Senate Budget and Fiscal Review

Subcommittee No. 3 2009 Agendas

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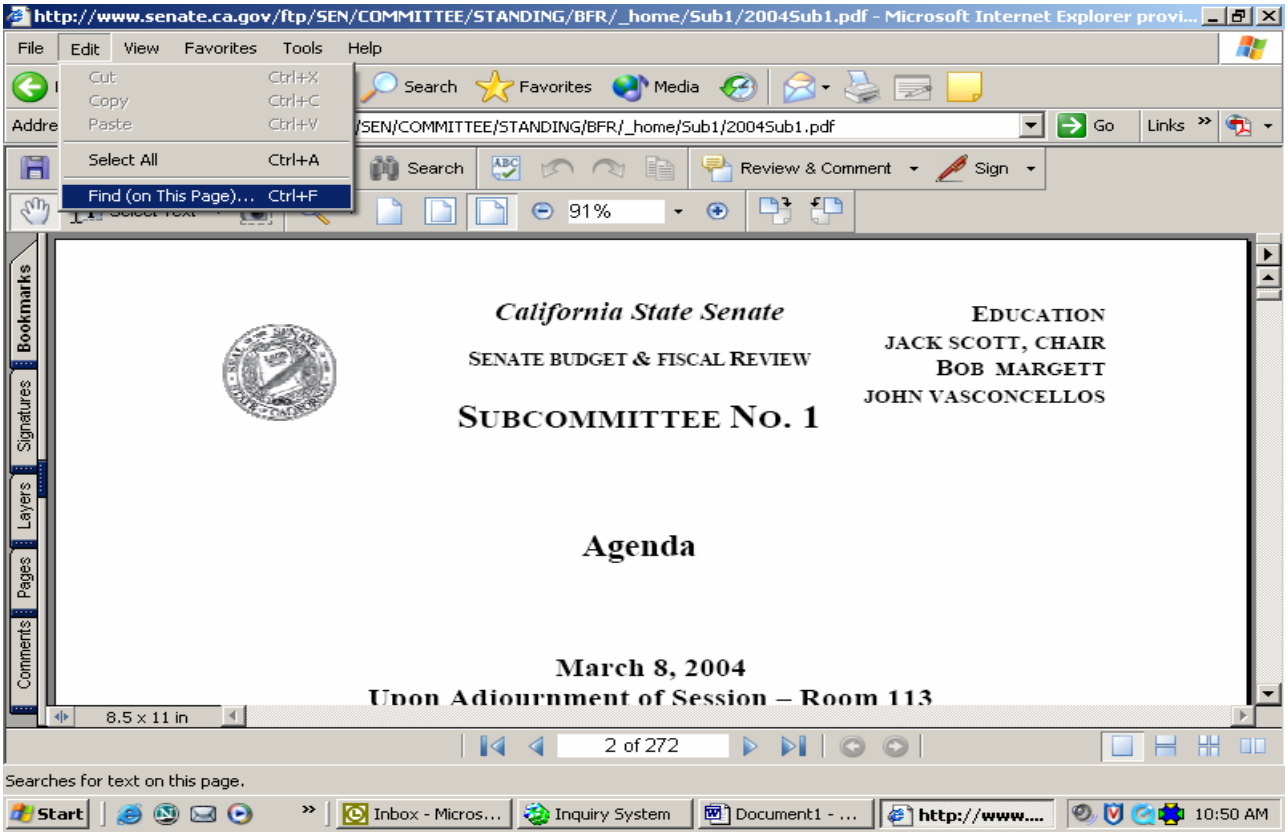

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator John Benoit

March 19, 2009

9:30 a.m. *or*
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item	**Department**
4265	**Department of Public Health--*Selected Issues***

- AIDS Drug Assistance Program
- Therapeutic Monitoring Program
- Genetic Disease Testing Program
- Tobacco Control Program
- Capital Outlay for Viral and Rickettsial Laboratory
- Contract Positions Transitioning to State Staff Positions

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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DEPARTMENT OF PUBLIC HEALTH-- Item 4265

A. OVERALL BACKGROUND

Purpose of the Department. The Department of Public Health (DPH) delivers a broad range of public health programs. Some of these programs complement and support the activities of local health agencies in controlling environmental hazards, preventing and controlling disease, and providing health services to populations who have special needs. Others are solely state-operated programs, such as those that license health care facilities.

According to the DPH, their goals include the following:

- ✓ Promote healthy lifestyles and appropriate use of health services
- ✓ Prevent disease, disability and premature death
- ✓ Protect the public from unhealthy and unsafe environments
- ✓ Provide and ensure access to critical public health services
- ✓ Enhance public health emergency preparedness and response

The department comprises five public health centers, as well as the Health Information and Strategic Planning section, and the Public Health Emergency Preparedness Program. The five public health centers are as follows: (1) Center for Chronic Disease Prevention and Health Promotion; (2) Center for Environmental Health; (3) Center for Family Health; (4) Center for Health Care Quality; and (5) Center for Infectious Disease.

Summary of Funding for the Department of Public Health. The budget proposes expenditures of almost $3.3 billion ($348.9 million General Fund) for the DPH as noted in the Table below. Most of the funding for the programs administered by the DPH comes from a variety of federal funds, including grants and subventions for specified areas (such as water, emergency preparedness and Ryan White CARE Act funds). Many programs are also funded through the collection of fees for specified functions, such as for health facility licensing and certification activities. Several programs are funded through multiple sources, including General Fund support, federal funds and fee collections.

Of the amount appropriated, $637.7 million is for state operations and $2.647 billion is for local assistance. The 2009-10 budget reflects a decrease of $210.1 million as compared to the revised 2008-09 budget.

Summary of Expenditures for Department of Public Health	2009-10
Public Health Emergency Preparedness	**$103,230,000**
Public and Environmental Health	**$3,019,360,000**
Chronic Disease Prevention and Health Promotion	317,001,000
Infectious Disease	665,288,000
Family Health	1,686,298,000
Health Information and Strategic Planning	25,999,000
County Health Services	47,648,000
Environmental Health	277,126,000
Licensing and Certification Program	**$162,058,000**
Licensing and Certification of Facilities	151,432,000
Laboratory Field Services	10,626,000
Total Expenditures for Department of Public Health	**$3,284,648,000**
Funding Sources	
General Fund	$348,873,000
Federal Funds	$1,605,401,000
Genetic Disease Testing Fund	$115,019,000
Licensing and Certification Fund	$81,060,000
WIC Manufacturer Rebate Fund	$329,901,000
AIDS Drug Assistance Program Rebate Fund	$234,467,000
Water Security, Clean Drinking Water, Beach Protection Fund	$23,422,000
Safe Drinking Water Account	$13,641,000
Drinking Water Treatment and Research Fund	$5,088,000
Childhood Lead Poisoning Prevention Fund	$22,072,000
Birth Defects Monitoring Fund	$3,595,000
Radiation Control Fund	$25,093,000
Food Safety Fund	$6,732,000
Reimbursements	$203,572,000
Other Special Funds	$266,712,000
Total Expenditures	**$3,284,648,000**

(Discussion items begin on the next page.)

B. ISSUES FOR DISCUSSION

1. AIDS Drug Assistance Program (ADAP) *(Pages 4 through 11)*

Summary of Budget Appropriation. The Budget Act of 2009 provides an appropriation of $418.1 million (total funds) for 2009-10 for the ADAP, including expenditures for eligibility screening and Medicare Part D premiums.

The Table below compares the two fiscal years, as updated in the February 18-month budget package, and key components of the ADAP expenditures.

Component	2008-09 Current Year (Revised January)	2009-10 Budget Year	Difference
Prescription Costs	$348,630,000	$403,487,000	$54,857,000
Pharmacy Contractor—Operations	$11,495,000	$12,611,000	$1,116
Subtotal	**($360,125,000)**	**($416,098,000)**	**($55,973,000)**
Local Health Officers—Administration of Enrollment & Eligibility Screening	$1,000,000	$1,000,000	--
Medicare Part D Premiums	$1,000,000	$1,000,000	--
TOTAL EXPENDITURES	**$362,125,000**	**$418,098,000**	**$55,973,000**
General Fund	**$96,349,000**	**$96,349,000**	--
Drug Rebate Funds	**$177,330,000**	**$233,303,000**	**($55,973,000)**
Federal Funds	**$88,446,000**	**$88,446,000**	--

As noted in the Table, the 2009-10 appropriation reflects an increase of almost $56 million, or about 15 percent, from the revised current year. The Office of AIDS states this increase is primarily attributable to the following:

- Overall drug price increases, including general price increases, new antiretroviral drugs becoming available for treatment, and physicians switching clients to more expensive antiretroviral drug combinations; and
- An increase in ADAP enrollment of about 1,400 clients, for a total of over 35,500 clients. In addition, the average length a client will access ADAP in a 12-month period is about 7.44 months which is for a longer period than compared to other years. (For example, 6.9 months in 2005; and 7.2 months in 2007)

As noted in the Table above, the ADAP is funded using General Fund support, federal funds (Ryan White CARE Act--Part B grant), and the ADAP Drug Rebate Fund. An increase of almost $56 million in ADAP Drug Rebate Funds is assumed to support ADAP in 2009-10. This fund is discussed further below under the issues section.

No increases in General Fund support or federal fund (Ryan White CARE Act Funds—Part B) support are provided. The federal Part B funds are awarded to California based upon California meeting certain "Maintenance of Effort (MOE)" requirements for maintaining state

expenditures for HIV-related functions. No issues have been raised regarding California meeting its MOE requirements for the receipt of these federal funds.

Summary of ADAP Caseload. The ADAP is the payer of last resort. Individuals who have private health insurance, are eligible for Medi-Cal, or are eligible for Medicare, must access these services first, before the ADAP will provide services. The following chart provides a summary of the ADAP client enrollment.

ADAP Clients by Coverage Group (2008-09)

Coverage Group	Clients	Percent
ADAP-Only coverage	20,951	61.20 %
Medi-Cal coverage	407	1.19
Private coverage	5,351	15.65
Medicare coverage	7,475	21.87
TOTAL	**34,184**	**100 percent**

Subcommittee Discussion Issues—Three Items. The AIDS Drug Assistance Program (ADAP) is a core state-operated program and its fiscal structure is complex. As such, through trailer bill legislation enacted last year, the Legislature directed the Office of AIDS to annually provide a comprehensive ADAP Estimate Package in January and at the May Revision for budget purposes. This is the first year of this submittal to the Legislature.

Upon review of the ADAP Estimate Package, the following issues have been identified for discussion in Subcommittee:

1. Estimate Methodology—Two Methods Used by Office of AIDS. The Office of AIDS has two methods for estimating expenditures in the ADAP—"Linear Regression Model", and the "Percent Change Model". *Both models are used by the Administration to compare and analyze expenditures for budget purposes.*

The Linear Regression Model was used exclusively by the Administration from 1998 through 2006 for estimating purposes. The underlying assumption for this model is that the data closely fit a straight line and the trend increases or decreases at a fairly *consistent* rate or slope over time. If data trends increase rapidly, a Linear Regression Model would likely underestimate projected expenditures. If data trends decline considerably, a Linear Regression Model would likely overestimate projected expenditures.

Over the past few years, the federal Health Resources and Services Administration (HRSA) worked with states, including California, to develop budget forecasting tools to assist all state AIDS drug programs. Through this effort, several options were developed including a federal HRSA "Percent Change Model". This is the *second model* that is used for estimating ADAP.

Generally, the federal HRSA Percent Change Model does the following:

- Uses the previous year's expenditures for the program;
- Identifies factors that will increase or decrease the annual expenditures;

- Assigns percentage costs or savings for each factor; and
- Calculates the revised estimate.

The Office of AIDS then applies five California specific factors to this model as follows:

- Medicare Part D Costs;
- New drug costs, mainly for anti-retrovirals;
- Drug price increases, including ADAP clients who switch to more expensive drugs;
- Increased client costs; and
- Certain transaction fees

This Percent Change Model approach was first used by the Office of AIDS last year at the May Revision and is still being refined since the federal HRSA did not offer guidance in some of the underlying assumptions of the model. Therefore, the Office of AIDS states that this "Percent Change Model" is *more subjective* than the previously used "Linear Regression Model".

A. Estimate Methodology for Revised Current Year. For the revised 2008-09 budget (as of January 2009), the Office of AIDS estimated costs based on *both* models.

The Percent Change Model projected expenditures of $327.8 million (total funds), while the Linear Regression Model projected expenditures of $360.1 million (total funds), or $32.3 million (total funds) *more* than the Percent Change Model as shown in the Table below.

The Office of AIDS has opted to use the Linear Regression Model with an upper bound of the 95 percent confidence level in order to *not* underestimate the need for ADAP services. The February budget package adopted the $360.1 million (total funds) for the current year.

Revised Current Year ADAP Information—Model Comparison

Model Type	Estimated Total Funds	Compared to Budget Act 2008
Budget Act** of 2008	$330.3 million*	--
Percent Change Model	$327.8 million	-$2.5 million
Linear Regression Model—with upper bound at 95% confidence. ($32.3 million *more* than Percent Change Model)	$360.1 million	+$29.8 million

**Prior to a $7 million reduction for "budget balancing".

The Administration funded the increase of $29.8 million, or 9 percent, using AIDS Drug Rebate Funds. The Administration will likely be updating the current year at the May Revision.

B. Estimate Methodology for Budget Year. For 2009-10, the Office of AIDS also estimated costs based on *both* models.

The Percent Change Model projected expenditures of $350.8 million (total funds) and the Linear Regression Model projected expenditures of $416.1 million (total funds), or $65.3 million (total funds) more than the Percent Change Model as shown in the Table below.

The Office of AIDS has opted to use the Linear Regression Model with an upper bound of the 95 percent confidence level in order to *not* underestimate the need for ADAP services. The February budget package adopted the $416.1 million (total funds) for the budget year.

Budget Year ADAP Information—Model Comparison

Model Type	Estimated Total Funds	Compared to Revised Current Year
Revised 2008-09 Amount	$360.1 million	--
Percent Change Model ($65.3 million *less* than Linear Regression)	$350.8 million	-$9.3 million
Linear Regression Model—with upper bound at 95% confidence. ($65.3 million *more* than Percent Change.)	$416.1 million	+$56 million

The Administration funded the increase of $56 million, or 15 percent, over 2008-09 using AIDS Drug Rebate Funds. The Administration will be updating the budget year at the May Revision.

2. ADAP Rebate Fund. Drug rebates constitute a significant part of the annual ADAP budget. This special fund captures all drug rebates associated with ADAP, including both mandatory (required by law) and voluntary supplemental rebates (additional rebates negotiated with drug manufacturers).

California is a member of the ADAP Crisis Task Force, a state coalition of large ADAPs in the country, which negotiates additional rebates with drug manufactures for selected drugs. The Office of AIDS notes that supplemental rebate agreements are in place for all antiretrovirals on the formulary. Most supplemental rebate agreements include terms based on either an additional rebate percentage and/or a price freeze credit approach. which benefits the state.

The exact amount of rebates to be collected varies due to a number of factors, including changes in the federal calculation for mandatory rebates and the voluntary nature of the supplemental rebates. It should be noted that drug rebate collections from drug manufacturers are received by the Office of AIDS in a timely manner—usually 85 percent are received within 60-days of the invoice.

The Office of AIDS' ADAP Rebate Fund condition statement displays the following key aspects for 2009-10:

- Beginning Balance from Previous Year (roll over) $ 86.5 million
- New ADAP Rebate Revenue (estimated) $178.5 million
- Interest $ 6.7 million
- TOTAL Resources Available $271.7 million

- Office of AIDS Estimated Expenditure from Fund ($234.6 million)

- Remaining Reserve (estimated) **$37.1 million**

As noted above, the Office of AIDS estimate expenditures are about $56 million more than the "new" anticipated rebate revenue. Fortunately, there are unexpended rebate funds from prior years when have been rolled over. As such a prudent reserve is still available.

The Office of AIDS states that generally, for every dollar of ADAP expenditure, the program obtains 46 cents in rebates. This 46 percent level is based on an average of rebate collections which includes both "mandatory" and "supplemental" rebates.

3. Medicare Part D—Potential Implications for ADAP. California's ADAP also has complex interactions with the federal Medicare Part D drug benefit, implemented in January 2006. The ADAP is the payer of last resort and serves as a wrap-around for enrolled clients because it is cost-beneficial to the state.

ADAP provides, where appropriate, payment for client's Medicare Part D premiums, copayments, and deductibles. According to the Office of AIDS, presently there are 7,475 ADAP clients enrolled in Medicare Part D. The ADAP spends about $25 million (total funds) on these individuals which represents about 7 percent of ADAP expenditures, based on the revised 2008-09 budget of $360 million for ADAP.

The federal Centers for Medicare and Medicaid Services (CMS) contracts with Medicare Part D drug plans on an annual basis and drug benefits available under Part D plans will vary from year to year, including drug formulary adjustments, changes to client out-of-pocket costs, and plans entering and exiting the market.

According to the Office of AIDS, ADAP will experience ongoing fluctuations in Part D related costs due to the following factors:

- Annual adjustments to Medicare Part D maximum out-of-pocket costs thresholds;
- Annual adjustments to Part D plan premiums;
- ADAP client Part D plan selections (clients enrolling in high cost versus low cost plans);
- ADAP client Part D "low-income subsidy" eligibility; and
- Part D plan prescription co-payment requirements.

The Office of AIDS states that Medicare Part D costs for ADAP are monitored on a monthly basis to track costs. As the payer of last resort, ADAP provides assistance to clients when Medicare Part D assistance is limited or is not available. For example, ADAP clients in Part D can move from being eligible for "low income subsidies" within Part D to receiving a "standard benefit" to hitting a coverage gap known as the "donut hole"). As such, ADAP expenditures can vary for Part D enrollees, particularly if they hit the "donut hole" where there is a coverage gap and all eligible costs are absorbed by the ADAP.

The Office of AIDS states that more ADAP clients will go into the "donut hole" in 2009-10 and remain there as opposed to transitioning to a lower cost catastrophic coverage category. This is because federal Medicare law prohibits state ADAPs spending from

counting towards a Medicare beneficiary's true out-of-pocket costs ("TrOOP"). The federal CMS does permit state pharmaceutical assistance programs to count towards TrOOP.

If ADAP payments counted towards TrOOP, this would be a considerable cost offset to the ADAP, allowing ADAP clients to move out of the Part D "donut hole" and into Part D "catastrophic coverage" where Part D would fund costs. According to the Office of AIDS, this would reduce the state's costs *significantly.*

The Table below provides a summary of estimated Medicare clients enrolled in the ADAP and their Medicare Part D scenario.

Summary ADAP Caseload Enrolled in Medicare Part D & Their Scenario (2008-09)

Medicare Part D Scenario	Clients	Percent
Standard Benefit	1,608	21.52%
Donut Hole	1,650	22.07
Dual Eligible (with share of cost)	1,536	20.55
Dual Eligible ("no" share of cost)	2,681	35.87
TOTAL	**7,475**	**100 percent**

Background—ADAP Uses a Pharmacy Benefit Manager. The AIDS Drug Assistance Program was established in 1987 to help ensure that HIV-positive uninsured and under-insured individuals have access to drug therapies.

Beginning in 1997, California contracted with a pharmacy benefit manager (PBM) to centralize the purchase and distribution of drugs under ADAP. Presently, there are over 200 ADAP enrollment sites and over 3,000 pharmacies available to clients located throughout the state. Subcommittee staff notes that use of a state-wide PBM has been a successful endeavor and has been very cost-beneficial to the state (See University of AIDS Research Program analysis of 2004).

The state provides reimbursement for drug therapies listed on the ADAP formulary (over 180 drugs). The formulary includes antiretrovirals (about 30), opportunistic infection drugs, hypolipidemics, anti-depressants, vaccines, analgesics, and antibiotics. Since the AIDS virus can quickly mutate in response to a single drug, medical protocol calls for inclusion of at least three different anti-viral drugs for patients.

According to the Office of AIDS, ADAP served over 32,800 clients in 2007-08 and filled over 953,000 prescriptions for these clients (most recent *actual* data). Actual drug expenditures were $306.6 million of which $271.8 million was for antiretrovirals, or about 88 percent of the total expenditures.

Background—How Does the AIDS Drug Assistance Program Serve Clients? ADAP is a subsidy program for low and moderate income persons with HIV/AIDS. Under the program, eligible individuals receive drug therapies through participating local pharmacies under subcontract with the statewide contractor (i.e., the pharmacy benefit manager).

Individuals are eligible for ADAP if they:

- Are a resident of California;
- Are HIV-infected;
- Are 18 years of age or older;
- Have an adjusted federal income that does not exceed $50,000;
- Have a valid prescription from a licensed CA physician; and
- Lack private insurance that covers the medications or do not qualify for no-cost Medi-Cal.

ADAP clients with incomes between $43,320 (400 percent of poverty as of April 1, 2009) and $50,000 are charged monthly co-pays for their drug coverage. A typical client's co-payment obligation is calculated using the client's taxable income from a tax return. The client's co-payment is the lesser of (1) twice their annual state income tax liability, less funds expended by the person for health insurance premiums, or (2) the cost of the drugs.

Background—ADAP is the Payer of Last Resort. Both federal and state laws require that ADAP funds be used as the payer of last resort. As such, ADAP is used *only* after all other potential payer options are exhausted. This means that all Medicare eligible ADAP clients are required to utilize the prescription drug benefits available under the Medicare Part D Program. Persons eligible for private insurance coverage are required to access and utilize

Background—ADAP Drug Rebates (Federal and State Supplemental). Both federal and state law *require* ADAP drug manufacturer rebates to be paid in accordance with the same formula by which state Medicaid (Medi-Cal) programs are paid rebates. This formula is established by the federal CMS.

California also negotiates additional supplemental rebates under ADAP via a special national taskforce, along with eight other states. The mission of this taskforce is to secure additional rebates from eight manufacturers of anti-retroviral drugs (i.e., the most expensive and essential treatment therapies) and other HIV-related drugs.

Background—ADAP is Cost-Beneficial to the State. The ADAP is a core state program. Without ADAP assistance to obtain HIV/AIDS drugs, individuals would be forced to: (1) postpone treatment until disabled and Medi-Cal eligible, or (2) spend down their assets to qualify, increasing expenditures under Medi-Cal. According to the Administration, 50 percent of Medi-Cal costs are borne by the state, whereas only 30 percent of ADAP costs are borne by the state.

Studies consistently show that early intervention and treatment adherence with HIV/AIDS-related drugs prolongs life, minimizes related consequences of more serious illnesses, reduces more costly treatments, and increases an HIV-infected person's health and productivity.

Legislative Analyst's Office Comment. The LAO, in their health issues brief (dated February 6, 2009) notes that other states with budget shortfalls have implemented cost-cutting measures, such as capping client enrollment, eliminating drugs from formularies, modifying copayment requirements, and limiting per-patient expenditures.

The LAO also notes that cost-cutting measures in ADAP would likely increase the barriers to receiving care for some patients, potentially impacting the health of HIV/AIDS patients and

increasing the associated public health risks. As such, the LAO notes they will be reviewing options and will provide specific recommendations at the May Revision regarding any potential cost-saving measures.

Subcommittee Staff Comment. ADAP is a core state program which is cost-beneficial to the state, as noted above. California's legislatively enacted requirement to utilize a Pharmacy Benefit Manager approach to the program has facilitated the program's cost efficiency. Further, the Office of AIDS has significant authority to administer the program, including the ability to modify the ADAP formulary, contingent upon best medical practices. ADAP is an efficient program and is the payer of last resort; as such, its program integrity is critical to maintain.

It should be noted that California will be receiving additional federal Ryan White CARE Act funds which have not yet been appropriated in the Budget Act of 2009 due to timing issues with receipt of these funds. California receives a portion of these federal funds based on certain formulas. As such, it is not yet fully known how much California will definitively receive; however, it is probable that an increase of at least $3 million or so will be obtained.

These funds will be addressed in the May Revision. The Office of AIDS will also be providing the Legislature with a current-year and budget-year May Revision estimate to update caseload, expenditures and Drug Rebate Funds.

Questions. The Subcommittee has requested the Office of AIDS to respond to the following questions regarding each of the *three identified issues*.

Issue #1--Office of AIDS Estimate Methodology

1. Please provide a *brief* summary of the ADAP budget request *and* the estimating methodology.
2. What *key* data factors is the Administration tracking for ADAP?
3. Is it likely that this same methodology—Linear Regression with upper bound at 95 percent confidence level-- will be used for the May Revision, and will both the current year and budget year be updated?
4. Is it likely that California will be receiving any increases in federal Ryan White CARE Act funds? If yes, please briefly explain.

Issue #2—ADAP Rebate Fund

1. Please provide a *brief* summary regarding drug rebates under the ADAP.
2. Are ADAP Rebates—mandatory or supplemental—to remain fairly stable in 2009-10?

Issue #3—Medicare Part D Interactions with the ADAP

1. Specifically, how does the Medicare Part D drug benefit interact with ADAP?
2. What are the key cost drivers in this relationship?
3. What can be done with the concerns regarding a client's TrOOP in Medicare? Any federal update here?

2. Therapeutic Monitoring Program—Update

Summary of Budget Appropriation. The Budget Act of 2009 provides a total of $8 million (General Fund) for the Therapeutic Monitoring Program.

The purpose of this program is to provide therapeutic monitoring assays for HIV positive people who cannot otherwise afford them. Priority for funding under the program is to be given to state-funded Early Intervention Program sites. Coverage awards are to be made to counties on the basis of need. Determination of awards is to be made by the Office of AIDS dependant on availability of state funding, including ADAP Drug Rebate funds, and federal funding for the program.

In addition, state statute notes that counties and cities may cover those assays that are deemed necessary and are not covered under this state program. Communities can fund assays using their federal Ryan White CARE Act—Part A funds.

Specifically, viral load and resistance testing is done to measure the degree to which an individual's HIV has become resistant or less sensitive to anti-retroviral drugs. About 20,000 clients accessing Therapeutic Monitoring Program services are enrolled in ADAP.

Subcommittee Staff Comment and Recommendation. It is recommended to maintain this level of for the Therapeutic Monitoring Program and to monitor need on a periodic basis which is what the Office of AIDS is presently doing. It should be noted that ADAP Drug Rebate Funds can also be used for this purpose, and have been used in prior years. However, expenditure of Rebate Funds within the AIDS Drug Assistance Program is the priority.

Questions. The Subcommittee has requested the Office of AIDS to respond to the following questions.

1. Office of AIDS, Please provide a *brief* update on this program and its expenditures.

3. Genetic Disease Testing Program

Summary of Budget Appropriation. The Budget Act of 2009 appropriates a total of $115 million (Genetic Disease Testing Fund) for the Genetic Disease Testing Program. This reflects a net reduction of $4.8 million (Genetic Disease Testing Fund), as compared to the current-year.

Summary of Total Program

Category of Program	Total for 2009-10	Difference Compared to 2008-09
Newborn Screening Program	$45,698,000	($52,000)
Prenatal Screening Program	$49,035,000	$1,558,000
SUBTOTAL	**$94,733,000**	**$1,506,000**
Administration	$20,286,000	($6,268,000)
TOTAL	**$115,019,000**	**($4,762,000)**

As noted in the Table above, the Newborn Screening Program reflects a net nominal change—just a small adjustment primarily for caseload-driven adjustments.

The Prenatal Screening Program reflects a more involved series of adjustments due to implementation of Senate Bill 1555 (Speier), Statutes of 2006, which provides for "integrated screening" through the availability of "First Trimester Screening". With the addition of First Trimester Screening, women may choose to receive screening services in both trimesters, including a second ultrasound during the first trimester. The Department of Public Health (DPH) notes that combining both screens will result in "integrated screening", an approach that improves detection rates.

The DPH states that the Prenatal Screening Program expansion, as referenced, will begin phased-in implementation as of April 1, 2009. As such, the budget year reflects adjustments as shown in the Table below.

Prenatal Screening Program Detail

Program Component	Total for 2009-10	Difference Compared to 2008-09
Contract Laboratories	$5,090,000	$1,114,000
Scientific Costs	$12,981,000	$900,000
System Equipment & Maintenance	$6,485,000	($3,175,000)
Follow-Up Costs After Tests	$4,978,000	$639,000
Prenatal Diagnostic Centers	$18,191,000	$2,465,000
Resulting Reporting & Fee Collection	$1,310,000	($385,000)
Total—Local Assistance	**$49,035,000**	**$1.5 million**

The DPH states that the above program component expenditures, as noted in the Table, are based on the following three aspects to the Prenatal Screening Program, and the related expansion:

- Prenatal Tests, which provides screening of pregnant women for genetic and congenital disorders, will cost $41.53 per test and the volume of tests will increase by 66,700 for a total of about 435,000 women in 2009-2010.
- Follow up, referral, and counseling refers to pregnant women whose prenatal tests have shown positive results. This category will cost $49.74 per case, for an increase of $3.40 per case over the current-year. This caseload is estimated to increase by about 15,300 women for a total of about 100,000 women.
- Clinical Diagnostic Services refers to pregnant women with positive results needing diagnostic work-up. This category will cost $760 per case, for an increase of about $58 per case over the current-year. This caseload is estimated to increase by about 3,670 women for a total of about 24,000 women.

It should be noted that these assumptions may evolve as the DPH obtains more experience with the Prenatal Screening Program expansion over the course of the upcoming year.

In addition, the Administration is modifying a $4.2 million General Fund loan repayment schedule which was provided to the Genetic Disease Testing Program. This General Fund loan was made to the program due to a shortfall in the special fund in prior years. Previously this loan was to be repaid as of June 30, 2009. This repayment schedule has now been shifted back to June 30, 2011.

Background—What is the Genetic Disease Testing Program? The Genetic Disease Testing Program consists of two programs—the Newborn Screening Program and the Prenatal Screening Program. Both screening programs provide public education, and laboratory and diagnostic clinical services through contracts with private vendors, meeting states standards. Authorized follow-up services are also provided as part of the fee payment. *Generally*, the programs are self-supporting on fees collected from screening participants through the hospital unit, third party payers or private parties using a special fund—Genetic Disease Testing Fund.

The Newborn Screening Program provides screening of all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is about $103 dollars. Where applicable, this fee is paid by the family's insurance, the Medi-Cal Program, or out-of-pocket.

The Prenatal Screening Program provides screening of pregnant women who consent to screening for serious birth defects. The fee paid for this screening is $162 dollars. Where applicable, this fee is paid by the family's insurance, the Medi-Cal Program, or out-of-pocket.

Subcommittee Staff Comment. No issues have been raised regarding the Genetic Disease Testing Program. However the DPH should provide comment regarding the expansion of the Prenatal Care Testing Program as well as the need to shift the repayment of the General Fund loan to June 30, 2011.

Questions. The Subcommittee has requested the Office of AIDS to respond to the following questions.

1. Department of Public Health, please provide a *brief* update on the implementation of the First Trimester Screening expansion within the Prenatal Screening Program, as well as *key* adjustments contained in the budget for this program.
2. Department of Public Health, please provide an update on the Genetic Disease Program's payment of the General Fund Loan.
3. Department of Public Health, are all of the Genetic Disease Testing Program fees being collected effectively? Are there any concerns with the collection or payment of the fees?

4. Augmentation for Richmond Laboratory Capital Outlay Project

Summary of Budget Appropriation. The Administration is proposing an augmentation of $3.1 million (General Fund) for the construction of modifications at the Viral and Rickettsial Disease Laboratory which is part of the DPH's Richmond Laboratory complex.

The DPH states that changes are desired for this laboratory to meet newly established guidelines for *"enhanced"* bio-safety Level III laboratories as determined by the U.S. Department of Agriculture, federal Centers for Disease Control and Prevention (CDC) and National Institutes for Health (NIH).

The DPH contends that compliance with these *"enhanced"* guidelines is essential for the safe *growing,* handling and examining of potentially high pathogenic influenza viral agents, thereby continuing the state's ability to respond quickly and control a potential outbreak of pandemic flu. In essence, the DPH states that this level of "enhanced" bio-safety is for *growing* the virus to have a clinical specimen to then compare any suspected samples.

Presently the Viral and Rickettsial Disease Laboratory meets bio-safety Level III preparedness but not the new "enhanced" level.

Subcommittee Staff Comments and Recommendation—Hold Open. The DPH submitted this request last year and it was deferred due to the fiscal crisis. Though the Budget Act of 2009 provides an appropriation of $3.1 million (General Fund) for this purpose, the Subcommittee may desire to amend this request for several reasons.

First, it is unknown at this time if federal stimulus funds are available for this purpose. The DPH is unclear on this matter and will be discussing this further with the federal Centers for Disease Control (CDC). Obtaining federal funding for this project makes sense and the DPH should be pursuing this venue aggressively.

Second, California continues to experience a decline in revenues, as recently reported by the Legislative Analyst's Office. As such, question arises as to how this expenditure corresponds with other potential priorities of the Legislature, such as direct health care services or services to other "core" health and human services programs.

As noted the "enhanced" guidelines are relatively new. According to the DPH, there presently are no states in the nation that meet "enhanced" guidelines but a few states maybe proceeding with changes, such as New York. The only laboratories presently certified to safely handle the Avian ("bird") Influenza viruses is the federal CDC laboratories located in Atlanta, Georgia; Ames, Iowa; and Fort Collins, Colorado.

The DPH states that in the event a case of Avian Influenza is suspected here in California, the general protocol is to use the federal CDC laboratories to conduct confirmatory testing.

Further, the DPH states where there have been two known instances where potential Influenza samples were sent to the federal CDC by the DPH for confirmation. *In both instances, the initial testing was conducted at the Richmond Laboratory complex with the federal CDC conducting the confirmatory analysis.*

In light of the state's fiscal situation and the availability of federal CDC "enhanced" bio-safety Level III laboratories to California for the specified purposes, it is recommended to keep this issue "open" until the May Revision.

Questions. The Subcommittee has requested the department to respond to the following questions.

1. DPH, Please provide a brief summary of the request.

5. Tobacco Control Program

Summary of Budget Appropriation. Several proposals were *excluded f*rom the February budget package "without prejudice" in order to provide for additional information and clarification. As such, these proposals would need *to be amended into* any future budget bill for inclusion in 2009-10.

Budget Request. The Department of Public Health (DPH) is requesting a *one-time only* increase of $6.8 million (Health Education Account, Cigarette and Tobacco Produce Surtax Funds) for the Tobacco Control Program.

This one-time only appropriation request would be funded using a portion of the reserves from the Health Education Account, Cigarette and Tobacco Produce Surtax Funds. Even with this appropriation, the Health Education Account would still have an overall reserve of $19.3 million. (It should be noted that a prudent reserve is necessary due to the fluctuation in these revenues.)

Of the requested increase, $4.5 million would be provided to the Media Campaign and $2.3 million for Competitive Grants. This increase would provide total funds of $20.2 million (Health Education Account) for the Media Campaign and $17.7 million (Health Education Account) for the Competitive Grants Program.

The DPH states the proposed augmentations would be used as follows:

- The Media Campaign would increase "target rating points" to a 500 per three-week flight in the top four media markets and maintain the target rating points in the remaining eight media markets.

- The Competitive Grant Program would add six to nine projects to be funded from $200,000 to $300,000 each. These projects may include, smoke-free multiunit housing, tobacco use in the movies, tobacco industry sponsorship, free tobacco product sampling, and tobacco cessation training and technical assistance services. Additionally, there are populations with high rates of smoking who would be focused on as well in an effort to reduce smoking in various population groups.

Background—The Tobacco Control Program. The purpose of this program is to decrease tobacco-related diseases and deaths in California by reducing tobacco use across the state. The program focuses on changing the broad social norm around the use of tobacco by indirectly influencing current and potential future tobacco users by creating an environment in which tobacco is less desirable (socially and legally where applicable). Specifically, the program focuses its tobacco control activities on:

- Countering pro-tobacco influences in the community by working to curb tobacco product retail advertisements and marketing practices;
- Reducing the exposure to secondhand smoke and tolerance of exposure;
- Reducing tobacco availability; and
- Promoting tobacco cessation services.

The DPH states that these strategies are achieved through a comprehensive infrastructure such as the *Media Campaign*, grassroots coalition efforts managed by non-profit community-based organizations, and projects funded by the *Competitive Grants Program*. In addition, the DPH supports an educational materials clearinghouse, training and technical assistance services, and the California Smokers' Helpline.

Background—Proposition 99 Funds. Proposition 99, the Tobacco Tax and Health Protection Act of 1988, established a surtax of 25 cents per package on cigarettes and other tobacco products, and provided a major new funding source for health education, indigent health care services, and resources programs.

Under the provisions of Proposition 99, revenues are allocated across six accounts based on specified percentages. These are: (1) Health Education Account—20 percent, (2) Hospital Services Account—35 percent, (3) Physician Services Account—10 percent, (4) Research Account—5 percent, (5) Unallocated Account—25 percent; and (6) Public Resources Account—5 percent.

Subcommittee Staff Comment and Recommendation. No issues have been raised regarding this request. Funds are available for this purpose from the reserves in the Health Education Account, and the Media Campaign and Competitive Grants Program are core components to the overall Tobacco Control Program.

It is recommended to adopt this proposal as requested by the DPH for inclusion in the next budget bill.

Questions. The Subcommittee has requested the department to respond to the following questions.

1. DPH, Please provide a *brief* summary of the request and how both the increase for the Media Campaign and the Local Lead Agencies would be used.

6. Department of Public Health—Shifts from Contracting to State Support

Summary of Budget Appropriation. Several proposals were *excluded f*rom the February budget package "without prejudice" in order to provide for additional information and clarification. As such, these proposals would need *to be amended into* any future budget bill for inclusion in 2009-10.

Within the DPH, there were four "without prejudice" proposals regarding the establishment of state civil service positions, in lieu of contracting out. A summary of these four proposals is shown in the Table below.

Summary of Proposals to Shift from Contracting to State Support

Program Area	Description	State Positions to Establish in 2009-10	Proposed 2009-10 Adjustment
Occupational Lead Program	Shifts $805,000 from external contracts to fund new state positions. State staff would maintain surveillance system, investigate cases of lead poisoning, collect fees from users of lead, and provide administrative support.	9.0	-$25,000 (Special)
Richmond Laboratory Complex	Shifts a total of $1.034 million from external contracts to provide janitorial services to fund new state positions for this function. The Richmond Laboratory complex consists of about 700,000 sq ft of space with eight laboratories and various other buildings.	23.0	--
Information Technology Division	Shifts a total of $852,000 from external contracts to fund new state positions. State staff would conduct various data processing functions, including software development, database development, and related program support.	6.0	-$95,000 (Federal)
Genetic Disease Program	Shifts $1.106 million from external contracts to fund new state positions. State staff would assist with customer service workload, including completing forms, assist with fee collection, and various accounting functions.	15.0	-$242,000 (Special)

The Department of Public Health (DPH) states that these requests are in response to recent rulings by the State Personnel Board that ruled the DPH had failed to meet its obligation to establish that there were no civil service job classifications to which it could appoint employees with the requisite expertise needed to perform the required work of the contracts in question.

Specifically, the Service Employees International Union (SEIU) challenged the DPH regarding: (1) the janitorial contract at the Richmond Laboratory; and (2) the information technology contract. Therefore, in order to respond to the State Personnel Board's ruling and to mitigate any future litigation, the DPH came forward with the above proposals to shift from the use of contractors to permanent state civil service classifications.

It should be noted that the DPH will be phasing in the state civil service positions over a period of time (i.e., from two to three years, commencing in 2008-09). In addition, no increased costs have been identified, only cost savings.

Subcommittee Staff Comment and Recommendation. These four DPH proposals appear to be consistent with the State Personnel Board's ruling and would potentially mitigate future litigation in this area. The requested staff adjustments appear reasonable and have no affect on the state's General Fund.

It is recommended to adopt these proposals as requested by the DPH for inclusion in the next budget bill.

Questions. The Subcommittee has requested the department to respond to the following questions.

1. DPH, Please provide a brief summary of the need for these requests, and a brief description of each request.
2. DPH, What are the benefits of using state civil service classifications?

Diane Van Maren
Senate Budget & Fiscal Review 651-4103

Outcomes for Subcommittee No. 3: Thursday, March 19th (Room 4203)
(Please use the Subcommittee Agenda for this day as a guide to this document.)

- Senator Ashburn absent.

1. AIDS Drug Assistance Program (ADAP) *(Pages 4 through 11)*

No action necessary at this time. The ADAP is funded at this time and we will await the May Revision for updates. The Chair requested the DPH to post the ADAP Estimate on-line for the public to access and the DPH concurred with this request. As such, the ADAP Estimate will be made available on-line every January and at the May Revision.

2. Therapeutic Monitoring Program—Update *(Page 12)*

No action necessary at this time. The Therapeutic Monitoring Program is funded at this time and we will await the May Revision for updates.

3. Genetic Disease Testing Program *(Page 13)*

No action necessary at this time. The Genetic Disease Testing Program is funded at this time and we will await the May Revision for updates.

4. Augmentation for Richmond Laboratory Capital Outlay Project *(Page 16).*

No action necessary at this time. However the Chair directed the DPH to seek federal funding for this project, in lieu of General Fund support, and noted that the Subcommittee may revisit this issue at the May Revision.

5. Tobacco Control Program *(Page 18).*

Action: Adopted the increase of $6.8 million (Health Education Account) for the Tobacco Control Program as proposed by the DPH.

Vote. 2-0 (Senator Ashburn absent)

6. Department of Public Health—Shifts to State Support *(Page 20).*

Action: Adopted the DPH's proposals as contained in the agenda to phase-out the use of contractors and to assign permanent state employees for these purposes.

Vote. 2-0 (Senator Ashburn absent)

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

March 26, 2009

9:30 a.m. *or*
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item	**Department**
4440	Department of Mental Health, selected issues as follows:

- State Hospitals
- Community Mental Health
  - o Fiscal Integrity Concerns
  - o Mental Health Managed Care
  - o Early and Periodic Screening, Diagnosis and Treatment Program

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible. Thank you.

DEPARTMENT OF MENTAL HEALTH-- Item 4440

A. OVERALL BACKGROUND

Purpose and Description of Department. The Department of Mental Health (DMH) administers state and federal statutes pertaining to mental health treatment programs, including programs that serve Medi-Cal enrollees.

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

Purpose and Description of County Mental Health Plans: Though the department oversees policy for the delivery of mental health services, counties (i.e., County Mental Health Plans) have the primary funding and programmatic responsibility for the majority of local mental health programs as prescribed by State-Local Realignment statutes enacted in 1991 and 1992. Further, as described below, counties also have an integral role in the Mental Health Services Act.

Specifically counties are responsible for: (**1)** all mental health treatment services provided to low-income, uninsured individuals with severe mental illness, within the resources made available, **(2)** the Medi-Cal Mental Health Managed Care Program, **(3)** the Early Periodic Screening Diagnosis and Testing (EPSDT) Program for children and adolescents, **(4)** mental health treatment services for individuals enrolled in other programs, including special education, CalWORKs, and Healthy Families, and **(5)** programs associated with the Mental Health Services Act of 2004 (known as Proposition 63).

Description of Mental Health Services for Medi-Cal Enrollees. Medi-Cal enrollees may receive mental health services through the Medi-Cal Mental Health Managed Care system or through the Medi-Cal Fee-For-Service system. The Mental Health Managed Care system is administered by the DMH through contracts with counties (County Mental Health Plans). County Mental Health Plans may directly provide services and/or contract with local providers to provide services. If the County Mental Health Plans contract with local providers, it selects and credentials its provider network, negotiates rates, authorizes services and provides payment for services rendered.

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

Summary of Funding for the Department of Mental Health. The February budget package provides expenditures of $5.231 billion ($1.9 billion General Fund) for mental health services. This is an increase of almost $49 million (total funds) from the revised current-year. It should be noted that $226.7 million (Mental Health Services Act Funds) of this appropriation is contingent upon passage of Proposition 1E in the May 19th, Special Election.

Of the total amount, $1.384 billion is proposed for long-term care services, mainly to operate the State Hospital system. The remaining $3.8 billion is for community-based mental health programs.

Table—Summary of Department of Mental Health

Summary of Expenditures (dollars in thousands)	**2008-09**	**2009-10**	**$ Change**
Program Source			
Community Services Program	$3,814,187	$3,842,455	$28,268
Long Term Care Services	1,364,288	1,384,063	19,775
Mental Health Services Oversight and Accountability Commission	4,089	4,739	650
Total, Program Source	**$5,182,564**	**$5,231,257**	**$48,693**
Funding Source			
General Fund	$2,101,992	$1,940,084	-$161,908
General Fund, Proposition 98	15,000	15,153	153
Mental Health Services Fund (Proposition 63 of 2004)	1,545,216	1,771,064	225,848
Federal Funds	66,262	62,963	-3,299
Reimbursements	1,452,384	1,440,424	-11,960
Traumatic Brain Injury Fund	1,165	1,172	7
CA State Lottery Education Fund	153	--	-153
Licensing & Certification Fund	392	397	5
Total Department	**$5,182,564**	**$5,231,257**	**$48,693**

Background—Summary of Key Aspects of Mental Health Services Act (Proposition 63 of 2004), including Local Assistance Funding. The Mental Health Services Act (Act) addresses a broad spectrum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support the local mental health system. It is intended to expand mental health services to children and youth, adults and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources). Most of the Act's funding will be provided to County Mental Health programs to fund programs consistent with their approved local plans. The Act provides for a *continuous appropriation* of the funds to a special fund designated for this purpose. The Act requires that each County Mental Health program prepare and submit a three-year plan which shall be updated at least annually and approved by the Department of Mental Health (DMH) after review and comment by the Mental Health Services Oversight and Accountability Commission (OAC).

B. ISSUES FOR DISCUSSION—State Hospitals

Overall Background Section

Summary of Budget Appropriation. The Budget Act of 2009 provides an appropriation of $1.384 billion ($1.289 billion General Fund, and $95.1 million in Reimbursements) for the State Hospital system, including the operation of five State Hospitals—Atascadero, Metropolitan, Napa, Patton, and Coalinga-- and two acute psychiatric programs at the California Medical Facility in Vacaville, and Salinas Valley State Prison. This amount also includes state administrative support.

The budget reflects an increase of $19.8 million (increase of $42.5 million General Fund). These increases are primarily due to**: (1)** continued implementation of a settlement agreement with the federal government regarding the Civil Rights for Institutionalized Persons Act (CRIPA); **(2)** continued activation of Coalinga State Hospital; and **(3)** increases for "Non-Level of Care" support at Salinas Valley State Prison. Each of these issues, along with patient population adjustments will be discussed further below.

Overall Classifications of Patient Population & Funding Sources. Patients admitted to the State Hospitals are generally either **(1)** civilly committed, or **(2)** judicially committed. These referrals come from County Mental Health departments, the courts, and the CA Department of Corrections and Rehabilitation (CDCR).

As structured through the State-Local Realignment statutes of 1991/92, County Mental Health Plans contract with the state to purchase State Hospital beds for civilly-committed individuals when appropriate (versus using community-based services). Counties reimburse the state for these beds using County Realignment Funds.

Judicially committed patients are treated *solely* using state General Fund support. The majority of the General Fund support for these judicially committed patients is appropriated through the Department of Mental Health (DMH), along with some reimbursement from the CDCR, primarily for services provided at the two acute psychiatric programs.

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

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

1. Sexually Violent Predators have the utmost priority due to the considerable public safety threat they pose.
2. Mentally Disordered Offenders have the next priority. These patients are former CDCR inmates who have completed their sentence but have been determined to be too violent to parole directly into the community without mental health treatment.

3. *Coleman v. Schwarzenegger* patients must be accepted by the DMH for treatment as required by the federal court. *Generally* under this arrangement, the DMH must have State Hospital beds available for these CDCR patients as required by the Special Master, J. Michael Keating Jr. If a DMH bed is not available the inmate remains with the CDCR and receives treatment by the CDCR.
4. Not Guilty by Reason of Insanity is the next priority.
5. Incompetent to Stand Trial is the last priority. It should be noted that there are about 250 to 300 individuals who are incompetent to stand trial who are presently residing in County jails due to the shortage of beds within the State Hospital system.

(Discussion issues for the State Hospitals begins on the next page.)

1. Update on Civil Rights for Institutionalized Persons Act (CRIPA)—Oversight

Oversight Issue. Based on recent fiscal data, the Legislature has approved about $31 million (General Fund) to enhance care at the four hospitals under the Consent Judgment (Coalinga State Hospital has not been formally included by the DOJ) to meet CRIPA requirements. In addition, this Subcommittee Agenda contains additional augmentations for 2009-10 to facilitate the DMH in meeting requirements at specific State Hospitals.

According to the Consent Judgment, the DMH has until November 2009 to fully comply. The Legislature receives periodic updates from the DMH regarding compliance. The Subcommittee has requested the DMH to provide an update, and has posed specific questions as noted below.

Background—Deficiencies at State Hospitals Lead to US DOJ Consent Judgment Regarding CRIPA. In July 2002, the U.S. DOJ completed an on-site review of conditions at Metropolitan State Hospital. Recommendations for improvements at Metropolitan in the areas of patient assessment, treatment, and medication were then provided to the DMH. Since this time, the U.S. DOJ identified similar conditions at Napa, Patton, and Atascadero (Coalinga was not involved). The Administration and US DOJ finally reached a Consent Judgment on May 2, 2006.

Under the Consent Judgment, the DMH has until *November 2009* to fully comply with the "Enhanced Plan" to improve patient treatment and hospital conditions. This Enhanced Plan provides a timeline for the Administration to address the CRIPA deficiencies and included agreements related to treatment planning, patient assessments, patient discharge planning, patient discipline, and documentation requirements. It also addresses issues regarding quality improvement, incident management and safety hazards in the facilities.

A key component to successfully addressing the CRIPA deficiencies is implementation of the "Recovery Model" at the State Hospitals. Under this model, the hospital's role is to assist individuals in reaching their goals through individualized mental health treatment, and self determination.

The "Recovery Model", as required by the Consent Judgment, includes such elements as the following:

- Treatment is delivered to meet individual's needs for recovery in a variety of settings including the living units, psychosocial rehabilitation malls and the broader hospital community.
- There are a broad array of interventions available to all individuals rather than a limited array.
- A number of new tracking and monitoring systems must be put in place to continually assess all major clinical and administrative functions in the hospitals.
- Incentive programs—called "By Choice" will be used to motivate individuals to make positive changes in their lives.

What is WaRMSS? The Wellness and Recovery Model Support System (WaRMSS) is the automation system used to address requirements identified in the CRIPA Agreement. According to the DMH, the key project objectives include the following:

- Automate patient specific data to assist in monitoring and evaluation.
- Develop a centralized application to support the new CRIPA required business processes for use by all five State Hospitals.
- Minimize redundant entry of data, facilitate ease of data retrieval, and allow for the access of prior hospitalization data upon admission to a different State Hospital.
- Standardize business processes across all State Hospitals.

Originally, WaRMSS was scheduled to begin development in May 2006 and be completed by January 1, 2009. The DMH's revised schedule now assumes a June 30, 2009 completion date.

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

1. DMH, Please provide a *brief* summary of the CRIPA compliance status on key variables.
2. DMH, Which key areas are proceeding well and which key areas need more improvement?
3. DMH, How is progress for WaRMSS progressing?
4. DMH, Since compliance needs to be achieved by November 2009 (per the Consent Judgment), what are the next *key* next steps over the course of these upcoming months?

2. Department's Methodology for State Hospital Estimate—Oversight

Oversight Issue—Can DMH Improve its State Hospital Estimate Package? Due to increasing expenditures at the State Hospitals and the need for budget accuracy, the Legislature required the DMH to submit a comprehensive budget "estimate" package with the Governor's budget (i.e., annually in January and at the May Revision). This estimate package has evolved over time but the need for more detail has become evident.

The DMH has been open to making changes to their estimate package. Each year more information has been provided, and further clarity has been achieved. However, with the tremendous growth in the program—a 20 percent annual increase in the past three years—compacted with high vacancy rates in clinical positions, increasing operating costs, and the need to meet CRIPA compliance—more information needs to be provided. There are several components to this discussion, including both short-term and longer-term considerations. These considerations are discussed below.

Results of OSAE Audit of DMH State Hospital Estimate. Through efforts initiated in this Subcommittee, the OSAE conducted an audit of the DMH's State Hospital budget estimate process (dated December 2008).

This audit came forth as efforts to provide more detailed information to the Legislature evolved, and concerns emerged as cost increases and patient caseload at the State Hospitals became more difficult to project (due to statutory changes, lawsuits, and interactions with the CA Department of Corrections and Rehabilitation).

The OSAE made the following observations in their audit report (which were *within* the scope of their audit):

- The DMH methodology for estimating patient caseload and Level-of-Care staff appears to be reasonable and adequately supported;
- The DMH methodology for estimating operating expenditures appears to be reasonable and adequately supported;
- Coalinga State Hospital operating expenditures were not included in the Budget Act of 2008 projection (note—DMH has corrected for this.); and
- Hospital expenditures are adequately monitored.

The OSAE also noted several other matters in their report which were *outside* the scope of this particular audit but came to their attention. As such, OSAE stated that the following issues should be considered to improve State Hospital operations:

- The current staffing model may not adequately reflect hospital work load;
- The equity pay increases resulting from lawsuits (such as Coleman, Plata and Perez) have not been incorporated into the budgeted overtime allocations; and
- Funding is insufficient for annual operating expenditures.

Though the OSAE noted some concerns which were outside the scope of this audit, OSAE generally noted that DMH's calculations and expenditures information supporting their budget estimate are accurate. Moreover, OSAE stated that the State Hospitals and DMH headquarters monitor operating expenditures to prioritize spending and prevent deficits.

As a result of the OSAE audit, the DMH must provide a "corrective action plan" to OSAE in response to the specific items which need to be modified, including a schedule of work products to be completed and timelines. (This is standard procedure for OSAE audits.)

Background—DMH Estimate Method. The DMH uses a regression analysis formula of patient census and historical costs to project anticipated patient caseloads and expenditures. The DMH uses a current-year adjustment factor to correct patient caseload projection variances exceeding 2.5 percent. Level-of-Care staffing ratios (i.e., clinical staff) are then applied to the patient population. For operating expenses, the DMH uses expenditures for the past three years and applies a straight-line regression analysis to project expenditures for the budget year.

It should be noted that the OSAE stated that both the patient and operating expenditures estimation methodology were acceptable. However they did note that Coalinga's operating expenditures were initially left out of the calculation and should now be included. (the DMH has now included them.)

Background—DMH Patient Expenditures for Past Five Years. According to OSAE, based on DMH information, the average cost per patient has increased approximately 34 percent over 5 years. Two thirds of this patient care costs increases occurred in personal services.

Table—DMH State Hospital Average Cost Per Patient

Total Expenditures	2003-04	2004-05	2005-06	2006-07	2007-08
Census at June 30th	4,423	4,907	5,002	5,183	5,317
Cost Per Patient	$144,798	$142,157	$158,712	$173,398	$194,732

The average personal services cost per patient increased $33,260 from $123,468 (in 2003-04) to $156,728 (in 2007-08). Increases in personal services costs were primarily due to the equity pay increases resulting from litigation (Coleman, Plata, and Perez lawsuits and the CRIPA Enhancement Plan). The other drivers for DMH's operating costs were primarily outpatient medical care, medical consultants, food and pharmaceuticals.

Legislative Analyst's Office Comment and Recommendation. The LAO is seeking several changes to both the Governor's budget display for the State Hospitals, as well as considerable changes to the DMH Estimate Package for the State Hospitals. Specifically they are recommending the following:

1. Require the DOF to display in the Governor's budget summary (January document) a breakout of expenditures by State Hospital.
2. Require the DMH to provide funding for the OSAE to contract with an independent consultant to identify what, if any, improvements are necessary to the current staffing model for the State Hospitals, including both Level-of-Care and Non-Level-of Care. The consultant should provide an evaluation of workload distribution issues, all staffing ratios,

and overtime. In addition, the LAO states that said consultant should also review whether the staffing levels established to meet federal CRIPA requirements are appropriate.

3. Require the DMH to include additional information in the Estimate Package, including the status of CRIPA compliance, waiting lists for State Hospital admissions, staffing vacancies and related recruitments, and various performance measures (such as average length of stay for patients broken out according to their hospital, commitment category, and major diagnosis).

Finally, the LAO is requesting the Legislature to direct the Administration to participate in a workgroup with legislative staff to develop an improved budget format for its January and May Revision packages.

Subcommittee Staff Comment and Recommendation. First, the OSAE generally noted that DMH's calculations and expenditures information supporting their budget estimate are accurate. Second, they noted that DMH adequately monitors their State Hospital expenditures.

However, the State Hospital Estimate Package has evolved over time and indeed needs to be modified to more comprehensively reflect various cost-factors. The DMH recognizes the need for changes and desires to take constructive steps over time.

Specifically, DMH has informed Subcommittee staff they intend to take the following actions in time for the May Revision:

(1) Include Level-of-Care and Non-Level-of Care charts to display personnel at the State Hospitals more comprehensively.

(2) Include prior-year expenditure charts for comparison purposes.

(3) Provide key program updates including a statement of change, if any, from the last estimate. For example, information regarding the activation of new beds.

(4) Provide information regarding *future* fiscal issues, if any.

Further, the DMH is willing to convene a workgroup in Fall to further discuss potential changes in its methodology and Estimate Package process.

With respect to additional data requests as referenced by the LAO, it should be noted that much of this information is already available or can be obtained from the DMH upon request. Chapter 74, Statutes of 2006 (trailer bill legislation) requires the DMH to provide the Legislature with a comprehensive quarterly report on CRIPA implementation and compliance. Considerable demographic information, that meets privacy requirements, is available from the DMH upon request. Staff vacancy information is also available upon request and is closely monitored by the DMH.

Therefore, it is recommended for the Subcommittee to have the DMH proceed with making their changes and to convene a more comprehensive workgroup in Fall. Since the DMH is willing to be proactive, no other action is recommended at this time.

Questions. The Subcommittee has requested the DMH and LAO to respond to the following questions:

1. DMH, Please provide a *brief* summary of your perspective of the OSAE audit.
2. DMH, Please provide a brief summary of the key changes to be done at the May Revision. Will you convene the workgroup in Fall?
3. LAO, Please provide a *brief* summary of your concerns and recommendations.
4. DMH, Any other comments?

3. Patient Caseload & Request for Trailer Bill Language

Summary of Budget and Issues. *First*, the February budget package reflects a *decrease* of $5 million (General Fund) for 2009-10 due to a series of patient population adjustments and corresponding changes in needed state staff at the facilities. Specifically, the DMH assumes a *ne*t decrease of 77 patients overall. This reduction reflects a decrease of 52 Level-of-Care positions at the facilities, including reductions in Psychiatric Technicians (28 positions), Registered Nurses (12), and several other classifications.

The DMH uses a regression analysis formula of patient census and historical costs to project anticipated patient caseloads and expenditures. The period used for the budget year is from July 1, 2006 to June 30, 2008. This methodology is applied to most of the patient populations, including NGI, MDO, SVP and other PC. The beds purchased by counties for civil commitments are done through contracts at an established rate.

Table #1, below, displays the adjustments for each patient classification. Of the total estimated patient population, *91 percent* of the beds are designated for penal code-related patients and about 9 percent are to be purchased by the counties, primarily by Los Angeles County.

The average cost for a penal code-related patient is $206,242 annually, based on 2008-09 expenditures. The daily cost for a county bed is about $453 based on 2008-09 rates, for an annual cost of $165,327 per patient. These costs will be updated for 2009-10 expenditures.

Table #1-- DMH State Hospital Caseload Summary Projection *(DMH Estimate)*

Category of Patient	**Current Year Caseload (Revised January)**	**Budget Year Caseload**	**Increase Over Current Year**
Sexually Violent Predators (SVPs)	776	845	69
Mentally Disorder Offenders (MDOs)	1,326	1,256	-70
Not Guilty by Reason of Insanity	1,228	1,229	1
Incompetent to Stand Trial	1,169	1,083	-86
Penal Code 2684s & 2974s (Referred for treatment by CDCR)	346	346	--
Other Penal Code Patients (various)	118	127	9
CA Youth Authority Patients	30	30	--
County Civil Commitments	542	542	--
SUBTOTAL-- State Hospitals	**5,535**	**5,458**	**-77**
SUBTOTAL—Acute Psychiatric (Referred for treatment by CDCR)	**540**	**540**	**--**
TOTAL ESTIMATED PATIENTS	**6,075**	**5,998**	**-77**

The largest projected *increase*, about 8 percent, is in the SVP population. This increase is generally attributable to more SVPs being committed by the courts to a State Hospital. (This process is described below in the background section.)

The largest projected *decrease*, about 7 percent, is in the IST population. The DMH notes they hired a consultant to complete a review of all State Hospitals. Among other things, this resulted in changes as to how the State Hospitals facilitate restoration of competency for these patients so they may return to the court to stand trial. From this process, the average length of stay at a State Hospital has decreased (the average now is about 5 months). Therefore, the DMH states that they have increased the overall number of ISTs served, but they are not residing long enough in the State Hospitals to significantly increase the in-patient census at the facilities.

Second, the DMH is proposing trailer bill language to extend by three years, from September 2009 to September 2012, their ability to house up to 1,530 penal-code patients at Patton State Hospital. The DMH is requesting this change due to the continued growth of penal code patients which exceeds the State Hospital systems legally defined capacity and the need to house penal code patients in a "secure facility".

The DMH notes that presently Patton State Hospital is licensed to house 1,287 patients and currently houses about 1,506 patients. The Department of Public Health has been providing licensing waivers for the DMH to "over-bed" for several years at Patton.

Due to pressures to make more beds available to accommodate ISTs, respond to the number of orders to show cause, changes to the SVP law, and the recent joint Coleman/Valdivia court order to take in parolees, the DMH expects continued growth in its forensic patient population.

Summary of Projected Patient Population at Each State Hospital. The proposed patient caseload for each State Hospital and Acute Psychiatric Facility is shown in Table #2, below. Each State Hospital is unique, contingent upon its original design, proximity to population centers, types of patients being treated at the facility and types of treatment programs that are available at the facility.

Penal-code patients must be housed in a "secure facility". However, the State Hospital system has only a limited number of secure facilities able to house forensic patients. As such, Atascadero, Patton and Coalinga have substantially more comprehensive security than others and generally house "high security" patients. There are existing restrictions, which have been forged with local communities, on where certain penal code patients can be housed.

Table #2: DMH Summary of Population by Hospital *(DMH Estimate)*

Facility	Budget Act of 2008	Proposed Patient Growth for 2009-10	Proposed 2009-10 Population (Ending as of 6/30/09)
Atascadero	1,296	-87	1,209
Coalinga	825	69	894
Metropolitan	694	0	694
Napa	1,195	-20	1,175
Patton	1,525	-39	1,486
Vacaville	300	0	300
Salinas	240	0	240
TOTALS	**6,075**	**-77**	**5,998**

Background—CA Department of Corrections & Rehabilitation (CDCR) Referral to the DMH. Specified sex offenders who are completing their prison sentences are referred by the CDCR and the Board of Parole Hearings to the DMH for screening and evaluation to determine whether they meet the criteria as SVP.

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

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

- *Evaluations.* Two evaluators (Psychiatrists and/or Psychologists), who are under contract with the DMH, are assigned to evaluate each sex offender while they are still held in state prison. Based on a review of the sex offender records, and an interview with the inmate, the evaluators submit reports to the DMH on whether or not the inmate meets the criteria for an SVP. If two evaluators have a difference of opinion, two additional evaluators are assigned to evaluate the inmate.

Offenders, who are found to meet the criteria for an SVP, as specified in law, are referred to District Attorneys (DAs). The DAs, then determine whether to purse their commitment by the courts to treatment in a State Hospital as an SVP.

If a petition for a commitment is filed, the clinical evaluators are called as witnesses at court hearings. Cases that have a petition filed, but that do *not* go to trial in a timely fashion may require updates of the original evaluations at the DA's request.

The amount of time it takes to complete the commitment process may vary from several weeks to more than a year depending on the availability of a court venue and the DA's scheduling of cases. While these court proceedings are pending, offenders who have not completed their prison sentences continue to be held in prison. *However*, if an offender's prison sentence has been completed, he or she may be held either in county custody or in a State Hospital.

Background—SB 1128 (Alquist), Statutes of 2006. This legislation made changes in law to generally increase criminal penalties for sex offences and strengthen state oversight of sex offenders. For example, it requires that SVPs be committed by the court to a State Hospital for an undetermined period of time rather than the renewable two-year commitment provided under previous law.

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

Background—Proposition 83 of November 2006—"Jessica's Law". Approved in November 2006, this proposition increases penalties for violent and habitual sex offenders and expands the definition of an SVP. The measure generally makes more sex offenders eligible for an SVP commitment by **(1)** reducing from two to one the number of prior victims of sexually violent offenses that qualify an offender for an SVP commitment, and **(2)** making additional prior offenses "countable" for purposes of an SVP commitment.

Subcommittee Staff Comment and Recommendation. *First*, it is recommended to adopt the Administration's proposed trailer bill language to extend by three years, from September 2009 to September 2012, their ability to house up to 1,530 penal-code patients at Patton State Hospital. Secure beds are needed and this facility does have the capacity for this purpose.

Second, the DMH will be providing an update on patient caseload and expenditures at the May Revision. At this time, the DMH should review both the current-year and budget year for adjustments, including any savings that may occur from unfilled positions.

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

1. **DMH,** Please provide a *brief* summary of the *key* population changes.
2. **DMH**, Please articulate why the trailer bill language is needed.
3. **DMH**, What is your plan within the next three years regarding secured-beds for penal code patients?

4. Continued Activation of Coalinga State Hospital

Summary of Budget and Issues. The February budget package reflects an increase of $3.380 million (General Fund) to support 44 additional state positions at Coalinga to (1) address staffing ratios identified in CRIPA; and (2) provide Non-Level-of Care positions to continue the activation of Coalinga.

First, based on the DMH patient population estimate, the DMH projects a patient population at Coalinga of 894 patients (ultimately it will be a 1,500-bed facility). The DMH states that it now needs to establish the clinical and administrative positions to implement the Wellness and Recovery Model as required by the CRIPA Enhancement Plan. This plan uses specified staffing ratios based on patient population. Specifically, the DMH proposes a total of 28 new positions for the plan as follows:

- Positive Behavioral Support Teams. A total of ten positions, including Psychiatric Technicians (4), Senior Psychologists (2), Registered Nurses (2), and Health Records Technicians (2), are to be provided.
- Compliance Monitoring. A total of 11.5 positions, primarily clinical staffs are to be provided. This includes Senior Psychiatrists (4.1), Senior Psychologist (2.6), Clinical Social Worker (1.6), Psychiatric Technician (1.6), and Health Records Technician (1.6), are to be provided.
- Clerical Support Team. A total of 6.5 positions for clerical support—Office Technicians—are to be provided.

Second, Coalinga is in the process of opening 6 additional units for a total of 300 beds. Three units are scheduled to open in the current year and three in the budget year. In order to accommodate this continued activation of the facility, the DMH proposes a total of 16 positions for Non-Level-of-Care functions as follows:

- Patient Related Services. A total of 12 positions are requested for a variety of patient related services. These services include medical record functions, correctional case records management, and health and dental management services.
- Management Positions. A total of 3 positions are requested to establish new units and provide management and supervisory staff, including a Program Director, Program Assistance, and Nursing Coordinator.
- Employee Training. A Nurse Instructor position is requested to provide administrative training and orientation for staff, including certain Level-of-Care staff.

The DMH uses a formula ratio for Non-Level-of Care staffing adjusted for each activation stage of Coalinga, as well was the actual patient population residing at Coalinga.

Background—Coalinga State Hospital (CSH). CSH, a 1,500 bed facility when fully operational is located adjacent to the Pleasant Valley State Prison. CSH is primarily to be used for housing and treating SVP patients, along with some other penal code-related patients, including Mentally Disordered Offenders (MDOs) and specified others.

Initial activation with patients occurred in September 2005. However, due to historic problems in attracting personnel to fill vacancies—both clinical and Non-Level-of-Care--, Coalinga has been very slow to activate and to fill its beds with patients.

The DMH states Coalinga will have 22 units open in 2009-10 with a projected patient population of 894 (as of June 30, 2010).

Subcommittee Staff Comment and Recommendation. The continued activation of Coalinga is important in order to balance the patient population accordingly across the State Hospitals and to fully utilize the capacity of the facility.

However, there have been historic concerns with attracting personnel to fill vacancies—both clinical and Non-Level-of Care. As of December 2008, there was a *24 percent vacancy rate* at Coalinga (including all positions). Personnel classifications with considerable vacancy rates included the following:

Coalinga State Hospital—Snap Shot of Vacancy Rates for Key Positions

Selected Personnel Classifications	Percent Vacant (December 2008)
Senior Psychiatrist	75%
Staff Psychiatrist	62%
Senior Psychologist	60%
Registered Nurse	31%
Licensed Vocational Nurse	33%
Rehabilitation Therapist	28%
Psychiatric Technician	20%

Several of these classifications are also positions for which the DMH has requested additional positions for CRIPA. Therefore, the Subcommittee may want to consider phasing-in funding for the positions provided in the February budget package. This can be done through a one-time salary savings adjustment. Consideration of such an adjustment should be discussed at the May Revision.

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

1. DMH, Please provide a *brief* update regarding the continued activation of Coalinga, including the timing of bringing 6 additional units (300 beds) on line.
2. DMH, Please provide a *brief* summary of this proposal.
3. DMH, Please provide an update on what recruitment and retention efforts are underway at Coalinga.

5. Expansion of Salinas Valley Psychiatric Program

Summary of Budget and Issues. The February budget package provided two adjustments for the expansion of the Salinas Valley Psychiatric Program for a total increase of $1.8 million (General Fund).

First, an increase of $1.1 million (General Fund) to fund 17 new Non-Level-of Care positions is provided due to the impending 64-bed expansion. The 17 positions include staff for information processing, staff training, personnel processing, accounting, medical records, and related administrative functions. The funds provided assume a July 1, 2009 hiring date for all of the positions.

Second, an increase of $681,000 (General Fund) is provided to augment the "Psychiatrist-on-call" (POC) system to provide psychiatric coverage after hours. The POC system requires that the psychiatrist be available by phone when needed. Further the POC may be required to return to the facility for evaluation or documentation requirements. The DMH states that additional funds are needed with the pending increase in beds at the facility, and due to requirements pertaining to "seclusion and restraint procedures".

State law and the Joint Commission on Accreditation Standards have requirements regarding the evaluation of a patient in seclusion or restraint, including face-to-face evaluation, as well as the length of time that such procedures can be used Specifically, the DMH states that current compensation for the POC is $1,000 per week which is significantly below the hourly equivalent of a Staff Psychiatrists salary. The DMH therefore took the mid-range hourly salary for a Staff Psychiatrist ($119.51 per hour) and multiplied this figure by the number of hours per week for the POC (i.e., 118 hours) to identify a new weekly amount of $14,102. Therefore, an increase of $681,000 is requested after a minor adjustment to account for existing funds available for this purpose.

The DMH contends that failure to approve this funding will result in the loss of existing Psychiatrists and the inability to recruit replacements and additional Psychiatrists.

Background—the DMH's Involvement with Salinas Valley and Coleman. In response to a March 2006 *Coleman* court order, the CA Department of Corrections and Rehabilitation (CDCR) is in the process of completing a new 64-bed facility for high custody level IV intermediate treatment on the grounds of Salinas Valley State Prison which will be operated by the DMH. When completed, this expansion would create a total of 240-beds at the facility.

The DMH has an interagency agreement to provide mental health services for the CDCR inmates per the *Coleman* court. The DMH provides these mental health beds primarily at Atascadero State Hospital, Coalinga State Hospital, the Vacaville Psychiatric Program and the Salinas Valley Psychiatric Program within the prison.

Further, in Valdivia/Coleman, the court ordered the DMH to provide parolees with access to inpatient care regardless of their revocation status or parole date. The DMH and CDCR are currently working on a plan to address process and procedures in providing services to parolees.

Subcommittee Staff Comment and Recommendation. No issues have been raised at this time. However, there may be a need to revisit this issue at the May Revision, contingent upon the completion of the expansion and the phasing-in of staff.

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

1. DMH, Please provide a *brief* status update on completion of the Salinas 64-bed expansion (to achieve a total of 240-beds) and the existing patient population at the facility.
2. DMH, Please provide a *brief* summary of the two budget increases—for 17 additional staff, and for the Psychiatrist on Call.

C. ISSUES FOR DISCUSSION—COMMUNITY MENTAL HEALTH

1. Concerns with State Fiscal Integrity and Federal CMS Audits

Budget Issue—Continued Concerns with Fiscal Integrity. Significant fiscal management issues have continued to be raised regarding the state's administration of the overall Medi-Cal mental health system (including the Early and Periodic Screening and Treatment Program, and Mental Health Managed Care).

There are several aspects to this concern, but first and foremost are fiscal audits by the federal Centers for Medicare and Medical (CMS), *coupled with* the need for continued work to "restructure" the payment process for the state to reimburse counties and other providers within a 30-day period, versus the 90-day to 120-day timeframe that exists today.

The DMH acknowledges that a "restructuring" of their payment process to shorten their current claiming, mainly for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, to pay claims *within* 30-days is necessary. They have been working diligently with the DHCS to craft such a process.

However, it is not clear to Subcommittee staff what the end product will be, or the timing of said restructuring. California can begin to draw enhanced federal funds from the American Recovery and Reinvestment Act of 2009 (ARRA) eminently. As such, it is important for the state to have a clear process on how the DMH will draw down these enhanced federal funds through their claiming process (including from October 2008 to the present, and going forward).

The Administration states that a new computer system—the "Short-Doyle/Medi-Cal Phase II" will, among other things, provide adjudicate claims and appropriately reimburse counties and providers for services rendered. However, the DMH needs to implement considerable accounting system changes to interface with this system. Further, the Short-Doyle/Medi-Cal Phase II system will not be ready for beta testing until February 2010.

This Subcommittee has discussed fiscal integrity issues regarding the operation of state mental health programs for the past three years, including five reports prepared by the Office of Statewide Audits and Evaluations (OSAE), Department of Finance. Though progress has been made to more comprehensively monitor, track and coordinate claims processing functions—which are very complex—considerably more work needs to be done.

The federal CMS audits, as discussed below, and the need to quickly restructure the claims processing system, will require a concerted effort on the part of the Administration.

Federal CMS Audits for Mental Health Services—Five Audits. The federal CMS has recently released two audits with findings and presently has three more audits that are in process. All of these audits and reviews pertain to concerns regarding lack of fiscal controls, overpayments, and lack of coordination with the Department of Health Care Services regarding the management of reimbursements made under Medicaid (Medi-Cal in California).

Key findings and outcomes from the two released audits (in September 2008 and December 2008) include the following:

- The DHCS and DMH systems are not adequate to comply with federal reporting requirements, resulting in the total mental health program expenditures reported to the federal CMS (using form 64) likely to be significantly misstated.
- DMH transferred a total of almost $21 million in federal funds back to the federal CMS as repayment for "excess" federal funds it had claimed incorrectly, due to overpayments in the EPSDT Program (for 2003-04), and claims the DMH made for programs not operated under Medi-Cal (i.e., certain state-only programs and other federal programs).
- The DHCS does not appear to provide adequate oversight over the Medicaid mental health program, specifically over the processing of DMH invoices (such as for the EPSDT Program and Mental Health Managed Care Program).
- California's existing reimbursement methods, processes and policies are not fully consistent with federal law, particularly regarding interim payment, reconciliation and cost-settlement processes. Therefore, the state must provide the federal CMS with a "State Plan Amendment" by July 1, 2009 that articulates all of these practices.
- By July 1, 2009, California must implement controls to ensure that the process used to count County Realignment Funds (i.e., "certified public expenditures") towards the federal match, meets federal requirements.
- California needs to implement procedures to ensure adequate oversight of amounts claimed as Medicaid mental health costs.

The three remaining federal CMS audits which are presently underway are described below:

- Audit #3—Financial Management Review. The federal CMS has completed field work at five counties, including San Francisco, Los Angeles, San Diego, Orange, and Sacramento to examine how counties utilize their County Realignment Funds to draw federal matching funds, and other aspects of the reimbursement process. Outcomes from this review are still pending.

- Audit #4—Payment Error Rate Measurement Audit. The federal CMS conducts this audit to identify program vulnerabilities that result in improper payments and to promote efficient Medicaid (Medi-Cal in California) programs. The state is presently working with the federal CMS regarding a "Post Project Review" document and a "Corrective Action Plan"; this information is due to the federal government by April 1, 2009.

- Audit #5—Program Integrity Audit. The federal CMS conducts this audit to determine overall program integrity to policies and procedures, and to learn how states receive and use information about potential fraud and abuse involving Medicaid providers. It is anticipated that the federal CMS will release the results of this audit in 60-days or so.

Background—Enhanced Federal Funds through ARRA. According to the DHCS, California is to receive an increase in the Federal Medicaid Assistance Percentage (FMAP) of 11.59 percent which would provide for a 61.59 percent FMAP for the *overall* Medi-Cal Program from October 1, 2008 through December 2010. Specifically, this enhanced FMAP

would provide California with at least $10.112 billion in additional federal funds for the 27-month period.

This enhanced federal funding is also applicable to the Medi-Cal program components administered by the DMH, including the EPSDT Program and Mental Health Managed Care Program because they serve Medi-Cal enrollees. However, the FMAP increases apply *only* if a state conforms to certain specified requirements, including the timely reimbursement of claims based on period of service.

Background—Office of Statewide Audits and Evaluations (OSAE). Fiscal integrity issues regarding the administration of the EPSDT Program and the DMH were first raised in 2006 and discussed in three separate Office of Statewide Audits and Evaluations (OSAE) reports over the course of two-years within this Subcommittee. Some of the issues identified by the OSAE have also been identified by the federal CMS. Though the DMH has done considerable work to rectify past concerns and to rebuild the integrity of the administrative processes, more work needs to be completed.

Background—Administration of California's Medi-Cal Program. The federal CMS requires each state to have a "single state agency" that is responsible for overall administration of the Medicaid Program (a jointly shared federal and state program). The Department of Health Care Services (DHCS) is California's agency. However, the DHCS delegates the responsibility for the administration of mental health programs to the DMH. Ultimately, both departments are responsible for the administration of these programs.

Subcommittee Staff Comment and Recommendation. First, the Administration needs to inform the Subcommittee on how it will restructure the payment process for the state to reimburse counties and other providers within a 30-day period to ensure timely payment and the receipt of federal funds.

Second, it is recommended to adopt *placeholder* trailer bill language to require the DHCS to provide the results of any federal audits, including federal CMS or any other federal agency, regarding the Medi-Cal Program to the fiscal and policy committees of the Legislature.

Third, it is recommended for the DHCS and DMH to provide the Subcommittee with a comprehensive implementation schedule for the "Short Doyle/Medi-Cal computer system.

Questions. The Subcommittee has requested the Administration to respond to the following questions:

1. Administration, Please provide a *brief* summary of the key concerns in the two released federal CMS audits.
2. Administration, Will the three pending federal CMS audits be released soon?
3. Administration, Please describe what is being done to restructure the claims process and when it will be completed.
4. Administration, Specifically, how will the claims from October 2008 to the present be processed to ensure that the enhanced federal funds will be received? Are any federal funds at risk here?
5. Administration, Please provide a *brief* update on the Short-Doyle/Medi-Cal system.

2. Mental Health Managed Care

Summary of Budget and Issues. The February budget package provides a total of $226.7 million (General Fund), and corresponding federal funds, for the Mental Health Managed Care Program. This reflects an increase of about $3 million ($1.5 million General Fund).

The increase of $3 million primarily includes adjustments for an increase in the number of individuals served in the Disabled Aid category of Medi-Cal, and for increases in the need for Psychiatric Inpatient Services. Individuals in the Disabled Aid category of Medi-Cal increased by 25,000 people for a total of 1.1 million. These individuals require more intensive services.

Background—Overview of Mental Health Managed Care: Under Medi-Cal Mental Health Managed Care psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, are the responsibility of a single entity, the Mental Health Plan (MHP) in each county.

Full consolidation was completed in June 1998. This consolidation required a Medicaid Waiver ("freedom of choice") and as such, the approval of the federal government. Medi-Cal recipients *must* obtain their mental health services through the County MHP.

The Waiver promotes plan improvement in three significant areas—access, quality and cost-effectiveness/neutrality. The DMH is responsible for monitoring and oversight activities of the County MHPs to ensure quality of care and to comply with federal and state requirements. This Waiver expires as of June 30, 2009 and must be renewed with the federal CMS.

Background—How Mental Health Managed Care is Funded*:* Under this model, County Mental Health Plans (County MHPs) generally are at risk for the state matching funds for services provided to Medi-Cal recipients and claim federal matching funds on a cost or negotiated rate basis. County MHPs access County Realignment Funds (Mental Health Subaccount) for this purpose.

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

Based on the most recent estimate of expenditure data for Mental Health Managed Care, County MHPs provided a 48 percent match while the state provided a 52 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

Subcommittee Staff Comment and Recommendation. First, the budget for this program will need to be modified at the May Revision to reflect caseload updates, and most importantly, the enhanced FMAP for the program. The enhanced FMAP (at 61.59 percent versus 50 percent) will result in state General Fund savings, as well as in County Realignment Fund savings.

Second, the DMH estimate also includes $485,000 (General Fund) for supporting certain ancillary services (physical health services) within Institutes for Mental Disease (IMD) which is no longer applicable. This would save $485,000 (General Fund).

Third, the federal Waiver for this program is up for renewal. The DHCS and DMH must provide the federal CMS with a Waiver renewal package by Spring 2009.

It is recommend to hold this issue open for the May Revision.

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

1. DMH, Please provide a *brief* summary of the budge and the potential General Fund savings that is likely to be generated from the enhanced FMAP.
2. DMH, Please provide an update on the Waiver renewal for this program.

3. The Early and Periodic Screening, Diagnosis and Treatment

Summary of Budget and Issues. The February budget package appropriates a total of $1.1 billion ($283.7 million General Fund, $226.7 million Mental Health Services Act Funds, $166.4 million County Realignment Funds, and corresponding federal funds). It should be noted the $226.7 million in Mental Health Services Act funds assumes passage of Proposition 1E inn the May 19th, Special Election.

The 2009-10 estimate assumes a $43.1 million (General Fund) increase over the Budget Act of 2008. The DMH states this increase is based on 70-months of historic data, and is weighted using 13 independent services used within the program, such as Mental Health Services; Psychiatric Health Facility; Crisis Stabilization; Day Treatment; Therapeutic Behavioral Services; Medication Support; and Targeted Case Management.

The DMH notes the EPSDT service that reflects the most growth is in the Mental Health Services category, which increased by 11 percent over the revised current-year. This category is for expenditures that pertain to individual or group therapies and interventions that are designed to provide a reduction of mental disability and restoration. Service activities may include assessment, plan development, therapy rehabilitation, and family services. This is a very broad category of service and reflects about 80 percent of the EPSDT Program's expenditures.

Unfortunately, the DMH does not provide any analysis as to why this category is increasing nor do they provide any other key fiscal information, such as the basis for the expenditures or related assumptions. Further, the DMH provides no discussion regarding changes to the program that were implemented in the Third Extraordinary Special Session of 2008 (February 2008) or the Budget Act of 2008, as referenced below.

In addition, a Special Master's Nine Point Plan (Plan) for the provision of Therapeutic Behavioral Services (i.e., Emily Q. Settlement), approved by the court on November 14, 2008 is not referenced as a policy issue in the estimate package. Though this Plan will be phased-in over time, it should have been discussed in the estimate package and it will likely require some funding in 2009-10.

Several Cost Containment Actions Taken in 2008. Due to fiscal constraints last year, the Legislature adopted three changes to the EPSDT Program. These changes were significantly less drastic than the Governor's overall proposals for the program.

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

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

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

Though the Department of Health Care Services (DHCS) is the "single state agency" responsible for the Medi-Cal Program, mental health services including those provided under the EPSDT, have been delegated to be the responsibility of the Department of Mental Health (DMH). Further, County MHPs are responsible for the delivery of EPSDT mental health services to children

In 1990, a national study found that California ranked 50th among the states in identifying and treating severely mentally ill children. Subsequently due to litigation (T.L. v Kim Belshe' 1994), the DHCS was required to expand certain EPSDT services, including outpatient mental health services. The 1994 court's conclusion was reiterated again in 2000 with respect to additional services (i.e., Therapeutic Behavioral Services—TBS) being mandated. The state has lost several lawsuits and is required to expand access to EPSDT mental health services.

County MHPs must use a portion of their County Realignment Funds to support the EPSDT Program. Specifically, a "baseline" amount was established as part of an interagency agreement in 1995, and an additional 10 percent requirement was placed on the counties through an administrative action in 2002.

Subcommittee Staff Comment and Recommendation. First, the budget for this program will need to be modified at the May Revision to reflect caseload updates, the enhanced FMAP for the program, and potentially, the Special Master's Nine Point Plan for Therapeutic Behavioral Services.

Second, the DMH should provide status updates enacted through last year's budget process, including their monitoring of the EPSDT Program, implementation of the PIP, and the effects of any other changes.

Third, the DMH needs to provide a more comprehensive estimate package to the Legislature; therefore, it is recommended to adopt *placeholder* trailer bill language for this purpose.

Further, it is recommend to hold this issue open for the May Revision.

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

1. DMH, Please provide a brief summary of the budget, including the $43 million (General Fund) increase in the program.
2. DMH, Please provide an update on the cost-containment measures enacted last year, including the enhanced DMH monitoring and implementation of the PIP.
3. DMH, Please provide a *brief* summary of the key aspects of the Special Master's Nine Point Plan as it pertains to implementation in 2009-10.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator John Benoit

April 23, 2009

9:30 a.m. *or*
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item	Department
4280	Managed Risk Medical Insurance Board • Healthy Families Program
4440	Department of Mental Health • Healthy Families Program (Supplemental mental health services)
4260	Department of Health Care Services • Medi-Cal Program—selected issues as noted

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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I. Managed Risk Medical Insurance Board (MRMIB)

A. OVERALL BACKGROUND

Purpose and Description of Department. The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health care coverage through private health plans to certain groups without health insurance. The MRMIB administers the: **(1)** Healthy Families Program; **(2)** Access for Infants and Mothers (AIM) Program; and **(3)** Major Risk Medical Insurance Program (MRMIP).

Summary of Budget Appropriation. The budget proposes total expenditures of just over $1.3 billion ($406.4 million General Fund) for all programs administered by the Managed Risk Medical Insurance Board for 2009-10 as shown in the chart below.

Summary of Expenditures

(dollars in thousands)	2008-09	2009-10	$ Change
Program Source			
Major Risk Medical Insurance Program (including state support)	$54,858	$39,439	-($15,419)
Access for Infants & Mother (with state support)	$133,695	$150,984	$17,289
Healthy Families Program (with state support)	$1,158,469	$1,130,900	$27,569
County Health Initiative Program	$2,420	$2,413	(-$7)
Totals Expenditures	**$1,349,442**	**$1,323,736**	**-($25,706)**
General Fund	$399,916	$406,352	$6,436
Federal Funds	$808,470	$801,579	-($6,891)
Other Funds	$141,056	$115,805	-($25,251)

(Discussion items for the Healthy Families Program begin in the next page.)

1. Healthy Families Program—Discussion of Existing Budget

Background—Funding for the Healthy Families Program (HFP). The Healthy Families Program (HFP) is California's version of the federal State's Children's Health Insurance Program (CHIP) and was implemented in 1997-98. California receives a 66 percent federal match for each state dollar provided. It should be noted that federal CHIP funding is an *"allotment",* and as such, this program is *not* an entitlement. In addition to the federal allotment and State General Fund support, premium payments received from families for the enrollment of their children (i.e., subscribers) are used to offset expenditures.

On February 4, 2009, President Barack Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CHIPRA was designed to "reauthorize" the financing of children's health insurance (Healthy Families in California) for the next 4.5 years (April 1, 2009 to September 30, 2013), as well as to make several other changes to the program. Due to timing, CHIPRA changes are *not reflected* in California's February budget package. The Administration will be bringing forth proposed changes at the May Revision to address these issues. (Further, a discussion of *budget-related* CHIPRA issues is included later in this Agenda.)

Summary of Budget Appropriation. The February budget agreement provides an appropriation of $1.121 billion ($403.9 million General Fund, $710.2 million Federal Title XXI Funds, $904,000 Proposition 99 Funds, and $6.5 million in reimbursements) for the HFP, excluding state administration.

This reflects a *net reduction* of $27.6 million (total funds), or a 2 percent reduction as compared with the revised current-year. Most of this difference is attributable to implementation of the various cost-containment actions taken in the Budget Act of 2008. Therefore, the revised current-year reflects only 4 months of savings whereas 2009-10, captures a full-year of savings. In addition, HFP caseload is estimated to increase by 3 percent, as discussed further below. No other significant changes are proposed.

Each of the previously enacted cost-containment issues and its estimated reduction amount is shown in Table #1, below. It should be noted that a total reduction of over $160 million ($57 million General Fund) is to be achieved over the two-year period.

Table #1: Summary of Enacted Reductions for Healthy Families Program

Description of Actions Taken in 2008	2008-09 Reduction Amount	2009-10 Reduction Amount	Two-Year Total Reduction
1. Increase premiums by an average of $1 per month per member**	$10.7 million ($2.9 million GF)	$62.5 million ($23.2 million GF)	$73.2 million ($26.1 million GF)
2. Reduce plan rates by 5 percent	$24.8 million ($8.8 million GF)	$57.1 million ($20.2 million GF)	$81.9 million ($29 million GF)
3. Annual benefit limit for dental coverage	--	$5.3 million ($1.9 million GF)	$5.3 million ($1.9 million GF)
Totals	$35.5 million ($11.7 million GF)	$124.9 million ($45.3 million)	$160.4 million ($57 million GF)

** Premium amounts vary by income level, family size and by type of plan.

Description of Change in the Premium (See #1, in above Table). Effective February 1, 2009, the MRMIB is applying the premium adjustments as described below. This application is consistent with the Legislature's direction provided in the Budget Act of 2008. The savings in Table #1, above, assume an enrollment reduction of almost 8,000 children in the current-year and about 44,000 children in 2009-10, as well as increased premium collections.

- There are no changes for families with incomes from 100 to 150 percent of poverty. Due to federal cost-sharing requirements, premiums cannot be raised. The premium is $7 per child with a maximum per family of $14 per month. If the "community provider" plan is chosen the premium is $4 per child with a maximum per family of $8. About 31 percent of the HFP scribers are in this income bracket.
- Families with incomes from 150 percent to 200 percent will have their premiums increased from $9 per child per month to $12 per child per month (i.e., $3 more per month). The family maximum amount for these subscribers will be adjusted from $27 per month to $36 per month. About 40 percent of the HFP scribers are in this income bracket.
- Families with incomes over 200 percent will have their premiums increased from $17 per child to $19 per child per month (i.e., $2 more per month). The family maximum amount for these subscribers will be adjusted from $45 per month to $51 per month. About 29 percent of the HFP subscribers are in this income bracket.

HFP does offer subscribers "premium discount options" to offset some costs associated with premiums and co-payments. Discounts offered include (1) $3 per child per month discount for enrollment in a "community provider plan"; (2) subscriber paying 3 months in advance to get one month "free"; and (3) a 25 percent monthly discount for payment of premiums through electronic funds transfer.

Description of HFP Plan Rate Reduction (See #2, in above Table). Effective February 1, 2009, MRMIB has negotiated and implemented an overall 5 percent rate reduction for plans participating in the HFP. Due to this negotiation, *81,000 children* needed to change plans since some plans dropped HFP coverage in certain geographic regions because of the rate reduction. Of these children: (1) 82 percent were shifted from Anthem Blue Cross coverage to other plans; (2) 10 percent were shifted from Health Net; and (3) 8 percent were shifted from Blue Shield to other plans.

Description of Dental Benefit Limit (See #3, in above Table). Effective July 1, 2009, MRMIB will proceed with the annual benefit limit of $1,500 for dental coverage as directed from actions taken in the Budget Act of 2008.

MRMIB estimates that about 5 percent of the HFP enrolled children *may* hit this limit in 2009-10. In addition, since this proposal reduces total benefits to subscribers it also reduces dental plan costs, thereby allowing for a reduction in the rates paid to these plans.

Budget Year Caseload Adjustments. *In addition*, the budget reflects HFP caseload increases. Specifically, it assumes enrollment of 941,786 children as of June 30, 2009, an increase of 36,200 children, or a growth rate of about 3 percent, over the revised current year enrollment.

This estimated HFP enrollment of children for 2009-10 is summarized by population segment below:

- Children in families up to 200 percent of poverty 701,496 children
- Children in families between 201 to 250 percent of poverty 240,276 children
- Children in families who are legal immigrants 17,592 children
- Access for Infants and Mothers (AIM)-Linked Infants 18,698 children
- New children due to changes in Certified Application Assistance 9,008 children
- Bottom-line adjustment attributable to enactment of reductions (-45,284) children

Overall Background—Description of the Healthy Families Program. The HFP provides health, dental and vision coverage through managed care arrangements to children (up to age 19) in families with incomes up to 250 percent of the federal poverty level, who are *not* eligible for Medi-Cal but meet citizenship or immigration requirements. The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis.

In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into the Healthy Families Program and can remain under the HFP until at least the age of two. If these AIM to HFP two-year olds are in families that exceed the 250 percent federal income level, then they are no longer eligible to remain in the HFP.

Table #2: Background Summary of Existing Eligibility for the Healthy Families Program

Type of Enrollee in the HFP	Income Level Based on Federal Poverty	Comments
Infants up to the age of two years who are born to women enrolled in Access for Infants & Mothers.	200 % to 300 %	• Income from 200% to 250%, covered through age 18. • Income is above 250 %, they are covered up to age 2.
Children ages one through 5 years	133 % to 250 %	Healthy Families Program covers from 133 percent and above because children below this are eligible for Medi-Cal.
Children ages 6 through 18 years	100 % to 250 %	Healthy Families Program covers children in families above 100 %. Families with two children may be "split" between programs due to age.
Some children enrolled in County "Healthy Kids" programs. These include (1) children without residency documentation; and (2) children from 250 percent to 300 percent of poverty.	Not eligible for Healthy Families Program, including 250 percent to 300 percent	State provides federal S-CHIP funds to county projects as approved by the *MRMIB.* Counties provide the match for the federal funds.

Background—HFP Benefit Package. The HFP benefit package is modeled after that offered to state employees, including health, dental and vision. The enabling federal legislation—the State's Children's Health Insurance Program (S-CHIP)—required states to use this "benchmark" approach. These benefits are provided through managed care arrangements. The HFP directly contracts with participating health, dental and vision care plans. Participation from these plans varies across the state but consumer choice has *historically* always been available.

In addition to these HFP benefits, enrolled children can also access the California Children's Services (CCS) Program if they have a CCS-eligible medical condition. An HFP enrolled child is also eligible to receive *supplemental* mental health services provided through County Mental Health Plans. These additional services are provided in accordance with state statute that created California's Healthy Families Program (i.e., California's S-CHIP). These services are also available to children enrolled in Medi-Cal.

Subcommittee Staff Comment and Recommendation. As discussed, the HFP is now implementing the reductions contained in the Budget Act of 2008. These adjustments will be updated at the May Revision, along with a revised caseload estimate for the current-year and budget-year.

It is important to hear from the MRMIB regarding its implementation of the reductions and to obtain preliminary information as to their potential affect on the program.

Questions. The Subcommittee has requested the Managed Risk Medical Insurance Board to respond to the following questions:

1. **MRMIB**, Please provide a *brief* summary regarding the implementation of the three reductions—i.e., the increase in premiums, negotiation of revised contract rates, and the capitation of dental services.
2. **MRMIB**, How has enrollment into the HFP been affected by these changes thus far, including the 81,000 children who had to shift plans due to the health plan rate reduction?
3. **MRMIB,** Please provide a *brief* summary of the existing budget and highlight *key* changes that have not already been referenced.

2. Reauthorization of CHIP Provides for: (A) Reauthorized Federal Allotment, (B) Covers Legal Immigrant Children, (C) Requires Citizenship Documentation & (D) Selected Other Issues

Background—Reauthorization of CHIP. The federal Children's Health Insurance Program Reauthorization Act (CHIRPA) of 2009, signed by President Barack Obama in February, is sweeping legislation. *First*, it was designed to "reauthorize" the financing of children's health insurance (Healthy Families in California) for the next 4.5 years (April 1, 2009 to September 30, 2013) and is financed largely by a $0.62 increase in the federal tax on cigarettes.

Second, it makes several other changes to the program by offering states additional children's coverage options, as well as requiring certain other programmatic changes to improve quality assurance measures, data collection and other components of the program. Some of these federal CHIPRA changes will be addressed through California's budget process as needed. Other issues will require state policy discussions over the next year or so as components of the federal legislation are clarified by MRMIB working with the federal CMS, as well as with involved stakeholders and the Legislature.

Third, it interacts with California's Medi-Cal Program in several areas. These issues will be discussed under the Department of Health Care Services, later in this Agenda.

Budget Discussion Issues. Due to timing, California's February 2009 budget package does *not reflect changes* contained within the federal CHIPRA. The MRMIB states that some CHIPRA issues will be forthcoming at the Governor's May Revision, to be received by the Legislature in late May. It is anticipated that fiscal changes, as well as trailer bill language proposals will be forthcoming.

However, it is important for the Subcommittee to discuss and clarify key aspects of the federal CHIPRA that pertain to California's budget *prior* to the May Revision. These issues are as follows:

- A. California's Federal CHIP Allotment. CHIPRA increases the federal allotment available to states and uses a three-part formula for states to determine their federal allotment amount. It also establishes a mechanism for "rebasing" state allotments every two years to ensure that federal funds are targeted to states that are using them, or the funds will be re-distributed.

  Based on an *initial* calculation, the MRMIB anticipates California to receive a federal allotment of $1.481 billion for federal fiscal year 2009 (October 1, 2008 to June 30, 2009). These federal Title XXI Funds (as the federal allotment is called) require a 35 percent General Fund match, *as needed*, to operate Healthy Families, as well as certain components within the Medi-Cal for Children Program.

According to the MRMIB and an independent consultant, this allotment of federal Title XXI Funds for California should be sufficient for the state to operate the Healthy Families Program without any concern of a federal funding shortfall.

Any unexpended federal Title XXI Funds can roll forward to the next federal fiscal year (two-years to expend). The law also outlines a system for redistributing unexpended federal funds to states facing any federal CHIP shortfall in future years.

Finally, it should be noted that CHIPRA allows States to expand eligibility or benefits under CHIP beyond the federal funding methodology contained in the law. States can request these expansions only in federal fiscal years 2010 and 2012. To do so, a State must submit a "State Plan Amendment" to the federal CMS by August 31st preceding the beginning of the applicable fiscal year (e.g., by August 31, 2009 for federal fiscal year 2010).

Therefore, if California desired to expand Healthy Families Program enrollment from 250 percent to 300 percent of poverty, it would need to submit a State Plan Amendment by August 31, 2009. In addition, this would require State statutory changes and increased expenditures of about $58.5 million ($21.1 million General Fund and $37.4 million federal funds) to provide coverage to about 50,000 children who are estimated to be in this aspect of the population and would otherwise be eligible for Healthy Families.

- B. Legal Immigrant Children—California Can Receive Federal Funds in Healthy Families. CHIPRA gives states the *option* of providing coverage for legal immigrant children with less than 5-years in the United States and receiving federal funds for this purpose.

  California law has always offered enrollment in Healthy Families for legal immigrant children with less than 5-years in the U.S. if they otherwise meet all other Healthy Families Program requirements. California has covered these children since inception of the Healthy Families Program using 100 percent General Fund support.

  As such, this CHIPRA *option* would now enable Healthy Families to draw federal funds for this purpose and *save about $12.2 million in General Fund support* based on the 2009-10 February budget package. Presently the HFP expends about $18.8 million (General Fund) on this coverage.

  However, the Administration states this savings estimate will be updated at the May Revision. MRMIB notes that under this CHIPRA *option* some children might have to provide additional documentation at "annual eligibility renewal (AER) to re-verify their documentation status. Presently the HFP requires a copy of documentation of children's legal status upon initial enrollment but no additional documentation at AER. In addition, they contend that implementing these provisions may result in lower program enrollment retention and could result in increased administrative costs.

  (The Medi-Cal Program will be discussed further below in this Agenda under the DHCS Item.)

- C. Citizenship Documentation—Added Requirements. The federal CHIPRA extends existing Medicaid citizenship *and* identity documentation requirements to CHIP (Healthy Families Program) which must be implemented by January 1, 2010.

  According to the MRMIB, about 92 percent of children enrolled in Healthy Families are born in California. Therefore, MRMIB could link to the vital statistics database created by the Department of Health Care Services (DHCS) for Medi-Cal citizenship documentation and could automatically identify children using California's birth certificate records (as maintained by the Department of Public Health).

  In addition, the MRMIB believes the "identity documentation" component of this new requirement can be addressed for most children through a revision to the "joint application" (an application used to enroll children who may be eligible for Medi-Cal or the Healthy Families Program). Specifically, the revised joint application would allow a parent/guardian to attest to the identity of children *less than* 17 years of age. Federal law provides for a parent/guardian's declaration for this age group.

  However, it is not clear how to satisfy the new requirement for 17 and 18 year olds enrolled in Healthy Families. Further, it is unclear what these administrative changes will cost the Healthy Families Program.

  The MRMIB states that changes to the HFP eligibility verification process as outlined above will likely require emergency regulations

  Finally, it should be noted that the Healthy Families Program does not collect Social Security Numbers (SSNs) are part of its enrollment process. The Medi-Cal Program does collect SSN information and is affected by the federal CHIPRA provisions in a different manner.

  (The Medi-Cal Program will be discussed further below in this Agenda under the DHCS Item.)

- D. Selected Other Issues. As noted previously, CHIPRA is sweeping legislation which addresses many aspects of the program. Other issues the Subcommittee should be aware of are as follows:

  - *Requires Dental Coverage*. CHIPRA requires States to include coverage of dental services as part of the benefit package. California has always provided dental coverage within the HFP.

    However, two issues have been raised. First, it is not yet clear if California's orthodontia benefit meets the CHIPRA requirement since the HFP coverage for this is specific dental procedure is limited. Second, CHIPRA requires certain encounter claims-based information for dental coverage and California does not presently collect this information; therefore, changes may be required.

    The MRMIB will provide an update on these issues at the May Revision.

- *Increased FMAP for Translation Services.* CHIPRA provides an enhanced federal matching rate (i.e., 75 percent) for translation and interpretation services in connection with enrollment of, retention of, and use of services for families whose primary language is not English. The MRMIB is presently assessing the cost-effectiveness of separating out these services from the Administrative Vendor contract and the Health Plan contracts where these services are presently provided and funded.

  The MRMIB states that more information should be available at the May Revision regarding this issue.

- *Additional Funds for Outreach & Enrollment "Grants".* CHIPRA provides $100 million for federal fiscal years 2009 to 2013 for outreach and enrollment "grants" designed to increase enrollment in CHIP (Healthy Families) and Medicaid (Medi-Cal). Of this amount, 10 percent is available to American Indian Reservations.

  MRMIB states that more information should be forthcoming from the federal CMS regarding these grants but noted that these funds can go to States, local governments and other organizations.

- *Prenatal Care for Pregnant Women—Unborn Option.* CHIPRA explicitly leaves intact an existing "unborn child" regulation whereby states can obtain federal CHIP funds for prenatal care provided to pregnant women. California presently has a federal Waiver for this purpose which enabled the state to save almost $200 million General Fund in the Budget Act of 2005 and forward (i.e., savings in the Access to Infants and Mothers Program and the Medi-Cal Program).

  The MRMIB states *no adjustments are necessary* to continue this existing approach.

Subcommittee Comment and Recommendation. The federal CHIPRA is sweeping legislation which provides California with an opportunity to obtain increased federal funding and continue the success of our Healthy Families Program, and Medi-Cal for Children Program. Due to the State's fiscal situation, the Subcommittee will need to focus its efforts on those CHIPRA changes which need to be in effect during the State's 2009-2010 fiscal year. At this time, it is recommended to have the MRMIB respond to questions and to leave these issues open until receipt of the May Revision (in late May).

Questions. The Subcommittee has requested the MRMIB to respond to the following questions:

1. **MRMIB**, Please discuss each issue as noted above (commencing with "A") and provide a brief summary and comment regarding the issue, including the potential need for budget action to be taken in 2009-10.

II. Department of Mental Health

1. Healthy Families Program—Supplemental Mental Health Services

Background—Healthy Families Program & Supplemental Mental Health Services. The Healthy Families Program (HFP), as discussed above under the Managed Risk Medical Insurance Board (MRMIB), provides health care coverage and dental and vision services to children as specified.

The enabling state statute for the HFP also provides *"supplemental" mental health* services to children referred by health plans participating in the HFP who have been diagnosed as being seriously emotionally disturbed (SED). Specifically, medically necessary mental health services for HFP enrollees with SED that go *beyond* the basic mental health services provided by participating health plans are the responsibility of County Mental Health Plans.

The Department of Mental Health (DMH) is responsible for budget appropriations for the HFP supplemental mental health services provided by County Mental Health Plans.

The supplemental mental health services provided to children enrolled in the HFP who are SED can be billed by County Mental Health Plans to the state for a federal Title XXI match. Counties pay the non-federal share from their County Realignment funds (Mental Health Subaccount) to the extent resources are available. The supplemental mental health services

Summary of Budget Appropriation. The February budget package reflects total expenditures of $49.2 million, including county administration expenditures, for 2009-10. This reflects an increase of $7.3 million (increase of $235,000 General Fund and $7.1 million in Reimbursements) as compared to the current-year.

Of the total amount, $44.7 million (total funds) is for local assistance and $4.5 million, or 10 percent, is for county administration costs. The DMH states that this estimate is based on current expenditures of approved claims as monitored by the DMH. Counties are responsible to provide a contributing 35 percent match to the program overall. Federal CHIP funds provide a 65 percent match, except for certain populations.

With respect to legal immigrant children residing in the U.S. for less than five years, the DMH presently provides a 65 percent General Fund match to the counties 35 percent match since federal CHIP funds were not previously available for this purpose until the CHIPRA changes.

Budget Discussion Issues. There are two key issues with this appropriation.

First, the federal CHIPRA will now provide federal funding at the 65 percent level for legal immigrant children residing in the U.S. for less than five years. As such, a May Revision adjustment will be forthcoming from the Administration to reflect this change. Since the state presently provides a 65 percent match for this population in lieu of federal fund support, a small amount of General Fund savings will be achievable.

Second, the MRMIB has just completed an analysis of these supplemental mental health services which was released on April 22nd. Key findings include the following:

- Very few children in the HFP receive services for treatment of mental health conditions from either County Mental Health Plans or from HFP participating health plans.
- The percentage of seriously emotionally disturbed children referrals accepted by counties has been declining. In 2006-07, sixty-three percent of HFP children referred for services were accepted by County Mental Health Plans as compared to 72 percent in 2004-05.
- The average cost per case increased 75 percent from $2,615 in 2000 to $3,488 in 2007, which is far greater than the average 4.3 percent annual increase in the medical consumer price index during these years.

Subcommittee Comment and Recommendation. First, the DMH will be providing updated expenditures and federal funding adjustments due to CHIPRA at the May Revision. This issue should be relatively straightforward at that time.

However, the issues raised in the MRMIB report released on April 22 require further deliberation. It is therefore recommended to direct the MRMIB and DMH to report back to the Subcommittee prior to the May Revision regarding potential follow-up.

Questions. The Subcommittee has requested the DMH and MRMIB to respond to the following questions:

1. **DMH**, Please provide a *brief* summary of the budget request.
2. **DMH,** Roughly, what amount of General Fund savings is likely to be achieved from the federal CHIPRA change for legal immigrants residing in the U.S. for less than five years?
3. **MRMIB**, Please provide a brief summary of the recent findings regarding the provision of mental health services under the HFP. What follow-up is being contemplated at this time?

III. Department of Health Care Services: Medi-Cal Program

A. OVERALL BACKGROUND

Purpose: The federal Medicaid Program (called Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance. *Generally*, California receives a 50 percent match from the federal government for most Medi-Cal Program expenditures. This federal match will increase to 61.59 percent under the federal American Recovery & Reinvestment Act, as discussed below, for a 27-month period.

Medi-Cal is at least three programs in one: (1) a source of traditional health insurance coverage for poor children and some of their parents; (2) a payer for a complex set of acute and long-term care services for the frail elderly and people with developmental disabilities and mental illness; and (3) a wrap-around coverage for low-income Medicare recipients.

Who is Eligible and Summary of Medi-Cal Enrollment: Generally, Medi-Cal eligibles fall into four categories of low-income people as follows: **(1)** aged, blind or disabled; **(2)** low-income families with children; **(3)** children only; and **(4)** pregnant women.

Men and women who are *not* elderly and do not have children or a disability *cannot* qualify for Medi-Cal no matter how low their income. Low-income adults without children must rely on county provided indigent health care, employer-based insurance or out-of pocket expenditures or combinations of these.

Generally, Medi-Cal eligibility is based upon family relationship, family income level, asset limits, age, citizenship, and California residency status. Other eligibility factors can include medical condition (such as pregnancy or medical emergency), share-of-cost payments (i.e., spending down to eligibility), and related factors that are germane to a particular eligibility category. States are required to include certain types of individuals or eligibility groups under their Medicaid state plans and they may include others—at the state's option.

The Medi-Cal Program also has several "special programs" that provide limited services for certain populations**.** These include the **(1)** Emergency Medical Services Program which provides emergency medical services to undocumented individuals; **(2)** the Family PACT Program which provides reproductive health care services; **(3)** the Breast and Cervical Cancer Program which provides services related to cancer for women up to 200 percent of poverty; **(4)** the Disabled Working Program which allows certain disabled working individuals to pay a premium to buy into the Medi-Cal Program; and **(5)** the Tuberculosis Program which provides treatment for TB. These programs are limited in their eligibility and in the services that are funded under them.

Estimated Medi-Cal enrollment for 2009-10 is about 7 million people. Medi-Cal provides health insurance coverage to about 18 percent of Californians. The projected Medi-Cal eligible caseload is summarized in the table below.

Summary of Caseload Medi-Cal Eligibles	2009-10 Estimate Eligibles
Families/Children	
CalWORKS	1,392,100
Working Families (1931 b Program)	3,006,935
Pregnant Women	43,700
Children (100 % and 133% programs)	277,945
Aged/Disabled	
Aged	699,914
Blind	23,800
Disabled	1,096,573
Medically Indigent	227,842
Other Various Categories	179,500
Undocumented Persons	68,600
TOTALS	**7,016,909**

Summary of Budget Appropriation*:* The budget proposes total expenditures of $40.5 billion ($15.4 billion General Fund, $24.3 billion federal Title XIX Medicaid funds, and $862.5 million in other state funds) for local assistance the Medi-Cal Program in 2009-10.

This reflects a *net* General Fund increase of $969.8 million, or an increase of about 6.6 percent above the revised current-year level as shown in the chart below.

Medi-Cal Funding Summary *(Dollars in Thousands)*	2008-09 Revised	2009-10 Budget	Difference	Percent
Local Assistance				
Benefits	$35,911,954	$37,335,221	$1,423,267	3.9%
County Administration (Eligibility)	$2,825,667	$2,901,702	$76,035	2.7%
Fiscal Intermediaries (Claims Processing)	$310,303	$295,136	(-$15,167)	(-4.9%)
Total Local Assistance	**$39,047,924**	**$40,532,059**	**$1,484,135**	**3.8%**
General Fund	$14,413,726	$15,369,562	$955,836	6.6%
Federal Funds	$23,785,630	$24,300,006	$514,376	2.2%
Other State Funds	$848,568	$862,491	$13,923	1.6%

The February budget package reflects the following *key* adjustments to the Medi-Cal Program for 2009-10 as shown below.

- *Restores Governor's Proposed Medi-Cal Eligibility Reductions.* The Legislature rejected all of the Governor's proposals to reduce Medi-Cal eligibility and restored $485 million in General Fund support for this purpose.

- *Deletes Funding for Medi-Cal Optional Benefits*. As proposed by the Governor, certain Medi-Cal Optional Benefits were not funded in the February budget package, nor was the trigger activated as specified to restore these services, including Adult Dental, Optical Labs, Optometrists/Opticians, Chiropractor, Psychologist services, Podiatrist, Acupuncturist, Audiologist and Incontinence Creams and Washes. This action reduced Medi-Cal by about $129 million in General Fund support. As has been previously discussed in the Subcommittee, elimination of these benefits is an extremely difficult action.

  The DHCS states they have accounted for potential cost-shifts to other services, such as emergency room usage; however, no one knows the potential consequences to enrollees or the health care safety net since this has never previously occurred. However, an increase of $8.2 million (General Fund) will be needed in the Department of Developmental Services to continue to provide these services through the Regional Center system. This will be discussed at a later date.

- *Redirects A Portion of the Safety Net Care Pool Funds*. As proposed by the Governor, a 10 percent reduction, or $54 million General Fund, was redirected from Public Hospitals to backfill for General Fund support in certain health care programs for 2009-10.

- *Suspends Cost Adjustment for Medi-Cal County*. As proposed by the Governor, the cost-of-doing business adjustment to support Medi-Cal eligibility processing conducted by counties, as a surrogate for the state, was not provided. This resulted in a reduction of $24.7 million in General Fund support for 2009-10.

- *Continues the Implementation Delay of Senate Bill 437 (Escutia), Statutes of 2006.* Among other things, this statute authorizes a pilot program in two counties to evaluate "self-certification" of income and assets by Medi-Cal applicants and Medi-Cal enrollees. The Governor vetoed funding for implementation in 2007, and implementation has been delayed since this time. The February budget package does not include funding for implementation.

(Discussion issues for this Subcommittee hearing begin on the next page.)

1. Implementation of SB 3X 24 (Alquist) and Receipt of Federal ARRA Funds

Background—Significant Increase to Federal Medical Assistance Percentage (FMAP). Among many things, Title V of the American Recovery and Reinvestment Act of 2009 (ARRA) increases the federal share of the Medicaid Program for states. The DHCS estimates California will receive an increase in our FMAP of 11.59 percent which would provide for a *61.59 percent* FMAP for California's Medi-Cal Program from October 1, 2008 through December 2010.

As shown in Table #1 below, this enhanced FMAP would provide California with an estimated $10.112 billion in *additional* federal funds for the 27-month period. These additional federal funds result in savings to the State of California, as well as to local governmental entities including counties. This is because federal Medicaid funds are used to support various health and human services programs operated by both the state and local governments where applicable.

The estimated combined State General Fund savings for 2008-09 and 2009-10 is $6.581 billion from the enhanced FMAP (i.e., $2.766 billion plus $3.817 billion). Due to the state's existing fiscal condition, it is critical for the DHCS to fully and quickly claim these enhanced federal funds, particularly for Medi-Cal services that have already been billed (i.e., from October 1, 2008 forward).

Table #1—DHCS Summary of Estimated Federal Funds from Increased FMAP (11.59%)

Area	State Fiscal Year 2008-09	State Fiscal Year 2009-10	State Fiscal Year 2010-11	Total Federal Funds
Estimate of Federal Funds for CA at Additional 11.59 percent	$3,269249,000	$4,561,824,000	$2,280,912,000	$10,111,985,000
GF Cost of SB 24 X3 (Alquist)	($9,322,500)	($91,902,000)	($91,902,000)	($193,126,500)
Total Net Savings from FMAP	**$3,259,926,000**	**$4,469,922,000**	**$2,189.010,000**	**$9,918,858,000**
Net Savings by Fund Source:				
State General Fund Savings	*$2,763,585,000*	*$3,817,405,000*	*$1,862,751,500*	*$8,443,741,500*
Other State Special Fund Savings	$4,346,000	$3,477,000	$1,738,500	$9,562,000
County/Local Savings	$491,995,500	$649,040,000	$324,520,000	$1,465,555,500
State General Fund Savings Split				
DHCS Operated Programs	$1,999,645,000	$2,821,824,000	$1,364,961,000	$6,185,430,000
Other State Department Programs	$764,940,000	$995,581,000	$497,790,500	$2,258,311,500

Most of the General Fund savings will accrue to the Medi-Cal Program administered by the DHCS. However other state departments-- most notably the Department of Mental Health (DMH), Department of Developmental Services (DDS), and Department of Social Services (DSS)—will also achieve savings from this additional federal support as reflected collectively in the Table above (i.e., "Other State Department Programs").

It should be noted that the 11.59 percent increase in federal FMAP is a *separate* federal match and needs to be tracked separately by the DHCS for reporting purposes to the federal CMS for accountability purposes.

Background—Medi-Cal Federal Claiming is Complex *and* ARRA Has Requirements.
Several departments administer complex "Waiver" programs for special populations, such as individuals with mental illness, individuals with developmental disabilities, and individuals utilizing In-Home Supportive Services. These various Waiver programs access federal Medicaid funds and have various payment arrangements.

For example, the DMH contracts with County Mental Health Plans to provide Medi-Cal mental health services, including Mental Health Managed Care and the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program. Various mental health providers also bill independently for these services. As discussed in the Subcommittee's March 26th hearing, the federal CMS has *released two audits* regarding significant concerns with the DMH billing practices and has *two additional audits* regarding the DMH which are forthcoming.

In order for the DHCS to obtain the retroactive 11.59 percent increase in FMAP (i.e., from October 1, 2008 forward) for other departments, including Waiver programs, the other departments need to submit revised invoices to the DHCS claiming the additional federal fund amounts. The DHCS states it has provided instructions to other departments for this purpose and revised invoices are being processed. To-date, over $1.7 billion in increased federal FMAP has been drawn by the DHCS.

The DHCS will need to assertively administer the program to meet the AARA requirements, *and* any additional federal CMS requirements that may come forth. The federal CMS will be tracking State's expenditures, as well as compliance with the provisions of the federal ARRA. As such, federal CMS audit exceptions could occur if the DHCS is not vigilant.

The ARRA specifies the following additional requirements for States to receive the enhanced federal funds:

- *1. No Eligibility Decreases or New Enrollment Hurdles*. States must maintain Medi-Cal eligibility levels at least at the same level as provided as of July 2008 and may not impose new procedural hurdles in enrollment. Any State out of compliance with this requirement has until July 1, 2009 to rescind the action. The State would then be *fully* eligible for the enhanced match, retroactive to October 1, 2008.

  However, any state that implements more restrictive policies as of July 1, 2008, and rescinds such policies *after* July 1, 2009, will *only* be eligible for the enhanced FMAP beginning with the first calendar quarter that it restored the eligibility policies. Therefore, any state in this situation would sacrifice their enhanced FMAP dollars for all of the preceding period—i.e., from October 1, 2008 until the policy was changed as referenced.

- *2. No Payment Delays—"Prompt Payment"*. States must comply with current rules to promptly pay provider Medi-Cal claims and must apply prompt payment rules to hospitals and nursing homes as well.

Federal prompt payment rules specify that states must pay 90 percent of "clean" claims within 30-days of receipt and 99 percent of "clean" claims within 90-days of receipt. This federal rule applies to provider, hospital, and nursing home Medi-Cal claims dated after the enactment of the ARRA. States are given until *June 1, 2009* to comply with these new prompt payment requirements.

- *3. No Increases in Local Financial Responsibilities*. States cannot increase localities' (such as counties) required shares of Medicaid (Medi-Cal) contributions above the levels in place as of September 30, 2008.

- *4. No Stockpiling of Federal Medicaid Funds*. States may not redirect the increased federal funds into any state reserves or rainy day funds.

To-date the Administration has contended that only one state statutory change was necessary to meet the federal ARRA requirements to obtain the additional FMAP. As discussed in our March 18th Subcommittee hearing, Senate Bill 24 X3 (Alquist), Statutes of 2009, made changes to Medi-Cal eligibility reporting by restoring "annual" eligibility for the enhanced federal fund period. This legislation was enacted to comply with the federal ARRA requirement as noted above. It is estimated that 191,488 children will remain eligible for Medi-Cal in 2009-10 due to this change.

In this hearing the DHCS committed to working with advocacy groups and other interested parties to ensure that Senate Bill 24 X3 (Alquist) is appropriately implemented and that County Welfare Departments, who conduct eligibility processing as a surrogate for the state, are fully informed of the changes.

However, due to reductions attributable to Section 99030 of the Government Code and Section 8.30 of the Budget Act of 2009 (i.e., trigger mechanism was not pulled), concerns have been expressed by constituency groups as to whether *all* of the ARRA requirements will be met as of July 1, 2009.

In addition, the DHCS as the lead State agency for Medi-Cal is obtaining additional direction from the federal CMS as the federal ARRA funds are accessed. Therefore, clarification from the DHCS is needed in order for any necessary changes to be remedied quickly.

Budget Discussion Issues. Due to timing, the February budget package does *not* reflect the enhanced FMAP of 61.59 percent as contained in the ARRA. The Administration states that changes to reflect this calculation will be in the Governor's May Revision to be received by the Legislature in late May. Based on the current DHCS estimate, a total of $6.581 billion in enhanced federal funds should be available for the two state fiscal years (2008-09 and 2009-10) which can be used to offset State General Fund support.

However, there are several *key* aspects regarding the receipt of these enhanced federal funds which need to be clarified *prior* to the May Revision discussion.

These *key* aspects include the following:

- Does California meet *all* ARRA requirements, as noted above, or are additional state statutory changes necessary?
- Specifically, how will the DHCS monitor and track claims for the enhanced federal funds from October 1, 2008 to June 30, 2009 for *all* of the programs it administers, as well as all of the various Waiver programs operated by other state departments?
- How will the federal CMS be providing states with additional direction and how will the DHCS keep the Legislature informed of these federal CMS directives?

Subcommittee Staff Comment and Recommendation. The DHCS should clarify for the Subcommittee key questions regarding the receipt of the federal ARRA funds as noted. It is recommended to keep this issue "open" pending receipt of the Governor's May Revision.

Further, it is recommended to adopt uncodified placeholder trailer bill language as follows to assist in maintaining Legislative oversight of these crucial federal funds:

> "The Department of Health Care Services (DHCS) shall provide the Legislature with a quarterly update, including key fiscal data provided to the federal Centers for Medicare and Medicaid, regarding the implementation of the federal ARRA as it pertains to California's Medi-Cal Program, including all Waiver programs. This quarterly update shall be provided to the fiscal and policy committees of the Legislature within 14 working days of the close of the quarter, commencing as of July 1, 2009. The first quarterly update to be received by the Legislature in July, 2009, shall reflect key issues and fiscal data as it pertains to the federal ARRA retroactive claiming (from October 1, 2008 to June 30, 2009)."

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Are *any* additional state statutory changes necessary in order to meet the federal ARRA requirements? If so, please be specific as to what is needed.
2. **DHCS,** How will the DHCS be monitoring and tracking Medi-Cal claims for these additional federal funds with respect to retroactive claiming (from October 1, 2008) as well as federal claiming for July 1, 2009 going forward?
3. **DHCS**, How will the Administration keep the Legislature informed of any additional federal CMS requirements or other key implementation issues regarding the federal ARRA?

2. Implementation of Federal CHIPRA in the Medi-Cal Program—Legal Immigrant Children and Pregnant Women

Background—Federal Funds Available for Medi-Cal Via CHIPRA. Though the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) primarily affects California's Healthy Families Program, it also contains provisions which interact with the Medi-Cal for Children Program.

CHIPRA enables states to obtain federal matching funds through Medicaid *and* CHIP financing for legal immigrant children and pregnant women during their first five years in the United States. Previously, the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 barred states from receiving federal assistance for this population.

California law has always provided legal immigrants (adults, children and pregnant women) with less than 5-years in the U.S. with *"full-scope"* Medi-Cal services if they otherwise meet all other Medi-Cal eligibility requirements. California has *primarily* used 100 percent General Fund support for this purpose due to the 1996 federal bar. However, when applicable, the DHCS has obtained federal Medicaid funding at a 50 percent match due to federal law regarding *"emergency services".* In addition, as noted under the MRMIB, California is also claiming federal CHIP funds for certain prenatal care as well.

Federal law requires states to provide emergency services (with federal financial participation) to immigrants who meet all other Medi-Cal eligibility requirements regardless of immigration status. *"Restricted-scope"* Medi-Cal includes "emergency services", prenatal care, 60-days of post-partum coverage, and on a very limited basis long-term care.

The DHCS states they are presently claiming a 50 percent federal match for pregnancy services (i.e., emergency services) for these legal immigrant individuals. Further, they are able to claim about 22 percent of the total costs as federal funds for the legal immigrant children's component due to emergency services claiming. The CHIPRA change will enable California to claim an even higher proportion of federal support.

California will be able to claim federal funds for the following populations using both Medicaid (through the ARRA) and CHIP (through the CHIPRA) financing. *Generally*, the type of federal financing available depends on the child's Medi-Cal aid code.

- A 65 percent federal matching rate for legal immigrant children (under 19 years), residing in the U.S. for less than 5-years, who are enrolled in Medi-Cal and eligible for CHIP funding (i.e., meet the expanded Medi-Cal Program requirements from 1998).
- A 61.59 percent federal matching rate for all non-pregnancy related services for legal immigrant pregnant women residing in the U.S. for less than 5-years, who are enrolled in Medi-Cal.
- A 61.59 percent federal match per the ARRA for legal immigrant children residing in the U.S. for less than 5-years who are enrolled in Medi-Cal and are not part of the CHIP funding stream.

Budget Discussion Issue. Due to timing, this CHIPRA funding is *not* reflected in the February 18-month budget package. The Administration will be reflecting this change in the Governor's May Revision.

However, based on preliminary estimates by the DHCS, a savings of $10.1 million (General Fund) can be achieved from the *additional* receipt of federal funds due to this CHIPRA change. Of this amount, $2 million would be attributable to 2008-09 (assuming an April 1, 2009 date), and $8.1 million would be achieved in 2009-10. Most of this federal funding support will be provided through Title XXI federal funding (i.e., funds used for Healthy Families support), with a smaller amount provided through Title XIX (i.e., funds used for Medi-Cal Program support).

It should be noted that the Administration will need to submit a "State Plan Amendment" (jointly for the MRMIB and DHCS) to the federal CMS in order for California to receive these enhanced federal funds.

Subcommittee Staff Comment and Recommendation. CHIPRA provides the option for States to obtain federal funds for this population as noted. This CHIPRA option would save about $10.1 million in General Fund support in Medi-Cal, as well as about $12.2 million in General Fund support in the Healthy Families Program (as discussed under the MRMIB item).

The Administration will be providing an update to this issue at the May Revision and as such, it is recommended to hold this issue "open" and to have the DHCS respond to questions.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Please provide a brief summary of this CHIPRA option and how California can obtain additional federal funds for this population which is already being served.
2. **DHCS**, What is needed for California to obtain these additional federal funds?
3. **DHCS**, Would any state statutory changes be needed within the Medi-Cal Program for this purpose?

3. Federal CHIPRA Changes to Citizenship Documentation

Background—Existing Citizenship Requirements and CHIPRA Changes. The federal Deficit Reduction Act (DRA) of 2005 required states to implement certain citizenship and identity documentation requirements in the Medicaid Program (Medi-Cal). Through state statutory changes and directives from the DHCS, California implemented these "DRA" citizenship and identity requirements in late 2007, with full statewide implementation by July 2008.

The DHCS states that the existing DRA citizenship and identity process costs about $30 million ($15 million General Fund) annually. County eligibility offices for Medi-Cal must process and verify documents received from Medi-Cal clients. For example, clients must provide an original or certified copy of their birth certificate and their driver's license. Copies of documents are not acceptable, and applicants must provide originals.

Effective January 1, 2010, federal CHIPRA provides states with the "option" to adopt a Social Security Number (SSN) verification process. The federal Social Security Administration would validate the name, SSN, and the citizenship status and identify of each SSN submitted by the state and return results to the state. States must submit the data match at least monthly.

CHIPRA establishes a reasonable opportunity period of 90-days for individuals to provide acceptable documentation *if* the state adopts the SSN verification option and does *not* receive verification from the federal Social Security Administration for the individual's SSN. CHIPRA also authorizes full-scope Medi-Cal coverage during this period for those who are otherwise eligible for Medi-Cal (meaning income eligible and the like).

CHIPRA also has a new monthly reporting requirement for states that requires a *three percent error rate* threshold for validation of SSN's. States must maintain this three percent threshold to avoid financial penalties. The financial penalty is the cost of services provided to *ineligible* beneficiaries above the three percent threshold.

However, the three percent error rate and financial penalty will *not* apply to a state if the state has agreed to submit data to the federal Social Security Administration on a "real-time" basis (versus the monthly basis as referenced).

The DHCS states that California currently has a *five percent error rate* for its bi-annual validation of SSN's. They note that this is using an older process for which the federal Social Security Administration did not provide citizenship information for all SSN's submitted by the state.

Budget Discussion Issue. This new CHIPRA option maybe more cost beneficial to the State, and may be more "consumer" friendly than the existing "DRA" citizenship and identity verification process. The Administration should explore this option more fully.

Subcommittee Staff Comment and Recommendation. In discussions with the DHCS, it appears the new CHIPRA option could simplify the Medi-Cal enrollment process over time, in lieu of using the existing "DRA" process.

Using the federal Social Security—either on a monthly basis or in "real time"-- would alleviate the burden currently placed on many Medi-Cal clients, and could be more cost-beneficial to the State overall. Additional documentation for Medi-Cal clients would only be needed for those individuals for whom the federal Social Security Administration cannot validate with an SSN match. These individuals would then have the 90-day window to provide information and they would receive full-scope Medi-Cal during this period.

The DHCS should report back at the May Revision regarding this option.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Could this new CHIPRA option be more consumer friendly for Medi-Cal clients, as well as more cost-beneficial to the state over time? If so, why?
2. **DHCS**, What may be needed to begin implementation of this option in 2009-2010?
3. **DHCS**, the effective date of this option is January 1, 2010, but when does the three percent error rate threshold requirement become effective as well as the financial penalty?

4. Federal CHIPRA—Potential for "Performance Bonus" Payments

Background—Federal CHIRPA and "Performance Bonus" Payments. CHIPRA offers federal fund performance bonus payments for enrollment and retention of children in the Medi-Cal Program. Performance bonus payments will be offered to states for five years (from federal fiscal year 2009 through 2013).

In order to be eligible for these performance bonus payments, a State *must*: **(1)** increase their Medicaid (Medi-Cal) enrollment among low-income children above a "baseline" threshold as defined in CHIPRA; and **(2)** implement at *least five* of eight specified enrollment and retention practices.

With respect to increased enrollment, the performance bonus payment is based on comparing each years "baseline" child enrollment as defined in CHIPRA, with California's actual child average monthly Medi-Cal enrollment during federal fiscal year 2009 and beyond. The calculation takes into consideration a state's growth rate in population for children as well in order to determine performance.

According to the DHCS, the federal performance bonus payments can vary from 15 percent to 62.5 percent of the average per-capita Medi-Cal cost of a child, with the higher percentage provided for the number of children enrolled in excess of 110 percent of the "baseline" threshold.

The eight enrollment and retention practices are listed below. According to the DHCS, California presently meets five of these enrollment and retention practices with the implementation of SB 24 X3 (Alquist), Statutes of 2009. Specifically, California has the first five items shown below.

- 12-month eligibility;
- Elimination of the asset test for children;
- Elimination of in-person interview requirements;
- Use of a joint application;
- Use of presumptive eligibility;
- Use of streamlined renewal;
- Use of a new "Express Lane" option that allows states to apply eligibility determinations made by other public agencies to Medicaid (Medi-Cal);
- Use of premium assistance subsidies.

As such, the amount of federal performance bonus payments California may receive is contingent upon increased enrollment among low-income children as calculated.

Constituency Concerns. The Subcommittee just received a letter from a constituency group questioning whether California indeed meets the joint application requirement (between Healthy Families and Medi-Cal for Children) since the constituency group's interpretation of the requirement is that both programs must also use the same verification process, which is presently not fully the case.

Therefore, they contend that other streamlining measures would be needed, such as implementation of SB 437 (Escutia), Statutes of 2006, or other pending legislation regarding administrative streamlining in order for California to meet the criteria to be eligible for any federal bonus.

Budget Discussion Issue. The federal CHIPRA performance bonus payment is a new concept and it appears that California may be eligible to obtain a federal payment during the 2009-10 state fiscal year. Therefore, the Administration may be coming forward at the May Revision with a calculation regarding receipt of these additional federal funds.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS,** is it likely that California will be eligible for a federal performance bonus payment? If so, what is the potential dollar range of this payment for California based on preliminary information? What would the potential timing of such payment be from the federal government?
2. **DHCS**, What can federal performance bonus payments be used for and are there any restrictions in the use of the funds?
3. **DHCS**, Any other aspects the Subcommittee should be aware of regarding this new federal performance bonus availability?

5. Medi-Cal Eligibility Verification—Trailer Bill, Contract Funds & Staff (See Hand Outs—three pieces)

Budget Discussion Issues. The February budget package provides $250,000 ($125,000 General Fund) for a contract, and funds for one Associate Governmental Program Analyst to conduct verification of assets for Medi-Cal applicants and enrollees whose Medi-Cal eligibility is based on being Aged, Blind, or Disabled (i.e., have these eligibility category aid codes). Trailer bill legislation is also proposed. The intent of this proposal is to comply with federal law changes.

The DHCS states this contract will be with a vendor to provide a secure, web-based means for counties to request asset information from financial institutions to supplement verification for Aged, Blind, or Disabled individuals in order to be compliant with new federal requirements. The vendor would also be required to track the required reporting elements based on the financial institutions responses and generate the reports for the DHCS when needed for submission to the federal CMS. At the request of the Subcommittee, the DHCS has provided a flow-chart to summarize how the this process is to work (See Hand Out).

The DHCS is *proposing sweeping* trailer bill language to require that Medi-Cal applicants and enrollees who are Aged, Blind, or Disabled provide authorization for the State to request from any financial institution any financial record held by the institution with respect to the applicant or enrollee and such other person, as applicable, whenever the State determines the record is needed for making a Medi-Cal eligibility determination.

This trailer bill language *also* requests exemption from provisions of the Public Contract Code and Department of General Services review for the DHCS to conduct its own competitive bid process to hire a contractor quickly (such as by Summer 2009) in lieu of going through the Department of General Services.

The DHCS contends an expedited contract process is necessary in order to show a "good faith" effort to meet the federal timeline contained in House Resolution 2642 of 2008. Specifically, this federal law requires an asset verification program, as specified, by October 1, 2009. The Administration notes that the federal CMS could impose sanctions on California for any delays, such as loss of federal funds.

Background—Federal House Resolution 2642 of 2008 (Hand Out). Title VII, Section 7001 (d) of this federal law adds Section 1940 to the Social Security Act which pertains to Medicaid asset verification through access to information held by financial institutions.

Specifically this federal law does the following:

- Requires States to electronically verify the assets of Medicaid (Medi-Cal) applicants and beneficiaries whose eligibility is based on being Aged, Blind, or Disabled through electronic requests sent to financial institutions, *whenever the State determines that such requests are needed in order to determine or re-determine the individual's eligibility.* California must implement a system by October 1, 2009, or show good faith that we are proceeding towards implementation.

- *Requires States to inform any person who provides authorization (i.e., access to their financial records) of the duration and scope of the authorization.*

- Generally declares that the federal Right to Financial Privacy Act does not apply for these purposes, as noted (See hand out—HR 2642, 2008, page 71, (d)).

- Requires each applicant or recipient whose eligibility is on the basis of being Aged, Blind, or Disabled, and any other person whose assets are required by law to be disclosed to determine the eligibility of that applicant or recipient, to provide authorization for the State to obtain from any financial institution any financial record with respect to the applicant/recipient *whenever the State determines* it is necessary to make the eligibility determination or re-determination.

- Directs that if an applicant or recipient of Medicaid (Medi-Cal) refuses to provide, or revokes, any authorization made by the applicant or recipient for the State to obtain from any financial institution any financial record, the State ***may***, on that basis, determine that the applicant or recipient is ineligible for Medicaid (Medi-Cal).

- Directs that there shall be *no cost* to the applicant or recipient for the State to obtain this information.

- Says that States may select and enter into a contract with a public or private entity meeting criteria and qualifications as the State determines appropriate, consistent with federal law. *Any contractor shall be subject to the same requirements and limitations on use and disclosure of information as would apply if the State were to carry out such activities directly.*

- Requires States to use an approach for verifying an individual's assets in a manner consistent with what the federal Social Security Administration is using.

- Requires States to submit a State Plan amendment to the federal CMS to specify the States' approach on implementing this law.

- Requires States to report certain information as specified to the federal CMS.

Constituency Concerns with Trailer Bill Language. The Subcommittee is in receipt of letters expressing considerable concerns with the trailer bill language. *First*, the language requires an individual to consent to the asset verification process as a condition of Medi-Cal eligibility. This requirement is beyond that which is contained in the federal law.

Second, the language broadly states that asset verification authorization shall be provided "whenever the State determines that the record is needed." No criteria is established or even outlined regarding how and when the authorizations will be required or what standards will be used for these activities. Therefore, implementation by individual counties or eligibility workers will likely be inconsistent and even *possibly* unintentionally discriminatory.

Third, the language broadly states that assets shall also be provided "by any other person whose resources are required by law to be disclosed". This provision most likely violates legal agreements in *Sneede v Kiser* (728, Supp. 607 of 1990) which limits whose assets can be counted towards the Medi-Cal enrollee's eligibility.

Fourth, there are also various important procedural issues which are not clear with the language or the proposal overall. These include the following:

- Will these Aged, Blind and Disabled applicants be delayed enrollment for long periods of time due to the need for the asset verification process? Will all other written documentation be waived if electronic verification of assets is conducted?
- How are county eligibility workers to process and track this information?
- Will "face-to-face" interviews now be necessary due to this proposed change?

Subcommittee Staff Comment and Recommendation. *First*, California will need to provide the federal CMS with a State Plan Amendment to our Medi-Cal Program to meet the requirements of the H.R. 2642. If we do not, it is very likely a loss in federal funds will occur. Therefore, no concerns are raised regarding the $250,000 for the contract or the need for the Associate Governmental Program Analyst.

Second, Subcommittee staff concurs with concerns expressed by constituency groups regarding the proposed trailer bill language. The DHCS proposed trailer bill is broadly written and goes further than federal law in some instances. In addition, it does not even contain appropriate clarity regarding privacy protections or notices to Medi-Cal enrollees explaining the system.

Third, the DHCS is proposing to implement these changes without regulation. The DHCS has a habit of skirting the development of appropriate State regulation by using an "All County Letter" process in which the DHCS provides direction as it sees fit. Often times these letters are modified or portions of them are modified, in lieu of doing State regulations. This process has created concerns with overall administration of the Medi-Cal Program. Therefore, the DHCS needs to include regulations as part of the trailer bill language.

Further, what is most disconcerting is that the Administration has not yet developed the criteria for determining which groups/individuals within the Aged, Blind and Disabled category would undergo electronic verification of assets. According to the DHCS, the federal CMS has indicated there is flexibility to "target" certain populations. Further the DHCS has expressed its desire to obtain constituency group input on criteria for determining who will be subject to this verification.

Therefore, it is recommended to leave the trailer bill language "open" and to direct Subcommittee staff to work with the DHCS and constituency groups to craft a compromise. This language would be brought back to the Subcommittee *prior* to the May Revision for consideration. As such, the DHCS needs to *quickly* proceed with conversations to obtain constituency group input.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Please provide a brief overview of this federal issue and the Administration's proposal to address it.
2. **DHCS**, Please provide a quick walk-through of the flow-chart provided to the Subcommittee.
3. **DHCS**, When will the state be meeting with constituency groups on this issue?

6. Update on Medi-Cal Managed Care and Proposed Trailer Bill Legislation

Budget Discussion Issue. The DHCS is proposing trailer bill language to clarify that a County Organized Healthcare System (COHS) can operate under Medi-Cal in more than one county without it being in a contiguous county. Specifically, the proposed trailer bill language modifies Section 14087.9 of Welfare and Institutions Code as follows:

> 14087.9. A combination of counties may contract with the department pursuant to this article for the provision of services ~~on a regional basis~~.

The DHCS states they are requesting this statutory change because Merced County plans to affiliate with a COHS that does not operate in a contiguous county. The DHCS contends that the existing statute is vague and could be interpreted to prohibit expansion of the COHS model of Medi-Cal Managed Care into counties outside of a finite area.

Specifically, Merced County officials have informed the DHCS that they plan to affiliate with Central Coast Alliance for Health, another COHS currently serving Santa Cruz and Monterey counties. As such, the DHCS believes this statutory change is needed.

It should be noted that the Medi-Cal Estimate for 2009-10 reflects an increase of $32.2 million ($16.1 million General Fund) to account for this trailer bill change to enable Merced County to contract with the Central Coast Alliance for Health. This increase assumes a July 1, 2009 implementation date.

This cost is attributable to the fact that Medi-Cal capitation payments will begin immediately, while Fee-For-Service Medi-Cal payments will continue to be paid for services provided before the expansion due to the time it takes providers to bill for services.

Background—Expansion of Medi-Cal Managed Care in 2005. Through the Budget Act of 2005 and accompanying trailer bill language, Medi-Cal Managed Care was geographically expanded to include 13 new counties.

The original expansion called for implementation using the “Geographic Managed Care” model and expanding existing COHS’s. However, through discussions with local stakeholders and local government, the DHCS has modified its plan accordingly.

The DHCS states that four of the original 13 expansion counties (El Dorado, Imperial, Marin and San Benito) are not ready or suitable for managed care expansion primarily due to concerns about assuring adequate provider networks. Two other counties—Merced and Ventura—pursued federal legislation to allow them to form new COHS (HR 6331 of 2008).

The following Table provides an update on expansion of the Medi-Cal Managed Care Program.

Table: Update on Medi-Cal Managed Care Expansion of 2005

Expansion County	Original Implementation Date	Revised Implementation Date	Managed Care Model
Placer	3/01/07	6/01/09	Geographic Managed Care
Fresno	10/01/07	10/01/10	Conversion to Tri-County Regional Two-Plan with Kings & Madera
Kings	10/01/07	10/01/10	Same as above
Madera	10/01/07	10/01/10	Same as above
Merced	10/01/07	10/01/09	COHS, Joining Central Coast Alliance
Lake	4/01/08	new date unknown	COHS, Joining Partnership Health Plan
Mendocino	4/01/08	new date unknown	COHS, Joining Partnership Health Plan
San Luis Obispo	4/01/08	Completed 3/01/08	COHS, with Santa Barbara Regional Health
Sonoma	4/01/08	10/01/09	COHS, Joining Partnership Health Plan
Ventura	4/01/08	new date unknown	COHS, will become its own

Background—Overview of Medi-Cal Managed Care. The DHCS is the largest purchaser of managed health care services in California with almost 3.5 million enrollees, or about 50 percent of enrollees, in contracting health plans.

The state's Managed Care Program now covers 23 counties through three types of contract models—Two Plan Managed Care, Geographic Managed Care, and County Organized Health Systems (COHS). Twenty health plans have contracts with Medi-Cal within the 23 counties. Some of the plans—like commercial plans—contract with Medi-Cal under more than one model (i.e., commercial plan in Two Plan Model and participate in the Geographic Managed Care model for example).

For people with disabilities, enrollment is mandatory in the County Organized Health Systems, and voluntary in the Two Plan model and Geographic Managed Care model. About 280,000 individuals with disabilities are enrolled in a Medi-Cal Managed Care plan.

Each of these models is briefly described below.

- *Two-Plan Model.* The Two Plan Model was designed in the 1990's. The basic premise of this model is that CalWORKS recipients (women and children) are automatically enrolled (mandatory enrollment) in either a public health plan (i.e., Local Initiative) or a commercial HMO. Other Medi-Cal members, such as aged, blind and disabled, can voluntarily enroll if they so choose. About 72 percent of all Medi-Cal managed care enrollees in the state are enrolled in this model.

- *County Organized Healthy Systems (COHS).* Under this model, a county arranges for the provision of medical services, utilization control, and claims administration for *all* Medi-Cal recipients. Since COHS serve all Medi-Cal recipients, including higher costs aged, blind and disabled individuals, COHS receive higher capitation rates on average than health plans under the other Medi-Cal managed care system models. About 632,000 Medi-Cal enrollees receive care from these plans. This accounts for about 18

percent of Medi-Cal Managed Care enrollees.

- *Geographic Managed Care Model.* The Geographic Managed Care model was first implemented in Sacramento in 1994 and then in San Diego County in 1998. In this model, enrollees can select from multiple HMOs. The commercial HMOs negotiate capitation rates directly with the state based on the geographic area they plan to cover. Only CalWORKS recipients are required to enroll in the plans. All other Medi-Cal recipients may enroll on a voluntary basis. Sacramento and San Diego counties contract with nine health plans that serve 358,000 Medi-Cal enrollees or about 10 percent of all Medi-Cal managed care enrollees in California.

Subcommittee Staff Comment and Recommendation. *First*, as noted in the Table above, Merced implementation has now moved to an October 1, 2009 implementation date. Therefore, the additional cost associated with the capitation payments will decrease. A more comprehensive update on these payments will be provided in the Governor's May Revision.

Second, the proposed language change appears to be a reasonable accommodation to enable Merced County to contract with Central Coast Alliance for Health.

No issues have been raised regarding the proposed trailer bill language. It is therefore recommended to adopt it as proposed.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Please provide a *brief* update on the status of the 2005 expansion of Medi-Cal Managed Care.
2. **DHCS**, Please provide a *brief* description of why the trailer bill language is being requested and its intended affect.

7. Request for Staff in the DHCS Waiver Unit for the Mental Health Services Waiver

Budget Discussion Issues. The DHCS is requesting an increase of $331,000 ($166,000 General Fund) to support three positions to enable the DHCS to respond to the federal CMS audits and to continue making improvements in the coordination and management of the Medi-Cal Mental Health Waiver.

As the lead state agency for Medi-Cal, the DHCS is ultimately responsible for administering California's Medi-Cal Program, including all Waivers which are operated by other state departments, such as the Department of Mental Health.

As noted below, and has been discussed recently in our March 26th hearing, more oversight is needed in order to effectively administer this Waiver. Even with the addition of this proposed staff, the DHCS states that California may face budget deficiencies, overpayments, and interest penalties for late payments to County Mental Health Plans.

In addition, the DHCS contends that the federal CMS *could even cancel* this Medi-Cal Mental Health Waiver due to federal CMS audit concerns.

Background-- Continued Concerns with Fiscal Integrity. This Subcommittee has discussed fiscal integrity issues regarding the operation of state mental health programs for the past four years, including *five reports* prepared by the Office of Statewide Audits and Evaluations (OSAE), Department of Finance.

Further, the Subcommittee's March 26th hearing regarding the Department of Mental Health, noted significant fiscal management issues have continued to be raised regarding the state's administration of the overall Medi-Cal mental health system (including the Early and Periodic Screening and Treatment Program, and Mental Health Managed Care).

There are several aspects to this concern, but first and foremost are fiscal audits by the federal Centers for Medicare and Medical (CMS), *coupled with* the need for continued work to "restructure" the payment process for the state to reimburse counties and other providers within a 30-day period, versus the 90-day to 120-day timeframe that exists today.

The federal CMS has recently released two audits with findings and presently has three more audits that are in process. All of these audits and reviews pertain to concerns regarding lack of fiscal controls, overpayments, and lack of coordination with the Department of Health Care Services regarding the management of reimbursements made under Medicaid (Medi-Cal in California).

Key findings and outcomes from the two released audits (in September 2008 and December 2008) include the following:

- The DHCS and DMH systems are not adequate to comply with federal reporting requirements, resulting in the total mental health program expenditures reported to the federal CMS (using form 64) likely to be significantly misstated.

- DMH transferred a total of almost $21 million in federal funds back to the federal CMS as repayment for "excess" federal funds it had claimed incorrectly, due to overpayments in the EPSDT Program (for 2003-04), and claims the DMH made for programs not operated under Medi-Cal (i.e., certain state-only programs and other federal programs).
- The DHCS does not appear to provide adequate oversight over the Medicaid mental health program, specifically over the processing of DMH invoices (such as for the EPSDT Program and Mental Health Managed Care Program).
- California's existing reimbursement methods, processes and policies are not fully consistent with federal law, particularly regarding interim payment, reconciliation and cost-settlement processes. Therefore, the state must provide the federal CMS with a "State Plan Amendment" by July 1, 2009 that articulates all of these practices.
- By July 1, 2009, California must implement controls to ensure that the process used to count County Realignment Funds (i.e., "certified public expenditures") towards the federal match, meets federal requirements.
- California needs to implement procedures to ensure adequate oversight of amounts claimed as Medicaid mental health costs.

The three remaining federal CMS audits which are presently underway are described below:

- Audit #3—Financial Management Review. The federal CMS has completed field work at five counties, including San Francisco, Los Angeles, San Diego, Orange, and Sacramento to examine how counties utilize their County Realignment Funds to draw federal matching funds, and other aspects of the reimbursement process. Outcomes from this review are still pending.

- Audit #4—Payment Error Rate Measurement Audit. The federal CMS conducts this audit to identify program vulnerabilities that result in improper payments and to promote efficient Medicaid (Medi-Cal in California) programs. The state is presently working with the federal CMS regarding a "Post Project Review" document and a "Corrective Action Plan"; this information is due to the federal government by April 1, 2009.

- Audit #5—Program Integrity Audit. The federal CMS conducts this audit to determine overall program integrity to policies and procedures, and to learn how states receive and use information about potential fraud and abuse involving Medicaid providers. It is anticipated that the federal CMS will release the results of this audit in 60-days or so.

Background—Overview of Mental Health Managed Care: Under Medi-Cal Mental Health Managed Care psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, are the responsibility of a single entity, the Mental Health Plan (MHP) in each county.

Full consolidation was completed in June 1998. This consolidation required a Medicaid Waiver ("freedom of choice") and as such, the approval of the federal government. Medi-Cal recipients *must* obtain their mental health services through the County MHP.

The Waiver promotes plan improvement in three significant areas—access, quality and cost-effectiveness/neutrality. The DMH is responsible for monitoring and oversight activities of the County MHPs to ensure quality of care and to comply with federal and state requirements. This Waiver *expires as of June 30, 2009 and must be renewed* with the federal CMS.

Subcommittee Staff Recommendation. *First*, it is recommended to provide the DHCS with the requested positions. However, due to the state's fiscal situation, it is recommended to reduce the Department of Mental Health's state support item by a like amount--$166,000 (General Fund) to fund the DHCS positions. The DMH can allocate this reduction as determined by the Director of the Department. For example, the reduction can be achieved through operating expense reductions, salary savings, contract reductions or other approaches, and can be spread across all administrative areas of the Department (such as the state hospitals section or the executive branch).

Second, it is recommended to adopt *placeholder* trailer bill language to require the DHCS to provide the results of *any* federal audits, including federal CMS or any other federal agency, regarding the Medi-Cal Program to the fiscal and policy committees of the Legislature.

Third, it is recommended to adopt *placeholder* trailer bill legislation to require the California Health and Human Services Agency (CHHS Agency) to provide the policy and fiscal committees of the Legislature with a comprehensive "Action Plan" as to what key changes are necessary to improve the operations of these services between these two departments, as well as a timeframe for when key milestones are to be completed, including all claims processing procedures and work products (such as the various recommendations contained in the OSAE Reports and federal CMS audits, as well as the Short-Doyle II system).

It should be noted that placeholder trailer bill language is recommended in order to draft a compromise which is workable for the Administration.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Please provide a *brief* summary of the Finance Letter request and why these positions are necessary.
2. **DHCS**, Please provide a brief update as to the state's submittal of the Waiver renewal for Mental Health Services since the existing Waiver expires as of June 30, 2009. Is the state's Waiver at risk due to the federal CMS audits as previously noted by the DHCS?

8. Trailer Bill Language & Staff for Mental Health Services Supplemental Payments Program (Hand Out)

Budget Discussion Issues. The Subcommittee is in receipt of a Spring Finance Letter to develop and implement a Mental Health Services Supplemental Payment Program to be administered by the Department of Health Care Services (DHCS).

The DHCS is requesting an increase of $101,000 ($50,000 in reimbursements from Counties and $50,000 in federal funds) to support an Associate Governmental Program Analyst, and comprehensive trailer bill language to establish the program. The position would be used to develop and administer the program, including the establishment of claims processing and payment protocols. No issues have been raised regarding the need for the position.

This new Mental Health Services Supplemental Payment Program would be modeled after other existing DHCS "supplemental payment" programs. Specifically, it would authorize County Mental Health Plans (County MHPs) to submit "certified public expenditures" (CPEs) to the DHCS for the purpose of claiming federal financial participation to reimburse County MHPs for the costs of mental health services provided to Medi-Cal enrollees that *exceed their current payment levels*.

The supplemental payment would consist of the difference between the current Fee-For-Service rate being paid for these services and the actual costs to the counties to provide the mental health services. It should be noted that these supplemental payments can also be used to reimburse providers of Medi-Cal mental health services other than counties; however, it is the county CPE that must be used to claim the federal reimbursement.

Participation in the program by counties would be completely voluntary. The DHCS would invite counties to participate on an annual basis. Generally, it would be large counties who would most likely choose to participate in order to claim the additional federal funds since they are more likely to be incurring these costs.

It should be noted that the DHCS has already submitted a *draft* State Plan Amendment to the federal CMS in order to implement the program retroactively to January 1, 2009. This provides California with a longer period in which to claim federal reimbursement for these uncompensated county expenditures. This new program would be eligible to obtain the federal ARRA level of federal FMAP at 61.59 percent.

Based on preliminary information as contained in the draft State Plan Amendment, it is anticipated that $27.7 million (federal funds) can be obtained for 2008-09 and $55.4 million can be obtained for 2009-10. This increased federal funding would be very beneficial to local entities providing mental health services.

Constituency Group Concerns. Several constituency groups representing the County Mental Health Directors Association and community-based providers have expressed concerns regarding the DHCS language and the need to be involved in the development of the new program. Discussions have commenced to hopefully achieve a compromise.

Subcommittee Staff Comment and Recommendation. The implementation of a Mental Health Services Supplemental Payment Program makes sense for California. It would enable the Medi-Cal Program to obtain additional federal funds for mental health services through the use of the CPE process.

Subcommittee staff believes a consensus could be reached where trailer bill language could be crafted which would enable certain providers, under specified circumstances, to benefit from these supplemental payments as well as County MHPs. It is recommended to direct interested parties to work with the Administration and Subcommittee staff to develop a compromise.

In addition, the DHCS and DMH need to ensure that full coordination between these two departments will occur so there are no federal CMS audit concerns.

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

1. **DHCS**, Please provide a *brief* summary of the proposal, including the proposed trailer bill language. Specifically, how would the program operate?
2. **DHCS and DMH**, How will coordination occur across the two departments to ensure appropriate development and implementation of this program?

9. Trailer Bill Language to Establish Maximum Allowable Ingredient Costs for Generic Drugs Dispensed by Pharmacists (Hand Out)

Budget Issues Discussion. The February budget package assumes savings of $2 million ($1 million General Fund) for 2009-10 by implementing trailer bill language to establish a *new* Maximum Allowable Ingredient Cost (MAIC) within the Medi-Cal Program. Annual savings are estimated to be $24 million ($12 million General Fund).

The savings assumes a June 1, 2010 implementation date by the DHCS since system changes and other administrative actions require time to implement. Trailer bill language needs to be enacted before this savings can be achieved.

The Administration's proposed trailer bill language would allow the Medi-Cal Program to set MAIC using *either* (1) the Average Manufacturer Price (AMP); (2) the Wholesaler Acquisition Cost (WAC); *or* (3) to contract with a vendor to establish MAIC prices.

The DHCS states that changes in the MAIC calculation are necessary because the existing Medi-Cal MAIC depends on the use of AMP as reported by the federal CMS to states. However, due to a federal court injunction and federal law changes, the federal CMS cannot readily provide this information to states.

The DHCS contends that the benefits to this trailer bill change are as follows:

- Increases the use of generic drugs in the Medi-Cal Program.
- Establishes a maximum reimbursement process that has been inactive in the Medi-Cal Program.
- Will maintain or increase savings in Medi-Cal.

Establishment of the new MAIC will reduce payment for many generic drugs. This will affect the reimbursement amount received by some pharmacies since the DHCS is not proposing any adjustments to the dispensing fee component of the rate. However, this proposal will also increase the use of some generic drugs. The DHCS contends that a shift away from some brand name drugs to generics with the new MAIC can be expected to financially benefit some pharmacies.

Overall, the extent of savings will depend on the differences between the current reimbursement and the new MAIC, and in those situations where the brand name drug is preferred, the difference between the net cost (cost after rebates) of the brand name drug and the net cost of the generic drugs, plus the drug utilization patterns after the new MAIC is established.

Background—Pharmacy Reimbursement Under Medi-Cal. Pharmacy reimbursement consists of two components—a drug ingredient cost and a dispensing fee. With respect to the drug ingredient cost component, Medi-Cal presently calculates this cost at the "Average Wholesale Price" minus 17 percent. The dispensing fee component is $7.25 per prescription except for long-term care pharmacies which receive $8.00 per prescription.

Generally, the drug ingredient cost constitutes about 85 percent of the payment per prescription to a Pharmacy.

The rate reduction for Pharmacy reimbursement enacted in AB 1183, Statutes of 2008, is presently not in affect due to a court injunction (a 10 percent reduction effective July 1, 2008 to February 2009 and then a 5 percent reduction effective March 1, 2009).

Background—Summary of Previous Efforts Regarding MAIC. MAIC is an upper payment limit that creates a maximum reimbursement for generically equivalent drugs. MAIC is only used by Medi-Cal.

Originally, MAIC was defined in regulations as being equal to Average Wholesale Price (AWP) minus 5 percent price of a reference generic drug (typically the drug with the lowest AWP) with the provision that the Drug Manufacturer of the generic drug would be able to provide enough drug products to meet Medi-Cal's needs.

Unfortunately, this regulation did not mandate for Drug Manufacturers to supply this information. Therefore, the DHCS was generally unable to establish new MAIC prices. As a result a "new" MAIC definition was established in state statute in 2004.

This MAIC definition in 2004 was to be based on the Wholesale Selling Price (WSP). WSP was to be the weighted (by unit volume) mean price, including discounts and rebates, paid by a pharmacy to a wholesale drug distributor. Instead of using a single product, this methodology would use all generic equivalent products to calculate a weighted average that would be MAIC.

This 2004 definition of MAIC was halted when Congress declared they would move to an Average Manufacturer's Price (AMP) based on Federal Upper Limits (FUL). In 2007 this definition was changed to make MAIC equal to the mean of the AMP of drugs generically equivalent to the particular innovator (i.e., brand drug) plus a percent markup determined by the DHCS to be necessary for MAIC to represent the average purchase price paid by retail pharmacies in California.

The federal CMS issued regulations (to be effective October 1, 2007) regarding this calculation of FUL and AMP prices. However, the National Association of Chain Drug Stores and the National Community Pharmacists Association filed a complaint for injunctive relief contending that implementation was unlawful and would cause harm. Federal court issued a temporary injunction barring federal CMS implementation. Further, House Resolution 6331 delays implementation of FUL prices and AMP reporting until October 1, 2009.

Since the MAIC for Medi-Cal relies on the use of AMP reported by the federal CMS to states, it has been impacted by both the federal court injunction as well as the delay enacted in H.R. 6331.

Background—Description of Key Terminology. The following key definitions and terminology are provided only as a reference for discussion purposes.

- Average Manufacturer Price (AMP). This is the average price paid to the Drug Manufacturer for the drug in the United States by wholesalers for drugs distributed to retail pharmacies.
- Average Wholesale Price (AWP). Historically, the AWP has been the generally accepted drug payment benchmark for many payers because it was readily available. The primary sources of AWP are the drug data companies—most notably "First Data Bank". The Medi-Cal Program currently uses First Data Bank as the source of AWP and other drug data reported by the Drug Manufacturers. Drug companies updated their database files continuously. Many pharmacies and third party payers, including Medi-Cal, obtain updated pricing on a weekly basis.
- Wholesaler Acquisition Cost (WAC). The WAC is generally a list price set by Drug Manufacturers for each of their products. WAC is supposed to represent what a wholesaler pays for a drug. However, WAC does not reflect discounts or price concessions offered by Drug Manufacturers. Drug Manufacturers report WAC prices directly to First Data Bank.
- Federal Upper Limit. Prior to certain federal law changes, the Federal Upper Limit (FUL) was defined as the reimbursement limit for each multiple source drug for which the federal Food and Drug Administration has *rated three or more* products therapeutically equivalent. Generally, drug products are considered pharmaceutical equivalents if they contain the same active ingredients are of the same dosage form, route of administration and are identical in strength or concentration.

  Federal law changes (Deficit Reduction Act of 2005) decreased the number of equivalent drugs from three to two and changed the reimbursement calculation. As noted above, these federal changes have not been implemented.
- Non-Innovator Multiple Source Drug. These drugs are often referred to as "generic drugs" and are *therapeutically equivalent* to Innovator Multiple Source Drugs which are referred to as "brand drugs".

Constituency Groups. The Subcommittee is in receipt of letters expressing some concerns with the crafting of the trailer bill language and have offered suggested changes to the DHCS. Some of the concerns include the following:

- The proposed trailer bill language needs to be more explicit in determining how the new MAIC will be set.
- The new MAIC for Medi-Cal should only be determined for those generic drugs that do not have a Federal Upper Limit established by the federal CMS.
- The new MAIC should only be determined for products that have at least three "A-rated" sources of every strength and are widely available for purchase in California pharmacies.

Subcommittee Staff Comment and Recommendation. It is makes fiscal sense for the DHCS to propose a new MAIC. However trailer bill language needs to be modified to address some constituency concerns and to make the mechanics of statue clearer.

Therefore, it is recommended to leave the trailer bill language "open" and to direct the DHCS to provide revised trailer bill language to the Subcommittee *prior* to the May Revision.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Please provide a *brief* summary of the proposed trailer bill language and the purpose of it.
2. **DHCS**, What are the specific benefits to the Medi-Cal Program for enacting this language?

Outcomes from Senate Subcommittee No. 3: Thursday, April 23

- Senator Ashburn absent.

THE MANAGED RISK MEDICAL INSURANCE BOARD

1. Healthy Families Program—Discussion of Existing Budget (Page 3)

- **Comment.** The May Revision will propose changes so no action is presently required.

2. Reauthorization of CHIP Provides for: (A) Reauthorized Federal Allotment, (B) Covers Legal Immigrant Children, (C) Requires Citizenship Documentation & (D) Selected Other Issues (Page 7)

- **Comment.** The May Revision will propose changes so no action is presently required.

II. Department of Mental Health

1. Healthy Families Program—Supplemental Mental Health Services (Page 11)

- **Comment.** The May Revision will propose changes so no action is presently required.

III. Department of Health Care Services: Medi-Cal Program (Page 13)

1. Implementation of SB 24 (Alquist) & Receipt of Federal ARRA Funds (Page 16)

- **Comment.** The May Revision will propose changes with respect to federal dollars, so no action is presently required on this component.

- ***Motion.*** Adopt trailer bill language as contained on page 19 of the Agenda to require the DHCS to provide the fiscal and policy committees of the Legislature with quarterly updates as specified on the federal Medicaid funds.

- ***Vote*: 2-0 (Senator Ashburn absent)**

2. Implementation of Federal CHIPRA in the Medi-Cal Program—Legal Immigrant Children and Pregnant Women (Page 20)

- **Comment.** The May Revision will propose changes with respect to federal dollars, so no action is presently required.

3. Federal CHIPRA Changes to Citizenship Documentation (Page 22)

- **Comment.** We will leave this open for the May Revision for further clarification.

4. Federal CHIPRA—Potential for "Performance Bonus" Payments (Page 24)

- **Comment.** We will leave this open for the May Revision for further clarification.

5. Medi-Cal Eligibility Verification—Trailer Bill, Contract Funds & Staff (Page 26)

- **Comment.** We will leave this open for the May Revision for further clarification.

6. Update on Medi-Cal Managed Care & Proposed Trailer Bill (Page 29)

- ***Motion***. Adopt the trailer bill language as proposed.
- ***Vote*: 2-0 (Senator Ashburn absent)**

7. Request for Staff at DHCS for the Mental Health Services (Page 32)

- **Motion**. I move to (1) approve the DHCS positions, (2) delete $166,000 in General Fund support from the DMH to fund the DHCS positions, (3) adopt placeholder trailer bill language to require the DHCS to provide results of any federal audits to the Legislature, and (4) adopt placeholder trailer bill language to require the Health and Human Services Agency to provide an "Action Plan" to correct the layers of fiscal concerns so noted today.
- ***Vote*: 2-0 (Senator Ashburn absent)**

8. Trailer Bill Language & Staff for Mental Health Services Supplemental Payments Program (Hand Out) (Page 35)

- **Comment.** Issue left open directed Subcommittee staff to work with constituency groups and departments to craft a compromise.

9. Trailer Bill Language to Establish Maximum Allowable Ingredient Costs for Generic Drugs Dispensed by Pharmacists (Hand Out) (Page 37)

- **Comment.** Issue left open directed Subcommittee staff to work with constituency groups and departments to craft a compromise.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

April 30, 2009

9:30 a.m. *or*
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

(Jennifer Troia)

Item	Department
0530	**Office of Systems Integration** • **Case Management, Information, and Payrolling System Replacement Project** • **CalWORKs Business Analytics and Reporting System**
5180	**Department of Social Services** • **Community Care Licensing Division - Program Overview and Licensing Client Protections**
4200	**Department of Alcohol & Drug Programs** • **Drug Medi-Cal Program - Post-Service, Post-Payment Reviews** • **Expenditure Authority for Residential and Outpatient Program Licensing Fund**

Please note: The Committee will discuss only the items contained in this agenda at this hearing. Please see the Senate File for dates and times of subsequent hearings.

The Committee will discuss the issues in the order noted in the agenda, unless otherwise directed by the Chair.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance from the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible.

Discussion Agenda

0530 Health & Human Services Agency, Office of Systems Integration (OSI)

OSI Issue 1: Case Management, Information and Payrolling System Replacement Project (CMIPS II)

Budget Issue: OSI has requested, in a Spring Finance Letter, to reduce its 2008-09 spending authority for the CMIPS II Project by $18.3 million ($6.6 million General Fund and $11.7 million federal funds) and to correspondingly increase this spending authority by $15.2 million ($5.5 million General Fund and $9.8 million federal funds) in the 2009-10 budget year. OSI states that this shift is necessary because of delays in project development and that it does not expect the project's costs or target completion date to change as a result of this request.

Costs and Funding for CMIPS II: The overall budget for the CMIPS II Project in the relevant budget years and the changes requested are summarized in the chart below, provided by OSI:

Category	2008-09 Budget	2008-09 Changes Requested in Finance Letter	2009-10 Budget	2009-10 Changes Requested in Finance Letter
OSI Staff	$1,679,000	$0	$1,680,000	$0
County Staff	$5,175,000	($3,200,000)	$20,865,000	$3,200,000
County Travel	$251,000	$0	$122,000	$0
CMIPS II Contract	$51,675,000	($2,849,000)	$61,962,000	$2,849,000
State Support Contracts	$6,010,000	$0	$6,967,000	$0
Interfaces	$15,358,000	($12,287,000)	$5,119,000	$9,215,000
Data Center Services	$934,000	$0	$2,009,000	$0
Other (OE&E)	$1,360,000	$0	$1,430,000	$0
TOTAL	**$82,442,000**	**($18,336,000)**	**$100,154,000**	**$15,264,000**

Background on CMIPS and CMIPS II: OSI provides project management services for automation projects of the Department of Social Services (DSS), including CMIPS, and the Employment Development Department. The existing CMIPS is a more than 20-year-old system that offers mainly payroll functions for providers in the In-Home Supportive Services (IHSS) program. The IHSS program provides in-home personal care services to qualified individuals who are blind, aged, or who have disabilities. IHSS services allow these recipients to stay in their homes and avoid institutionalization. CMIPS II was approved in recent years and is currently being developed. CMIPS II is intended to be a web-based solution that integrates off-the-shelf products to perform IHSS case management, payroll, and timesheet processing, as well as reporting and

data exchange functions. OSI has indicated that this new system will offer a number of benefits as compared with the existing system, including more timely updates of information; more easily accessible reports; increased work automation; and a greater ability to interface with other data systems.

The Development of CMIPS II: The development of CMIPS II is expected to be completed in July, 2011. According to OSI, the requested current year reduction and related budget year increase are necessary because of a delay related to a change in the CMIPS II development strategy. The original project schedule proposed by EDS involved overlapping of the main project development phases. The state has since requested that EDS instead break out those design phases, so that one will be completed before the next begins (known as a "waterfall" model).

Prior to this phase of the CMIPS II project, contract development and procurement began in fiscal year 1999-00. Procurement was delayed due to funding reductions in 2003, program changes in 2004, and the efforts of OSI and DSS to ensure a competitive process. Final proposals from bidders were received in August, 2006. The incumbent contractor, Electronic Data Systems (EDS), was the sole bidder. The contract award was supposed to be made on July 1, 2007, but negotiations took longer than anticipated. As a result, the contract was awarded to EDS in March, 2008. Project initiation and planning began July 1, 2008.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the $18.3 million reduction in OSI spending authority for the CMIPS II Project in the current year and the related increase of $15.2 million in the 2009-10 budget year.

Question for OSI/DSS:

1. Please summarize the anticipated benefits of CMIPS II for the IHSS program, including anticipated benefits to caseworkers, providers, and recipients.

2. Are the delays in this project, including this one, expected to result in additional workload to OSI, DSS and/or the vendor? How confident are you that they will not result in increased overall costs for this project?

OSI and DSS Issue 2: CalWORKs Business Analytics and Reporting System (CBARS)

Budget Issue: OSI and DSS have requested a combined total of $1.8 million ($1.2 million from the Office of Systems Integration Fund and $600,000 from federal Temporary Assistance for Needy Families (TANF) block-grant funds) in 2009-10 to begin the planning and procurement process for CBARS, which is intended to provide more timely access to data from implementation of the California Work Opportunity and Responsibility to Kids (CalWORKs) program. The $1.2 million from the OSI fund would support OSI's project management responsibilities. The $600,000 from TANF funds would support new positions at DSS to provide program direction.

According to the Feasibility Study Report for CBARS, the procurement, development, and initial implementation of the solution is expected to span three and a half years, at a total estimated cost of $13.5 million (including the $1.82 million requested for 2009-10).

Breakdown of the Requested Funds: The chart below from OSI summarizes the total funds requested for 2009-10:

	2009-10 Request
State Staff– OSI	$447,229
State Staff– DSS	$506,665
Acquisition Support Services	$165,278
Data Center Services	$25,556
Agency Facilities	$334,506
Consortia Data Extract Costs	$175,000
Other (OSI)	$62,237
Other (DSS)	$103,167
Total	**$1,819,638**

Background on CalWORKs & the Statewide Automated Welfare System (SAWS): CalWORKs is California's implementation of the federal TANF program and is operated in all 58 California counties by the county welfare departments or their contractors. CalWORKs provides temporary cash assistance to families who are unable to meet basic needs (shelter, food, and clothing) on their own. CalWORKs also provides education, training, and employment programs to assist these families in their move to self-sufficiency. The state requires CalWORKs recipients to engage in welfare-to-work activities that are designed to meet federal work participation requirements (WPR) and avoid federal financial penalties.

California's WPR is significantly lower than the federal requirement. In 2007, California achieved a WPR of 22.3 percent, compared with the required 40.7 percent. According to DSS, as a result of the state's failure to meet the federal WPR, California is currently

paying $180 million per year to meet increased maintenance of efforts requirements and expects to pay $150 million in annual penalties.

County caseworkers record case management data (including data that leads to the calculation of the state's WPR) into SAWS, which actually consists of four separate and distinct automated systems. The four systems are operated by consortia of multiple counties (with the exception of Los Angeles County, which has its own system). Although OSI provides project oversight of SAWS, counties have significant autonomy in developing and maintaining their systems.

Rationale Behind Request for CBARS: Even though the four consortia's systems are technically part of a statewide system, DSS does not have direct access to a statewide view of the data they contain. DSS instead relies on individual consortia or counties to provide data, which it must then aggregate. According to DSS, this lack of timely and detailed data makes it impossible for the department to make mid-course corrections in program policies or provide impactful technical assistance. The proposed CBARS project would instead create a system through which DSS could assess WPR performance at any point in time. The department and OSI also intend for CBARS to improve the ability of various other state-level data systems to interface with CalWORKs data, including, e.g., the Medi-Cal Eligibility Data System.

Subcommittee Staff Comment & Recommendation: Notwithstanding the need to improve CalWORKs data collection and reporting, given the current fiscal situation facing the state, this project may not be urgent enough to necessitate approval of the requested funds for 2009-10. Staff recommends holding this issue open pending May Revision.

Questions for DSS and/or OSI:

1. Please summarize the need for the proposed CBARS and the reasons you see this as the best solution to meet those needs. In particular, can SAWS reporting tools be used instead of CBARS?

2. Please describe the end-users you would anticipate including as CBARS is developed. Would counties--in particular caseworkers--or the public have direct access to information contained in CBARS? What reports might be produced for the public and/or stakeholders?

3. How do you anticipate that CBARS would help CalWORKs clients?

5180 Department of Social Services (DSS)

DSS Issue 1: Licensing Client Protections Budget Change Proposal

Budget Issue: DSS requests $3.5 million (approximately $3 million from a 16 percent increase in licensing fees and the remaining $500,000 from federal funds) and 30 positions in response to increased criminal background check workload and concerns about the need to assure compliance with laws related to sex offenders and licensed facilities, certified homes, or county-approved relative homes. The chart below, from DSS, displays a breakdown of the requested funds between these purposes:

	POSITIONS	TOTAL FUNDS
1. Caregiver Background Check Bureau	**21.5**	**$2,095,000**
2. Protections Related to Registered Sex Offenders (RSO)		
Website	1.0	$111,000
Data Match	3.5	$1,008,000
Megan's Law	4.0	$303,000
RSO Subtotal	**8.5**	**$1,422,000**
OVERALL TOTAL	**30.0**	**$3,517,000**

The proposed efforts to monitor registered sex offenders include providing online data to parole and probation officers about the locations of licensed facilities, conducting an annual match of offenders' address data with licensee addresses, and extending the address match process to county-licensed homes and approved relatives' homes.

Background on the Community Care Licensing (CCL) Division of DSS: With a total budget of about $120 million (approximately $38 million General Fund), CCL oversees the licensure of approximately 86,000 facilities, and has the responsibility to protect the health and safety of the individuals served by those facilities. The facilities licensed by CCL include child care centers; family child care homes; foster family and group homes; adult residential facilities; and residential care facilities for the elderly. CCL does not license skilled nursing facilities (licensed by the Department of Health Care Services) or facilities that provide alcohol and other drug treatment.

All individuals seeking to be licensed to operate, work in, or reside at a community care facility must first complete a criminal background check that is processed (and in some circumstances investigated) by CCL. CCL is also responsible for reviewing and responding to any reports of criminal activity that lead to an arrest subsequent to an initial background check. As a result of these subsequent criminal arrest investigations, CCL may revoke an individual's permission to be involved with a facility.

CCL also performs inspection visits to licensed facilities, with an underlying statutory requirement to conduct a routine visit to every community care facility at least once every five years. According to DSS, compared with 2007-08, in 2008-09 CCL has increased its frequency of facility visits and decreased a backlog of overdue inspections (although CCL still projects 200 overdue inspections per month). The overall number of complaints and citations has also decreased during that time.

Rationale Behind Requested Caregiver Background Check Positions: According to CCL, there has been a 17 percent increase in the overall workload related to criminal arrest records submitted to the bureau for review over the last three years. For example, the department processed 206,768 background check applications in 2004-05, which increased to 229,912 in 2007-08. The number of subsequent arrest rap sheets received by the department rose from 16,485 in 2004-05 to 26,394 in 2007-08. As a result of the workload increase, CCL estimates that there is an existing backlog of about 1,400 individuals whose backgrounds or arrests require its review or investigation. Pending the investigation of a subsequent arrest, some of these individuals may continue to work in community care facilities.

Rationale Behind Requested Positions for Monitoring Registered Sex Offenders: The Department of Justice (DOJ)'s database of registered sex offenders contains a list of more than 59,000 offenders who live in California's communities. Last year, the Bureau of State Audits (BSA) conducted an audit on the placement of these offenders in residential facilities. During that audit, BSA also discovered 49 instances in which the registered addresses in DOJ's database were the same as the addresses of facilities licensed by DSS to serve children. Upon further investigation, two of these matches pointed to instances in which a registered sex offender had access to a facility where children were present. The department immediately suspended those facilities' licenses. The department also suspended the licenses of 11 other facilities to which an offender had access, even though no children were present.

LAO Alternative to DSS's Proposal: The LAO recommends "(1) a higher fee increase of 25 percent (raising $5.4 million), (2) funding the workload increase related to subsequent crime arrest investigations (at a cost of $1.8 million), and (3) funding the data-sharing portion of the expanded efforts related to registered sex offender investigations now (at a cost of $96,000) and delaying consideration of the remaining efforts for two years. This option results in a net General Fund benefit of $3.5 million in 2009-10, with similar savings in 2010-11." (italics removed)

The LAO points out that licensing fees have not been raised since 2004-05 and that fees currently cover only about 35 percent of the state's costs for licensing and enforcement activities. Under proposal, a 25 percent fee increase could raise the state's cost recovery to about 45 percent of the cost of licensing and enforcement activities.

The LAO supports funding the data-sharing capabilities for monitoring the presence of registered sex offenders. However, the LAO also believes that CCL has a sound

existing process in place through criminal background checks and reviews of arrest records to check for the presence of registered sex offenders in facilities and therefore recommends a two-year delay before consideration of the remaining efforts to expand CCL's sex offender investigations.

The chart below from the LAO's report compares the current fee schedule to the fees proposed by CCL and by the LAO:

Figure 15

Community Care Licensing Fees
Examples of Current and Proposed Fees

Facility Type	Annual Fee			Application Fee		
	Current	Governor's Proposal	LAO Proposal	Current	Governor's Proposal	LAO Proposal
Family child care home (1-8 children)	$60	$70	$75	$60	$70	$75
Child care center (1-30 children)	200	232	250	400	464	500
Adult day facility (16-30 adults)	125	145	156	250	290	313
Residential facility (16-30 residents)	750	869	938	1,500	1,739	1,875
Foster family agency	1,250	1,449	1,563	2,500	2,898	3,125

Subcommittee Staff Comment & Recommendation: Staff recommends holding these issues open pending May Revision.

Questions for DSS:

1. Please provide an overview of the funding for CCL in recent years and how the department has performed with respect to its criminal background check, routine inspection and complaint investigation responsibilities. Please specify what CCL already does in the area of criminal background check protections.

2. Please briefly summarize your request for additional positions to conduct criminal background checks and monitor registered sex offender's presence in community care facilities.

Issue 1: Criminal background checks

3. Please summarize the trends in criminal background check workload over the last few years, including subsequent arrests of individuals working in community care settings. How long have the incidences of criminal history and subsequent arrest reports been increasing? What might account for these increases?

Issue 2: Checks and monitoring of individuals who are registered sex offenders

4. Please provide an overview of the State Auditor's findings and recommendations with regard to Registered Sex Offender Investigations. What corrective actions have you already taken in response to the Audit? Why are the proposed new activities needed in addition to existing processes?

5. Have you considered whether increased licensing inspection visits to facilities where children are present might provide similar protections, in addition to other benefits?

Question for LAO:

1. Please summarize your alternative proposal for increasing fees and improving the licensing and oversight of facilities, including how the proposal differs from CCL's and what the resulting General Fund implications might be.

4200 Department of Alcohol and Drug Programs (ADP)

ADP Issue 1: Drug Medi-Cal Post-Service, Post-Payment Reviews

Budget Issue: ADP requests an increase of $1.4 million ($893,000 from licensing fees collected in the Residential and Outpatient Program Licensing Fund (ROPLF) and the remainder from federal funds) and 13 positions to expand the department's ability to conduct Drug Medi-Cal (DMC) Post-Service, Post-Payment (PSPP) reviews and complaint investigations. Eight of the 13 positions would be new and would be dedicated to conducting DMC PSPP reviews. The other five positions would be continuing limited-term positions devoted to complaint investigation.

Background on ADP Licensing Functions and DMC: With a proposed budget of approximately $719 million ($312 million General Fund) for fiscal year 2009-10, ADP is responsible for administering prevention, treatment, and recovery services for alcohol and drug abuse and problem gambling. To carry out part of this mandate, ADP certifies facilities, reimburses DMC claims, investigates DMC-related complaints, and conducts onsite PSPP reviews to ensure facility compliance with billing and reimbursement-related requirements for services provided to Medi-Cal eligible clients. The Licensing and Certification Division (LCD) of ADP has a total proposed 2009-10 budget of $10.6 million ($1.1 million General Fund and $3.2 million ROPLF), including these requested funds. State law (Health & Safety Code Section 11833.02(e)) requires the LCD, unless otherwise specified, to be supported entirely by federal and special funds beginning in the 2010-11 fiscal year.

Nearly one-third of ADP's total expenditures support the DMC program, which is jointly funded by the federal and state government to provide drug and alcohol treatment services to persons lacking health insurance and with incomes up to 250 percent of the federal poverty level. DMC treatment is provided through these four modalities: 1) the Narcotics Treatment Program for persons who are opiate addicted, 2) Day Care Rehabilitative services, 3) Outpatient Drug Free services, and 4) Perinatal substance abuse services. According to ADP, there are currently 1,409 DMC providers in California certified to bill the DMC program (a number they project to increase to 1,577 by the 2010-11 budget year).

Post-Service, Post-Payment Reviews: Neither statutes nor regulations currently specify how frequently ADP must conduct PSPP reviews. According to ADP, PSPP reviews are currently conducted for each DMC certified program approximately once every five years. The additional eight positions requested would instead allow for PSPP reviews approximately once every two years. The department believes this greater frequency is necessary because it has become increasingly concerned regarding questionable billings or billing errors by DMC providers.

In 2005-06, ADP identified recoupments that resulted in $276,000 in recovery of General Fund resources. From 2006-07, $74,000 General Fund was recovered.

According to the department, cases from 2006-07 pending investigation could also result in up to $2 million in General Fund recoveries.

Complaint Investigations: According to ADP, the number of complaints the department received increased from seven in the 2004-05 budget year to 33 in 2007-08. As a result, in 2007-08 ADP received four limited-term positions to address workload associated with complaint investigations. The department projects that complaints will continue to increase, to an estimated 43, in 2009-10. Therefore, ADP requests to continue these limited-term positions, as well as one limited-term staff counsel position through fiscal year 2010-11.

Subcommittee Staff Comments & Recommendation: Notwithstanding the benefits of increasing the frequency of PSPPs, given the budget situation currently facing the state, staff recommends rejecting the eight new positions requested and instead offsetting an appropriate amount of General Fund expenditures from the Licensing and Certification Division of ADP. Pending additional information from ADP regarding the complaints at issue, staff recommends holding open the request to continue the five limited-term positions related to complaint review. Staff also recommends that the Subcommittee ask ADP to consider whether additional training for providers might provide an avenue for addressing some of the concerns that led to this request.

Questions for ADP:

1. Please summarize the overall funding for the Licensing and Certification Division, including how much is currently supported by General Fund. How does this proposal align with the department's mandate to be supported entirely by federal and special funds beginning in the 2010-11 fiscal year?

2. Please summarize the current frequency of PSPP reviews and how that frequency would change as a result of eight positions you are requesting. Why is this expansion of services so urgent right now?

3. How many staff does ADP currently have to respond to complaints? What are the most frequent subjects of the complaints? What actions are typically taken to investigate the complaints?

ADP Issue 2: Expenditure Authority for Residential and Outpatient Program Licensing Fund (ROPLF)

Budget Issue: ADP proposes Budget Bill Language (BBL) to allow the department to submit a one-time request to the Department of Finance by April 15, 2010 to increase its fiscal year 2009-10 ROPLF expenditure authority and decrease by a corresponding amount General Fund and/or Substance Abuse Treatment Trust Fund expenditures for its Licensing and Certification Division (LCD). Before submitting such a request, ADP would be required to assess the ROPLF fund balance resulting from licensing and certification fees to determine that there is a sufficient fund balance with a prudent reserve. Prior to approving such a request, the Department of Finance would be required to provide 30 days notice in writing to the Joint Legislative Budget Committee.

ADP states that this request will allow the department to maximize the use of the available ROLPF balance and to reduce its reliance on General Fund resources to support licensing and certification activities.

ROPLF Fund Condition: The fund's revenues (approximately $3.6 million in 2008-09) come from regulatory licenses and permits and renewal fees. Expenditures supported by the fund include state operations costs for ADP. The fund reserve at the end of 2007-08 was $1.8 million. That amount is estimated to increase to $3.5 million for 2008-09.

Background on ROPLF and Rationale for this Request: The Administration requested, and the Legislature approved as part of the 2007-08 human services budget trailer bill (SB 84, Chapter 177, Statutes of 2007) authorization for ADP to collect fees from all providers to fund ADP's licensing and certification activities. SB 84 also established ROPLF as a new fund for the collection of the fee revenues. Prior to SB 84, only for-profit providers were charged the fees. SB 84, as codified in Health & Safety Code Section 11833.02(e), also requires the LCD, unless otherwise specified, to be supported entirely by federal and special funds beginning in the 2010-11 fiscal year.

Subcommittee Comments & Staff Recommendation: Given that these licensing fee revenues are relatively new and that this request creates authority for one-time-only flexibility to reduce the non-fee-based funding for LCD, staff recommends approval of the requested BBL.

Question for ADP:

1. Please explain why this authority is being requested and summarize the proposed process for making this one-time request.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

Actions Taken April 30, 2009

(Jennifer Troia)

0530 Health & Human Services Agency, Office of Systems Integration (OSI)

OSI and DSS Issue 1: Case Management, Information and Payrolling System Replacement Project (CMIPS II)

Approved (2-0) (Ashburn absent) the reduction of $18.3 million in local assistance budget for CMIPS II Project in the current year and the related increase of $15.2 million in the 2009-10 budget year.

OSI and DSS Issue 2: CalWORKs Business Analytics and Reporting System (CBARS)

Issue **held open** pending May Revision.

5180 Department of Social Services (DSS)

DSS Issue 1: Licensing Client Protections Budget Change Proposal

Issues **held open** pending May Revision.

4200 Department of Alcohol and Drug Programs (ADP)

ADP Issue 1: Drug Medi-Cal Post-Service, Post-Payment Reviews

Action 1: **Rejected** (2-0) (Ashburn absent) the eight new positions requested for conducting post-service, post-payment reviews and instead offset an appropriate amount of General Fund expenditures from the Licensing and Certification Division of ADP.

Action 2: **Held open** the request to continue five limited-term positions related to complaint review.

ADP Issue 2: Expenditure Authority for Residential and Outpatient Program Licensing Fund (ROPLF)

Approved (2-0) (Ashburn absent) requested Budget Bill Language to allow the department to submit a one-time request to the Department of Finance by April 15, 2010 to increase its fiscal year 2009-10 ROPLF expenditure authority and decrease by a corresponding amount General Fund and/or Substance Abuse Treatment Trust Fund expenditures for its Licensing and Certification Division (LCD).

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

May 7, 2009

9:30 a.m. *or*
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item	Department
4265	Department of Public Health—*Items for Vote Only*
4300	Department of Developmental Services—*Selected Issues*

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Public comment is welcomed.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible. Thank you.

I. Items for "Vote Only" (Page 2 to 3))

A. Department of Public Health

1. Department's Correction for Genetic Disease Screening Program

Budget Issue. The Department of Public Health (DPH) has submitted a Spring Finance Letter to correct a technical adjustment for the Genetic Disease Screening Program. Specifically, the DPH requests an increase of $437,000 (Genetic Disease Testing Fund) to restore the base funding level for 2009-10 that was inadvertently deleted by the DPH when they were creating a new local assistance item for the program.

Subcommittee Staff Comment and Recommendation—Approve Finance Letter. Subcommittee staff has raised no issues with this technical adjustment and funds from the Genetic Disease Testing Fund are available for this correction.

It is recommended to approve the Spring Finance Letter.

2. California Electronic Death Registration System

Budget Issue. The DPH is requesting a *net reduction* of $212,000 (Health Statistics Special Fund) and to permanently establish 9 state positions to finalize the implementation of the California Electronic Death Registration System.

Specifically, 13 limited-term positions are set to expire as of June 30, 2009. The DPH wants to establish 9 of these positions as permanent to continue the work originally required by the 13 positions. The DPH notes that there are sufficient funds in the Health Statistics Fund to support the positions.

This staff is needed for a variety of functions, including oversight and management of the electronic death registration process, user account maintenance, cross-matching births and deaths for health and security purposes, compiling and disseminating statistical data, and training users of the system.

The DPH contends these positions are necessary in order to provide death data to the public, local agencies, and the state and federal governments.

Background—California Electronic Death Registration System. This system is used to register 98 percent of all deaths in California. The system is presently being used by over 4,000 users, including funeral homes, coroners, medical examiners, physicians, Local Registrars, Health Officers and many others. The system is being expanded to cover all Local Registrars and hopes to have this accomplished by June, 2010.

Subcommittee Staff Comment and Recommendation—Approve Finance Letter. Subcommittee staff has raised no issues with this adjustment. It is recommended to approve the Finance Letter.

3. Enterprise-Wide Online Licensing Project

Budget Issue. The DPH is requesting an increase of $174,000 (Safe Drinking Water State Revolving Fund) and two positions (two-year limited-term) to conduct the department's Enterprise-Wide Online Licensing Project. This is the second year funding request for this project.

Use of this project for the DPH's Drinking Water Program will enable the program to establish new data collection process both for contract data and permitting process data. It will provide an electronic forum for the request, generation, and issuance of water system permits and all related activities.

Background—Enterprise-Wide Online Licensing Project. There are five programs within the DPH which are participating in this online project that are subject to licensing, enforcement and billing. Many of these program areas various application and operating structures for collecting fees and maintaining data. As such, a more comprehensive system is being developed and implemented. This project will enable the DPH to consistently receive and review applications for initial licenses and renewals, and to oversee services provided under this licensure for adherence to governing laws and regulations.

Subcommittee Staff Comment and Recommendation—Approve Finance Letter. Subcommittee staff has raised no issues with this adjustment. It is recommended to approve the Finance Letter.

B. Department of Developmental Services

1. Trailer Bill Language to Extend the Adult Residential Facilities for Persons with Special Health Care Needs Pilot ("SB 962" Homes)

Budget Issue. The DDS has proposed trailer bill language requesting a one-year extension of the sunset date for this residential pilot program and its associated report on outcomes. Specifically, the language extends the independent evaluation for the program until January 1, 2010, and extends the residential pilot program until January 1, 2011.

Background--"SB 962" Homes. Senate Bill 962 (Chesbro), Statutes of 2005, directed DDS to establish a new pilot residential project designed for individuals with special health care needs and intensive support needs. Examples of health services that can be provided in this type of home include, but are not limited to, nutritional support; gastrostomy feeding and hydration; renal dialysis; and special medication regimes including injections, intravenous medications, management of insulin, catheterization, and pain management. Nursing staff will be on duty 24-hours per day.

This pilot is a joint venture with the Department of Social Services (DSS) and will serve up to 120 adults, with no more than five adults residing in each facility. This pilot is to be limited to individuals transitioned from Agnews Developmental Center.

Subcommittee Staff Comment and Recommendation. No issues have been raised regarding this extension. It is recommended to adopt the trailer bill language.

II. Items for Discussion-- Department of Developmental Services--

A. OVERALL BACKGROUND (Pages 4 to 7)

Purpose and Description of Department. The Department of Developmental Services (DDS) administers services in the community through 21 Regional Centers (RC) ***and*** in state Developmental Centers (DC) for persons with developmental disabilities as defined by the provisions of the Lanterman Developmental Disabilities Services Act. Almost 99 percent of consumers live in the community, and slightly more than one percent live in a state-operated Developmental Center.

To be eligible for services, the disability must begin before the consumer's 18th birthday; be expected to continue indefinitely; present a significant disability; and be attributable to certain medical conditions, such as mental retardation, autism, and cerebral palsy.

The purpose of the department is to: **(1)** ensure that individuals receive needed services; **(2)** ensure the optimal health, safety, and well-being of individuals served in the developmental disabilities system; **(3)** ensure that services provided by vendors, Regional Centers, and the Developmental Centers are of high quality; **(4)** ensure the availability of a comprehensive array of appropriate services and supports to meet the needs of consumers and their families; **(5)** reduce the incidence and severity of developmental disabilities through the provision of appropriate prevention and early intervention service; and **(6)** ensure the services and supports are cost-effective for the state.

Description and Characteristics of Consumers Served. The department annually produces a Fact Book which contains pertinent data about persons served by the department. As noted below, individuals with developmental disabilities have a number of residential options. Almost 99 percent receive community-based services and live with their parents or other relatives, in their own houses or apartments, or in group homes (various models) that are designed to meet their medical and behavioral needs.

Department of Developmental Services—Demographics Data from 2008

Table 1 Age	Number of Persons	Percent of Total	*Table 2* Residence Type	Number of Persons	Percent of Total in Residence
Birth to 2 Yrs.	26,559	12.4	Own Home-Parent	156,204	72.6
3 to 13 Yrs.	59,643	27.7	Community Care	26,744	12.4
14 to 21 Yrs.	36,989	17.2	Independent Living /Supported Living	18,802	8.7
22 to 31 Yrs.	30,716	14.3	Skilled Nursing/ICF	8,811	4.1
32 to 41 Yrs.	22,163	10.3	Developmental Center	2,891	1.3
42 to 51 Yrs.	21,229	9.9	Other	1,594	0.7
52 to 61 Yrs.	12,157	5.7			
62 and Older	5,590	2.6			
Totals	***215,046***	***100.0***	***Totals***	***215,046***	***100.0***

Background on Regional Centers (RCs). The DDS contracts with 21 not-for-profit Regional Centers (RCs) which have designated catchment areas for service coverage throughout the state. The RCs are responsible for providing a series of services, including case management, intake and assessment, community resource development, and individual program planning assistance for consumers.

RCs also purchase services for consumers and their families from approved vendors and coordinate consumer services with other public entities. Generally, RCs pay for services only if an individual does not have private insurance or they cannot refer an individual to so-called "generic" services that are provided at the local level by the state, counties, cities, school districts, and other agencies. For example, Medi-Cal services and In-Home Supportive Services (IHSS) are "generic" services because the RC does not directly purchase these services.

RCs purchase services such as **(1)** residential care provided by community care facilities; **(2)** support services for individuals living in supported living arrangements; **(3)** Day Programs; **(4)** transportation; **(5)** respite; **(6)** health care; and many other types of services.

Services and supports provided for individuals with developmental disabilities are coordinated through the *Individualized Program Plan (IPP) (or the Individual Family Service Plan if the consumer is an infant/toddler 3 years of age or under)*. The IPP is prepared jointly by an interdisciplinary team consisting of the consumer, parent/guardian/conservator, persons who have important roles in evaluating or assisting the consumer, and representatives from the Regional Center and/or state Developmental Center. Services included in the consumer's IPP are considered to be entitlements (court ruling).

In addition, as recognized in the Lanterman Act, differences (to certain degrees) may occur across communities (Regional Center catchment areas) to reflect the individual needs of the consumers, the diversity of the regions which are being served, the availability and types of services overall, access to "generic" services (i.e., services provided by other public agencies which are similar in charter to those provided through a Regional Center), and many other factors. This is intended to be reflected in the IPP process.

Background on State-Operated Developmental Centers. State Developmental Centers (DCs) are licensed and federally certified as Medicaid providers via the Department of Health Services. They provide direct services which include the care and supervision of all residents on a 24-hour basis, supplemented with appropriate medical and dental care, health maintenance activities, assistance with activities of daily living and training. Education programs at the DCs are also the responsibility of the DDS.

The DDS operates five Developmental Centers (DCs)—Agnews, Fairview, Lanterman, Porterville and Sonoma. Porterville is unique in that it provides forensic services in a secure setting. In addition, the department leases Sierra Vista, a 54-bed facility located in Yuba City, and Canyon Springs, a 63-bed facility located in Cathedral City. Both of these facilities provide services to individuals with severe behavioral challenges.

Background—Transitioning to Community Services. The population of California's Developmental Centers has decreased over time. The development of community services as an alternative to institutional care in California mirrors national trends that support the development of integrated services and the reduced reliance on state institutions.

The implementation of the Coffelt Settlement agreement resulted in a reduction of California's Developmental Center population by more than 2,320 persons between 1993 and 1998. This was accomplished by creating new community living arrangements, developing new assessment and individual service planning procedures and quality assurance systems.

The United States Supreme Court decision in *Olmstead v L.C., et al (1999)* stated that services should be provided in community settings when treatment professionals have determined that community placement is appropriate, when the individual does not object to community placement, and when the placement can reasonably be accommodated.

Summary of Budget Appropriation for the Department of Developmental Services.

The February budget package provides a total of $4.645 billion ($2.778 billion General Fund) for 2008-09, and $4.824 billion ($2.726 billion General Fund) for 2009-10 for the Department of Developmental Services (DDS). This reflects an overall increase of $179 million (total funds) from the revised current year.

As shown in the Table below, the Developmental Centers Program is $689.5 million (total funds) for 2009-10. The Developmental Centers Program reflects the *closure* of Agnews Developmental Center in San Jose, as well as other cost-containment measures in the Developmental Centers which have been enacted over the past several years, including furloughs, reductions to operating expenses, staffing adjustments, and budget balancing reductions. According to the DDS, about $124.8 million ($72.5 million General Fund) has been reduced in 2008-09.

Summary of Budget for Department of Developmental Services

Program Component	2008-09 Revised Total Funds	2009-10 February Total Funds	Difference
Community Services	$3,888,239,000	$4,096,986,000	$208,747,000
Developmental Center Program	$719,485,000	$689,457,000	-$30,028,000
Headquarters Support	$37,992,000	$38,265,000	$273,000
TOTAL, All Programs	**$4,645,716,000**	**$4,824,708,000**	**$178,992,000**
Funding:			
General Fund	$2,778,543,000	$2,726,413,000	-$52,130,000
Health & Human Services Fund *(Proposition 10 Funds)*	0	265,000,000	265,000,000
Title XX—Social Services Grant	203,903,000	228,173,000	24,270,000
Public Transportation Fund	138,275,000	138,275,000	0
Program Development Funds	1,855,000	1,912,000	57,000
Federal Funds	90,829,000	54,093,000	-36,736,000
Mental Health Services Fund	1,119,000	1,121,000	2,000
Developmental Services Account	75,000	0	-75,000
Lottery Education Fund	495,000	0	-495,000
Reimbursements (Various)	$1,430,622,000	$1,409,721,000	-20,901,000
Regional Center Consumers	229,675	242,520	12,845
Developmental Center Residents	2,404	2,279 (as of April)	-125

The Community Services (funds provided primarily to Regional Centers) appropriation is about $4.1 billion (total funds) for 2009-10. This appropriation reflects the following *key* adjustments:

- Restoration of $234 million (General Fund) provided by the Legislature to offset the $334 million (General Fund) reduction proposed by the Governor (i.e., resulting in a $100 million General Fund reduction).
- Reflects a 3 percent payment reduction of Regional Center providers for a reduction of $118.2 million ($72.4 million General Fund) as proposed by the Governor.
- A fund shift of $265 million (General Fund) to the Health & Human Services Fund (Proposition 10 Funds of 1998) for the Early Start Program within the DDS. This fund shift is *contingent upon voter approval* of Proposition 1D in the Special Election of May 19, 2009.
- Continues all cost-containment enacted for the past several years.

Medi-Cal Optional Benefits for Individuals with Special Needs. As proposed by the Governor, certain Medi-Cal Optional Benefits were *not* funded in the February budget package, nor was the trigger activated as specified to restore these services, including Adult Dental, Optical Labs, Optometrists/Opticians, Chiropractor, Psychologist services, Podiatrist, Acupuncturist, Audiologist and Incontinence Creams and Washes. This action reduced Medi-Cal by about $129 million in General Fund support. As has been previously discussed in the Subcommittee, elimination of these benefits is an extremely difficult action.

The DHCS states they have accounted for potential cost-shifts to other services, such as emergency room usage; however, no one knows the potential consequences to enrollees or the health care safety net since this has never previously occurred.

However, an increase of $8.2 million (General Fund) will be needed in the Department of Developmental Services to continue to provide these services through the Regional Center system. This will be discussed at the May Revision.

Budget Act Language—Allows for Transfer Between Items. Finally, it should be noted that the annual Budget Act contains Budget Act Language which provides for the transfer of funds as necessary between the Developmental Centers Program and the Community Services appropriation (See provision 3 on page 335 of Senate Bill 1, Statutes of 2009). The purpose of this language is to enable the DDS to transfer funds, as appropriate, for individuals transitioning from a Developmental Center to the community.

B. Issues for Discussion: Results of Joint DDS& Stakeholder Process

Background-- Overall Budget Issue and the $100 million. In the Governor's January budget, the Administration proposed to reduce the Department of Developmental Services' (DDS) allocation for the Regional Centers by $334 million (General Fund). Specifically, the Administration stated that: "The DDS Regional Centers continue to experience significant and unsustainable expenditure growth. The DDS will work with the Legislature and stakeholders in the coming months to develop proposals to maintain the 2008-09 fund level and achieve the targeted savings while maintaining the entitlement and ensuring program and service integrity." (Pages 30 and 31 of the Governor's Budget 2009-10 publication.)

In lieu of the Administration's proposal to reduce by $334 million (General Fund), the Legislature *increased* the Regional Center budget by $234 million (General Fund) and adopted trailer bill language, as contained in AB 3X 5 (Evans), Statutes of 2009 (See Section 10). Therefore, a reduction of $100 million (General Fund) was enacted. Now a specific plan on how to achieve this was necessary.

The trailer bill legislation directed the DDS to submit a Plan to the Legislature that shall identify specific cost containment measures to achieve $100 million (General Fund) in reductions in 2009-10, instead of the Governor's original proposal to reduce by $334 million (General Fund). This Plan is to include a comprehensive description of each proposal, any applicable comment from the department and stakeholders as deemed appropriate by the department, its General Fund savings, and draft statutory language necessary to implement each proposal, and its potential effect on the developmental services system.

A key aspect of the legislation was to direct the DDS to use a comprehensive "stakeholder process" to include statewide organizations representing the interests of consumers, family members, service providers, and statewide advocacy organizations, as well as staff from the Legislature, to craft the components of the Plan.

Finally, the legislation also contained a provision that in the event statutory changes are *not enacted by September 1, 2009* to achieve the $100 million (General Fund) reduction for 2009-10, the DDS shall direct Regional Centers to reduce most payments for services and supports (as specified in Section 10) provided on or after September 1, 2009, by 7.1 percent. To the extent that statutory changes are enacted at a later date to produce a portion of the $100 million reduction amount, then the 7.1 percent reduction may be reduced accordingly. This language was added in order to ensure that a mechanism exists to achieve the reduction.

Background—Stakeholder Processes. The DDS used three processes to obtain public information to craft the Plan. First, DDS convened three public forums in Sacramento, Oakland, and Los Angeles. In total, about 1,400 stakeholders participated in these forums. Second, the DDS participated in a California Disability Community Action Network town hall meeting and received over 1,350 written recommendations outlining budget suggestions.

Third, the DDS convened focused "Workgroup" meetings to discuss proposals with representatives from statewide groups impacted by the reductions. These Workgroup meetings were very involved and required immense commitment by the representatives from the statewide groups as well as the DDS. All involved parties should be commended for their constructive efforts under extremely difficult circumstances with this fiscal crisis.

Summary Chart of DDS & Workgroup Proposal for $100 million (General Fund)

Name of Proposal	TBL or Reg?	2009-10 Total Savings (GF Savings)	Annual Savings
1. Transportation reform	Both	$18.4 million **($16.9 million GF)**	$39.9 million **($36.6 million GF)**
2. Uniform holiday schedule	TBL	$22 million **($16.3 million GF)**	$22 million **($16.3 million GF)**
3. Create a new program component for seniors	TBL	$1.4 million **($1 million GF)**	$1.4 million **($1 million GF)**
4. Custom Endeavors Options	TBL	$17.1 million **($12.7 million GF)**	$17.1 million **($12.7 million GF)**
5. Maximizing Generic Resources in Supported Living	TBL	$1.9 million **($1.3 million GF)**	$1.9 million **($1.3 million GF)**
6. Amend Support Living Services	Both	$10.5 million **($6.9 million GF)**	$21 million **($13.8 million GF)**
7. Utilization of Neighborhood Preschools	TBL	$8.9 million **($8.9 million GF)**	$17.8 million **($17.8 million GF)**
8. Early Start--Access Private Insurance (0-3 years)	TBL	$6.5 million **($6.5 million GF)**	$13 million **($13 million GF)**
9. Early Start--Restrict eligibility for low risk	TBL	$15.5 million **($15.5 million GF)**	$15.5 million **($15.5 million GF)**
10. Change the duties of some respite workers	Both	$4 million **($3 million GF)**	$4 million **($3 million GF)**
11. Cap Regional Center operations for one-time costs	--------	$3.5 million **($3.5 million GF)**	$3.5 million **($3.5 million GF)**
12. Eliminate Regional Center Triennial Review	Both	$1.5 million **($1 million GF)**	$1.5 million **($1 million GF)**
13. Update Parental Fee Program	Both	$900,000 **($900,000 GF)**	$2.2 million **($2.2 million GF)**
14. Consolidate Quality Assurance Evaluation	TBL	$2 million **($2 million GF)**	$2.2 million **($2.2 million GF)**
15. First Use “Group Instruction” for Behavioral Instruction	TBL	$8.1 million **($6.4 million GF)**	$16.2 million **($12.8 million GF)**
TOTAL		$122.2 million **($102.8 million GF)**	$179.2 million **($152.7 million GF)**

B. Issues for Discussion: Results of DDS & Workgroup Process *(Continued)*

Of key importance to the DDS and Workgroup was to identify proposals with the least adverse impact on the consumer while still ensuring program and service integrity. Other goals included maximizing the use of generic resources pursuant to the Lanterman Developmental Disabilities Services Act, and maximizing receipt of federal funds.

Each of the 15 proposals is discussed below. The Subcommittee has requested the DDS, and Workgroup participants to respond to questions as noted under *each* of the proposals below. Overall public comment will then be obtained on all of the proposals. Everyone's public comments are welcomed. Written comments are also welcomed.

1. Transportation Reform (See Trailer Bill Hand Out—Section 10)

Background. Regional Centers purchase transportation services for over 56,000 consumers annually. These purchased services include specialized transportation, vouchers, taxis, bus passes for public transportation, and services provided by Day and Residential programs as an additional component of their vendored service. Transportation is provided so consumers can attend Day Programs, Infant Development Programs, therapies and medical care, social-recreation activities, work, and other daily activities.

It is estimated that Regional Centers would spend about $239 million (total funds) for transportation services in 2009-10, absent this reduction proposal. Of this total amount, about $100 million is based on contracted transportation services.

Summary of Proposal. The intent of this proposal is to increase the use of "generic" and least costly transportation methods.

Under this proposal, at the time of development, scheduled review or modification of a consumer's Individual Program Plan (IPP) or Individual Family Service Plan (IFSP), Regional Centers would be directed to:

- No longer fund *"specialized"* transportation services for *adults* who can *safely* access and utilize public transportation, *when such transportation is available*;
- Only fund the *least* expensive transportation modality that meets the consumer's needs as set forth in the consumer's IPP or IFSP;
- Fund transportation, when required, from the consumer's residence to the lowest cost vendor (program) that provides the service that meets the consumer's needs; (lowest cost here means the cost of the vendor and transportation)
- Only fund transportation services for minor children when the family provides documentation that they cannot provide transportation themselves.

This proposal is estimated to result in a reduction of $18.4 million ($16.9 million General Fund) in 2009-10, with an annualized savings of $39.9 million ($36.6 million General Fund).

This savings level assumes that about 10,000 consumers, or about 28 percent of the estimated 36,000 consumers who may be affected by the proposal, will move from a higher

cost type of transportation to a lower cost method of transportation over the course of the year.

This proposal requires trailer bill legislation, regulation changes and an amendment to the Home and Community-Based Waiver (under the Medi-Cal Program as administered by the DDS).

Subcommittee Staff Comment and Recommendation. This proposal seems reasonable as a cost savings measure and would not adversely impact consumers since it would be contingent upon their IPP or IFSP and their needs. It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

2. Uniform Holiday Schedule (See Trailer Bill Hand Out—Section 18)

Background and Summary of Proposal. The intent of this proposal is to increase the number of uniform holidays to a *total of 14 specific* days in order to achieve savings across the various Day Programs, Work Programs, *and* associated transportation costs to and from these programs.

This proposal is estimated to result in a reduction of $22 million ($16.3 million General Fund) in 2009-10, with annualized ongoing savings of the same amount.

Under this proposal, trailer bill language would be adopted which states that Regional Centers shall *not compensate* any work activity program, activity center, adult development center, behavior management program, social recreation program, adaptive skills trainer, infant development program, program support group (day service), socialization training program, client/parent support behavior intervention training program, community integration training program, community activities support service, or creative arts program, as defined in Title 17 of the California Code of Regulations, for providing any services to any consumer on any of the specified, uniform holidays. Monday holidays would be observed in the event a specified holiday falls on a Saturday or Sunday.

The uniform holidays would include the following: (1) January 1; (2) the third Monday in January; (3) the third Monday in February; (4) March 31st; (4) the last Monday in May; (5) July 4th; (6) the first Monday in September; (7) November 11th; (8) Thanksgiving Day; (9) December 25th; and (10) the *four days between December 25th and January 1st*.

The effect of this proposal is that on these uniform holiday days, consumers will either be with their family, friends, or if they live in an out-of-home placement they would be with the residential provider.

Presently the 21 Regional Centers have slightly varying holiday schedules. The DDS states that: (1) six Regional Centers have 12 holidays; (2) eleven Regional Centers have 10 days; and (3) four Regional Centers have less than 10 days.

Subcommittee Staff Comment and Recommendation. *First*, this proposal would have less impact on consumers than potentially other proposals. *Second*, this proposal would affect residential providers since the consumer (i.e., consumers living out-of-home) would not be participating in any of various day programs as referenced, and instead, maybe staying home. However, many of these consumers would be with family and friends during a portion of this "traditional" holiday time. *Third*, it would affect various day program providers as referenced since the added holidays would, in effect, serve as "furlough time". It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

3. Create a New Program Component for Seniors at a Reduced Rate (See Trailer Bill Hand Out—Section 14)

Background and Summary of Proposal. Presently, consumers participate in various Day Programs (including look-alike) and Work Activity Programs. These programs are based on a staff to consumer ratio grounded in providing specific activities and services. Generally, reimbursement for these providers is based on the staffing ratios and types of services provided.

The intent of this proposal is that some consumers presently participating in these programs would want to "retire" or participate in less intensive services. Under the proposal, a new program component for seniors, or individuals desiring a less rigorous Day Program, would be created as an alternative choice. This new program component would be reimbursed at a reduce rate and would have a *lower* staff to consumer ratio of 1 to 8 (as compared to a 1 to 3, 1 to 4, or 1 to 6).

To achieve savings, the rate of reimbursement would be reduced from as high as $72.42 per day and as low as $35.34 per day (i.e., the existing range) down to $35 per day due to the lower staffing ratio and less intensive program.

This proposal is estimated to result in a reduction of $1.4 million ($1 million General Fund) in 2009-10, with annualized ongoing savings of the same amount. This savings level assumes five percent of adults served in the programs referenced would prefer this new program component, and that providers are reimbursed at the $35 per day level.

It should be noted that providers would be required to offer this alternative (i.e., has to be in their existing vendored capacity) or savings would not be achieved.

Selection of this alternative program component would be based on a consumer's IPP.

Subcommittee Staff Comment and Recommendation. This proposal creates a new program component that offers additional consumer choice, based upon their IPP. It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

4. Custom Endeavor Option (See Trailer Bill Hand Out—Section 15)

Background and Summary of Proposal. The DDS states that about 51,000 consumers are served by Day Programs (including look-alikes) annually and receive about 120 hours per month of services.

Some of these consumers often want to work, volunteer or become self-employed. The intent of this proposal is to provide a customized employment or volunteer option with support from existing providers for 5 percent of the current consumers. This would increase consumer independence and choice of activities.

Under this proposal, a provider would offer this customized program component to a consumer in lieu of their current program. This alternative would be based on a consumer's IPP.

This proposal is estimated to result in a reduction of $17.1 million ($12.7 million General Fund) in 2009-10, with annualized ongoing savings of the same amount. This savings level assumes that 5 percent of current consumers will opt out of their existing Day Program and select this alternative. Of those which choose this alternative, half of the consumers will receive 20 hours of services per month and the other half will receive 80 hours of services per month.

The Day Programs affected by this option include: (1) Community Integration Training; (2) Community Activities Support Services; (3) Activity Center; (4) Adult Development Center; and (5) Behavior Management Program.

Subcommittee Staff Comment and Recommendation. This proposal creates a new program component that offers additional consumer choice, based upon their IPP. It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

5. Maximizing Generic Resources in Supported Living (See Trailer Bill Hand Out—Sections 16 & 17)

Background—Generic Services. Regional Centers purchase services for consumers and their families from approved vendors and coordinate consumer services with other public entities. Generally, Regional Centers pay for services only if an individual does not have private insurance or they cannot refer an individual to so-called "generic" services that are provided at the local level by the state, counties, cities, school districts, and other agencies. For example, Medi-Cal services and In-Home Supportive Services (IHSS) are "generic" services because the Regional Center does not directly purchase these services.

Background—Supported Living Services (SLS). Supported Living Services consist of a broad range of services to adults with developmental disabilities who, though the Individual Program Plan (IPP) process, live in homes they themselves own, rent, or lease in the community.

Background—IHSS Services for Consumers in Supported Living Arrangements. DDS states that about 10,909 Regional Center consumers currently receive In-Home Supportive Services (IHSS).

From the time a consumer applies for IHSS services to the time their application is approved, domestic "personal care services" are purchased through the Regional Center in order for consumers to maintain living in a "Supported Living" arrangement. The amount of time between applications to approval (i.e., a "lag period") *varies from one to three months.* Reimbursement for these services should be made from the IHSS Program at the local county level.

Currently during this "lag period", the DDS is paying a *higher rate* to the Supported Living Service provider than it would if the consumer were enrolled in IHSS. Once IHSS is approved, the Supported Living Service provider no longer provides the "personal care services", and the IHSS provider takes over at the IHSS rate (along with a county share-of-cost).

Payment for the "lag period" is at issue. The Department of Social Services' policy is that county IHSS offices will reimburse only "out-of-pocket" expenses incurred in this period, referring to what is paid directly by the consumer for "like" services. In actuality, the consumer does not pay out of pocket for services due to California's service delivery model with funding for all services coming through the Regional Center. *Therefore, Regional Centers are not getting reimbursed for the "lag period" (waiting period).*

Summary of Proposal. The intent of this proposal is to maximize the use of *generic* IHSS services. There are two key aspects to this proposal. *First*, In addition, the DDS proposes that during the "lag period" (waiting for IHSS enrollment), personal care services (i.e., "like services") would only be reimbursed at the local IHSS rate and not at the higher Supported Living Services rate

Second, Regional Centers will be *prohibited* from purchasing "personal care services" for consumers who are Medi-Cal enrollees and are therefore eligible for IHSS. This is because

there is a small number of consumers that do not apply for IHSS and could be eligible. Due to fiscal constraints, this generic service needs to be maximized.

This proposal is estimated to result in a reduction of $1.9 million ($1.3 million General Fund) in 2009-10, with annualized ongoing savings of the same amount.

Subcommittee Staff Comment and Recommendation. The Administration, including all of the health and human services departments, need to provide more comprehensive assistance to the Regional Centers and consumers in order to more fully and appropriately maximize the use of "generic" services prior to the "purchasing" of services. The intent of this proposal is a step in that direction, but the trailer bill language needs to be carefully constructed to ensure the correct intent of this action.

It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

6. Amend Existing Supported Living Services (See Trailer Bill Hand Out---Section 16)

Background—Supported Living Services (SLS). Supported Living Services consist of a broad range of services to adults with developmental disabilities who, though the Individual Program Plan (IPP) process, live in homes they themselves own, rent, or lease in the community. About 10,000 individuals use Supported Living Services at a cost of about $300 million (total funds) annually.

Summary of Proposal. Under this proposal, several changes would be made in how supported living services are funded. *Key* changes are as follows:

- Requires Regional Centers to review and re-negotiate rates with Supported Living Services Agencies as specified.
- Restricts conditions under which Regional Centers can supplement a consumer's rent, mortgage, or lease payment.
- Requires Regional Centers, where applicable and appropriate, to use the same Supported Living Services Agency to provide services that meet individual consumer's needs as determined through the IPP process, of consumers who reside in the same home.

This proposal is estimated to result in a reduction of $10.5 million ($6.9 million General Fund) in 2009-10, with annualized ongoing savings of $21 million ($13.8 million General Fund).

This proposal requires trailer bill legislation, regulation changes and an amendment to the Home and Community-Based Waiver (under the Medi-Cal Program as administered by the DDS).

Subcommittee Staff Comment and Recommendation. This is a complex proposal that may require additional clarification as to how it would be implemented. It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

7. Utilization of Neighborhood Preschools (See Trailer Bill Hand Out—Section 12)

Summary of Proposal. The intent of this proposal is to expand the availability and use of neighborhood preschools as a natural environment which may be less costly than segregated center-based Infant Development Programs.

The DDS estimates that increased use of Preschool programs would save $8.9 million (General Fund) in 2009-10, and $17.8 million (General Fund) on an annual basis. This savings estimate assumes that *5 percent* of the children, or 1,535 children, served by Infant Development Programs could be served in a neighborhood Preschool Program. The use of a neighborhood Preschool would be based on the child's Individualized Family Service Plan (IFSP).

This savings level assumes that additional resources are provided for an early interventionist or speech therapist to provide specialized early intervention services at the Preschool.

This proposal does require trailer bill language, as well as a revision to the state's Early Start Program that will need to be submitted to the federal government.

According to the DDS, the Frank D. Lanterman Regional Center presently uses this approach for some children receiving services. The Regional Center funds Preschools and Child Care Centers for children in their Early Start Program. The service is listed on the child's IFSP as specialized instruction, a required early intervention service, to address socialization or speech development using typically developing children as role models. Occasionally, individually vendored therapists, primarily a speech therapist, are funded by the Regional Center to provide early intervention services at the Preschool.

The DDS notes that about 60,000 infants and toddlers receive services through the Early Start Program, and about 30,841 children, or over 50 percent, are receiving services through Infant Development Programs. There are 419 Infant Development Programs operating in California.

Background—the Early Start Program (0 to 3 years) The Early Start Program is administered by the DDS through the Regional Centers, local education agencies, and Family Resource Centers.

The program provides coordinated early intervention services to infants and toddlers (aged 0 to 3 years) and their families with or at-risk for developmental delays or disabilities. The services provided to infants and toddlers are contingent upon their Individualized Family Service Plan (IFSP).

Currently, Early Start serves infants and toddlers who:

- Are At high risk for developmental disability;
- Manifest established risks for developmental delay; or
- Have developmental delays

Early Start provides specialized early intervention services in the home, community and center-based settings through Infant Development Programs by a team of qualified interdisciplinary professionals that often include early interventionists, physical therapists, occupational therapists, and speech and language therapists.

Usually, toddlers begin attending center-based programs (Infant Development Programs) *after* turning 18-months of age. Typically, attendance at an Infant Development Program ranges from two to three times per week for about 3-hours each day. The rates for Infant Development Programs range from about $29 to $48 per day (at a 1 to 3 staff to consumer ratio) to about $43 to $74 per day (at a 1 to 2 ratio).

In some areas of the state, Regional Centers fund social-recreational programs or preschool using the Child Day Care service code at a "usual and customary" or negotiated rate. This results in a rate of from $13 to $25 per hour. These programs are used to enhance social and language development. However, they do not meet the description for specialized instruction or therapeutic services.

According to the DDS, about 60,000 infants and toddlers are served annually in the Early Start Program. Of these infants and toddlers, about 13,800 (23 percent) enter the Regional Center caseload at 3 years of age as *ongoing* Regional Center consumers.

Background—Early Start Program Budget for 2009-10. The DDS states that the "purchase of services" (POS) for the Early Start Program is about $400.2 million ($50.7 million federal Part C grant funds, $135.2 million General Fund, and $265 million Proposition 10 Health and Human Services Fund)

It should be noted that the $265 million appropriated from the Proposition 10 Health and Human Services Fund is *contingent upon voter approval* of Proposition 1D in the Special Election of May 19, 2009.

It should also be noted that the American Recovery & Reinvestment Act, signed by President Obama in February, 2009, will provide an additional $53.2 million in federal Part C grant funds to California for two years (i.e., $26.6 million for two years). The Governor's May Revision should reflect this change. This issue will be before the Legislature in late May.

Background—Neighborhood Preschools. Generally, neighborhood preschools provide a variety of child care and development programs to young children and youth up to 12 years of age. Preschools may include public and private programs. Specific services and age ranges offered are based on program design.

Preschool programs under the California Department of Education's Child Development Division serve three to five year olds and are state and federally funded. Their rates are based on "usual and customary rates" in each region of the state.

Subcommittee Staff Comment and Recommendation. There are a few Regional Centers who presently use this approach for some children receiving services. The Lanterman Act requires Regional Centers to use generic services when available and when

applicable (based on an individual's IFSP or IPP). Adoption of trailer bill language will encourage a more coordinated approach.

It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

8. Use of Private Insurance for Early Start Program Consumers (See Trailer Bill Legislation Hand Out—Section 1)

Summary of Proposal. Under this proposal, families would be required to access private insurance for all identified medical services, *other than* evaluation and assessment, for service provision or denial prior to service provision by a Regional Center as payer of last resort (This is already required for children age three years and older).

The identified medical services include the following: Acute Care Hospital; Durable Medical Equipment Dealer; laboratory and radiological services; other medical equipment supplies; orthopedic services; prosthetic services; pharmaceutical services; physician/surgeon; hearing & audiology facilities; licensed vocational nurse; other medical services; audiology; speech pathology; physical therapy; occupational therapy; and genetic counselor.

Of the total expenditures for the Early Start Program, the DDS estimates that $89.4 million is in medical-related expenditures.

The DDS estimates this change would save $6.5 million (General Fund) in 2009-10, and $13 million (General Fund) on an annual basis. This estimate assumes that 25 percent of medical-related costs for families with insurance coverage are to be covered by insurance. It is assumed that 58 percent of the families have health insurance (based on the CA Health Insurance Survey of 2005).

In situations where the medical service is determined to be not medically necessary, but is developmentally necessary, then the service would be a required early intervention service under federal regulations.

The DDS notes that this proposal complies with existing federal law, and conforms to the state's Lanterman Act which requires Regional Centers to pursue other sources of funding for services (i.e., "generic" services and payer of last resort).

This proposal does require trailer bill language, as well as a revision to the state's Early Start Program that will need to be submitted to the federal government.

Further, DDS states this proposal would be effective as of July 1, 2009 with a phase-in during 2009-10 consisting of dissemination of information to families participating in the Early Start Program and to Regional Centers.

Background—the Early Start Program (0 to 3 years) The Early Start Program is administered by the DDS through the Regional Centers, local education agencies, and Family Resource Centers.

The program provides coordinated early intervention services to infants and toddlers (aged 0 to 3 years) and their families with or at-risk for developmental delays or disabilities. The services provided to infants and toddlers are contingent upon their Individualized Family Service Plan (IFSP).

Currently, Early Start serves infants and toddlers who:

- Are At high risk for developmental disability;
- Manifest established risks for developmental delay; or
- Have developmental delays

Early Start provides specialized early intervention services in the home, community and center-based settings through Infant Development Programs by a team of qualified interdisciplinary professionals that often include early interventionists, physical therapists, occupational therapists, and speech and language therapists.

According to the DDS, about 60,000 infants and toddlers are served annually in the Early Start Program. Of these infants and toddlers, about 13,800 (23 percent) enter the Regional Center caseload at 3 years of age as *ongoing* Regional Center consumers.

Background—Early Start Program Budget for 2009-10. The DDS states that the "purchase of services" (POS) for the Early Start Program is about $400.2 million ($50.7 million federal Part C grant funds, $135.2 million General Fund, and $265 million Proposition 10 Health and Human Services Fund)

It should be noted that the $265 million appropriated from the Proposition 10 Health and Human Services Fund is *contingent upon voter approval* of Proposition 1D in the Special Election of May 19, 2009.

It should also be noted that the American Recovery & Reinvestment Act, signed by President Obama in February, 2009, will provide an additional $53.2 million in federal Part C grant funds to California for two years (i.e., $26.6 million for two years). The Governor's May Revision should reflect this change. This issue will be before the Legislature in late May.

Background—Department of Managed Health Care Letter *(See Hand Outs).* In a March 9, 2009 letter, the Department of Managed Health Care notified Knox-Keene health care plans that the DMHC is directing these plans to significantly improve their performance in several areas with respect to providing services for individuals diagnosed with Autism Spectrum Disorders.

Key aspects of this letter are as follows:

- DMHC will be asking health plans to demonstrate that their systems and processes support timely screening and diagnosis of individuals, including mental health services.
- DMHC directs that health plans must assure that treatment plans are developed by qualified and licensed providers, and include information about available health care treatment options.
- DMHC directs that health plans are required to coordinate covered services for the treatment of Autism Spectrum Disorders among their various providers to help implement treatment plans.
- DMHC requires all plans to cover all basic health care services required under the Knox-Keene Act, including speech, physical, and occupational therapies for persons with Autism Spectrum Disorders, when those health care services are medically necessary.

- DMHC states that they will continue to enforce existing law regarding the grievance and Independent Medical Review process and will be initiating a rulemaking process to formalize health plan requirements and provide additional clarity through an open and public process.

Subcommittee Staff Comment and Recommendation. This proposal would *extend* to families with children aged 0 to 3 years the requirement to access private insurance for all identified medical services *other than* evaluation and assessment, for service provision or denial prior to service provision by a Regional Center as payer of last resort.

It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

9. Early Start Program—Restrict Eligibility for Low-Risk
(See Trailer Bill Legislation Hand Out—Section 2)

Summary of Proposal. Under this proposal, eligibility for the Early Start Program would prospectively limit eligibility for Early Start services to only those infants and toddlers at the highest risk of a developmental disability in most need of program services entering Early Start at 24 months of age or older.

This proposal does require trailer bill language, as well as a revision to the state's Early Start Program that will need to be submitted to the federal government.

Specifically, *two changes* would occur under this proposal as follows:

> At Risk. Presently, those determined "at-risk" can enter the Early Start Program at any age (0 to 3 years). Under this proposal, those who are determined "at-risk" *and* are aged 24 months or older would not be eligible for Early Start.
>
> Developmental Delay. Presently, those who have a "developmental delay" of 33 percent or greater in one of five domains can enter into the Early Start Program at any age. Under this proposal, those who have a "developmental delay" in *only* one domain *and* are aged 24 months or older would need to have a "developmental delay" of 50 percent or greater.

Currently, Early Start serves infants and toddlers who are at risk for developmental disability, who manifest established risks for developmental delay, or who have developmental delays in one or more of five domains (cognitive, self-help, physical, communication and social-emotional). Of the 60,000 children served annually in Early Start, about 23 percent enter the Regional Center caseload at age 36 months as *ongoing* Regional Center consumers.

The DDS estimates this change would save a total of $15.5 million (General Fund) in 2009-10, and $15.5 million (General Fund) on an annual basis. Of this total amount, $13.4 million (General Fund) would be reduced from Purchase of Services and $2.1 million (General Fund) would be reduced from Regional Center Operations.

This reduction level assumes the following *key* assumptions:

- It is assumed that for restricting "at risk" eligibility" at 24 months or older there would be a savings of $333,740 from the Purchase of Services. This assumes 205 children out of a total of 244 children in this category would no longer be eligible for services in Early Start.

- It is assumed that for restricting "developmental delay" eligibility at 24 months or older there would be a savings of $13.1 million from the Purchase of Services. This assumes 10,691 children out of a total of 17,174 children in this category would no longer be eligible for Early Start.

  The DDS states that about 93 percent of the children with a delay in one domain only have a speech delay domain (i.e., communication development as referenced in the federal regulation discussion below).

- The reduction of $2.1 million from Regional Center Operations is based on the core staffing formula and ratios and upon a mid-year caseload reduction of 5,346 consumers

The DDS notes that this proposal does not impact the eligibility of any infant or toddler under the age of 24 months, and may result in fewer children transitioning to Regional Center caseloads at the age of 36 months. On the other hand, without early intervention, some infants and toddlers may enter the Regional Center system or special education at an older age.

The DDS also states that other services may be available for children who may no longer be eligible for Early Start services due to this proposal. Families may be able to access private insurance, Medi-Cal, or Head Start for services where applicable.

Background—Existing Federal Regulations. There are two components to federal regulation that pertain to this issue. Part 303.16 of the federal regulations states as follows:

303.16 Infants and Toddlers with Disabilities.
(a) As used in this part, infants and toddlers with disabilities means individuals from birth through age two who need early intervention services because they:
(1) Are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas (This is California's developmental delay definition):

(i) Cognitive development;
(ii) Physical development, including vision and hearing.
(iii) Communication development.
(iv) Social or emotional development
(v) Adaptive development; *or*

(2) Have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. (This is California's "established" risk definition).

(b) The term may also include, at a State's discretion, children from birth through age two who are at risk of having substantial developmental delays if early intervention services are not provided. (This is California's "at-risk" definition).

303.300 State Eligibility Criteria and Procedures.
Each statewide system of early intervention services must include the eligibility criteria and procedures, consistent with 303.16, (above) that will be used by the State in carrying out programs under this part.
(a) The State shall define developmental delay by the following (This is California's developmental delay definition):

(1) Describing, for each of the areas listed in 303.16 (a)(1), the procedures, including the use of informed clinical opinion, that will be used to measure a child's development; *and*

(2) Stating the levels of functioning or other criteria that constitute a developmental delay in each of those areas.

(b) The State shall describe the criteria and procedures, including the use of informed clinical opinion, that will be used to determine the existence of a condition that has a high probability of resulting in developmental delay under 303.16(a)(2). (This is California's established risk definition).

(c) If the State *elects* to include in its system children who are at risk under 303.16(b), the State shall describe the criteria and procedures, including the use of informed clinical opinion that will be used to identify those children. (This is California's "at risk" definition).

Background—the Early Start Program (0 to 3 years) The Early Start Program is administered by the DDS through the Regional Centers, local education agencies, and Family Resource Centers.

The program provides coordinated early intervention services to infants and toddlers (aged 0 to 3 years) and their families with or at-risk for developmental delays or disabilities. The services provided to infants and toddlers are contingent upon their Individualized Family Service Plan (IFSP).

Currently, Early Start serves infants and toddlers who:

- Are At high risk for developmental disability;
- Manifest established risks for developmental delay; or
- Have developmental delays

Early Start provides specialized early intervention services in the home, community and center-based settings through Infant Development Programs by a team of qualified interdisciplinary professionals that often include early interventionists, physical therapists, occupational therapists, and speech and language therapists.

According to the DDS, about 60,000 infants and toddlers are served annually in the Early Start Program. Of these infants and toddlers, about 13,800 (23 percent) enter the Regional Center caseload at 3 years of age as *ongoing* Regional Center consumers.

Background—Early Start Program Budget for 2009-10. The DDS states that the "purchase of services" (POS) for the Early Start Program is about $400.2 million ($50.7 million federal Part C grant funds, $135.2 million General Fund, and $265 million Proposition 10 Health and Human Services Fund)

It should be noted that the $265 million appropriated from the Proposition 10 Health and Human Services Fund is *contingent upon voter approval* of Proposition 1D in the Special Election of May 19, 2009.

It should also be noted that the American Recovery & Reinvestment Act, signed by President Obama in February, 2009, will provide an additional $53.2 million in federal Part C grant funds to California for two years (i.e., $26.6 million for two years). The Governor's May Revision should reflect this change. This issue will be before the Legislature in late May.

Subcommittee Staff Comment and Recommendation. It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

10. Modify the Duties of In-Home Respite Workers (See Trailer Bill—Section 13)

Summary of Proposal. The DDS states that many consumers are medically fragile but medically stable and receive respite services from Home Health Agencies or Licensed Vocational Nurses. In some cases, In-Home Agency employees with proper training could provide the respite care in lieu of the Home Health Agency or Licensed Vocational Nurse.

Under this proposal, "In-Home" Respite Agency employees would include certain additional services, *as appropriate*, in their duties. By having In-Home Respite Agency employees perform these services, it is assumed that less respite hours would need to be provided by Home Health Agencies and Licensed Vocational Nurses which are more expensive.

The intent of this proposal is to have non-licensed respite workers provided training by licensed health care professionals to be able to perform incidental medical services as follows:

(1) Colostomy and ileostomy: changing bags and cleaning stoma.

(2) Urinary catheter: emptying and changing bags.

(3) Gastrostomy: feeding, hydration, cleaning stoma, and adding medication per physician's or nurse practitioner's orders for the routine medication of patients with stable conditions.

The draft trailer bill language provided by the DDS states that any consumer who is provided these additional services by an In-Home Respite Agency employee would need to have their treating physician or surgeon give assurances to the Regional Center that the consumer's (patient) condition is stable prior to the Regional Center's purchasing incidental medical services from an In-Home Respite Agency.

This proposal requires trailer bill language, regulation changes and an amendment to the state's Home and Community-Based Waiver (under the Medi-Cal Program).
It assumes savings of $4 million ($3 million General Fund) for 2009-10 and the same amount on an annualized basis. This level of savings assumes the following:

- Reduction of 10 percent in the number of respite hours purchased from Home Health Agencies and Licensed Vocational Nurses.
- Corresponding increase of 10 percent in the number of respite hours purchased through In-Home Respite Agencies.
- Increase of $0.50 per hourly wage (limited to hours providing "skilled" respite services), *plus* a 16.76 percent increase for the employer costs due to the wage increase (for social security, worker's compensation, unemployment compensation), for In-Home Respite Agencies (employees and employer as noted).
- Provides that Regional Centers may reimburse In-Home Respite Agencies up to $200 semi-annually for providing training to its employees for the additional services to be conducted.

Subcommittee Staff Comment and Recommendation. It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

11. Cap Regional Center Operations for One-Time Costs

Summary of Proposal. Under this proposal, funding for one-time costs associated with certain Regional Center administrative costs would be reduced from $6.5 million (General Fund) to a total of $3.0 million for 2009-10 for a savings of $3.5 million (General Fund).

One-time funding for Regional Centers is used for opening a new branch office, moving expenses, expansion of communication services or other similar expenditures.

This proposal does *not* require any trailer bill legislation or any other related changes.

Subcommittee Staff Comment and Recommendation. Regional Centers will need to prudently manage their one-time costs but otherwise, no issues have been raised.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

12. Eliminate Triennial Quality Assurance Review (See Trailer Bill—Section 9)

Summary of Proposal. Under this proposal, the existing requirement for Regional Centers to conduct quality assurance evaluations to be done a minimum of once every three years would be eliminated. This action would require trailer bill language, a regulation change and a modification to the State's Home and Community Based Waiver (under the Medi-Cal Program).

Under the current "triennial quality assurance review", Regional Centers conduct a detailed review of vendored Community Care Facilities which includes record reviews, consumer observation and interviews to determine satisfaction with facility services, and an assessment of the facility in assisting consumers in achieving their individual life quality outcomes.

The DDS does not believe elimination of this requirement will be problematic because other health and safety reviews will still be conducted as noted in the background section below.

This proposal would save $1.5 million ($1 million General Fund) in 2009-10 and have an annual savings of $1.5 million ($1 million General Fund). The savings results from reduced Regional Center staffing needs.

Background—Overview of Quality Assurance Activities. There are several existing quality assurance functions which are conducted to help ensure the health and safety of consumers in the Regional Center system. These include the following:

- A Regional Center representative must meet at least quarterly with each consumer to review progress towards achieving their Individual Program Plan (IPP) objectives. At least two of these reviews must occur at the consumer's residence and may be unannounced.
- Each Regional Center must designate a liaison for each facility. The RC facility liaison is responsible for completing a minimum of one monitoring visit to each facility each year.
- The DDS and Regional Centers have implemented revised Client Development and Evaluations for consumers which includes a personal outcomes element which includes questions to capture the quality of each consumer's school, work, and living environments.
- The DDS has a monitoring protocol for quality assurance evaluations under the Home and Community-Based Waiver.
- The Department of Social Services conducts annual licensing visits.

Subcommittee Staff Comment and Recommendation. This cost-containment measure seems reasonable given there are other quality reviews and assurances in place. It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

13. Increase the Parental Fee for Out-of-Home Arrangements
(See Trailer Bill Legislation—Section 11)

Summary of Proposal. Under this proposal, the Parental Fee that applies to parents of children under the age of 18 who live in any out-of-home care arrangement (including community-based or a Developmental Center) would be increased and the increase in the fees would be placed into the General Fund. The current Parent Fee was last adjusted in 1989, except for an increase in the maximum fee amount in 2003 which took the fee to $662 (maximum monthly amount).

The DDS states the Parental Fee would be changed in *two ways*. *First*, the minimum income level upon which the fee is based would be updated to be equivalent to 100 percent of poverty, or $18,310 for a family of three. Presently, families at the income level of $12,501 are subject to payment. This action will *decrease* the number of families subject to the fee by about 10 percent.

Second, the fee would be updated across all levels of income and adjusted to reflect the 2007 data available from the U.S. Department of Agriculture's survey on the cost of raising a child in California (adjusting for the consumer price index from the survey date to the present). Parents are assessed a fee based on a sliding scale that varies by family income and family size. The fee is the same regardless of where the child is placed out-of-home.

The Hand Out Package contains a detailed chart on this proposal. to reflect the monthly fee. For some low-income families, no fee would be assessed. The maximum fee may *not* exceed (1) the cost of caring for a normal child at home, or (2) the cost of services provided, whichever is less. The revised maximum amount a family would pay under the proposal would be $1,877 per month for the highest income families with the oldest children.

Some examples of fees from the chart are as follows:

- Family of two with an income of $18,310 would pay a maximum of $75 per month.
- Family of four with an income of $22,050, with one child aged 0 to 6 would pay $116 per month (previously it would be $85 per month).
- Family of three with an income of between $33,000 and $36,999 would pay a maximum of $375 per month.
- Family of three with an income between $45,000 and $48,999 would pay a maximum of $601 per month.
- Family of four with an income of $88,200, with one child age 7 to 12 the fee would be $1,027 per month (previously it would be $441 per month).

For parents currently paying a fee, the increase would be phased-in over three years. For parents of children who begin living in an out-of-home care arrangement after June 30, 2009, the full fee amount would be assessed.

This proposal would save $900,000 (General Fund) in 2009-10 and have an annual savings of $2.2 million (General Fund).

Background—Overview of Parental Fee Program. This program applies to parents of children under the age of 18 who live in any out-of-home arrangement. Parents are assessed a fee based on a sliding scale that varies by family income and family size. The fee is the same regardless of where the child is placed out-of-home.

The DDS determines the parents' ability to pay, assesses the fee and bills the parents on a monthly basis until the child turns 18 years. *Currently*, revenues generated by this program are deposited in the "Program Development Fund" and used for developing community-based resources.

Background—Overview of Family Cost Participation Program. This program, effective in 2005, requires Regional Centers to assess a share of the cost of respite, child day care, and camping services to parents who have a child *living at home* and *not* eligible for Medi-Cal. About 5,000 families are in the program. Families are informed of the number of units of service for which they are financially responsible and they pay this amount directly to the provider. About $4 million is saved annually under this program. The program was expanded in the Budget Act of 2008 to include all children aged 0 through 17 years, and the share of cost was adjusted.

Subcommittee Staff Comment and Recommendation. The DDS needs to clarify how this adjustment to the Parental Fee Program may affect the amount any family pays per child under the Family Cost Participation Program which is linked to the parental fee schedule within the Parental Fee Program.

It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **DDS**, Please explain the interaction with the Parental Fee Program and the Family Cost Participation Program
3. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

14. Consolidate Quality Assurance Evaluation (See Trailer Bill—Sections 4, 5, 6, and 8)

Summary of Proposal. Under this proposal, the existing Life Quality Assessment (LQA) and the evaluation of people with developmental disabilities moving from Developmental Centers into the community would be consolidated into a single quality assessment tool and data collection effort.

The DDS would still contract with the State Council on Developmental Disabilities to conduct surveys of consumers but on a much more limited basis. Information obtained from these surveys would then be used by the DDS and another contractor, operating under the direction of the DDS, to develop certain quality assurance performance and outcome indicators which are intended to do the following:

- Provide consistent and measurable data for DDS' "Quality Management System".
- Enable the DDS, Regional Centers and policy makers to benchmark the performance of California against that of other states, as well as a comparison of quality measures across all 21 Regional Centers.
- Provide a stratified, random sample of surveys among the entire DDS consumer population.
- Avoid the duplicative data collection of personal outcome elements (e.g., school, work, health, safety), currently generated by the Client Development and Evaluation Report.

This proposal would save $2 million (General Fund) in 2009-10 and have an annual savings of $2.2 million (General Fund). Most of this savings is derived from a reduction of reimbursements provided to the State Council.

This proposal requires trailer bill language and an amendment to the Home and Community-Based Waiver (under the Medi-Cal Program and administered by the DDS).

Subcommittee Staff Comment and Recommendation. A redesign of this process is warranted but this proposal needs further clarification regarding the use of data obtained from the surveys and the ability of the state to analyze a broader spectrum of outcome measures.

It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

15. First Use "Group Instruction" for Behavioral Instruction Prior to In-Home (See Trailer Bill Hand Out—Section 3)

Summary of Proposal. Under this proposal, expenditures for certain behavior intervention services would be redefined such that group instruction on behavior intervention for parents (or guardians) *must be* completed *prior* to receipt of in-home behavior services. Training would include the basics of behavior intervention, how to manage less severe behavioral challenges, and the role and responsibilities of parents (or guardians) in the provision of in-home behavioral services.

This proposal would save $8.1 million ($6.4 million General Fund) in 2009-10 and have an annual savings of $16.2 million ($12.8 million General Fund). The savings level assumes a six-month phase-in, and reflects a shift in service usage between the group trainings and the in-home behavior services.

The DDS states that training would be provided by a Board Certified Behavior Analyst with teaching experience and costs approximately $1,200 per training. For an averaged sized Regional Center, the assessed need is about 24 trainings per year.

This proposal requires trailer bill language and an amendment to the Home and Community-Based Waiver (under the Medi-Cal Program and administered by the DDS).

The DDS states that this proposal is a proven model of providing cost-effective behavior intervention services. Three Regional Centers (Valley Mountain, North Los Angeles, and Lanterman) provide group training to parents on behavior intervention.

Background. According to the DDS, Regional Centers spent $44.5 million (total funds) on in-home behavior services for consumers residing in their families homes. These expenditures include those services billed as "Client/Parent Support Behavior Intervention Training" and "Parent Coordinated Home Based Behavior Intervention Program for Autistic Children".

Behavior intervention services are often critical to a consumer remaining with their family at home.

Subcommittee Staff Comment and Recommendation. It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

Additional Public Comment on All Issues (1 through 15)

Diane Van Maren 651-4103
Senate Budget & Fiscal Review
5/08/2009

OUTCOMES FOR: Subcommittee No. 3: Thursday, May 7, 2009
(Please use this document with the Agenda for this day.)

I. Items for "Vote Only" (Pages 2 to 3))

- **Vote: 2-0 (Senator Ashburn absent)**

- **Approved Vote Only Items as follows:**

1. Department of Public Health

    - Department's Correction for Genetic Disease Screening Program
    - California Electronic Death Registration System
    - Enterprise-Wide Online Licensing Project

2. Department of Developmental Services

    - Trailer Bill Language to Extend SB 962 Homes

II. Discussion Items for the Department of Developmental Services

- **Left Open for Continued Discussion**

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

May 14, 2009

9:30 a.m. *or*
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

AGENDA #1
(Diane Van Maren)

Item	Department
4270	**California Medical Assistance Commission (CMAC)—Vote Only**
4440	**Department of Mental Health—Vote Only**
4265	**Department of Public Health**
4260	**Department of Health Care Services**

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Public comment is welcomed.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible. Thank you.

A. Items for "Vote Only"--Pages 2 through 5

1. CA Medical Assistance Commission: Technical Adjustment

Background and Budget Discussion Issue. The CMAC negotiates contracts with certain hospitals under the Medi-Cal Program (called the Selective Provider Contracting Program), as well as contracts for Geographic Managed Care within the Medi-Cal Program (for Sacramento and San Diego).

The Subcommittee is in receipt of a Spring Finance Letter from the CMAC requesting an increase of $29,000 (Reimbursements which are federal funds from the Department of Health Care Services) for contract negotiation activities.

Subcommittee Staff Comment and Recommendation—Approve Finance Letter. This is a technical adjustment and no issues have been raised. It is recommended to approve the Finance Letter.

2. DHCS: Technical Adjustment for the Expanded Access to Primary Care

Background and Budget Discussion Issue. The Expanded Access to Primary Care Program reimburses community clinic providers for primary care services delivered to patients with family incomes at, or below, 200 percent of poverty who have no other means to pay. The state reimburses at $71.50 per visit.

During the current-year, the EAPC Program will reimburse 197 non-profit community clinic corporations for services at 548 clinic sites in 52 counties and pay for about 378,000 visits that would have otherwise been uncompensated.

The Subcommittee is in receipt of a Spring Finance Letter from the Department of Health Care Services (DHCS) that requests a transfer of $200,000 (Cigarette and Tobacco Product Surtax Funds—Proposition 99 Funds) from DHCS state operations to local assistance within the EAPC to help pay for administrative costs associated with the processing of claims generated by community clinics participating in the EAPC.

Subcommittee Staff Comment and Recommendation—Approve Finance Letter. The transfer of funds from state operations to local assistance to help with claims processing makes sense. This is a technical adjustment and no issues have been raised. It is recommended to approve the Finance Letter.

3. DHCS: Delay Implementation of CA Discount Prescription Drug Program

Budget Discussion Issue. The Subcommittee is in receipt of a Spring Finance Letter from the Department of Health Care Services (DHCS) requesting to delay implementation of this new program for one more year due to the fiscal crisis.

Overall Background—AB 2911 (Nunez), Statutes of 2006. This legislation created the CA Drug Discount Prescription Drug Program to address concerns regarding the lack of access to affordable prescription drugs by lower-income Californians. This program is a drug discount program, not a benefit. The general structure of the program is for the state to negotiate with drug manufacturers and pharmacies for rebates and discounts to reduce prescription drug prices for uninsured and underinsured lower-income individuals.

Participation in the program is eligible uninsured California residents with incomes below 300 percent of the federal poverty, individuals at or below the median family income with unreimbursed medical expenses equal to or greater than 10 percent of the family's income, share-of-cost Medi-Cal enrollees, and Medicare Part D enrollees that do not have Medicare coverage for a particular drug.

Subcommittee Staff Comment and Recommendation—Approve Finance Letter. Though implementation of this new program has merit, due to the fiscal crisis it is recommended to adopt the Spring Finance Letter to delay implementation of this program for 2009-10. The state is not in a position to commence with a new program when existing core programs are being reduced.

4. DPH: Trailer Bill Language for Emergency Physicians & Proposition 99 Funds (See Hand Out Package)

Budget Discussion Issue. The February budget package appropriates $24.803 million (Proposition 99 Funds) to reimburse physicians, surgeons and hospitals for uncompensated emergency medical services within the Department of Public Health (DPH). This appropriation is consistent with appropriations made for this purpose for the past several years, since 2000. These funds are used at the county level to reimburse physicians for uncompensated emergency medical services to persons who cannot afford to pay for such services.

Trailer bill language to allocate these funds to emergency physicians is also needed. The trailer bill language provided by the DPH for this purpose is the same language that was adopted for last year's process.

Subcommittee Staff Comment and Recommendation—Adopt Trailer Bill Language. No issues have been raised regarding this language. It is recommended to adopt the language as proposed.

5. DMH: Trailer Bill Language for Patton State Hospital

Budget Discussion Issue. The DMH is proposing trailer bill language to extend by three years, from September 2009 to September 2012, their ability to house up to 1,530 penal-code patients at Patton State Hospital. The DMH is requesting this change due to the continued growth of penal code patients which exceeds the State Hospital systems legally defined capacity and the need to house penal code patients in a "secure facility".

The DMH notes that presently Patton State Hospital is licensed to house 1,287 patients and currently houses about 1,506 patients. The Department of Public Health has been providing licensing waivers for the DMH to "over-bed" for several years at Patton.

Due to pressures to make more beds available to accommodate ISTs, respond to the number of orders to show cause, changes to the SVP law, and the recent joint Coleman/Valdivia court order to take in parolees, the DMH expects continued growth in its forensic patient population.

Prior Subcommittee Hearing. This issue was discussed in the March 26th hearing. Since this facility has the ability to best accommodate this population, no issues were raised.

Subcommittee Staff Comment and Recommendation—Adopt Trailer Bill Language. No issues have been raised regarding this language. It is recommended to adopt the language as proposed.

6. DMH: Technical Adjustment for Program Reimbursements

Budget Discussion Issue. The Subcommittee is in receipt of a Finance Letter from the DMH that requests an increase of $40 million in Reimbursements (from County Mental Health Services Act Funds) and a decrease of $40 million from the Mental Health Services Act Funds due to a technical error by the Administration. This technical adjustment is requested to accurately reflect Reimbursements received from county Mental Health Services Act Funds, not state Mental Health Services Act Funds.

This technical fund shift is needed to make a correction regarding special projects of a state-wide significance. These projects include: (1) Suicide Prevention; (2) Student Mental Health Initiative; and (3) Stigma and Discrimination Reduction.

Subcommittee Staff Comment and Recommendation—Adopt Finance Letter. No issues have been raised with this Finance Letter. It is recommended to adopt it.

7. DMH: California Health Information Survey (CHIS)

Budget Discussion Issue. The Subcommittee is in receipt of a Spring Finance Letter that requests a *one-time* appropriation of $1.3 million (Mental Health Services Act Funds) to fund a mental health component of the California Health Interview (CHIS) Survey for 2009. It should be noted that a portion of Mental Health Services Act Funds have been used previously for this purpose.

This survey has been conducted every two years since 2001 and is the largest health survey of states in the nation. CHIS data are used by state agencies, local public health agencies, community-based organizations, health care providers, advocacy organizations, federal agencies, foundations, the Legislature, and researchers.

The DMH states that CHIS provides the opportunity to:

- Identify populations by socioeconomic, race/ethnic, or geographic characteristics that are underserved;
- Help specify the barriers that contribute to disparities in treatment utilization, including stigma, cost, and adverse experiences with treatment;
- Inform the California mental health policy debate with population data on mental health status and its links to physical health status, health insurance, and economic well-being.
- Highlights trends over time in mental health status and use of mental health services.

The total request for the mental health component of CHIS in 2009 is $1.568 million. The Finance Letter is requesting an increase of only $1.3 million since carry-over funds are also available for this purpose. The $1.568 million would be expended as follows:

- CHIS Adult survey content (ages 18 and up) = $1.333 million total
    - Mental Health Assessment = $751,000
    - Perceived need and utilization of mental health services = $261,000
    - Mental/emotional health disability and severity = $150,000
    - Stigma as a barrier to service utilization = $16,000
    - Suicide = $155,000
- CHIS Adolescent survey content (ages 12 to 17) = $92,000
    - Mental Health Assessment = $49,000
    - Perceived need and utilization of mental health services = $27,000
    - Suicide = $16,000
- Data Dissemination = $143,000

This is for developing and producing mental health "SNAPSHOTS", two policy research reports, and two policy briefs. The collected data is to be made widely and easily accessible through a number of different outreach methods.

Subcommittee Staff Comment and Recommendation—Adopt Finance Letter. No issues have been raised with this Finance Letter. The CHIS is a well-known survey that provides reliable data which can be used for many diverse purposes. Use of Mental Health Services Act Funds (Proposition 63, Statues of 2004) is appropriate for this purpose as well. It is recommended to adopt the Finance Letter.

B. Issues for Discussion—By Department

Emergency Medical Services Authority

1. Pharmaceutical Cache (Stand By) for Mobile Hospital

Budget Discussion Issue. Through the Governor's January budget, the EMSA requested an increase of $448,000 (General Fund) to fund a pharmaceutical cache for the Mobile Field Hospitals. This request *was not included* in the February budget package but it was agreed that it would be discussed through the Subcommittee process "without prejudice".

The EMSA states that this funding would ensure a fresh supply of pharmaceuticals to be on-hand and delivered within 48 hours of the deployment of a Mobile Field Hospital. Pharmaceutical caches consist of medications, treatment kits, intravenous solutions, and other medical supplies.

It should be noted that this same request was denied last year due to the fiscal crisis.

An allocation of $18 million (General Fund, one-time only) was provided in 2006 for the purchase of pharmaceutical drugs, maintenance, medical supplies and related materials. In addition, $1.7 million (General Fund, ongoing) was provided for pharmaceutical drugs, storage, staff and maintenance.

Subcommittee Staff Comment and Recommendation. In the event of an emergency, the Governor can authorize increased funding for medical supplies, including pharmaceuticals. Further, the state operates under a "mutual aid" agreement where by local governments also play a significant role in providing assistance, along with the federal government.

Due to the short shelf life of most pharmaceuticals (about 2/3rds have a 12-month shelf life with the remaining 1/3 having about an 18-month shelf like) the EMSA would need on-going support even if no emergency requiring pharmaceuticals occurred.

It is recommended to "hold" this issue "open" pending receipt of the Governor's May Revision.

Questions. The Subcommittee has requested the EMSA to respond to the following questions:

1. EMSA, Please provide a brief summary of the request.

Department of Public Health

1. New Health Associated Infection Surveillance, Prevention & Control Program

Budget Discussion Issue. The Subcommittee is in receipt of a Spring Finance Letter that requests an increase of $1.4 million (Licensing and Certification Fees) to support 11 new state positions to establish a Health Associated Infection Surveillance, Prevention and Control Program, as well as database development and website enhancement.

The purpose of this request is to respond to chaptered legislation—Senate Bill 1058 (Alquist), Statutes of 2008, Senate Bill 158 (Flores), Statutes of 2008, and Senate Bill 739 (Speier), Statutes of 2006—regarding healthcare associated infections. These three bills create the basis for this new program area within the DPH's Licensing and Certification Division.

The 11 positions requested to complete the requirements of the chaptered legislation, including public reporting processes, are as follows:

- Public Health Medical Officer III. This position would coordinate development and implementation of the Health Associated Infection (HAI) Program by **(1)** providing supervision and guidance to staff; **(2)** overseeing development of directives and guidelines for the reporting of HAI by hospitals; **(3)** conducting annual evaluations of the HAI surveillance, prevention and control activities; and **(4)** planning, organizing and coordinating the data reporting activities of the HAI, including the required data summaries of the hospitals.

- Two Nurse Consultant III's. These positions would be used to **(1)** provide oversight, consultation and education to the hospitals on the methodology for the collection of data to be reported to the DPH; **(2)** develop and publish directives and guidelines for the reporting of HAI; **(3)** conduct onsite evaluations of health facility data; **(4)** participate as a member, and assist in the coordination of, the HAI Advisory Committee; **(5)** review and evaluate federal and state regulations and accreditation standards; and **(6)** work with the health education consultant in the development of infection prevention information.

- Three Research Scientist/Analyst Positions. These positions would **(1)** develop and implement systems for the collection and reporting of HAI; **(2)** develop quality control protocols; **(3)** conduct statistical analyses and interpret results; **(4)** maintain database systems; **(5)** conduct stakeholder work groups to develop guidelines for reporting HAI data; and **(6)** provide field work assistance as needed to Licensing and Certification personnel regarding these issues.

- Health Education Consultant II. This position would **(1)** design, develop and host a public website for the display of mandated infection surveillance data and public education related to infection prevention and control; **(2)** perform timely posting of infection prevention data as it becomes available; **(3)** translate educational materials and interpretations of data to a language level suitable for the general public; **(4)** perform program evaluation including conducting an annual evaluation of the HAI data reporting program and making recommendations for program improvements.

- Health Program Specialist. This position would **(1)** develop, evaluate and research policy and regulations for HAI; **(2)** provide coordination for the activities of program in the prevention and control of community pathogens and HAI; **(3)** serve as a liaison between the program, local health departments, healthcare facilities and other agencies; and **(4)** assist in developing guidelines, educational programs materials and legislative reports.

- Two Support Positions. These positions would perform data entry, obtain data from hospitals as appropriate and provide clerical support for the program.

The DPH states that development of this program will fulfill the mandates of the chaptered legislation, including the updating of state guidelines for infection control and prevention which have *not* been updated since 1970. These state guidelines will also be made consistent with national guidelines and standards.

The DPH also states that "measurable goals and objectives will be established and updated" as needed. Process and outcome measures will be developed to evaluate the program's effectiveness and identify areas of weakness or needing improvement. Program evaluation is to be undertaken periodically to assess the program's effectiveness in meeting its goals, identify problem areas and specify activities to be undertaken for program improvement.

The costs associated with this workload would result in increased Licensing Fees to be paid by hospitals and nursing homes. According to the DPH, the impact on Licensing Fees for the proposal is as follows:

Table: Administration's Increase in Licensing Fees

Facility Type	2009-10 Base Fee (Per Bed)	Incremental Fee for HAI Proposal (Per Bed)	Total Revised Fees for 2009-10 (Per Bed)
General Acute Care Hospitals	$257.76	$18.58	$276.34
Acute Psychiatric Hospitals	257.76	0.21	257.97
Nursing Homes—Skilled	287.00	0.83	287.83

Background--Health Associated Infections (HAI). According to the DPH, healthcare facilities increasingly lack the capacity to adequately address infection prevention and surveillance problems, keeping up with changes in information and technology, or respond to outbreaks.

Health associated infections (HAI) that occur during or as a consequence of the provision of healthcare, are major public health problems in California. In California's 450 General Acute alone, account for an estimated 240,000 infections, 13,500 deaths, and $3.1 billion dollars in excess health care costs annually. Infections also occur in California's 1,500 nursing homes, 800 Intermediate Care Facilities, 600 ambulatory surgical centers, and 350 dialysis centers.

Subcommittee Staff Comment and Recommendation. The DPH's proposal appears to be consistent with the requirements contained within the legislation. No issues have been raised. It is recommended to approve the Spring Finance Letter.

Questions. The Subcommittee has requested the DPH to respond to the following questions:

1. **DPH,** Please provide a *brief* summary of the proposal and request for the positions.
2. **DPH**, What core components of the program will be implemented first as a priority?
3. **DPH**, The federal American Recovery Reinvestment Act (ARRA) provides $50 million in federal grants for states to address hospital acquired infections. Will California be applying for some of these federal grant funds?

2. Lead-Related Construction Program Funding

Background and Budget Discussion Issue. The Lead-Related Construction Program was created in 1993 to protect children, families and workers by preventing lead exposure from housing and public buildings in accordance with the federal Residential Lead-Based Paint Hazard Reduction Act of 1992 and Title X of the Housing and Community Development Act. Among other things, this program (1) provides accrediting training to instructors to teach students how to identify and correct lead hazards; and (2) certifies individuals who are qualified to identify and correct lead hazards. This DPH program is recognized by the U.S. Environmental Protection Agency (EPA) as an authorized state program which makes California eligible to receive certain federal grants.

The Subcommittee is in receipt of a Spring Finance Letter that requests an increase of $500,000 (General Fund) for the Lead-Related Construction Program. The DPH states that this request would restore half of the General Fund amount that was eliminated in the Budget Act of 2008 through a Governor's veto.

Specifically, about $1 million (General Fund) was vetoed by the Governor in 2008. However the Administration now recognizes that about $500,000 is annually deposited into the General Fund from fees collected through this program from certification fees.

Further, the Administration contends that the requested restoration of $500,000 (General Fund) is needed in order to maintain eligibility for federal grant funds received by the California Department of Community Services and Development. Specifically, the Department of Community Services and Development receives about $22 million (federal funds) annually from the federal Housing and Urban Development (HUD) for lead hazard control.

The DPH states that the federal government gave California permission to utilize certain federal grants for 2008-09 (about $747,000) to temporarily support the Lead-Related Construction Program, due to the Governor's veto. However, these funds end as of September 2009. It is not known at this time if additional federal funds can be obtained for continued operation of the Lead-Related Construction Program.

The DPH notes that 8,100 children were found to have elevated blood lead levels in 2007 and about 85 percent of the cases investigated indicate expose to lead-based paint and lead-contaminated soil. As such, the Lead-Related Construction Program is important to continue since it provides training for inspection for lead hazards and remediation.

Subcommittee Staff Comment and Recommendation. In lieu of the Finance Letter, it is recommended to **(1)** establish a special fund into which the fees for the program will be paid; and **(2)** appropriate $500,000 *(one-time only*) from the Occupational Lead Poisoning Prevention Account in lieu of using General Fund dollars for 2009-2010 to continue the Lead-Related Construction Program.

This action would not affect the General Fund, would better reflect the collection of fee revenues to be used for the program, and would continue the program for one more year so the state may obtain the federal grant funds.

The existing fee revenue deposited in the General Fund could remain for 2009-10. New fees collected during 2009-10 could be placed into a new special fund. This would clarify that these revenues are a "fee" and not a "tax".

The Occupational Lead Poisoning Prevention Account funds would be used on a one-time only basis for the program. The Fund Condition Statement shows there is a $1.7 million reserve in this fund. Therefore, $500,000 is available from this account and it is for a lead-related purpose.

Questions. The Subcommittee has requested the DPH to respond to the following questions:

1. DPH, Please provide a brief summary of the program and proposal.
2. DPH, Please comment on the staff recommendation from a "technical assistance" basis.

Department of Health Care Services

1. Medi-Cal Eligibility Verification—Trailer Bill, Contract Funds & Staff (See Hand Out)

Budget Discussion Issue. The February budget package provides $250,000 ($125,000 General Fund) for a contract, and funds for one Associate Governmental Program Analyst to conduct verification of assets for Medi-Cal applicants and enrollees whose Medi-Cal eligibility is based on being Aged, Blind, or Disabled (i.e., have these eligibility category aid codes). Trailer bill legislation is also proposed. The intent of this proposal is to comply with federal law changes.

The DHCS states this contract will be with a vendor to provide a secure, web-based means for counties to request asset information from financial institutions to supplement verification for Aged, Blind, or Disabled individuals in order to be compliant with new federal requirements. The vendor would also be required to track the required reporting elements based on the financial institutions responses and generate the reports for the DHCS when needed for submission to the federal CMS.

Prior Subcommittee Hearing—Concerns with Trailer Bill Language. In the April 23rd Subcommittee hearing, considerable concerns were expressed regarding the Administration's proposed trailer bill language. The Subcommittee discussed the language and requested the DHCS to work with stakeholders to re-craft it.

Key concerns expressed in this *prior* hearing included the following:

- The language requires an individual to consent to the asset verification process as a condition of Medi-Cal eligibility. This requirement is beyond that which is contained in the federal law.

- The language broadly states that asset verification authorization shall be provided "whenever the State determines that the record is needed." No criteria is established or even outlined regarding how and when the authorizations will be required or what standards will be used for these activities. Therefore, implementation by individual counties or eligibility workers will likely be inconsistent and even *possibly* unintentionally discriminatory.

- The language broadly states that assets shall also be provided "by any other person whose resources are required by law to be disclosed". This provision most likely violates legal agreements in *Sneed v Kiser* (728, Supp. 607 of 1990) which limits whose assets can be counted towards the Medi-Cal enrollee's eligibility.

- There are various important procedural issues which are not clear with the language or the proposal overall. Such as--Will these Aged, Blind and Disabled applicants be delayed enrollment for long periods of time due to the need for the asset verification process? Will all other written documentation be waived if electronic verification of assets is conducted? How are county eligibility workers to process and track this information?

Administration's Revised Trailer Bill Language (Hand Out). The DHCS has considerably modified its original trailer bill language. *Key* changes include the following:

- The revised language no longer requires asset verification to be a condition of eligibility. It adds subdivision (e) to Section 14013 to clarify that applicants or recipients of Medi-Cal that refuse to provide or choose to later revoke their authorization *may* be determined ineligible for Medi-Cal

- The revised language now requires the DHCS to work with counties and stakeholder groups. It adds (g) to Section 14013.5 to require the DHCS to work with counties and stakeholders to develop the criteria to be used for asset verification.

- In response to concerns with privacy protections the revised trailer bill language now includes a reference to federal law to add privacy protections and notifications to applicant/recipient under Section 14013.5(d).

- With regards to concerns with how information would be obtained from financial institutions, revised trailer bill language does the following:

    - Requires the DHCS to reimburse the financial institutions with no cost to the applicants and recipients;
    - Requires the financial institution to furnish the DHCS with bank records for applicants and recipients who have provided authorization;
    - Allows the authorization obtained by the DHCS to meet the requirements of the Right to Financial Privacy Act (Act)and allows the DHCS to waive the certification requirements of this Act with the obtain authorization from the applicant/recipient;

- The revised language makes other language changes to clarify the purpose of the statutory changes. These include the following key items:

    - Includes language that the asset verification system implementation would be pursuant to, and only to the extent required by, federal law.
    - Incorporates the basic provisions of the federal law into state law.
    - Includes language that the authorization to request asset information be required of only those applicants and recipients designated by the DHCS in conformance with federal requirements and guidelines.

Subcommittee Staff Comment and Recommendation. The DHCS has made a commendable effort to recraft their trailer bill language. It is recommended to adopt the revised trailer bill language as placeholder language with one modification. The DHCS needs to include a date or time period as to when the regulations would be developed. Subcommittee staff suggests for regulations to be in effect within three-years since it is a new process which is contingent upon federal guidance which is still pending.

Questions. The Subcommittee has requested the DHCS to respond to the following question:

1. **DHCS,** Please provide a *brief* description of the revised trailer bill language.

2. Trailer Bill Language to Establish Maximum Allowable Ingredient Costs for Generic Drugs Dispensed by Pharmacists (Hand Out)

Budget Discussion Issues. The February budget package includes savings of $2 million ($1 million General Fund) for 2009-10 by implementing trailer bill language to establish a *new* Maximum Allowable Ingredient Cost (MAIC) within the Medi-Cal Program. Annual savings are estimated to be $24 million ($12 million General Fund).

The savings assumes a June 1, 2010 implementation date by the DHCS since system changes and other administrative actions require time to implement. Trailer bill language needs to be enacted before this savings can be achieved. The DHCS will also be entering into contracts with a vendor and is seeking an exemption from certain Public Contract Code requirements in order to implement this system quickly.

The Administration's proposed trailer bill language would allow the Medi-Cal Program to set MAIC using *either* (1) the Average Manufacturer Price (AMP); (2) the Wholesaler Acquisition Cost (WAC); *or* (3) to contract with a vendor to establish MAIC prices. The DHCS states that changes in the MAIC calculation are necessary because the existing Medi-Cal MAIC depends on the use of AMP as reported by the federal CMS to states. However, due to a federal court injunction and federal law changes, the federal CMS cannot readily provide this information to states.

The DHCS contends that the benefits to this trailer bill change are as follows:

- Increases the use of generic drugs in the Medi-Cal Program.
- Establishes a maximum reimbursement process that has been inactive in the Medi-Cal Program.
- Will maintain or increase savings in Medi-Cal.

Establishment of the new MAIC will reduce payment for many generic drugs. This will affect the reimbursement amount received by some pharmacies since the DHCS is not proposing any adjustments to the dispensing fee component of the rate. However, this proposal will also increase the use of some generic drugs. The DHCS contends that a shift away from some brand name drugs to generics with the new MAIC can be expected to financially benefit some pharmacies.

Overall, the extent of savings will depend on the differences between the current reimbursement and the new MAIC, and in those situations where the brand name drug is preferred, the difference between the net cost (cost after rebates) of the brand name drug and the net cost of the generic drugs, plus the drug utilization patterns after the new MAIC is established.

Prior Subcommittee Hearing—Concerns with Trailer Bill Language. In the April 23rd Subcommittee hearing, constituency groups expressed a few concerns regarding the crafting of the trailer bill language.

Key concerns expressed in the prior Subcommittee hearing included the following:

- The proposed trailer bill language needs to be more explicit in determining how the new MAIC will be set.
- The new MAIC for Medi-Cal should only be determined for those generic drugs that do not have a Federal Upper Limit established by the federal CMS.
- The new MAIC should only be determined for products that have at least three "A-rated" sources of every strength and are widely available for purchase in California pharmacies.

The Subcommittee discussed the language and requested the DHCS to work with stakeholders to re-craft it.

Administration's Revised Trailer Bill Language (Hand Out). In response to concerns raised by interest groups, the Administration modified their trailer bill language to address *four* specific concerns. *First,* the DHCS agreed to establish a MAIC only when *three* or more generically equivalent drugs are available for purchase and dispensing by retail pharmacies in California. Previously the DHCS had proposed when only two or more were equivalent drugs. This change means that it is more likely for a pharmacy to obtain a competitive drug ingredient cost in the first place (i.e., when there is three or more).

Second, the DHCS clarified certain vendor provisions so the language is more clearly constructed as to how the MAIC will be set.

Third, the DHCS added a provision to enable providers to seek a change to a specific MAIC when the provider believes the MAIC does not reflect current available MAIC prices. If the DHCS determines the MAIC change is warranted, the DHCS may update a specific MAIC.

Fourth, the DHCS is proposing to use a volume weighted average based on specific drugs dispensed to Medi-Cal enrollees to help ensure that the MAIC is fully applicable to California and the Medi-Cal marketplace.

Background—Summary of Previous Efforts Regarding MAIC. MAIC is an upper payment limit that creates a maximum reimbursement for generically equivalent drugs. MAIC is only used by Medi-Cal.

Originally, MAIC was defined in regulations as being equal to Average Wholesale Price (AWP) minus 5 percent price of a reference generic drug (typically the drug with the lowest AWP) with the provision that the Drug Manufacturer of the generic drug would be able to provide enough drug products to meet Medi-Cal's needs.

Unfortunately, this regulation did not mandate for Drug Manufacturers to supply this information. Therefore, the DHCS was generally unable to establish new MAIC prices. As a result a "new" MAIC definition was established in state statute in 2004.

This MAIC definition in 2004 was to be based on the Wholesale Selling Price (WSP). WSP was to be the weighted (by unit volume) mean price, including discounts and rebates, paid by a pharmacy to a wholesale drug distributor. Instead of using a single product, this methodology would use all generic equivalent products to calculate a weighted average that would be MAIC.

This 2004 definition of MAIC was halted when Congress declared they would move to an Average Manufacturer's Price (AMP) based on Federal Upper Limits (FUL). In 2007 this definition was changed to make MAIC equal to the mean of the AMP of drugs generically equivalent to the particular innovator (i.e., brand drug) plus a percent markup determined by the DHCS to be necessary for MAIC to represent the average purchase price paid by retail pharmacies in California.

The federal CMS issued regulations (to be effective October 1, 2007) regarding this calculation of FUL and AMP prices. However, the National Association of Chain Drug Stores and the National Community Pharmacists Association filed a complaint for injunctive relief contending that implementation was unlawful and would cause harm. Federal court issued a temporary injunction barring federal CMS implementation. Further, House Resolution 6331 delays implementation of FUL prices and AMP reporting until October 1, 2009.

Since the MAIC for Medi-Cal relies on the use of AMP reported by the federal CMS to states, it has been impacted by both the federal court injunction as well as the delay enacted in H.R. 6331.

Background—Pharmacy Reimbursement Under Medi-Cal. Pharmacy reimbursement consists of two components—a drug ingredient cost and a dispensing fee. With respect to the drug ingredient cost component, Medi-Cal presently calculates this cost at the "Average Wholesale Price" minus 17 percent. The dispensing fee component is $7.25 per prescription except for long-term care pharmacies which receive $8.00 per prescription.

Generally, the drug ingredient cost constitutes about 85 percent of the payment per prescription to a Pharmacy.

The rate reduction for Pharmacy reimbursement enacted in AB 1183, Statutes of 2008, is presently not in affect due to a court injunction (a 10 percent reduction effective July 1, 2008 to February 2009 and then a 5 percent reduction effective March 1, 2009).

Background—Description of Key Terminology. The following key definitions and terminology are provided only as a reference for discussion purposes.

- Average Manufacturer Price (AMP). This is the average price paid to the Drug Manufacturer for the drug in the United States by wholesalers for drugs distributed to retail pharmacies.
- Average Wholesale Price (AWP). Historically, the AWP has been the generally accepted drug payment benchmark for many payers because it was readily available. The primary sources of AWP are the drug data companies—most notably "First Data

Bank". The Medi-Cal Program currently uses First Data Bank as the source of AWP and other drug data reported by the Drug Manufacturers. Drug companies updated their database files continuously. Many pharmacies and third party payers, including Medi-Cal, obtain updated pricing on a weekly basis.

- Wholesaler Acquisition Cost (WAC). The WAC is generally a list price set by Drug Manufacturers for each of their products. WAC is supposed to represent what a wholesaler pays for a drug. However, WAC does not reflect discounts or price concessions offered by Drug Manufacturers. Drug Manufacturers report WAC prices directly to First Data Bank.

- Federal Upper Limit. Prior to certain federal law changes, the Federal Upper Limit (FUL) was defined as the reimbursement limit for each multiple source drug for which the federal Food and Drug Administration has *rated three or more* products therapeutically equivalent. Generally, drug products are considered pharmaceutical equivalents if they contain the same active ingredients are of the same dosage form, route of administration and are identical in strength or concentration.

  Federal law changes (Deficit Reduction Act of 2005) decreased the number of equivalent drugs from three to two and changed the reimbursement calculation. As noted above, these federal changes have not been implemented.

- Non-Innovator Multiple Source Drug. These drugs are often referred to as "generic drugs" and are *therapeutically equivalent* to Innovator Multiple Source Drugs which are referred to as "brand drugs".

Subcommittee Staff Comment and Recommendation--Approve. The DHCS has responded to many of the constituency group concerns and it is recommended to adopt the DHCS language at this time as placeholder.

Questions. The Subcommittee has requested the DHCS to respond to the following question:

1. **DHCS,** Please provide a *brief* description of the revised trailer bill language.

3. Trailer Bill Language & Staff for Mental Health Services Supplemental Payments Program (Hand Out)

Budget Discussion Issue. The Subcommittee is in receipt of a Spring Finance Letter to develop and implement a Mental Health Services Supplemental Payment Program to be administered by the Department of Health Care Services (DHCS).

This new Mental Health Services Supplemental Payment Program would be modeled after other existing DHCS "supplemental payment" programs. Specifically, it would authorize County Mental Health Plans (County MHPs) to submit "certified public expenditures" (CPEs) to the DHCS for the purpose of claiming federal financial participation to reimburse County MHPs for the costs of mental health services provided to Medi-Cal enrollees that *exceed their current payment levels*.

The supplemental payment would consist of the difference between the current Fee-For-Service rate being paid for these services and the actual costs to the counties to provide the mental health services. It should be noted that these supplemental payments can also be used to reimburse providers of Medi-Cal mental health services other than counties; however, it is the county CPE that must be used to claim the federal reimbursement.

Participation in the program by counties would be *completely voluntary*. The DHCS would invite counties to participate on an annual basis. Generally, it would be large counties who would most likely choose to participate in order to claim the additional federal funds since they are more likely to be incurring these costs.

It should be noted that the DHCS has already submitted a *draft* State Plan Amendment to the federal CMS in order to implement the program retroactively to January 1, 2009. This provides California with a longer period in which to claim federal reimbursement for these uncompensated county expenditures. This new program would be eligible to obtain the federal ARRA level of federal FMAP at 61.59 percent.

Based on preliminary information as contained in the draft State Plan Amendment, it is anticipated that $27.7 million (federal funds) can be obtained for 2008-09 and $55.4 million can be obtained for 2009-10. This increased federal funding would be very beneficial to local entities providing mental health services.

Prior Subcommittee Hearing. The Subcommittee discussed this issue in its April 23rd hearing. In this hearing several constituency groups expressed concerns regarding the DHCS trailer bill language. As such, the Subcommittee requested the DHCS to work with constituency groups and legislative staff to re-craft the proposed language.

Administration's Revised Trailer Bill Language (Hand Out). The DHCS has re-crafted its trailer bill language to incorporate several of the constituency groups concerns. *Key* changes include the following:

- Clarified that "certified public expenditure" (CPE) are funds expended by "public agencies", including counties, cities, city and county, or the University of California. This clarification will recognize the availability of more CPE to match with federal funds.

- Clarified Subdivision (c)(2) of Section 5783 to make it clear that County Mental Health Plans, or other public agencies, will reimburse contractors based on actual, allowable costs as determined by California's Medi-Cal State Plan, and shall be made on an interim basis until such time as actual, allowable costs are finally determined.

  In addition, (c)(3) of this section was changed to provide public agencies with one or more lump sums of federal supplemental payment or on any other federally permissible basis. This way public agencies can receive federal supplemental payments in a timely manner and not have to "float" their funds for periods of time waiting for federal reimbursement.

- Provides for the DHCS to adopt regulations as necessary to implement this new supplemental payment method but that Medi-Cal bulletins or similar instruction will be used for expedited implementation purposes until June 30, 2011.

Subcommittee Staff Comment and Recommendation. The DHCS has modified the trailer bill language to incorporate several changes. The DHCS notes that the opportunity for public agencies (primarily County Mental Health Plans) to obtain supplemental mental health funding through the use of CPEs is *voluntary* and requires federal Centers for Medicare and Medicaid (CMS) approval. As such, the DHCS needed to craft their revisions in a manner that would be acceptable to public agencies and the federal CMS.

It is recommended to adopt the revised trailer bill language as placeholder.

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

1. **DHCS**, Please provide a *brief* summary of the revised trailer bill language.
2. **DHCS and DMH**, How will coordination occur across the two departments to ensure appropriate development and implementation of this program?

4. Genetic Handicapped Persons Program—Three Proposals from the DHCS (See Hand Out)

Budget Issues Discussion. The February budget package provides a total of $78.1 million ($44.5 million General Fund) for 2009-10 which reflects a *net* increase of $5.8 million (total funds) as compared to the revised current-year.

The Table below reflects the DHCS' assumes for base expenditures for certain specified diseases.

Table: DHCS Base Expenditure Assumptions for Specified Disease for 2009-10

Diagnosis	Average GHPP-Only Caseload	Average Annual Cost per Case	Total Program Expenditure
Hemophilia	428	$165,100	$70,646,000
Cystic Fibrosis	412	14,500	5,963,000
Sickle Cell	310	3,600	1,108,000
Huntington's	160	2,100	342,000
Metabolic	116	700	82,000
Total People	1,426	$54,800	$78,141,000

This appropriation assumes passage of trailer bill language to change the structure of the Genetically Handicapped Persons Program (GHPP). The trailer bill language was *not* adopted as part of the February budget package.

After working with constituency groups and legislative staff, the DHCS has revised its original language to craft a more workable product. Specifically, the *revised* trailer bill language contains *three key components* as described below.

- 1. New "Crowd-Out" Provisions. The trailer bill would add *new* provisions to the GHPP to encourage continued enrollment in employer-sponsored health insurance, where applicable, and to make some individuals *ineligible* for the GHPP for a period of up to six months if they are terminated from their existing employer-sponsored health insurance *unless* certain conditions occur. These conditions include: (1) a loss of employment or a change in employment status; (2) a change in address to a zip code that is not covered by the employer-sponsored coverage; (3) the employer discontinued health benefits to all employees; (4) the death of an individual, or legal separation or divorce from the individual through whom the applicant was covered; (5) the applicant's employer-sponsored health coverage became unavailable because the services paid for under such coverage attained the lifetime coverage limit; or (6) coverage was under a COBRA policy, and the COBRA coverage period has ended. An individual may appeal decisions of ineligibility and the DHCS must provide written notification of any ineligibility determination.

  The language also provides the Director of the DHCS with the authority to waive determinations of *ineligibility* pursuant to this new provision if it will result in undue hardship. Further, the language provides for a stakeholder process for implementation purposes.

The DHCS states that this change is needed in order to prevent individuals from dropping their employer-sponsored health care coverage to enroll into the GHPP. If an individual is eligible for Medi-Cal then this "crowd-out" provision does *not* apply. The DHCS estimates savings of $14,000, assuming a July 1, 2009 implementation date.

- 2. DHCS Authority to Pay Premiums for Other Health Care Coverage. The trailer bill would add new provisions to provide the DHCS with authority to pay premiums for a GHPP client's other health care coverage that will pay for the GHPP client's health care services in lieu of the GHPP. The DHCS does have this authority in certain other programs where it is cost-beneficial for the state. The DHCS estimates savings of $593,000 (General Fund) from this action, assuming a July 1, 2009 implementation date.

- 3. GHPP Enrollment Fee. The trailer bill would re-craft the existing GHPP Enrollment Fee and increase the level of the fee to be 1.5 percent of total gross income for families with incomes from 200 percent to 300 percent of poverty, and up to 3 percent for families with incomes greater than 300 percent of poverty. This is would be an annual fee.

  In the event the annual enrollment fee determined exceeds the cost of care incurred during the applicable year of enrollment, the DHCS shall reduce the enrollment fee by refund or credit it to an amount equal to the cost of care. The DHCS estimates savings of $1.4 million (General Fund) from this action, assuming a July 1, 2009 implementation date.

Follow-Up Regarding Collection of Drug Rebates for Blood Factor Product. As noted in the Table above, 90 percent of the expenditures for the GHPP are for the treatment of Hemophilia. A significant expenditure for the treatment of Hemophilia is the provision of Blood Factor Product.

As directed by trailer bill legislation in 2003, the DHCS is to collect rebates from manufacturers of Blood Factor Product. In 2008, the DHCS experienced problems with the collection of these GHPP rebates. Specifically, the DHCS Director noted that $4.4 million in rebate funds were due the State dating back to June 2006 (March 2008 letter). It was anticipated that these "past due" rebates would be collected, and ongoing rebates would be obtained.

Presently, the GHPP budget reflects the following drug rebate collections:

Fiscal Year 2008-09 Collection		Fiscal Year 2009-10 Collection	
2006-07 =	$500,000	2008-09 =	$2,000,000
2007-08 =	$3,900,000	2009-10 =	$2,000,000
2008-09 =	$2,000,000		
TOTAL =	**$6,400,000**	**TOTAL =**	**$4,000,000**

It would be useful to hear from the DHCS with respect to the status of drug rebate collections to ensure that the State is indeed obtaining the level of drug rebate it should be for this critical program, particularly given these difficult fiscal circumstances and changes in the structure of the GHPP as proposed in trailer bill by the DHCS.

Background—Genetically Handicapped Persons Program (GHPP). The Genetically Handicapped Persons Program (GHPP) provides comprehensive health care coverage for persons with specified genetic diseases including Cystic Fibrosis, Hemophilia, Sickle Cell Disease, Huntington's Disease, Joseph's Disease, metabolic diseases and others. GHPP also provides access to social support services that may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions.

Persons eligible for GHPP must reside in California, have a qualifying genetic disease, and be otherwise financially *ineligible* for the CCS Program. GHPP clients with adjusted gross income above 200 percent of poverty pay enrollment fees and treatment costs based on a sliding fee scale for family size and income.

Subcommittee Staff Comment and Recommendation. The DHCS has modified their trailer bill language in response to concerns expressed by constituency groups. It is recommended to adopt this revised trailer bill language as placeholder language.

Further, the DHCS should provide an update regarding its collection of drug rebates within the GHPP.

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

1. **DHCS**, Please provide a brief summary of the program, and the proposed trailer bill changes.
2. **DHCS**, Please provide an update regarding the collection of drug rebates under the GHPP. Are all drug manufacturers providing the State with rebates as required? Is it likely that more rebates will be collected in 2009-10 since drug expenditures are likely to increase?

5. California Children's Services (CCS) Program (See Hand Out for Letters)

Summary of Budget Appropriation. The CCS program is a complex program that provides specialized, pediatric health care services to low-income children and young adults, aged 21 years and under, who have CCS-eligible medical conditions.

The February budget package for the CCS Program, within the DHCS' Children's Medical Services Division, is $270.4 million (total funds). This budget includes expenditures for county administration, CCS-Only children, CCS-Healthy Families Program children, certain therapy costs, and other administrative support activities (such as fiscal intermediary processing and information technology). (Most expenditures for CCS-Medi-Cal children are in the Medi-Cal Program budget).

The 2009-10 State appropriation of $270.4 million ($69.3 million State Funds, $134.9 million federal Healthy Families Program funds, $59.3 million federal funds from the Safety Net Care Pool, $6.9 million federal Title V Maternal and Child Health Funds) reflects an increase of $22.1 million (total funds) as compared to the revised current-year.

As a "county-realignment" program, the DHCS estimates that counties will provide about $117.8 million in County Funds for their share of the CCS Program.

Constituency Concerns—County Administration of CCS Eligibility and Case Management Funding. The Subcommittee is in receipt of letters expressing concerns regarding both the adequacy and allocation of funding to counties to perform CCS county administrative functions.

Specifically, the DHCS implemented a new method of funding CCS county administrative functions in 2008, including CCS eligibility determinations, and case management functions which includes the authorization of services to providers for medically-needy children requiring CCS services.

As a result of this new DHCS methodology, some counties and provider groups contend that CCS eligibility determinations will be delayed and children will not be referred for services to physicians and hospitals in a timely manner.

Overall Background on CCS: The DHCS administers the CCS Program. Their *primary* functions are (1) establishing policy and procedures for the program; (2) certifying CCS participating pediatric specialty care providers, and (3) reimbursing providers for services. In addition, the State operates three Regional Offices to provide assistance, as noted below, for smaller counties.

Other CCS Program administrative functions, including making eligibility determinations, providing authorization for case management, and providing authorization for medical treatment of services are conducted *primarily* at the county level. Large counties operate their own CCS Programs whereas smaller counties share the operation of their program administration with State CCS Regional Offices in Sacramento, San Francisco, and Los Angeles.

The CCS Program is the oldest managed health care program in the State and the only one focused specifically on children and young adults (up to age 21) with special health care needs.

CCS provides medical diagnosis, case management, medical treatment and therapy to financially eligible children with specific medical conditions, including birth defects, chronic illness, genetic diseases and injuries due to accidents or violence. Only *certain conditions* are eligible for CCS coverage. Further, CCS services must be deemed to be *"medically necessary"* in order for them to be provided.

CCS enrollment consists of children enrolled as: **(1)** CCS-only (not eligible for Medi-Cal or the Healthy Families Program), **(2)** CCS and Medi-Cal eligible, and **(3)** CCS and Healthy Families eligible. All children must be a permanent resident of the California County where they apply for CCS enrollment.

For CCS-only children to be considered financially eligible, they must either (1) be uninsured with an annual family income of less than $40,000; or (2) projected to have more than 20 percent of annual family income for treatment of a CCS condition.

The CCS Program depends on a network of specialty physicians, therapists and hospitals to provide this medical care. By law, CCS services are provided as a separate and distinct medical treatment (i.e., *carved-out service*).

Funding for the program is a patchwork consisting of State General Fund support, County Realignment Funds, and federal reimbursement provided under the federal Children's Health Insurance Program (i.e., Healthy Families in California) and the Medi-Cal Program as applicable.

Subcommittee Staff Comment and Recommendation. The CCS Program is complex and comprehensive discussions need to occur regarding the program. Subcommittee staff contends that CCS eligibility and treatment authorization can be, and should be, streamlined in an effort to reduce administrative burdens and to better serve the child and family.

The DHCS needs to consider a more comprehensive approach to address both short-term and longer-term CCS Program needs. For the short-term, the following Budget Bill Language is proposed to address immediate concerns:

"The department shall convene a diverse workgroup as applicable that, at a minimum, represents families enrolled in the CCS Program, counties, specialty care providers, children's hospitals, and medical suppliers to discuss the administrative structure of the CCS Program, including eligibility determination processes, the use and content of needs assessment tools in case management, and the processes used for treatment authorizations. The purpose of this workgroup will be to identify methods for streamlining, administrative cost-efficiencies, and better utilization of both State and county staff, as applicable, in meeting the needs of children and families accessing the CCS Program. The department *may* provide the policy and fiscal committees of the Legislature with periodic updates of outcomes as appropriate.**"**

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. DHCS, Please provide a brief overview of the CCS Program and discusses that have occurred over this past year regarding changes to CCS county administrative allocations. What next steps are anticipated in the short-term and longer-term?

Subcommittee No. 3: Thursday, May 14 (Room 4203) 9:30 or adjournment
(Please use Agenda I as a reference document.)

I. Items for "Vote Only" (Pages 2 through 5))

- **Action**. Approved the Vote Only Items as noted on Pages 2 through 5.
- **Vote 2-0 (Senator Ashburn absent)**

B. Issues for Discussion—By Department (Page 6)

1. Pharmaceutical Cache (Stand By) for Mobile Hospital (Page 6)

- **Action**. None taken.

Department of Public Health (DPH) (Page 7)

1. New Health Associated Infection Surveillance, Prevention & Control Program

- **Action**. Approved the Finance Letter.
- **Vote 2-0 (Senator Ashburn absent)**

2. Lead-Related Construction Program Funding (Page 10)

- **Action.** (1) Eliminated the General Fund augmentation; (2) adopted language to provide for a loan of $500,000 from the Occupational Lead Poisoning Prevention Account on a one-time only basis; and (3) established a special fund to collect the fees under the Lead-Related Construction Program Fund to begin as of July 1, 2010.
- **Vote 2-0 (Senator Ashburn absent)**

Department of Health Care Services (Page 12)

1. Medi-Cal Eligibility Verification—Trailer Bill, Contract Funds & Staff (See Hand Out)

- **Action.** Adopted revised trailer bill language with a 3-year date for regulations.
- **Vote:** 2-0 (Senator Ashburn absent)

2. Trailer Bill Language to Establish Maximum Allowable Ingredient Costs for Generic Drugs Dispensed by Pharmacists (Hand Out) (Page 14)

- **Action.** Adopted revised trailer bill language.
- **Vote:** 2-0 (Senator Ashburn absent)

3. Trailer Bill Language & Staff for Mental Health Services Supplemental Payments Program (Hand Out) (Page 18)

- **Action.** Agreed with the concept of the trailer bill language but kept the language open for discussions.

4. Genetic Handicapped Persons Program—Three Proposals from the DHCS (See Hand Out) (Page 20)

- **Action.** Adopted the revised trailer bill language as placeholder.
- **Vote:** 2-0 (Senator Ashburn absent)

5. California Children's Services (CCS) Program (See Letters) (Page 23)

- **Action.** Adopted the Budget Bill Language as contained in the Agenda
- **Vote:** 2-0 (Senator Ashburn absent)

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

May 14, 2009

9:30 a.m. *or*
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

Agenda II (Jennifer Troia)

Item	Department
0530	**Health and Human Services Agency, Office of Systems Integration** • CalWORKs Business Analytics and Reporting System
4170	**Department of Aging** • Health Insurance Counseling and Advocacy Program, Federal Funds Authority
4200	**Department of Alcohol and Drug Programs** • Licensing and Certification Division
5175	**Department of Child Support Services** • Multiple issues (see next pages for detailed listing)
5180	**Department of Social Services** • Multiple issues (see next pages for detailed listing)

Please note: The Committee will discuss only the items contained in this agenda at this hearing. Please see the Senate File for dates and times of subsequent hearings. The Committee will discuss the issues in the order noted in the agenda, unless otherwise directed by the Chair.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance from the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible.

Vote-Only Agenda

Discussion Agenda

VOTE-ONLY AGENDA

0530 Health and Human Services Agency - Office of Systems
5180 Integration (OSI) and Department of Social Services (DSS)

OSI Issue 1: California Work Opportunity and Responsibility to Kids (CalWORKs) Business Analytics and Reporting System (CBARS)

Budget Issue: As the Subcommittee agenda for April 30, 2009 described in greater detail, OSI and DSS have requested a combined total of $1.8 million in 2009-10 (all Temporary Assistance for Needy Families (TANF) block grant funding, with $1.2 million of those funds directed to the Office of Systems Integration Fund via DSS's local assistance budget) to begin planning and procurement for CBARS. $1.2 million of the funds would support OSI's project management responsibilities and the remaining $600,000 would support new positions at DSS to provide program direction.

According to the Feasibility Study Report for CBARS, the procurement, development, and initial implementation of the solution would be expected to span three and a half years, at a total estimated cost of $13.5 million (including the $1.82 million requested for 2009-10). The intention of CBARS is to provide more timely access to data from implementation of the program.

Subcommittee Staff Comment & Recommendation: Given the fiscal situation facing the state, this project is not urgent enough to necessitate approval at this time. Staff recommends deleting the funding for CBARS from the 2009-10 budget and making the requested funds instead available for TANF costs that would otherwise be funded with General Fund.

4170 California Department of Aging (CDA)

Department of Aging Issue 1: Health Insurance Counseling and Advocacy Program (HICAP), Federal Funds Authority Revision

Budget Issue: CDA requests, in a spring finance letter, an increase in federal fund authority of $410,000 for fiscal year 2009-10 for unexpended resources supporting state operations costs. No state funds are requested or will be obligated as a result. According to CDA, some of its federal grant-funded activities, including those related to HICAP, have been delayed because of the overlapping state and federal budget cycles and the recent budget standoffs. This authority is necessary to ensure that the department can carry-over unobligated federal funds to complete grant-supported activities.

Background: The overall budget for HICAP state operations and local assistance is around $11 million (no General Fund). A summary of the requested authority for specified federally-supported expenditures is below:

Increase to State Operations—2009/2010 Supplemental Federal SHIP Grants	
SHIP HICAP Awards	Requested Augmentation Increase
Low-Income Subsidy Supplemental Grant	$200,000
Performance Award (07-08)	$72,998
Performance Award (08-09)	$62,500
Long-Term Care Award	$73,545
Totals	$409,043

CDA administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the State. Specifically, the Department contracts with a network of Area Agencies on Aging (AAAs), who directly manage a wide array of federal and state-funded services that help older adults find employment; support older and disabled individuals to live as independently as possible; promote healthy aging and community involvement; and assist family members in care-giving.

HICAP is the state's equivalent of the federal State Health Insurance Assistance Program (SHIP), a Medicare counseling and education program that offers community education, individualized health insurance counseling, informal advocacy services, and legal referrals. There are over 4.3 million Medicare beneficiaries in California who are potential consumers of HICAP services. Twenty-four local HICAPs rely on staff, as well as paid volunteers, to carry out these activities. CDA also has a state HICAP office.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of this request to ensure that CDA can fully utilize these federal grant-funds. To facilitate Legislative oversight, staff also recommends adoption of budget bill language to amend Item 4170-101-0890, Provision 2 by adding the underlined:

> 2. Notwithstanding subdivision (e) of Section 28.00, the Department of Finance, upon notification by the California Department of Aging, may authorize augmentations in this item for federal Title III, Title VII, HICAP one-time only allocations, and for unexpended 2008–09 federal grant funds. The Department of Finance shall provide notification of the augmentation to the Joint Legislative Budget Committee within 10 working days from the date of the Department of Finance approval of the adjustment.

4200 Department of Alcohol and Drug Programs (ADP)

ADP Issue 1: Licensing & Certification Division BCP & Spring Finance Letter

Budget Issue: As the Subcommittee agenda for April 30, 2009 described in greater detail, ADP requested, in a BCP, an increase of $1.4 million ($893,000 from licensing fees collected in the Residential and Outpatient Program Licensing Fund (ROPLF) and the remainder from federal funds) and thirteen positions to expand the department's ability to conduct Drug Medi-Cal (DMC) Post-Service, Post-Payment (PSPP) reviews and complaint investigations. Eight of the thirteen positions would have been new and dedicated to conducting DMC PSPP reviews. The Subcommittee voted to reject those positions on April 30th. The other five positions, which were held open by the Subcommittee, were proposed to be continuing limited-term positions devoted to complaint investigation.

As the April 30, 2009 agenda also described, the administration proposed Budget Bill Language (BBL) in a spring finance letter to allow ADP to submit a one-time request to the Department of Finance by April 15, 2010 to increase its fiscal year 2009-10 ROPLF expenditure authority and decrease by a corresponding amount the General Fund and/or Substance Abuse Treatment Trust Fund expenditures for its Licensing and Certification Division. To allow the department to reduce or eliminate its reliance on General Fund resources for its Licensing and Certification functions, the Subcommittee voted on April 30th to approve this BBL.

Subcommittee Staff Comments & Recommendation: In conformity with action taken by the Assembly's Subcommittee #1 on May 6, 2009, staff recommends:

1) Approving another two-year term for the five continuing, limited-term positions requested for complaint intake and investigation, to be funded entirely by ROPLF;

2) Removing and scoring all remaining General Fund support of the Licensing and Certification Division ($1.1 million) and correspondingly approving equal expenditure authority in 2009-10 for the ROPLF; and

3) As a technical adjustment given the above actions, rescinding the Subcommittee's prior approval of the spring finance letter (Issue 051) on expenditure authority for the ROPLF and instead rejecting that request.

As a result, the Licensing and Certification Division would be entirely fee-supported in the 2009-10 budget year.

5175 Department of Child Support Services (DCSS)

DCSS Issue 1: Proposal for $25 Annual Fee

Budget Issue: DCSS proposes trailer bill language to authorize the department, as of October 1, 2010, to charge a $25 federally-established annual fee to custodial parents who have never received public assistance and who receive more than $500 in child support disbursements through the services of their local child support agency during the federal fiscal year (FFY). In order to implement this new fee, the department estimates one-time costs of approximately $2.6 million ($900,000 General Fund) for automation changes and $116,000 ($39,000 General Fund) for mailing notices to affected families in the 2009-10 budget year. In future years, the department estimates annual fee revenue of $5.8 million ($2 million General Fund).

Background: The Federal Deficit Reduction Act of 2005 (FDRA) required states, effective January 1, 2008, to charge an annual $25 fee to never-assisted families to whom they disburse at least $500 in child support in a FFY. Under the FDRA, states may collect the mandatory $25 fee in the following ways: 1) Retain the fee from the custodial parent's child support collections (as is proposed by DCSS); 2) bill the fee to the custodial parent; 3) bill the fee to the non-custodial parent; or 4) pay the federal share of the fee from the General Fund. For the 2008-09 and 2009-10 budget years, the State elected to remit the federal share of the fee to the federal government without recouping it from the families, at a total annual cost of $3.5 million General Fund.

DCSS estimates that the fee would apply to approximately 230,000 never-assisted families. If fee collection is authorized, the department would change California Child Support Automation System (CCSAS) in order to track child support distributions and withhold the fee after those distributions surpass $500 in a given FFY. DCSS staff would also validate the collection information quarterly. The State would continue to remit the federal share of fees to the federal government upfront and then restore the General Fund resources upon recovery of the fee from custodial parents.

Subcommittee Staff Comment and Recommendation: Staff recommends that the Subcommittee approve the administration's proposal to collect the federally-established $25 fee from never-assisted parents and approve the accompanying trailer bill language with the effective date of the fee as October 1, 2010.

5180 Department of Social Services (DSS)

DSS Issue 1: Community Care Licensing Division (CCL) - Licensing Client Protections

Budget Issue: As the Subcommittee agenda for April 30, 2009 described in greater detail, DSS requested $3.5 million (approximately $3 million from a 16 percent increase in licensing fees and the remaining $500,000 from federal funds) and 30 positions in response to increased criminal background check workload and concerns about the need to assure compliance with laws related to sex offenders and licensed facilities, certified homes, or county-approved relative homes.

Facility Inspections: In addition to its criminal background check responsibilities, the Community Care Licensing Division of DSS is responsible for performing different types of inspection visits to licensed facilities. Some providers and advocates have commented that an increased frequency of these inspection visits would provide a better vehicle for improving upon the protection of clients in community care facilities.

Under current law, facilities with complaints filed against them or those with new applications receive prompt inspections in response to the complaint or application. Facilities that require close monitoring due to their compliance history or because they care for developmentally disabled clients (approximately ten percent) also receive annual inspections. The remaining ninety percent of facilities are subject to a thirty percent random sampling of facilities for inspection each year. In addition, there is a separate statutory requirement that all facilities must be visited at least every five years.

Subcommittee Staff Comment and Recommendation: To reduce the criminal background check backlog, improve efficiency of background checks, increase the number of random facility inspection visits, and better safeguard against the presence of registered sex offenders in community care facilities, staff recommends the approval of a smaller approximately 10 percent fee increase and the adoption of corresponding, amended placeholder trailer bill language. This new fee revenue would be used for:

1. Approximately 12 positions to increase the frequency of random licensing inspection visits sample to roughly 34 percent of facilities per year (an increase of approximately 2500 facilities per year);

2. Approximately 9 criminal background check positions, plus $200,000 to be used for increased efficiency via improved access to CLETS; and

3. The proposed website to promote law enforcement access to information about licensed facilities.

Exact numbers of positions and corresponding fee and funding amounts would be determined by the Department of Finance in consultation with DSS and Subcommittee staff.

DSS Issue 2: Kinship-Guardianship Assistance Program (Kin-GAP) Dual Agency Rate

Budget Issue: The Administration proposes trailer bill language to allow approximately 300 children benefiting from a higher dual-agency (child welfare agency and regional center) Aid to Families with Dependent Children-Foster Care (AFDC-FC) rate while in foster care to be eligible for that rate when they exit foster care to Kin-GAP. DSS estimates that the proposed statutory changes would result in an increase of $1.1 million General Fund budgeted for Kin-GAP, and a corresponding savings of $465,000 General Fund for foster care and child welfare services.

The intent of this proposal is to remove an unintended barrier that was created by SB 84 (Chapter 177, Statutes of 2007) to children with special needs exiting foster care to permanent homes with kin. SB 84 created a new rate structure and rate-setting process for children who are both consumers of a regional center and recipients of AFDC-FC or Adoption Assistance Program benefits. However, the bill failed to apply the new rate to children benefiting from Kin-GAP.

Background on Kin-GAP: Overall funding for the Kin-GAP program is $176.2 million (75 percent General Fund and 25 percent county-funded). The General Fund expenditures are currently counted toward the state's Maintenance of Effort expenditures for the federal Temporary Assistance for Needy Families (TANF) program. Kin-GAP was created by SB 1901 (McPherson), Chapter 1055, Statutes of 1998, with the goal of enhancing stability for foster children by supporting long-term placements with relatives who become their legal guardians. The relative guardians receive a monthly aid payment equal to 100 percent of the rates paid to foster family homes (an average basic rate of around $570 per month, plus any applicable clothing allowances or specialized care increment). Although the juvenile court retains some form of jurisdiction, children served by Kin-GAP (estimated at nearly 16,000 in 2008-09) no longer receive foster care services and supports.

Subcommittee Staff Comment and Recommendation: Staff recommends that the Subcommittee adopt the requested trailer bill language.

DSS Issue 3: Group Home Classification Rate Relief

Budget Issue: The Administration proposes an extension of group home "rate relief" trailer bill language, with no associated expenditure request.

Background: The group home "rate relief" provision was originally adopted for the state's 2002-03 fiscal year and has been extended each subsequent fiscal year. Facing a financial crisis, the state did not provide a 3.7 percent (based on the California Necessities Index) Cost of Living Adjustment (COLA) to group home providers for 2002-03. Instead, group home "rate relief" adjusted the Rate Classification Level (RCL) point

ranges used to classify group home programs and establish their resulting Aid to Families with Dependent Children (AFDC)-Foster Care (FC) rates for the care and supervision of children. Thus, "rate relief" was designed not to increase actual AFDC-FC expenditures. Instead the policy allows group home providers to receive a reimbursement rate that is higher than their staffing configurations would otherwise have allowed under the standard RCL system.

There are fourteen standard group home RCLs. The points used to establish each RCL are based on the number of hours per child per month of care and supervision, social work and mental health treatment services. As an example, under the standard RCL ranges, a provider assigned 360-389 points would be classified at an RCL of 12 and would receive a rate of $5,613 per child per month. Under the adjusted RCL point range, that same provider would instead need only 339-367 points to meet this same RCL and receive the related rate.

Subcommittee Staff Comment and Recommendation: Staff recommends that the Subcommittee approve the proposed trailer bill language.

DSS Issue 4: Disability Service Determination Division (DSDD) – Relocation of Los Angeles State Program (LASP) Branch

Budget Issue: DSS requests, in a BCP, a budget augmentation of $970,000 ($485,000 General Fund) to relocate the DDSD-LASP. Of the $970,000, $634,000 ($317,000 General Fund) is for one-time relocation costs and $336,000 ($168,000 General Fund) is for six months' worth of a rent increase in FY 2009-10. DSS estimates future annual costs of a rent increase starting in FY 2010-11 at $672,000 ($336,000 General Fund). The request is based upon notice from the Department of General Services (DGS), Real Estate Service Division to DSS in 2007 that the LASP Branch location does not meet DGS's seismic safety compliance standards.

Additional Background: DDSD-LASP has been in its current location for thirteen years. The lessor of the facility is unwilling to fund the costs ($750,000) of retrofitting the building to meet the state's seismic compliance standards. The original lease was a ten-year lease, with rate adjustments based on the Consumer Price Index. The most recent lease is for a one-year term that is set to expire April 1, 2010. DGS estimates that it would take twelve months to obtain an alternative rental site and complete the relocation.

Subcommittee Staff Comment & Recommendation: Notwithstanding the importance of the need for state offices to be located in facilities that meet DGS's seismic safety policies, given the fiscal situation facing the state, staff recommends rejecting the requested funding and directing the department to work with DGS to plan for postponing any relocation of this office.

DSS Issue 5: California Work Opportunity and Responsibility to Kids (CalWORKs)- Work Incentive Nutritional Supplement (WINS)

Budget Issue: The administration proposes trailer bill language to impose a two-year delay in the implementation of WINS. As a result, the state would delay by this period approximately $2 million in General Fund costs for automation changes that are necessary to begin implementation of the program. After automation changes in the first year of WINS implementation, the department estimates costs (countable as Maintenance of Effort for the federal Temporary Assistance for Needy Families (TANF) program) of $18 million in the second year of WINS implementation and $28.4 million for ongoing costs of the program each year thereafter.

If the proposed trailer bill language were adopted, full implementation of WINS would be required by April 1, 2012 (instead of 2010) and the payment of WINS benefits would not begin before October 1, 2011 (instead of 2009). The proposed language would also eliminate a requirement for the department to convene a workgroup to consider WINS implementation in tandem with a pre-assistance employment readiness (PAERS) program and other options for impacting the state's caseload reduction credit (CRC) and work participation rate (WPR).

Background on WINS: The 2008-09 budget adopted by the Legislature (AB 1279, Chapter 759, Statutes of 2008) included $2 million General Fund to make automation changes necessary to begin implementation of WINS. That funding was vetoed by the Governor in September, 2008.

Under WINS, the state would pay 100 percent of the costs of a $40 food assistance benefit paid to families receiving food stamps in which at least one parent or caretaker is "work eligible" as defined in TANF and meets the related-federal work participation requirements. Consistent with federal nutrition assistance laws, the receipt of WINS benefits would not cause a reduction in other aid those families may receive (e.g. SSI/SSP).

The PAERS working group was created as a means of exploring options for how to offset a potential increase in the state's CalWORKs caseload (and possible resulting decrease in its caseload reduction credit) resulting from WINS. Under existing language, if the workgroup concluded that PAERS would be a favorable option for the state, the department would be required to submit a proposal on the subject to the Legislature by a specified deadline.

Subcommittee Staff Comment and Recommendation: CalWORKs policy and the issues surrounding the WPR will be evolving in the near future given changes in the economy, the recent change in the federal administration, and pending TANF reauthorization in 2010. Therefore, staff recommends that the Subcommittee approve the proposed delay of WINS implementation for two years. However, staff recommends rejecting the proposed deletion of PAERS language, as pre-assistance programs may be viable and important options for the state to explore before implementing WINS.

Staff instead recommends applying a similar two-year delay to the PAERS requirements.

DISCUSSION AGENDA

5175 Department of Child Support Services (DCSS)

DCSS Issue 1: Update on Federal Performance Measures

Budget Issue: Pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), since federal fiscal year (FFY) 2000, the federal government has awarded incentive funding to state child support programs based on specific performance measures. The 2007 Human Services budget trailer bill required DCSS to provide an annual update to the Legislature in the subcommittee process, beginning in 2008, on state and local performance on those measures and on child support collections. The department will provide this annual update during this hearing.

Background on Child Support Services: DCSS has an overall budget of $1.3 billion ($400,000 million General Fund and $900,000 million federal funds). For fiscal year 2008-09, the department projects anticipated total child support collections of $2.3 billion, including $219.7 million in collections that will become revenue for the General Fund. The primary purpose of the child support program is to collect support payments for custodial parents and their children from absent parents. Local Child Support Agencies (LCSAs) provide services such as locating absent parents; establishing paternity; obtaining, enforcing, and modifying child support orders; and collecting and distributing payments. When a family receiving child support is also receiving public assistance (in approximately 20 percent of cases), the LCSAs distribute the first $50 per month collected from the non-custodial parent to the custodial parent and child. Any additional support collected is deposited into the General Fund to partially offset the state's costs for providing public assistance.

Federal Outcome Measures: The PRWORA performance measures are described below, along with information from the department on California's recent performance. The federal government uses these measures as a basis for distributing incentive funding among states. In FFY 2008, the total pool of incentive funds available to states was $483 million. For state fiscal year 2008-09, the department estimates that California will receive $45 million in incentive funds.

- **Statewide paternity establishment percentage.** This performance standard measures the total number of children born out-of-wedlock for whom paternity was acknowledged or established in the fiscal year, compared to the total number of children born out-of-wedlock during the preceding fiscal year. The minimum federal threshold is 50 percent. Based on information provided by DCSS, in 2008, California ranked 8th out of the 33 states for which PEP outcomes were available.

Paternity Establishment Percentage	IV-D PEP (measure of entire caseload) FFY 2002 - 77.5% FFY 2004 - 87.6% FFY 2006 - 90.3% FFY 2008 - 94.2% Statewide PEP (measure of one year) FFY 2002 -108.7% FFY 2004 -117.8% FFY 2006 -109.9% FFY 2008 -101.4%

- **Percent of cases with a child support order.** This standard measures cases with support orders, compared to the total caseload. Support orders are broadly defined as all legally enforceable orders, including orders for medical support only and zero-support orders. The minimum federal threshold is 50 percent. Based on information provided by DCSS, in 2008, California ranked 30th out of the 51 states (including the District of Columbia) for which this outcome was measured.

Percent of Cases with a Child Support Order	FFY 2002 - 75.3% FFY 2004 - 78.1% FFY 2006 - 80.6% FFY 2008 - 80.2%

- **Current collections performance**. This standard measures the amount of current support collected, compared to the total amount of current support owed. The minimum federal threshold is 40 percent. Based on information provided by DCSS, in 2008, California ranked 46th out of the 51 states.

Current Collections Performance	FFY 2002 - 42.4% FFY 2004 - 48.0% FFY 2006 - 50.4% FFY 2008 - 52.8%

- **Arrearage collections performance.** This standard measures the number of cases with child support arrearage (past due) collections, as compared with the number of cases with arrearages during the FFY. The minimum federal threshold is 40 percent. Based on information provided by DCSS, in 2008, California ranked 41st out of the 51 states.

Arrearage Collections Performance	FFY 2002 - 54.9% FFY 2004 - 54.9% FFY 2006 - 56.5% FFY 2008 - 59.1%

- **Cost effectiveness performance level.** This standard measures the total amount of distributed collections, as compared to the total child support program expenditures for the fiscal year, expressed as distributed collections per dollar of expenditure. The minimum federal threshold is $2.00. Based on information provided by DCSS, in 2008, California ranked 51st out of the 51 states.

Cost Effectiveness Performance Level	FFY 2002 - $2.23 FFY 2004 - $2.12 FFY 2006 - $2.03 FFY 2008 - $1.96* *The actual FFY 2008 statewide total cost effectiveness is $2.04. Due to an error, the department instead reported it as $1.96.

Subcommittee Staff Comment and Recommendation: This is an informational item, and no action is required.

Questions for DCSS:

1) Please provide a brief update on the trends in California's child support caseloads and the state's performance on the five federal measures.

2) What are some factors that have led to California's stronger comparative performance in establishing paternities and support orders than in collecting the support that is ordered? What can be done to improve upon child support collections and the cost-effectiveness of child support services?

DCSS Issue 2: California Child Support Automation System (CCSAS)

Budget Issue: The 2009-10 budget passed in February included $118 million ($40 million General Fund and $78 million federal funds) for CCSAS. About $66 million ($22.4 million General Fund) of the total funds were for maintenance, such as system support staff, software updates, and equipment replacement expenses. Approximately $2 million ($680,000 General Fund) were for change requests to obtain additional functionality that was previously deferred. The remaining $50 million ($17 million General Fund) were for ongoing baseline project expenditures.

Background: CCSAS was fully implemented in November, 2008, after eight years and $1.5 billion in costs. The system then received federal certification as a single statewide automation system, ending the threat of further federal penalties and lifting the cap placed on federal support for automation costs. DCSS is responsible for maintaining the functionality of CCSAS and ensuring that LCSAs have access to the system in order to support their child support enforcement activities.

CCSAS consists of two major components, the State Disbursement Unit (SDU) and the Child Support Enforcement (CSE) component. The SDU was fully implemented in May 2006, and collects, processes, and distributes child support payments. The CSE component provides a central database and case management system to support child support enforcement activities in all LCSAs.

Subcommittee Staff Comment and Recommendation: In conformity with action taken by the Assembly's Subcommittee #1 on May 6, 2009, staff recommends that the Subcommittee adopt placeholder trailer bill language to require the Office of the Chief Information Officer (OCIO) and DCSS to jointly produce an annual report for the policy and fiscal committees of the Legislature on CCSAS implementation, including (1) a clear breakdown of funding elements for past, current, and future years, (2) descriptions of implemented functionalities and a description of their usefulness in child support collections by LCSAs, (3) a review of current federal considerations, and (4) a policy narrative on future, planned changes to the CCSAS system and how they will advance activities for workers, collections for the state, and payments for recipient families. Per a suggestion from LAO, staff also recommends the formulation of a working group to discuss the components of the report if the trailer bill is enacted.

Questions for DCSS and/or the OCIO:

1) Please describe the current status and functionality of CCSAS.

2) How has CCSAS improved child support services for these constituencies:
   a. LCSA staff, including case workers;
   b. Custodial and noncustodial parents who use child support services; and
   c. DCSS and other state-level stakeholders, including the Legislature?

3) What are your future plans for CCSAS?

DCSS Issue 3: Revenue Stabilization Proposal

Budget Issue: The administration proposes a new estimate premise that reflects an augmentation of $18.7 million ($6.4 million General Fund and the rest federal funds) to LCSAs to maintain LCSA caseworker staffing levels and stabilize child support collections. DCSS estimates that this augmentation would result in increased recoupment of $14.4 million in public assistance costs ($6.6 million of which would be General Fund revenue, with the remainder as revenue to the federal government). The augmentation is also expected to result in the collection of an additional $70 million in child support payments that would be passed on to custodial parents and their children.

Background: Since 2003-04, state and federal funding support for LCSA basic administrative expenses have been held flat, with the exception of two one-time increases. According to DCSS, as a result of this flat funding and local increases in the costs of doing business, LCSA staffing levels have declined by 1,935 positions (including 517 caseworkers) or 23 percent from their peak in 2002-03; and child support collections have decreased as a result. During that same time, the child support caseload statewide declined by about 11 percent (200,000 cases). DCSS estimates that the proposed increased funding would allow LCSAs to retain 259 staff, including 182 caseworkers. DCSS also notes that securing child support for custodial parents and children who do not currently receive public assistance can help those families continue to avoid public assistance.

LAO Comments: The LAO notes that "Although the retention of child support caseworkers would likely have a positive impact on collections to some degree, it is unclear whether this proposal would result in a net General Fund benefit" because of "several risky assumptions." Based on its observation that LCSAs have no fiscal stake in the child support program, the LAO recommends an alternative approach which establishes a voluntary matching program for LCSAs wishing to access new funds.

Subcommittee Staff Comment and Recommendation: In conformity with action taken by the Assembly's Subcommittee #1 on Health and Human Services on May 6, 2009, staff recommends approval of this revenue stabilization premise with: 1) an assumption of net General Fund revenue as determined by the Department of Finance and 2) direction to the Department of Finance to display the augmentation in future budget proposals through the creation of a new item in the Budget Act that specifically identifies that these dollars are for the purposes of revenue stabilization.

Staff additionally recommends the adoption of placeholder trailer bill language to require the following:

1) Each LCSA shall submit an Early Intervention Plan with all components to take effect upon receipt of their additional revenue stabilization allocation.

2) Funds shall be distributed to counties based on their performance on federal performance measures. These measures may include Measure 3: Collections on Current Support and Measure 4: Cases with Collections on Arrears, depending upon discussion around other possible measures.

3) DCSS shall submit an interim report to the fiscal committees of the Legislature by January 1, 2010 that tracks and evaluates the impact of the augmentation on revenue collections and cost-effectiveness, with an additional oral report to be provided during the spring subcommittee review process.

4) LCSAs shall be required to use and assure that 100% of the new funds allocated are dedicated to maintaining caseworker staffing levels in order to stabilize child support collections.

5) DCSS shall, at the end of each fiscal year that this augmentation is in effect, provide a report on the cost-effectiveness of this augmentation, including an assessment of caseload changes over time.

6) Possible inclusion of an appropriate sunset date for these provisions to reflect ongoing oversight and review of this augmentation during the usual budget review process.

Questions for DCSS:

1) Please briefly summarize how the $12 million ($4.1 million General Fund) augmentation for LCSA performance improvement in the 2006-07 budget was expended and what impact those funds had on performance.

2) Please summarize this estimate premise, including the dynamic between staffing levels, collections, and caseload, as well as your methodology and how the additional funding would be distributed to LCSAs.

3) Please describe the early intervention efforts that LCSAs would engage in and provide specific examples of how these efforts have proven effective in the past.

4) In the budget year and future years, how would you track and assess the effectiveness of the proposed augmentation and resulting revenue increase?

5180 Department of Social Services (DSS)

DSS Issue 1: Child Welfare System (CWS) - Child and Family Services Review (CFSR) / Program Improvement Plan (PIP)

Budget Issue: The Administration has proposed new estimate premises directly related to the most recent CFSR and resulting PIP, as below:

1) $15.2 million ($6.8 million General Fund, $5.6 million federal funds and $2.9 million county funds) for relative search and engagement on behalf of children newly entering the foster care system and older youth (over age sixteen) who have been in foster care longer than 18 months and who are not living with relatives;

2) $7.4 million ($3.3 million General Fund, $2.7 million federal funds and $1.4 million county funds) to increase family case planning meetings; and

3) $699,000 in savings ($171,000 General Fund, $272,000 federal funds and $256,000 county funds) from establishing Multi-Dimensional Treatment Foster Care (MTFC) rates.

The Administration also proposed a new estimate premise for $11.9 million ($5.3 million General Fund, $4.3 million in federal funds and $2.3 million in county funds) to increase caseworker visits. Although DSS created this estimate in response to federal law (P.L. 109-288, the Child and Family Services Improvement Act of 2006), the changes would also positively impact the state's performance on a related CFSR measure.

Child Welfare Funding and the CFSR: The Governor's proposed budget for 2009-10 included around $5.3 billion ($1.36 billion General Fund) in spending from all funds for child welfare services, foster care and adoptions. The primary sources of federal funding are Titles IV-B (child welfare services) and IV-E (foster care) of the Social Security Act. The CFSR is the federal government's program for reviewing the performance of states that receive funding under those provisions.

In 2002, the federal Administration for Children and Families (ACF) conducted its first CFSR of California's child welfare system. California passed two of the seven systemic factors and failed all seven of the outcome measures pertaining to child safety, well-being, and permanency. As a result of this review, the federal government assessed $9.0 million (all General Fund) in penalties against the state (plus $1.1 million in interest that accrued on those penalties in 2008).

ACF recently performed another CFSR in California and published the results in 2008. The state was in substantial conformity with three of seven systemic factors and again failed all seven outcome measures. Based on this second round of reviews, the federal penalty could under the worst-case scenario exceed $107 million (all General Fund). After this recent CFSR, DSS developed a draft PIP to improve outcomes for children

and families and hopefully avoid these fiscal penalties. The state is currently negotiating the details of that PIP with the federal government.

According to ACF, challenges facing the state with regard to its performance included high caseloads and turnover of social workers, an insufficient number of foster homes and lack of caregiver support and training, a lack of statewide implementation of innovative practices, and a lack of needed services (e.g. mental health and substance abuse treatment services).

Concerns from CWDA: The County Welfare Directors Association (CWDA) supports the Administration's efforts to improve child welfare outcomes, but expresses concern about the county share required in the estimates. CWDA contends that the child welfare system is already critically under-funded and social worker caseloads remain much higher than was recommended by a study conducted pursuant SB 2030 (Costa, Statutes of 1998). According to CWDA, the state has failed to fund the actual costs of operating the child welfare program since 2000-01, resulting in a loss of $486.4 million ($206.9 million General Fund) annually. Counties have partially bridged this funding gap by investing significant amounts of local dollars into the program, overmatching the state's contribution by more than $150 million a year. However, counties contend that they no longer have the capacity to backfill for such severe shortfalls in the state's allocation.

Subcommittee Staff Comments and Recommendation: To improve outcomes related to the safety, permanency and well-being of children in the state's care and custody and avoid federal financial penalties, staff recommends that the requested funding remain in the 2009-10 budget. No action is required to achieve that outcome.

To ensure effective implementation of the premises on family search and engagement and participatory case planning, staff additionally recommends the adoption of placeholder trailer bill language (TBL). The recommended TBL would require DSS to consult with stakeholders, including at least representatives of counties, foster youth and organizations or entities that have experience providing family search and engagement services or technical assistance, to determine how best to ensure that existing best practices, including but not limited to training or technical assistance, are institutionalized statewide. To the extent possible, DSS shall also consult with birth parents or relatives, and caregivers. The recommended TBL would also require DSS to provide information at future budget hearings regarding the implementation of these efforts, including any available outcome data.

Questions for DSS:

1) Please provide an update on the current status of PIP development and negotiations with the federal government. What is the timeline for any potential exposure to penalties based on the most recent review?

2) How does the department plan to implement the new premises on relative search and engagement and participatory case planning? What kinds of requirements, training, and support for the counties are anticipated?

3) How does the department plan to achieve its PIP goal of enhancing and expanding caregiver recruitment, retention, training, and support efforts?

Question for CWDA:

1) How might counties respond if no further allocation is made to accommodate the new PIP-related responsibilities?

DSS Issue 2: Child Safety

Budget Issue: DSS requests, in a BCP, $265,000 ($182,000 General Fund and $83,000 federal funds) to establish 3.0 positions (2.0 full-time, permanent and 1.0 full-time, two-year limited-term) to perform activities associated with review of and reporting on incidences of child fatalities and near-fatalities resulting from abuse and neglect.

Background: Federal law, under the Child Abuse Prevention and Treatment Act (CAPTA) requires states to disclose findings and information to the public about cases of abuse and neglect that result in fatalities or near-fatalities. A few years ago, the federal Administration for Children and Families notified California that the state was out of compliance with CAPTA. As a result, the state implemented a Corrective Action Plan. Since that time, SB 39 (Migden, Chapter 468, Statutes of 2008) has also strengthened the state's compliance with CAPTA. SB 39 requires counties to respond directly to public requests for information related to child fatalities resulting from abuse or neglect. While DSS remains responsible for responding to requests regarding near-fatalities and producing annual reports on aggregated data, the bulk of the work of responding to public requests is now the responsibility of California's counties. According to DSS, the state is currently in compliance with CAPTA.

As the primary source of direct government interaction with children and families involved in the system, the counties are also responsible for ensuring the safety of children through the direct provision of child welfare services, including monthly visits to children in foster care. As described in the previous agenda item, DSS has budgeted an increase of $11.9 million ($5.3 million General Fund, $4.3 million in federal funds, $2.3 million in county funds) in 2009-10 to support increased caseworker visits.

In its role as the principal entity responsible for the state's child welfare system and in conformity with AB 636 (Steinberg, Chapter 678, Statutes of 2001), DSS also provides oversight, and measures and monitors the performance of each county child welfare system. As a result, all 58 counties receive quarterly data reports on their outcomes in the areas of safety, permanency and well-being of children and families who come into contact with the child welfare system. Each county conducts a self-assessment to help identify and remove barriers to improving performance. Following the self-assessments, counties are required to develop System Improvement Plans (SIP). The counties submit their SIPs to DSS. The department reviews each plan and works with counties to identify areas for further support. These efforts are intended to improve results for children and youth and to enable California to reduce the number who are abused or neglected in the state.

Subcommittee Staff Comment and Recommendation: Staff recommends that the Subcommittee reject the requested funding. As a result, DSS would continue to absorb minor workload associated with reporting aggregate data and responding to requests regarding near-fatalities. DSS would also continue to use AB 636 and other existing processes to provide appropriate oversight of counties' relevant policies and practices.

Questions for DSS:

1. Please briefly describe the requirements of CAPTA and how the state currently meets those requirements.

2. Under SB 39, the bulk of the work for responding to public requests for information regarding child fatalities is the responsibility of the county child welfare agencies, but the department remains responsible for responding to requests for information regarding near-fatalities. How many of those requests related to near-fatalities does the department typically receive?

3. Please briefly summarize the AB 636 outcomes and accountability system, and how the state uses that system to evaluate and provide technical assistance regarding county child welfare agencies' performances.

DSS Issue 3: Non-provisional foster care fiscal audits

Budget Issue: The Administration proposes trailer bill language (TBL) that would allow DSS to conduct non-provisional program audits covering a period of fewer than twelve-months. The proposed TBL would also remove an existing prohibition against reducing a group home's Rate Classification Level (RCL) and related monthly rate for the care and supervision of a child based on a non-provisional audit of fewer than twelve months. A twelve-month audit period would still be required, however, before the department could establish a foster care overpayment. According to DSS, the proposed TBL would increase its flexibility to manage its audit workload efficiently and to conduct audits with fewer resources.

Background: In accordance with Welfare and Institutions Code Section (WIC) 11462, DSS is required to perform a provisional rate audit of all new group home providers, new programs by existing providers, or existing providers who receive an RCL increase. The purpose of these audits is to determine whether programs are providing the services and maintaining the documentation to support their provisional rates. Auditors review two months of records supporting the paid-awake hours reported for child care and supervision, social work, and mental health services. If a provider passes the audit, the rate becomes permanent. If a provider fails the audit, the rate will be reduced. There is no overpayment associated with these provisional rate audits.

DSS is also required, under WIC 11466.2, to perform non-provisional group home program and fiscal audits as needed. These non-provisional audits are also conducted to determine whether an established provider has documentation of the level of care and services provided to the children in care at the foster care rate being paid. The audits are onsite and begin with a review of three prior months of documentation and can extend up to twelve prior months plus a current month (depending on the outcome of the three-month review). Based on the audit findings, the department can reduce a provider's RCL and assess an overpayment. The department gives providers an opportunity for corrective action and the right to appeal.

Concerns from Providers: The California Alliance of Child and Family Services, an association that represents group home and other foster care providers, expressed its opposition to the proposed TBL prior to a recent hearing on this issue in the Assembly. Among its concerns, the Alliance believed that the proposed language could have resulted in an increased number of erroneous audits. The Department and the Alliance worked together over the last few weeks on the amended language recommended below, and the Alliance no longer objects to the specific text of the TBL.

Subcommittee Staff Comments and Recommendation: Staff recommends adoption of amended placeholder trailer bill language that would result in the following changes to the Welfare and Institutions Code:

Section 11466.2 …

(a)(2) Notwithstanding paragraph (1), ~~t~~the department shall not ~~reduce a group home program's AFDC-FC rate or RCL, or~~ establish an overpayment based upon a nonprovisional program audit, ~~of~~ conducted on less than a one year audit period.

(3) Notwithstanding paragraph (2), the department may conduct audits covering a period of less than 12 months. Based upon the findings of such audits, the department may reduce a group home program's AFDC-FC rate or RCL pursuant to this paragraph.

(A) In an audit of a period of less than 12 months, if a provider's audited RCL is no more than three levels below the paid RCL, the provider's rate and RCL will be reduced to the audited RCL. The provider will be allowed the opportunity to bring a program into compliance with the paid RCL.

(B) In an audit of a period of less than 12 months, if the provider's audited RCL is more than three levels below the paid RCL, the department shall conduct an audit as identified in 11466.2(a)(2). The provider will be allowed the opportunity to bring a program into compliance with the paid RCL.

(C) A group home provider may request a hearing of the department's RCL determination under subparagraph (a)(3)(A) no later than 30 days after the date the department issues its RCL determination. The department's RCL determination shall be final if the group home provider does not request a hearing within the prescribed time. Within 60 days of receipt of the request for hearing, the department shall conduct a hearing on the RCL determination. The standard of proof shall be the preponderance of the evidence and the burden of proof shall be on the department. The hearing officer shall issue the proposed decision within 45 days of the close of the evidentiary record. The Director shall adopt, reject, or modify the proposed decision, or refer the matter back to the hearing officer for additional evidence or findings within 100 days of issuance of the proposed decision. If the director takes no action on the proposed decision within the prescribed time, the proposed decision shall take effect by operation of law.

Section 11468.6

…(e) (4) If the director fails to take action on the proposed decision within 120 days of the submission of the proposed decision, the proposed decision shall take effect by operation of law.

Question for DSS:

1) Please briefly summarize why this trailer bill language is needed and how you expect it to change the department's auditing practices. How will it impact group home providers?

DSS Issue 4: Title IV-E Child Welfare Waiver Demonstration Capped Allocation Project (CAP)

Budget Issue: DSS requests, in a BCP, $952,000 ($476,000 General Fund and the rest federal funds), to fund 5.5 permanent positions to support the implementation of the IV-E Waiver CAP and a contract for an independent third-party evaluation of the project. Implementation of the IV-E Waiver CAP began on July 1, 2007 and is scheduled to last for a term of five years.

Background: The federal Title IV-E program is an open-ended entitlement program that guarantees federal reimbursement to states for maintaining an eligible child in foster care. This program accounts for nearly half of federal child welfare spending in states. Two large counties, Los Angeles and Alameda, are currently participating in a federal Title IV–E Child Welfare Waiver CAP that allows more flexibility for IV-E fund usage. As the project title implies, these more flexible waiver funds are, however, a capped allocation. These two participating counties are responsible for the care of around 25,000 children in foster care (37 percent of the total statewide).

In 2006-07, prior to the IV-E Waiver CAP beginning, DSS had 4.0 two-year limited-term positions to prepare for its implementation. In 2007-08, another 1.5 two-year limited term positions were added (for a total of 5.5 positions at the peak when some of these positions overlapped). In 2008-09, the department had a total of 3.5 positions to support the CAP (the Legislature rejected another 2 requested position extensions).

DSS has contracted with San Jose State University Research Foundation to conduct the evaluation of the IV-E Waiver project, including process, fiscal and outcome components.

Subcommittee Staff Comment and Recommendation: Staff recommends that the Subcommittee approve 3.5 of the 5.5 requested positions for the duration of the remaining term of the IV-E Waiver CAP (through July 1, 2012). The approved positions would include 1.0 Staff Services Manager I; 1.0 Associate Accounting Analyst; 1.0 Research Program Specialist II; and .5 Staff Counsel III. The rejected positions would include 1.0 Research Analyst II in the Estimates and Research Services Bureau and 1.0 Social Services Consultant II position. Finally, staff recommends that the Subcommittee approve the $379,000 requested for the third-party evaluation contract.

Questions for DSS:

1) Please provide a brief update on the status and impacts of the IV-E Waiver CAP and a summary of the department's role to date in supporting its implementation.

2) When do you anticipate that the results of the San Jose State evaluation of the Waiver project will be available (during the last years of implementation or only after the waiver ends)?

DSS Issue 5: Disability Determination Services Division (DDSD) – Furlough Program

Budget Issue: In February 2009, the Legislature adopted the Governor's proposal to implement a two-day-per-month furlough of nearly all state workers (with California Highway Patrol officers as the main category of employees excluded). Workers experienced an accompanying 9.2 percent reduction in their monthly pay beginning in February, 2009 and scheduled to end June 30, 2010. The proposal was intended to reduce 2008-09 and 2009-10 fiscal year General Fund expenditures by $385.8 million and $1 billion, respectively, and other expenditures $285.2 million and $688.4 million, respectively. While the Administration originally specified the two days per month that state workers were required to take-off, the policy has since been modified to allow greater flexibility. Employees' paychecks reflect the 9.2 percent reduction, but they can now save furlough hours and take them at any time, subject to supervisor approval; however, all furlough hours must be used within two years of the end of the Furlough Program--that is, no later than June 30, 2012. The 1600 employees of the DDSD were included in the Furlough Program.

Background on DDSD: DDSD is the state agency responsible for determining the eligibility of California residents for Social Security Disability Insurance (SSDI), Supplementation Security Income (SSI), and Medi-Cal, Medically Needy Only benefits. The budget for DDSD's Federal Program, which processes around 360,000 SSDI and SSI cases annually, is $200.4 million (all federal funds). The budget for the State Program of DDSD, which is responsible for evaluating approximately 60,000 Medi-Cal, Medically Needy Only cases annually, is $19.5 million (50 percent General Fund and 50 percent federal funding). According to DSS, the average time it took to process initial claims in California as of February, 2009 was 79.4 days for SSDI and 83.5 days for SSI claims, both of which are shorter than the national averages. The department has not yet provided information on whether those average times have changed since the furloughs began.

Concerns About DDSD Furloughs: In a New York Times article published on April 13, 2009, the Commissioner of the Social Security Administration, Michael Astrue, is quoted as saying that "governors are hurting their own states, their own citizens, and increasing the backlog of claims" even though "states do not save any money when they furlough or lay off these employees" because the federal government pays "the full freight" for their work. A spokesman for Governor Schwarzenegger is quoted in the same article, saying that "The governor has not made exemptions to the furlough order because he believes that the state government needs to cut back…"

Subcommittee Staff Comment and Recommendation: This is an informational item. No action is required at this time.

Questions for DSS:

1. Please describe how the furloughs are currently being applied, including at DDSD.

2. What, if any, are the savings the state achieves by furloughing DDSD employees, including those in the Federal Program?

3. Has the overall number of cases for DDSD to process changed in the last few months since the furlough has been in effect? If so, what were the changes?

4. How have the furloughs impacted applicants for disability benefits? What was the average amount of time for processing applications prior to the furloughs? Has it changed at any time as a result of the furloughs?

5. What has been the impact of the furloughs on the workload for staff responsible for evaluating cases? Has the amount of authorized overtime increased since the furloughs began?

DSS Issue 6: In-Home Supportive Services (IHSS) - Conlan v. Shewry Court Order BCP and Spring Finance Letter

Budget Issues: DSS requests, in a BCP, $128,000 ($64,000 General Fund) to extend by two years an existing 1.0 limited-term Staff Services Manager I position which would otherwise expire in June 2009. In a spring finance letter, DSS further requests $228,000 ($114,000 General Fund) for the permanent extension of one 1.0 limited-term Associate Governmental Program Analyst (AGPA) position and the creation of two 2.0 new permanent AGPA positions. If these requests are granted, the Conlan II unit at DSS for 2009-10 would consist overall of one Staff Services Manager (position set to expire in 2011) and three permanent AGPA positions. DSS states that these positions are necessary to meet the provisions of the Conlan II court order.

Background on Conlan II and DSS Workload: The IHSS program provides in-home personal care services to qualified individuals who are blind, aged, or who have disabilities. IHSS services allow these recipients to stay in their homes and avoid institutionalization. Conlan II was a series of lawsuits that resulted in court decisions regarding the reimbursement of IHSS recipients for specified out-of-pocket, medically-necessary expenses they paid beginning in 1997. The court approved the state's plan for implementing the decisions in 2006. Under this plan, there are two time periods for which recipients can claim expenses: 1) claims for services received between 1997 and November 16, 2006, which must have been filed by November 16, 2007, and 2) claims for services received after November 16, 2006, which must be submitted within one year of service receipt.

According to DSS, as of January, 2009, the department was out-of-compliance with the 120-day processing timeframe required by the Conlan II court order. DSS states that the Conlan II cases have resulted in an increasing and permanent workload that could include up to 400 claims per year. At the time of the spring finance letter, DSS had received a total of 765 claims for excess share-of-cost from all sources; 366 of those claims were awaiting adjudication. The department estimates that each claim takes an average of 10 to 12 hours to review (with some claims instead taking up to 20 hours).

Subcommittee Staff Comment & Recommendation: Given the need for timely reimbursement of IHSS recipients for out-of-pocket costs and compliance with the Conlan II court order, staff recommends that the Subcommittee approve the extension of one 1.0 SSM I position for an additional two-years; the permanent extension of one 1.0 limited-term Associate Governmental Program Analyst (AGPA) position and the creation of one 1.0 new permanent AGPA position. Staff recommends the corresponding rejection of one 1.0 permanent AGPA position requested.

Questions for DSS:

1) Please briefly summarize the number and nature of the Conlan II claims for reimbursement of out-of-pocket expenses that are currently awaiting processing

by the department. What is the timeframe in which the department generally processes these claims?

2) Why do you believe that the number of annual Conlan II claims might increase so significantly in the budget year?

DSS Issue 7: California Work Opportunity and Responsibility to Kids (CalWORKs) – Temporary Assistance Program (TAP)

Budget Issue: The administration proposes trailer bill language (TBL) to eliminate TAP, which DSS is currently required to implement by April 1, 2010. TAP is effectively cost-neutral to the state because the funds for the program ($220 million in recipient benefits and $5.3 million in automation expenses) are already included in the CalWORKs budget. General Fund resources that otherwise would have been used to meet the required Maintenance of Effort (MOE) for CalWORKs would instead be shifted to fund the solely-state funded TAP (which is not countable as MOE). As long as excess-MOE funds are available to backfill the resulting loss of MOE, TAP would be cost neutral.

As a result of implementing TAP, California would improve its performance on its work participation rate (WPR) as measured by the federal government in accordance with the Temporary Assistance for Needy Families (TANF) program.

Background: CalWORKs is California's implementation of the federal TANF program and is operated in all 58 California counties by the county welfare departments or their contractors. CalWORKs provides temporary cash assistance to families who are unable to meet basic needs (shelter, food, and clothing) on their own. CalWORKs also provides education, training, and employment programs to assist these families in their move to self-sufficiency. The state requires CalWORKs recipients to engage in welfare-to-work activities that are designed to meet federal work participation requirements (WPR) and avoid federal financial penalties.

TAP was authorized in the 2006 human services trailer bill (AB 1808, Chapter 75, Statutes of 2006) as a voluntary program to provide cash aid and other benefits with solely state funding to a group of current and future CalWORKs recipients who are exempt from state work participation requirements (estimated to apply in 24,000 cases). TAP was intended to allow these recipients to receive the same assistance benefits through TAP as they would have under the CalWORKs program, but without any federal restrictions or requirements.

To date, implementation complexities, largely due to challenges with child support automation, have prevented TAP from moving forward. As a result, trailer bill language has been adopted for two years to delay the implementation date of TAP, including a change last year to move the date from April 1, 2009 to April 1, 2010.

Subcommittee Staff Comment and Recommendation: Staff recommends rejecting the administration's proposed TBL and instead adopting another delay--to October 1, 2011-- of the deadline for TAP's implementation.

Questions for DSS and the Department of Child Support Services:

1) Please briefly describe the implementation challenges that have prevented the timely implementation of TAP.

2) How has or might the Statewide Child Support Automation System help to resolve these issues?

DSS Issue 8: State Hearings Division (SHD)

Budget Issue: DSS requests, in a spring finance letter, an increase of $928,000 ($510,000 General Fund) in fiscal year 2009-10 to address growth in its caseload of administrative hearings by funding 6.0 Administrative Law Judge and 1.0 Office Technician positions.

Background on SHD Funding: DSS is required to provide state hearings for the CalWORKs, supplemental nutrition, Medi-Cal, foster care and IHSS programs. In fiscal year 2005-06, the SHD budget was reduced by $1.2 million ($486,000 General Fund) as part of an unallocated reduction to DSS's budget. The department projects that between the 2005-06 and 2008-09 fiscal years, the total number of due process hearing requests also increased by more than 16,000. According to the department there is therefore a growing backlog of requests that are awaiting hearings, particularly in the IHSS program. In the 2008-09 fiscal year, DSS transferred $928,000 from IHSS Local Assistance to State Operations on a one-time basis and relied on retired annuitants to handle this increased caseload.

Possible Penalties: If cases are not adjudicated in accordance with specified federal and court-mandated time requirements (sixty days for the food stamps or supplemental nutrition program and commonly ninety days for other programs), the department may have to pay penalties that begin at $5 to $37 per day to the impacted recipients. These penalties can increase to a maximum of $100 per day. The department projects that it will pay approximately $145,000 in such penalties in the 2008-09 fiscal year. If the requested resources are not provided, the department estimates that those penalties could increase to up to $1.4 million by the end of the 2009-10 fiscal year.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the requested increase to fund 4.0 permanent Administrative Law Judge and 1.0 Office Technician positions in fiscal year 2009-10 to address growth in the caseload and reduce the risk of penalties. Given the fiscal situation facing the state, staff recommends rejecting the remaining 2.0 requested Administrative Law Judge positions.

Questions for DSS:

1. Please summarize the total state hearings caseload in the last few years and the number of cases currently awaiting adjudication. What is the total number of Administrative Law Judges currently available to adjudicate those cases?

2. Please describe how penalties are assessed if cases are not adjudicated within the required timelines.