty Mental Health Services Consolidation Waiver that identifies counties as pre-paid inpatient mental health plans for specialty care, and the Targeted Case Management and Rehabilitative Mental Health Services SPAs, expire June 30, 2020. CBHDA will evaluate issues and identify options for counties' roles in the delivery of care and consider financing, care coordination, integration, workforce and regional needs.

2. Preserve the Affordable Care Act and Publicly Funded Health Coverage. The Affordable Care Act (ACA) majorly expanded access to behavioral health care in both private insurance markets and through the benefit and coverage expansion Medi-Cal. Millions more Californians now have access to behavioral health care than they did prior to a few years ago. We will continue to oppose federal efforts to dismantle ACA and block grant Medicaid. The dismantling of the ACA threatens mental health and SUD services via evisceration of the Essential Health Benefits. If Medicaid is block granted, several million Californians risk losing this coverage.

3. Eliminate the Institute for Mental Diseases (IMD) Federal Funding Exclusion. The decades old IMD exclusion prohibits the provision of federal Medicaid matching funds for inpatient services states and counties provide 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 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 SUD, 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.

C. Substance Use Disorder Issues

CBHDA has long supported improving the availability of and public resources for high-quality SUD prevention and treatment services.

Historically, the California system of SUD services has been underfunded in relation to the needs of the state's population. Alcohol and drug addiction is a major problem that creates impaired health, harmful behaviors and major economic and social burdens. The opioid epidemic is a national crisis that directly impacts California counties, and the recent legalization of recreational marijuana poses significant challenges for the SUD continuum of care, especially with regard to youth access. Substance use disorders are also a significant factor and cost driver in many other public systems, including criminal justice, child welfare, trauma care, public health and social welfare.

Addiction is a chronic, relapsing disease that can be effectively treated. Prevention and early intervention have proven to be very effective strategies to address SUD problems. Addiction treatment also requires continuity of care, including acute and follow-up care, relapse management and satisfactory outcome measures. A growing body of evidence demonstrates that enhanced medical and public health approaches - in combination with social supports and treatment for the "whole person" - can effectively reduce harmful use of alcohol and other drugs. Since substance use disorders often co-occur with other mental and physical illnesses, treatment is most effective when integrated with physical and mental health care. CBHDA will continue to support California's implementation of the federal Section 1115 Waiver for Drug Medi-Cal, which provides additional federal and state funding for SUD treatment and supports an organized delivery system that ensures access to a full continuum of care from assessment and early intervention to recovery supports.

Support:

1. Funding for alcohol and drug prevention, early intervention, treatment and recovery services that provide county flexibility and discretion for local planning processes.

2. Funding a SUD continuum of care for adolescents, including youth in the juvenile justice system as well as youth transitioning out of foster care.

3. Establishing statewide regulations and treatment standards for a publicly-funded continuum of SUD care for youth, so that county SUD programs and community-based providers are better equipped to develop, deliver, and oversee high-quality services for young people around the state.

4. Funding SUD treatment in lieu of incarceration for adults and adolescents who are justice-involved due to offenses related to their substance use disorders.

5. Expanding community-based prevention coalitions that promote environmental approaches to preventing alcohol and drug related problems in the community, as well as individual and primary prevention programs.

6. Prioritizing wrap-around SUD recovery support services with an emphasis on employment services and job training.

7. Improving Drug Medi-Cal collaboration and communication between the state and counties, enhancing the provider certification

review process, and increasing provider engagement and training.

8. Eliminating FQHC same-day billing restrictions for Drug Medi-Cal beneficiaries who are receiving more than one treatment or recovery support service on a single day.

9. Requiring Proposition 64 revenues dedicated to SUD prevention and treatment to be allocated directly to local governments as a formula-based allocation for all counties, rather than a grant program, with County Behavioral Health or Public Health (wherever SUD services are located) named as the lead agency.

10. Requiring the independent evaluation of Proposition 64 to consider the effects of marijuana use on the developing teen brain and the relationship between availability and teen use, and to identify short-term impacts and long-term outcomes of legalization, including changes in consumption, data on safety and health risks, the amount of fees and tax revenues collected, and the amounts invested in SUD prevention, early intervention and treatment.

11. Requiring health insurance plans to cover non-opioid therapies or medications for pain at parity with the coverage of opioid medications.

12. Eliminating discrimination in laws and policies against people in SUD recovery who are qualified for employment, insurance, housing and other necessities.

13. Giving counties broader control over who runs Driving Under the Influence programs, including programs that address the needs of specific cultural and linguistic communities and populations.

14. Establishing a single state professional licensure or certification process for SUD counselors.

15. Promoting dedicated funding as well as non-monetary strategies to build a highly competent and diverse SUD workforce that effectively employs both SUD counselors and LPHAs.

16. Promoting recovery housing.

Oppose:

17. Reducing the availability and accessibility of SUD prevention, early intervention, treatment and recovery services, including legislation that restricts the availability of recovery housing.

18. Compromising existing treatment services through measures such as reducing the frequency of client treatment contact, reduced length of treatment, and placement of clients in levels of care inconsistent with their assessed need.

D. Children's Issues

Children with behavioral health needs are some of the most vulnerable Californians counties serve.

These children include those with the Medi-Cal EPSDT benefit and tens of thousands of foster youth and youth with trauma caused by Adverse Childhood Experiences (ACEs). Due to extensive political and policy attention to children and youth issues via the Continuum of Care Reform, student mental health, youth addiction, early psychosis detection, out of county foster care transfers, health plan provision of the mild-to-moderate benefit and trauma screening, these issues will all remain high on the CBHDA agenda. There will be more opportunities to work with groups such as CWDA, CPOC, the Alliance of Child & Family Services, the Steinberg Institute, Children Now and the First Five Statewide Commission to advance policies and regulatory issues in foster care, child welfare, children's mental health, juvenile justice and youth SUD, among many others.

Support:

1. Funding for children's mental health and SUD treatment needs.

2. Pursuing related funding through the state budget process.

3. A complete SUD continuum of care for children and youth.

4. Work with stakeholders to continue focus on school based behavioral health services for K-12, community colleges and four-year college students. Ensure adequate workload support for county MHPs and ODS providers.

5. Work with stakeholders to continue focus on school based behavioral health services for K-12, community colleges and four-year college students. Ensure adequate workload support for county MHPs and ODS providers.

6. Effective implementation of recently enacted laws, including SB 1004 (Wiener), MHSA PEI; AB 403 (Stone), Continuum of Care Reform; AB 1299 (Ridley-Thomas), which requires the transfer of county SMHS for foster youth transferred out of county; and AB 340 (Arambula), which requires the establishment of an advisory group about screening protocols for childhood traumas.

7. Actively partnering with CWDA and stakeholders to continue effective implementation of the Child and Adolescent Needs and Strengths (CANS) in both the mental health and child welfare systems, while avoiding overlap and duplication.

8. Broadening the use of youth peers with lived experience and their role in delivering interventions to individuals in a behavioral health crisis.

9. Developing infrastructure and increasing capacity for youth crisis services, including triage personnel, mobile crisis teams and crisis residential options. Demand for these services for youth continue to exceed supply.

10. Increasing educational and training opportunities regarding the impacts of trauma on child development and health outcomes, and expanding the use of trauma-informed care.

E. Mental Health Services Act (MHSA)

Numerous aspects of the MHSA will remain a high priority of CBHDA and many other stakeholders in the legislative and regulatory environment.

The MHSA provides additional funding that expands and improves the capacity of existing systems of care and provides an opportunity to integrate funding at the local level.

Support:

1. Successful implementation of recently enacted laws, SB 688 (Moorlach) MHSA Annual Revenue and Expenditure Reports (ARERs) and SB 1004 (Wiener) MHSA Prevention and Early Intervention. Continuing promotion of flexibility in the allocation of MHSA funds to counties.

2. Increasing flexibility in utilization of MHSA Innovation funds.

3. Proposals to conduct a statewide evaluation of MHSA.

4. Efforts to increase transparency that align with, or enhance, existing processes and reporting structures.

Oppose:

5. Redirecting the MHSA funding to current state services instead of the local services for which it was originally intended.

6. Diverting MHSA funds away from the provision of behavioral health services. Any further diversions of this funding will disrupt local programming.

7. Diverting local control of MHSA funds away from counties unless specific provisions ensure the funding will be designated to the local county at a rate no less than the original allocation.

F. Crisis Continuum

County behavioral health departments provide an array of crisis and psychiatric inpatient care services to Med Cal beneficiaries who meet medical necessity criteria, individuals

who are a danger to themselves or others due to a mental disorder, and others to the extent resources are available.

As pre-paid inpatient health plans, county Mental Health Plans must provide inpatient and post stabilization care and disposition from hospital emergency rooms to enrollees. However, due to a range of challenges, counties, consumers and families report the availability of crisis and inpatient mental health services is lacking throughout the state. Hospitals, law enforcement and the courts are also concerned that a lack of adequate crisis and inpatient care leads far too many individuals to visit hospital emergency departments or find themselves arrested and in jail.

Support:

1. Partnering with the health care delivery system and law enforcement to increase the capacity of an array of options along a continuum of care for individuals in crisis.

2. Expanding treatment options that prioritize the least restrictive level of care and invest in prevention, alternatives to psychiatric hospitalization, acute crisis needs, inpatient care and post-discharge community-based options.

3. Expanding the crisis continuum to include funding for SUD, detox and recovery services.

4. Broadening the use of peers with lived experience and their role in delivering interventions to individuals in a behavioral health crisis.

5. Developing infrastructure and increasing capacity for crisis services, including triage personnel, mobile crisis teams and crisis residential options. While SB 82 has been critical for the development of these services in counties across California, the demand continues to exceed the supply.

6. Reducing local siting challenges related to SB 82 implementation.

7. Partnering with hospitals, private health plans, Medicare and Medi-Cal managed care plans to meet the needs of individuals with medically complicated health issues.

8. Reforming the Lanterman-Petris-Short Act in a manner that protects patients' due process rights, accounts for the county role under the Act and increases funding for services mandated by the Act.

9. Funding for facilities that serve consumers in need of a higher level of care, including expansion of beds in IMDs and state psychiatric hospitals.

G. Housing and Homelessness

Homelessness and housing affordability will remain at the top of the California Legislative agenda, as housing prices continue to escalate and homelessness rates skyrocket.

Ensuring housing affordability and reducing rates of homelessness for people living with behavioral conditions remain high priorities for CBHDA. While increased housing costs and poverty are the leading causes of homelessness in California, people living with mental health and SUD issues are significantly impacted.

CBHDA will seek opportunities to partner with key stakeholders such as Housing California and the Corporation for Supportive Housing to cosponsor legislative proposals that improve access to affordable housing for County behavioral health clients. CBHDA will support proposals that effectively address financial and/or regulatory barriers to housing access and affordability through means consistent with the principles outlined in this Platform.

Support:

1. Funding for affordable housing which does not rely on redirecting existing funds from the public behavioral health system. Statewide investments in housing should be balanced with investments in behavioral health care and other supportive services that assist individuals in maintaining housing.

2. Funding housing construction, operating subsidies, and supportive services. These three categories of costs must all be addressed in order to create permanent supportive housing, and/or increase housing affordability, for clients with behavioral health conditions.

3. Housing programs and policies that benefit residents of all counties and are flexibly designed to meet local needs, including the Special Needs Housing Program and other programs/strategies that complement No Place Like Home.

4. Models to respond to and prevent homelessness. Models including Housing First, rapid re-housing and permanent supportive housing help remove barriers to housing for people with behavioral health conditions, and investments in supportive services and discharge or re-entry planning help prevent vulnerable individuals from becoming homeless.

5. Efforts to address “Not In My Backyard” (NIMBY) and siting challenges and to reduce stigma and housing discrimination against people with behavioral health conditions.

6. Timely and effective implementation of No Place Like Home.

Oppose:

7. Shifting housing and homelessness costs to the counties in a disproportionate way.

8. Abrupt termination or interruption of any housing program wherein county funds are already encumbered.

H. Workforce Development

California faces a significant shortage of public behavioral health professionals.

There is a mismatch between supply and demand for many types of professionals

across both the mental health and SUD provider landscapes.

The state also suffers from an uneven geographic distribution of certain professionals and a lack of specialized skills in competencies like care for the older adult population and SUD treatment for youth and young adults. There is also a lack of diversity, with too few behavioral health consumers and family-members in the workforce and many racial, ethnic and cultural populations underrepresented.
Consumers/clients/peers/family members are an essential part of the behavioral health workforce.

Support:

1. Funding workforce development in order to build a diverse, highly-qualified and sustainable workforce. Funding strategies should support sustainability and long-term workforce development goals and leverage resources from health care partners that share the state's Behavioral Health workforce.

2. Recruiting new behavioral health professionals and building the skills of those already in the field to promote workforce retention.

3. Increasing the diversity of the behavioral health workforce to better represent California's diverse population..

4. Developing a workforce that can effectively serve people of all ages, address a wide variety of behavioral health conditions, and engage difficult-to-reach and underserved populations.

5. Increasing opportunities for people with lived experience to enter the workforce and to advance professionally.

6. Increasing behavioral health training slots at public universities and teaching hospitals.

7. Locating behavioral health training programs in additional counties/regions.

8. Ensuring behavioral health professionals are compensated in a manner that reflects their credentials and competencies.

9. Defining career ladders and increasing professional opportunities for licensed and unlicensed professionals.

10. Building the expertise and capacity needed to treat co-occurring MH and SUD conditions.

11. Expanding vocational rehabilitation and supported employment services for county behavioral health clients, particularly evidence-based approaches like the Individual Placement and Support model.

I. Criminal Justice

Over the past several years, significant state criminal justice reforms and passage of the Affordable Care Act have resulted in county behavioral health systems serving a greater number of justice-involved individuals than ever before.

In collaboration with local law enforcement partners and the courts, county behavioral health systems provide community-based services to individuals who can be diverted from the criminal justice system. For individuals who cannot be diverted, counties deliver behavioral health services in custody and upon re-entry to support successful reintegration back into the community.

However, there are a myriad of challenges to establish a comprehensive continuum of services for justice-involved populations. These include the lack of affordable housing options, community treatment options as alternatives to incarceration and workforce training on the unique needs of the justice-involved population. In addition, the growing wait list for state hospital beds for individuals found Incompetent to Stand Trial increases capacity issues in county jails and treatment facilities. CBHDA supports solutions that address these challenges and develop a robust range of services for justice-involved individuals with behavioral health needs.

Support:

1. Funding for counties to expand diversion programs.

2. Proposals that support successful implementation of AB 1810 and SB 215, which establish a one-time $100 million investment in IST diversion activities as well as broader and ongoing diversionary statutes.

treatment for individuals with SUD who are incarcerated in prison or jail.

4. Restoring permanent and adequate funding for the Substance Abuse and Crime Prevention Act of 2000 (Proposition 36).

5. Creating additional opportunities to decriminalize behavioral health conditions by expanding community treatment for people living with mental illness and substance use disorders.

6. Investing in housing resources for justice-involved populations with behavioral health conditions.

7. Maximizing federal opportunities to draw down federal Medicaid funding for individuals in custody.

8. Information-sharing between state and county law enforcement and behavioral health entities within the parameters of federal and state privacy laws..

9. Strengthening requirements for crisis intervention training on mental health and substance use disorders for law enforcement personnel and first responders.

10. Increasing minimum standards for behavioral health care in custody, including services such as medication assisted treatment, counseling, and comprehensive pre-release discharge planning.

11. Expanding services and housing for parolees with behavioral health needs who are exiting the state prison system.

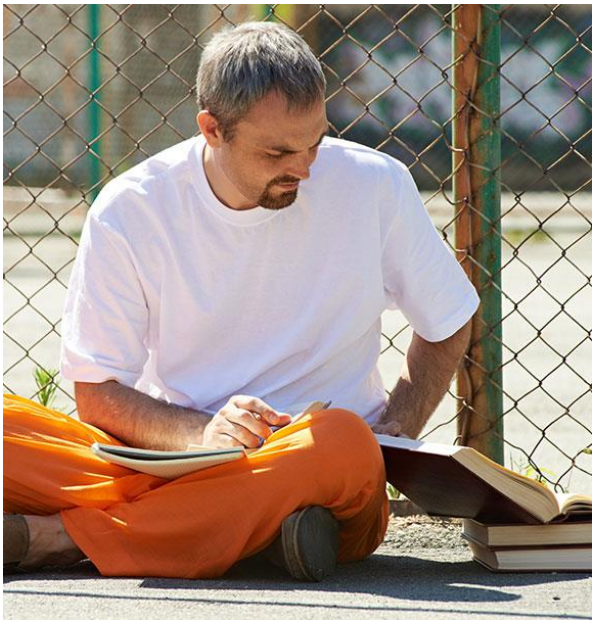
12. Reducing barriers to housing for former offenders.

13. Suspending Medi-Cal benefits for incarcerated individuals for the full duration of their incarceration rather than the current one-year limit.

14. Increasing funding for infrastructure and facilities improvements to adequately address population management and the needs of AB 109 inmates, especially those with acute and chronic illness and serious mental health issues.

15. Enhancing the juvenile mental health competency process, including providing adequate funding for competency restoration curriculum and training, mental health services, and supportive services for juveniles found incompetent to stand trial.

16. Support proposals that increase counties' ability to work collaboratively with law enforcement, justice, policy makers, crisis and behavioral health service partners to adopt and apply the Stepping Up framework to reduce incarceration of people with mental illness. This includes proposals that provide resources to increase crisis co-response of mental health and law enforcement, provide comprehensive screening and assessment for mental health in jail, collect baseline data for this population, divert those with mental illness from arrest and incarceration, expand services in custody and in the community, and track outcomes.



J. Realignment

Implementation of SB 90, Chapter 25, Statutes of 2017, which establishes the cost shift of hundreds of millions of dollars in In-Home Supportive Services (IHSS) costs from the state to the counties will remain a focus of CBHDA, CSAC and other county affiliates in 2019.

Unfortunately, while this state budget proposal enacted in July 2017 benefits counties in the aggregate, by reducing net county cost burdens, the proposal "redirects" the entirety of counties' 1991 Realignment Vehicle License Fee (VLF) growth funds for three years from Mental Health, Health, and County Medical Services subaccounts to pay for IHSS costs. In the two years that follow, half of those VLF growth funds will be swept to pay for IHSS.

There is a codified "reopener" contained in this law. This reopener provision must look at if 1991 Realignment funding is meeting program costs, how IHSS costs are growing compared to the inflation factor, the impact of the IHSS on funding available to Mental Health, Health and County Medical Services and other social services programs and the status of collective bargaining. Our interests will be in softening the long-term impact of the multi-year funding sweep from 1991 Realignment mental health growth funding to IHSS.