Senate Budget and Fiscal Review

Subcommittee No. 3 2010 Agendas

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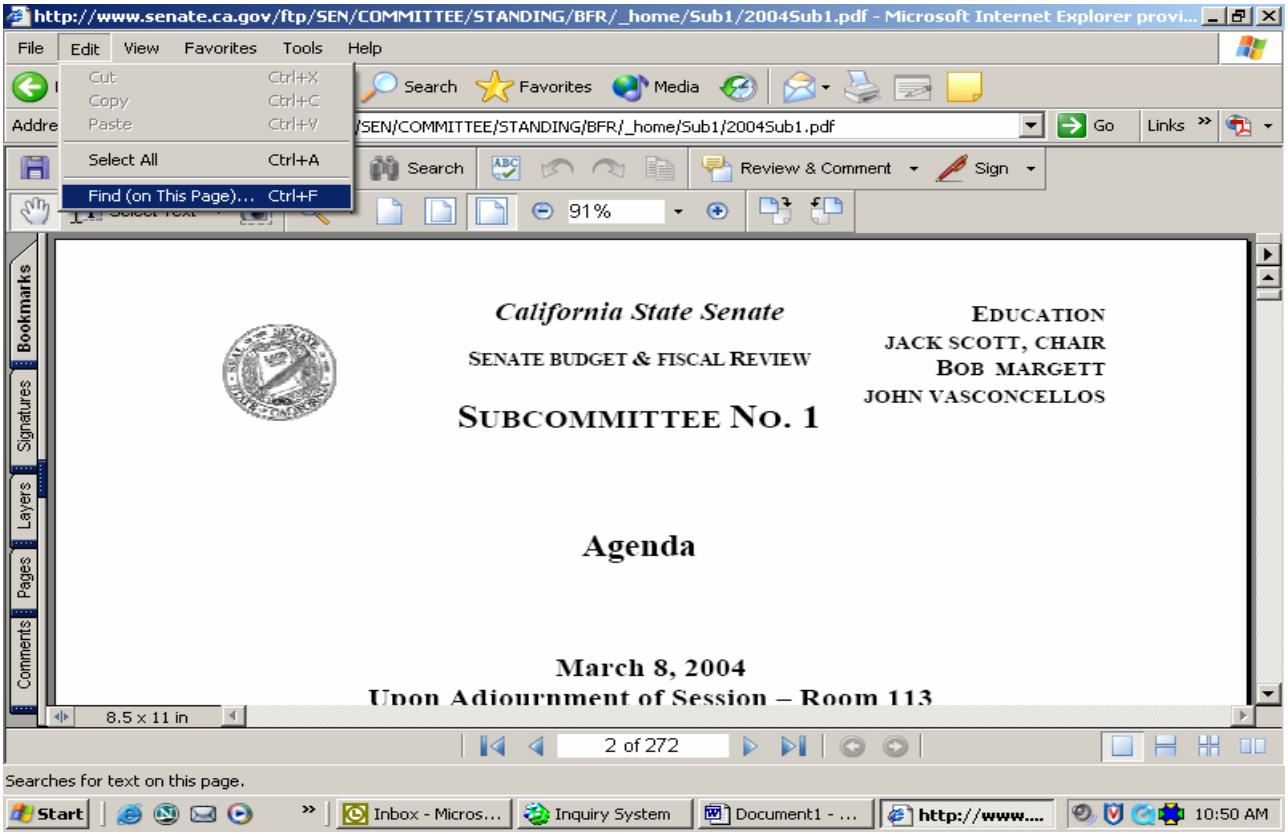

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

March 11, 2010

9:30 a.m. *or*
Upon Adjournment of Session
Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

PLEASE NOTE:
Only those items contained in this agenda will be discussed at this hearing. Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. *Please* see the Senate File for dates and times of subsequent hearings. 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 or by calling 916-324-9335. Requests should be made one week in advance whenever possible. Thank you.

Item 4120--Emergency Medical Services Authority

I. OVERALL BACKGROUND

Purpose and Description of Department. The overall responsibilities and goals of the Emergency Medical Services Authority (EMS Authority) are to: **(1)** assess statewide needs, effectiveness, and coordination of emergency medical service systems; **(2)** review and approve local emergency medical service plans; **(3)** coordinate medical and hospital disaster preparedness and response; **(4)** establish standards for the education, training and licensing of specified emergency medical care personnel; **(5)** establish standards for designating and monitoring poison control centers; **(6)** license paramedics and conduct disciplinary investigations as necessary; **(7)** develop standards for pediatric first aid and CPR training programs for child care providers; and **(8)** develop standards for emergency medical dispatcher training for the "911" emergency telephone system.

During an emergency, the role of the EMS Authority is to respond to any medical disaster by mobilizing and coordinating emergency medical services' mutual aid resources to mitigate health problems.

Table: Summary of Emergency Medical Services Authority

Summary of Expenditures (dollars in thousands)	**Actual**	**Estimated 2009-10**	**Proposed 2010-11**	**$ Change**
Program Source				
Emergency Medical Services	$21,749	$21,568	$24,231	$2,645
Funding Source				
General Fund	$11,459	$8,422	$9,016	$594
Emergency Medical Services Personnel	$1,415	$1,426	$1,565	$139
Emergency Medical Services Training	$342	$400	$440	$40
Emergency Medical Services Technician	--	--	$1,459	$1,459
Federal	$1,973	$2,398	$2,525	$127
Reimbursements	$6,578	$8,940	$9,226	$286

II. VOTE ONLY (Pages 3 and 4)

1. Workload for Paramedic Licensing Activities and Fee Adjustment

Budget Issues. First, the EMSA requests an increase of $86,000 (Emergency Medical Services Personnel Fund) to support a Program Technician II position to address workload associated with various paramedic licensing activities. The EMSA contends additional resources are necessary in order to ensure the timely licensing of paramedics, to identify any discrepancies in reporting, and to monitor required continuing education information reported by paramedics. There are about 17,000 paramedics in California and all workload has increased correspondingly.

The EMSA unit is staffed with three permanent employees and three retired annuitants. This staff is charged with (1) receiving, reviewing and processing paramedic applications; (2) issuing licenses; and (3) providing technical assistance to paramedics regarding licensing and enforcement issues. The additional position will facilitate this workload as well.

Second, the EMSA proposes to increase fees effective as of July 1, 2010 as provided for in AB 2917, Statutes of 2008. Existing law enables the EMSA to increase fees as appropriate to administer this program. According to the EMSA, public meetings were held and the rulemaking is anticipated to be completely by Spring 2010. The proposed increased as shown below. The EMS Commission is the entity that will approve all fee adjustments.

EMSA Fee Proposal

Activity	Applicants	Revised Fee	Revenue
Renewal Application	8,450	$160	$1,352,000
New Applicant Licensure	1,300	$160	$208,000
In-State Initial	1,200	$50	$60,000
Out-of-State Initial	100	$100	$10,000
State Licensure Match	8,450	$5	$42,250
Late Fee	400	$50	$20,000
TOTAL Revenues			$1,692,250

Background on Paramedic Licensing Program. Paramedics are required to be licensed and to re-license every two years. The EMSA administers the licensing and enforcement program is authorized to charge licensing fees, as applicable, for various aspects of the licensing process (initial application, renewals and related items).

Subcommittee Staff Recommendation—Approve. No issues have been raised with this proposal and it is recommended for approval.

2. Emergency Medical Technician 2010 Project

Budget Issue. The EMSA proposes an increase of $1.2 million (Emergency Medical Technician Certification Fund) to implement AB 2917, Statutes of 2008, which established the EMSA's authority to (1) establish fees in regulation; (2) have a centralized, statewide registry of Emergency Medical Technicians; (3) conduct background checks; and (4) reimburse Administrative Law Judges for emergency medical technician discipline hearings.

Specifically, the $1.2 million will be used to (1) support four permanent positions to implement the requirements of the legislation; (2) support one two-year limited-term position to conduct research and develop reports regarding the background checks; (3) fund data processing, storage and software maintenance associated with a centralized registry; and (4) reimburse Administrative Law Judges for disciplinary hearings (about $300,000).

The EMSA has received approval from the Office of the State Chief Information Officer (OCIO) in April 2009 for the centralized registry. Generally, this system augments the current paramedic licensing system with a web-based system

Subcommittee Staff Recommendation—Approve. No issues have been raised. The proposal appears to be consistent with the intent of the legislation and the need of the workload.

III. ISSUE FOR DISCUSSION

1. Pharmaceutical Cache (Stand By) for Mobile Hospital

Budget Issue. The EMSA requests an increase of $448,000 (General Fund) to fund a pharmaceutical cache for the Mobile Field Hospitals (total of three).

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.

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. The EMSA contends that only $24,000 of the $1.7 million (General Fund) is available for ongoing pharmaceutical supplies.

Subcommittee Staff Recommendation-- Deny. 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 significant roles 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.

On-going support General Fund support is not feasible at this time. It should be noted that this same request has been denied for the past two-years due to the fiscal crisis. If necessary, the Governor can authorize appropriate funding in an emergency.

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

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

Item 4560--Mental Health Services Oversight & Accountability Commission

I. OVERALL BACKGROUND (Pages 6 through 8)

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

The (OAC) provides the vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure Californians understand mental health is essential to overall health. The OAC holds public systems accountable and provides oversight for eliminating disparities, promoting mental wellness, recovery and resiliency and ensuring positive outcomes for individuals living with serious mental illness and their families.

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

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

Background—The Mental Health Services Act, Proposition 63 of 2004. The MHSA imposes a 1 percent income tax on personal income in excess of $1 million. These tax receipts are reconciled and deposited into the MHSA Fund on a "cash basis" (cash transfers) to reflect funds actually received in the fiscal year. The MHSA provides for a continuous appropriation of funds for local assistance.

The purpose of the MHSA is to expand mental health services to children, youth, adults and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to *supplement* and not supplant existing resources).

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

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

- **Prevention and Early Intervention.** This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations.

- **Innovation.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and to promote interagency collaboration.

- **Workforce Education and Training.** The component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness.

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

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

Mental Health Services Act Fund Fiscal Report—January 2010. The Department of Mental Health (DMH) is required to provide two annual fiscal updates—in January and May-- to the Legislature regarding revenues and expenditures of MHSA Funds. This report reflects the following information for revenues and expenditures.

Table 1: DMH Report on Mental Health Services Act Funds as of January 2010

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

*All figures are from the DMH January 2010 Report, except for item 4 which is from the Fund Condition Statement for the MHSA Funds (Page 158, Volume 2, Governor's Budget).

Table 2: Mental Health Services Act: Local Assistance Expenditures

DMH Report: Local Expenditure by Component	Actual 2008-09	Estimated 2009-10	Proposed 2010-11
1. Community Services & Supports	$650,000,000	$900,000,000	$783,600,000
2. Prevention and Early Intervention	$252,900,000	$310,000,000	$196,500,000
3. Innovation	$71,000,000	$71,000,000	$119,600,000
4. Workforce Education & Training, and State Level Projects	$2,523,000	$3,000,000	$3,000,000
5. Capital Facilities & Technology	$108,400,000	--	--
Local Assistance Total	**$1,084,523,000**	**$1,284,000,000**	**$1,102,700,000**

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

Table 3 below reflects MHSA Funds expended for State Administration which cannot exceed five percent of the annual MHSA revenues. It should be noted that the 2010-11 amounts reflect the Governor's proposal to reduce on a pro-rata basis in order to stay within the five percent cap. This issue will be discussed further below.

Table 3: Mental Health Services Act: State Administrative Expenditures

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

II. ISSUE FOR DISCUSSION

1. Independence of Mental Health Services Oversight & Accountability Commission

Budget Issue. The budget proposes to **(1)** transfer $4.589 million (MHSA Funds) and 22 positions from the Department of Mental Health (DMH), *and* **(2)** reduce by $474,000 (MHSA Funds) to reflect a proposed pro rata reduction of State administration to be within the 5 percent administrative cap requirements of the Mental Health Services Act. *Therefore*, the total amount proposed for the Mental Health Services Oversight & Accountability Commission (OAC) is $4.115 million (MHSA Funds) for 2010-11.

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

Position Title	Positions
Executive Officer	1
Staff Counsel III	1
Mental Health Administrator	1
Mental Health Program Supervisor	2
Consulting Psychologist	1
Staff Mental Health Specialist	8
Associate Mental Health Specialists	3
Information Officer II	1
Staff Services Analyst	2
Office Technician	2
Total	22

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

- Review, comment and approve County Plans for the various components of the MHSA;
- Develop policy related to the implementation of the MHSA and associated statutory mandates;
- Provide for a comprehensive evaluation of the MHSA (two phases);
- Provide community outreach and education;
- Convene monthly OAC meetings;
- Continue work with the five committees within the OAC framework (Client and Family Leadership; Services; Evaluations; Cultural and Linguistic; and Funding and Policy);
- Provide vision, leadership, and oversight necessary to prevent mental illness from becoming severe and disabling and transform the public and private systems charged with providing services, and support to Californians living with mental illness;
- Develop strategies to combat and overcome stigma related to mental illness;
- Advise the Governor and Legislature regarding actions the State may take to improve care and services for individuals experiencing mental illness; and

- Identify critical issues related to the performance of County Mental Health programs and refer the issues to the Department of Mental Health.

Assembly Bill 5 (Third Extraordinary Session), Statutes of 2009. Among other things, this budget trailer bill made statutory changes to the MHSA Act to assist in the implementation and effectiveness of the Act, including the following:

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

Mental Health Services Act—"Administrative Cap" of Five Percent. The MHSA allows up to five percent of the total annual revenues in each fiscal year to be used for State administrative expenditures, including the OAC and other State entities.

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

Subcommittee Staff Comment and Recommendation. Though the OAC was established in 2005, in prior years its appropriation has been budgeted within the Department of Mental Health. Over time, concerns were raised regarding the need for the OAC to have its own appropriation item and to operate separate and apart from the DMH, as intended by the MHSA Act. With the passage of budget trailer bill AB 5 (Third Extraordinary), Statutes of 2009, a transfer of funds from the DMH to a separate line-item for the OAC is warranted.

However, the Administration is also proposing to reduce the OAC by $474,000 (MHSA Funds) to address *potential* concerns regarding the need to maintain the "administrative cap" of 5 percent. It is recommended to reject this "pro rata" reduction since the OAC is a core component within the MHSA Act. If necessary, reductions to other State departments should be taken and the OAC should be *held harmless*.

Therefore it is recommended to approve the full transfer amount of $4.589 million and to reject the five percent reduction.

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

1. OAC, Please provide a brief description of the Commission's core functions and recent accomplishments. What is envisioned for 2010-11?
2. OAC, Please summarize the Commission's framework for performance measures and outcomes with regards to MHSA Funding and the Act.

Item 4440--DEPARTMENT OF MENTAL HEALTH

I. OVERALL BACKGROUND (Pages 11 through 12)

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.

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).

Background—Overview of Medi-Cal Mental Health Services Waiver. California provides "specialty" mental health services under a comprehensive Waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services.

County Mental Health Plans are the responsible entity that ensures services are provided and Medi-Cal clients *must* obtain their specialty mental health services through the County. The DMH is responsible for monitoring and oversight activities of the Counties to ensure quality of care and to comply with federal and State requirements. The DHCS is the "single State agency" as designated by the federal CMS for overall responsibility of California's Medi-Cal Program. The DHCS delegates the responsibility for the administration of mental health programs to the DMH. Ultimately, both departments are responsible for the administration of this program.

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

The Agenda will discuss each of these programmatic areas separately under the discussion section below.

Table—Summary of Department of Mental Health as Proposed by the Governor

Summary of Expenditures (dollars in thousands)	**Actual**	**Estimated 2009-10**	**Proposed 2010-11**	**$ Change**
Program Source				
1. Community Services Program	$3,245,352	$3,356,269	$3,160,667	-$195,602
2. Long Term Care Services	$1,301,726	$1,239,264	$1,400,568	$161,304
3. MHSA Oversight & Accountability	$2,912	$4,739	--	transferred
Total, Program Source	**$4,549,990**	**$4,600,272**	**$4,561,253**	**-$39,019**
Funding Source				
General Fund	$1,914,497	$1,697,777	$1,459,342	-$238,435
General Fund, Proposition 98	$2,743	$27,257	$15,000	-$12,257
Mental Health Services Fund (Proposition 63 of 2004)	$1,112,993	$1,319,394	$1,582,771	$263,377
Federal Funds	$64,362	$64,055	$64,230	$175
Reimbursements (mainly federal)	$1,453,912	$1,490,134	$1,439,427	-$50,707
Traumatic Brain Injury Fund	$1,141	$1,172	--	transferred
CA State Lottery Education Fund	-$8	$104	$99	-$5
Licensing & Certification Fund	$350	$379	$384	$5
Total Department	**$4,549,990**	**$4,600,272**	**$4,561,253**	**-$39,019**

II. VOTE ONLY CALENDAR

1. Transfer Traumatic Brain Injury Responsibilities

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

Subcommittee Staff Recommendation--Approve. The budget conforms to enacted legislation and no issues have been raised. It is recommended to approve this proposal.

2. Transfer of San Mateo Pharmacy and Laboratory Services Program

Budget Issue. The DMH proposes a decrease of $2.4 million ($932,000 General Fund and $1.5 million federal reimbursements) for 2010-11 to reflect the transfer of this program to the Department of Health Care Services effective as of July 1, 2010.

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

Subcommittee Staff Recommendation--Approve. This action is consistent with discussions regarding this program.

III. ISSUES FOR DISCUSSION:

A. State Administration Issues

1. Expenditure of Mental Health Services Act (MHSA) Funds for State Support

Budget Issues. The DMH has overall responsibility for administering and managing the Mental Health Services Act (MHSA) Funds. They propose three changes for State administrative functions. These are as follows:

a. Transfer $4.589 million (MHSA Funds) to the MHSA Oversight and Accountability Commission as designated by Chapter 20, Statutes of 2009 (AB 3X 5). (This proposal conforms to the OAC item on today's Agenda, above.)

b. Pro-rata reduction of $4.8 million (MHSA Funds) to 17 State departments to comply with the administrative cap requirements within the MHSA Act. (Discussed below.)

c. Increase of $113,000 (MHSA Funds) to convert a limited-term Staff Counsel position to permanent. (Discussed below.)

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

Department of Mental Health's MHSA Pro-Rata Reduction for Administration	Proposed Pro-Rata Reduction	Total 2010-11
Judicial Branch	-$100,000	$893,000
State Controller's Office	--	727,000
Consumer Affairs Regulatory Boards	-31,000	91,000
Office of Statewide Health Planning & Dev.	-65,000	583,000
Aging	-25,000	218,000
Alcohol & Drug Programs	-29,000	272,000
Health Care Services	-99,000	752,000
Managed Risk Medical Insurance Board	-18,000	159,000
Developmental Services	-112,000	984,000
Mental Health	-3,538,000	30,739,000
Mental Health Oversight & Acct Commission	-474,000	4,115,000
Rehabilitation	-22,000	198,000
Social Services	-80,000	712,000
Education	-71,000	613,000
CA State Library	-17,000	165,000
Board of Governor's—Community Colleges	-17,000	208,000
Military Department	-45,000	406,000
Department of Veterans Affairs	-48,000	460,000
Department of Finance—FISCAL	--	28,000
Total State Administration	**-$4,791,000**	**$42,323,000**

Staff Counsel Position—Convert to Permanent. The DMH presently has three Attorneys who are assigned to the MHSA area. One of these positions sunsets as of June 30, 2010 and the DMH proposes an increase of $113,000 (MHSA Funds) to make it permanent.

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

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

Subcommittee Staff Comment and Recommendation—Deny Pro Rata, and Approve Position. The DMH request to reduce State administrative expenditures to remain within the five percent MHSA cap is premature and should be denied.

The DMH calculation of revenues for determining the cap was based upon May 2009 data, not January 2010 data, and is out-of-date. The DMH contends that this budget proposal is a "place-holder" and will be updated at the May Revision. Since the MHSA revenues are presently higher than projected last May, it maybe that no adjustment is needed in 2010-11.

Further, if an adjustment is needed to stay within the five percent cap, the Administration should prioritize how the reduction is taken, and not simply propose a pro-rata reduction. In some instances, a pro-rata reduction would simply not make sense. (For example funding two-thirds of a full-time position, or reducing "core" functions at the same level as other less-central functions.).

It is suggested that *if* the DMH needs to propose an adjustment at the May Revision, they consult with the Mental Health Services Oversight and Accountability Commission (OAC) on prioritizing State administrative resources.

Finally, no issues have been raised on the Staff Counsel position.

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

1. DMH, Please provide a *brief* description of the proposed "pro rata" reduction to the 17 State departments in order to meet the 5 percent State administrative cap requirements.
2. DMH, Please provide a *brief* description of why the Staff Counsel position should be made permanent.

III. ISSUES FOR DISCUSSION (Continued):

B. Community Mental Health Issues

1. Oversight: Federal Concerns with State's Mental Health Services Waiver

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

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

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

According to the DHCS and DMH, a *draft* State Plan Amendment has been submitted to the federal CMS. The DHCS states this draft is confidential since they are negotiating directly with the federal CMS, but portions of it have been shared with County Mental Health Plans for comment. According to the Administration, the required State Plan Amendment is to address the following key concerns:

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

  First, the State must provide updated procedures and methodologies regarding the use of "certified public expenditures" (CPEs) provided by County Mental Health Plans (using County Realignment Funds and where applicable, Mental Health Services Act Funds, or other revenues) to obtain federal matching funds. This is a critical issue since California relies on funding sources outside of General Fund revenues to operate the specialty mental health care system.

Second, the State must better define what is considered an "allowable" cost for the purpose of reimbursement. The federal CMS was concerned that the State was reimbursing for actual costs instead of allowable costs which are more narrowly defined.

Third, the State must revise various cost-reporting documents to report, track and reconcile both psychiatric inpatient services and all outpatient services. A comprehensive "oversight" plan must be provided to the federal CMS after finalization of these revised documents.

Fourth, the State must issue revised instructions to the Counties on claiming procedures and must provide new training to ensure compliance with all of the cost-reporting documentation requirements.

In a September 28, 2009 letter to the DHCS, the federal CMS conveys the need for the changes and to have regular monitoring meetings with them on progress. Further the letter notes that if the program is not updated as directed, a "renewal application" for this Waiver should be submitted by July 1, 2010.

Federal CMS Concerns Stem from Audit Issues. The federal CMS has expressed considerable concerns regarding the operation of this Waiver through two "final" audits which are public and one *"draft"* audit which is *not* public but was provided to the Administration in September 2009.

The draft audit—"Review of Certified Public Expenditures Used to Finance Medi-Cal Payments in CA's Specialty Mental Health Services Program"—reviewed five counties to examine financial components to the program, including the use of CPEs to obtain federal funds, payment reconciliation processes, and final cost settlement processes. The selected counties included Los Angeles, Sacramento, San Diego, San Francisco, and Orange. In addition the review encompassed the State's rules for calculating certain payments (upper payment limit) and the definition of mental heath specialty services.

Many of the outcomes from this draft, confidential federal CMS audit generated the need for the State Plan Amendment and Waiver changes.

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

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

Background--Continued Concerns with Fiscal Integrity. Significant fiscal management issues have continued to be raised regarding the State's administration of the overall Medi-Cal Specialty Mental Health Waiver.

The Subcommittee has discussed fiscal integrity issues regarding operations for the past five years, including five reports prepared by the independent Office of Statewide Audits and Evaluations, as well as the two released fiscal audits by the federal CMS.

As discussed below, additional resources were provided by the Legislature for more oversight and the CHHS Agency was statutorily required to provide an Action Plan (receipt pending) to more comprehensively implement needed changes from all of these previous fiscal reviews and audits.

CA Health & Human Services Agency "Action Plan" Is Overdue. Due to concerns discussed in the Subcommittee last year regarding fiscal integrity and coordination between the DHCS and DMH, trailer bill legislation as contained in AB 5 (Fourth Extraordinary Session), Statutes of 2009, required the CHHS Agency to provide the Legislature with an Action Plan.

The Action Plan was due to the Legislature as of February 1, 2010 in order to fully problem solve and remedy continued concerns, as well as to facilitate any needed discussion and review through the Legislature's budget and policy committee processes. On March 3, the CHHS Agency informed Subcommittee staff that this Action Plan would be forthcoming in the next couple of weeks.

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

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

It is important for this Action Plan to be provided soon to the Legislature.

Additional Resources Provided to DHCS for the Waiver in Budget of 2009. As discussed by the Subcommittee last year (April 23rd hearing), the DHCS was provided an increase of $331,000 (total funds) for three positions to enable them to respond to federal CMS audits and to continue making improvements in the coordination and management of the Medi-Cal Mental Health Waiver.

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

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

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

Background—Overview of Medi-Cal Mental Health Services Waiver. California provides "specialty" mental health services under a comprehensive Waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. County Mental Health Plans are the responsible entity that ensures services are provided and Medi-Cal clients *must* obtain their specialty mental health services through the County.

The DMH is responsible for monitoring and oversight activities of the Counties to ensure quality of care and to comply with federal and State requirements.

The DHCS is the "single State agency" as designated by the federal CMS for overall responsibility of California's Medi-Cal Program. The DHCS delegates the responsibility for the administration of mental health programs to the DMH. Ultimately, both departments are responsible for the administration of this program.

Subcommittee Staff Comment and Recommendation. The Medi-Cal Mental Health Waiver provides over $1.7 billion (total funds) in vital mental health treatment services to people. Though the Administration was notified by the federal CMS in September 2009 regarding concerns, including only a one-year extension (to September 2010), the Legislature was not informed. The Administration has acknowledged this communication gap but there is still much that is unknown regarding the future of this Waiver.

Another federal CMS final audit is pending which cannot yet be provided to the Legislature, and the State is negotiating a State Plan Amendment on the Waiver that is not yet public as well. As such, it is not fully clear how this Waiver may need to evolve. Of particular concern is the potential for mental health service definitions being changed, and issues regarding reimbursement payments (such as "upper limit payments") and the use of "certified public expenditures" (CPEs). Further, it is not clear when the Administration can or will provide detailed information.

It is recommended to adopt “placeholder” trailer bill legislation to require the DHCS, as the State’s Medi-Cal agency, to provide the fiscal and policy committees of the Legislature with semi-annual updates regarding all of California’s Medi-Cal Waivers (about 16 presently) to be provided in March and October of each year. This would provide a mechanism for the Administration to regularly convey the status of Waivers to the Legislature.

It is recommended for the Administration to meet with constituency groups, including legislative staff, to more fully convey the contents of the pending State Plan Amendment and to clarify more details regarding specific federal CMS concerns.

It is also recommended for the Administration to provide a written update on the status of this Waiver as part of the DMH May Revision estimate package.

The DHCS was required through trailer bill legislation in 2009 to provide the Legislature with *final* audits provided to the State by the federal CMS so the audit regarding the DMH should be forthcoming when considered final.

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

1. DHCS and DMH, Please provide an update on the Waiver and the key concerns of the federal CMS in only providing the State with a one-year approval.
2. DHCS and DMH, What are the key aspects of the State Plan Amendment?
3. DHCS and DMH, Is it likely that California will need to redefine key aspects of the existing Waiver, such as definitions of mental health services, reimbursement payment methodologies and other key items?
4. DHCS and DMH, Are there any other key aspects for which the Subcommittee should be informed?

2. Oversight: Implementation of Short-Doyle System--Phase II (DHCS and DMH)

Oversight Issue—Implementation in Progress. Changes to the Short-Doyle system, a critical system for claims processing for Medi-Cal specialty mental health services, have been on-going for several years. As referenced in the background section below, a revised Short-Doyle system is necessary to address critical payment system problems and various State and federal audit control issues.

As of January 2010, the Administration proceeded with a phased-in approach to bring Counties and certain direct providers into the modified system. As of March, the Administration states that 24 Counties have submitted claims for processing with additional Counties expected to submit claims as they work through a variety of technical issues. Los Angeles County will not be submitting claims until April 1st.

The Administration states they are providing technical assistance to Counties and will also be "re-engineering" some of their own business practices within the DMH to ensure that payments are made to Counties and providers within 30-days (upon completion of changes). (See Subcommittee Hand-Out package for a diagram of this entire process.)

At this time, more information is needed in order to better understand the Administration's progress with the overall system, including changes to existing business practices internal to the departments.

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

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

Summary of Existing Contracts. Based on information provided by the DHCS in Fall 2009, the following table provides a summary of contracts regarding implementation of Short-Doyle II.

Table: DHS Description of Contracts for Short-Doyle Project ($6.9 million total)

Date of Award	Contractor Name	Role of Contractor	Contract Term	Total Funds
5/2007	Eclipse Solutions	Independent Validation and Verification	34 months	$289,850
11/2007	Trinity Technology	Design, Develop and Implement the system	3 years	$5.1 million
5/2007	Hubbert Systems	HIPAA Project Manager	1 year	$253,400
6/2008	Hubbert Systems	HIPAA Technical Support	1 year	$249,800
5/2009	Hubbert Systems	Project management support and special reporting	18 months	$450,000
7/2009	Hubbert Systems	Conduct external test activities with Counties and vendors	1 year	$292,000
6/2008	Visionary Integration	Independent Project Oversight	25 months	$116,160
6/2008	Celer Systems	Build and Maintain the physical environment	1 year	$161,000

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

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

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

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

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

Since 2006, the Administration has focused its efforts on the Short Doyle Phase II portion of the project to have a more fully integrated, function claims adjudication system. The system is to be operational in Spring 2010.

Subcommittee Staff Comment. The need for system change is evident and the Administration is working diligently to complete tasks, but there are concerns.

First, as noted in the Hand-Out, the overall system for processing claims is quite involved and relies not only on the Short-Doyle Phase II system operations but also additional interactions within the DMH and DHCS, and finally the State Controller's Office for actual payment to be provided to Counties and providers. The Administration needs to ensure the Counties and others that the business practices to be re-engineered at the State level are fully functional, in addition to the operations of the Short-Doyle Phase II system.

Second, there are several unresolved issues regarding the Short-Doyle system itself. The State is still in the process of clarifying how certain Medi-Cal/Medicare claims (dual eligibles) are to be managed and how this will impact Counties and system processing. This critical issue needs to be resolved expeditiously.

Third, over 30 Counties, including Los Angeles, have not yet submitted claims. The DMH anticipates all remaining counties, except for Los Angeles, will be submitting claims in March since this will be their *only* option for payment. (The prior claims processing system will not be available, except to Los Angeles.) As such March, April and May will be mission critical months as the remaining Counties transition to the system and claims volume increases substantially.

Fourth, the DHCS notes that initial management reports are still under development but the first priority is for the DMH invoice report to be operational. This invoice report will be used to help reduce the claim payment cycle, which is good. But management reports need to be completely soon for system oversight functions to be operating appropriately.

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

1. DHCS and DMH, Please provide a *brief* overview of key components to Short-Doyle Phase II and progress on implementation, including how community mental health partners are involved.
2. DHCS and DMH, What key implementation steps are pending and what risks are involved with next steps? Is the Medi-Cal/Medicare dual eligibles claiming process being clarified?
3. DMH, How is the re-engineering of related business practices for claims processing proceeding?
4. DHCS and DMH, Will the Administration be providing Counties with an up-to-date Claims and Billing Manual consistent with changes associated with Short-Doyle Phase II?

3. Medi-Cal Mental Health Managed Care

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

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

- Proposes to Redirect Mental Health Services Act Funds. Redirects $61.2 million in Mental Health Services Act Funds from locals to backfill for General Fund support through legislation to amend the Mental Health Services Act of 2004 which would require voter approval.

  This issue was discussed extensively in the Special Session (January 26th hearing in the Senate) and was *not* adopted.

- Program Cost Increases. Provides an increase of $23.4 million ($11.7 million General Fund and $11.7 million federal reimbursements) due to increased caseload and utilization of services.

- Receipt of Federal Funds—ARRA Extension. Assumes savings of $25.4 million (General Fund) due to increased federal funding of 61.59 percent in Medi-Cal through the American Recovery and Reinvestment Act (ARRA). The Governor assumes this level of ARRA funding will be extended for another six months to June 30, 2010. This extension is in President Obama's proposed federal budget. This savings is contained within Control Section 8.65 of the Budget Bill.

- Receipt of Federal Funds—Increase Base to 57 Percent. Assumes savings of $30.6 million (General Fund) through federal law changes which would increase California's "Federal Medical Assistance Percentage" (FMAP) to an average received by other states nationwide. This is part of the Governor's overall federal request. This savings is contained within Control Section 8.65 of the Budget Bill.

- Continues Reduction From Budget Act of 2009. Continues as a baseline adjustment the reduction of $64 million (General Fund) as proposed by the Governor.

Summary of Budget Actions Taken in 2009 (July). The Budget Act of 2009 (July) resulted in an appropriation of $295.3 million ($113.3 million General Fund and $182.1 million federal funds) for Mental Health Managed Care. Key adjustments included the following:

- Reduced by $64 million (General Fund) as proposed by the Governor based on data from the DMH which stated these funds were expended on outpatient services that were not federally reimbursable. As such, the DMH noted that Counties could choose to provide these services using their own funds, and not state General Fund support intended for Medi-Cal clients.

- Recognized increased federal funds of $53.3 million (federal funds) from enhanced funds (61.59 percent) received through the American Recovery and Reinvestment (ARRA) Act to backfill for General Fund support.

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

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

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

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

Background—Overview of Medi-Cal Mental Health Managed Care. California provides "specialty" mental health services under a comprehensive Waiver, as previously referenced.

County Mental Health Plans are the responsible entity that ensures services are provided and Medi-Cal clients *must* obtain their specialty mental health services through the County. Under Medi-Cal Mental Health Managed Care, adults receive psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, through their specific county.

The DMH is responsible for monitoring and oversight activities of the County Mental Health Plans to ensure quality of care and to comply with federal and state requirements. This Waiver expires as of September, 2010 and must be renewed with the federal CMS.

Subcommittee Staff Comment and Recommendation. It is recommended to keep this issue open pending receipt of the Governor's May Revision. Both caseload adjustments and any federal funding adjustments can be made at that time.

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

1. DMH, Please provide a *brief* summary of the program and budget proposal.

4. The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)

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

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

1. Proposes to Redirect Mental Health Services Act Funds. Redirects $391.2 million in Mental Health Services Act Funds from locals to backfill for General Fund support through legislation to amend the Mental Health Services Act of 2004 which would require voter approval.

   This issue was discussed extensively in the Special Session (January 26th hearing in the Senate) and was *not* adopted.

2. Estimate Cost Adjustments. Increases by $106.9 million (General Fund) to reflect increases in costs, utilization, and some caseload.

3. Emily Q. Plan. Provides a total of $16.8 million (General Fund), to address issues related to the Emily Q. plan. The Emily Q. Plan is the result of a legal settlement in which a Special Master has crafted a nine-point plan for the provision of Therapeutic Behavioral Services which the DMH and County Mental Health Plans are required to implement. This plan is being phased-in over time.

4. Reimburses for County Deferral. Increases by $15.796 million (General Fund) to reimburse County Mental Health Plans for deferred payments from 2009 to be paid in 2010.

5. Past Audit Settlements on EPSDT. Increases by $16.1 million ($2.2 million General Fund) for audit settlements due from the DMH to the counties for fiscal years 1998-99 through 2004-05. The DHCS and DMH need to clarify if the federal CMS will provide federal matching funds for this purpose.

6. Receipt of Federal Funds—ARRA Extension. Assumes savings of $61.2 million (General Fund) due to increased federal funding of 61.59 percent in Medicaid (Medi-Cal) through the American Recovery and Reinvestment Act (ARRA). The Governor assumes this level of ARRA funding will be extended for another six months to June 30, 2010. This extension is in President Obama's proposed federal budget. This savings is contained within Control Section 8.65 of the Budget Bill.

7. Receipt of Federal Funds—Increase Base to 57 Percent. Assumes savings of $73.9 million (General Fund) through federal law changes which would increase California's "Federal Medical Assistance Percentage" (FMAP) to an average received by other states nationwide. This is part of the Governor's overall federal request. This savings is contained within Control Section 8.65 of the Budget Bill.

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

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

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

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

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

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 Mental Health Plans 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. According to the DMH, about $84.9 million (County Realignment) is estimated to be expended in 2010-11 to meet this county requirement.

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

Subcommittee Staff Comment and Recommendation. It is recommended to keep this issue open pending receipt of the Governor's May Revision. Both caseload adjustments and any federal funding adjustments can be made at that time.

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

1. DMH, Please provide a brief description of the program and budget proposal.

C. State Hospital Issues

Overall Background Section (Pages 29 through 30)

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

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

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

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

Key Adjustments to State Hospitals in Budget Act of 2009 (July). The following key adjustments were enacted in July for 2009-2010:

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

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

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

Judicially committed patients are treated *solely* using state General Fund support. The majority of the General Fund support for these judicially committed patients is appropriated

through the 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.)

ISSUES FOR DISCUSSION

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

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

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

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 for an "Enhanced Plan" of operations on May 2, 2006.

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

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

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

Wellness and Recovery Model Support System. The DMH has developed and implemented the Wellness and Recovery Model Support System (WaRMSS), a real-time application used to assist with treatment. WaRMSS allows clinical teams to tailor individualized treatment plans, document patient goals, document progress toward goals, and modify treatment plans as needed. The DMH states that WaRMSS will enable them to assume an effective long term self-monitoring and oversight role.

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, What are the next *key* steps in 2010-11 for compliance to be achieved?

2. Oversight: Update on Coleman Court and DMH Activities

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

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

At the Subcommittee's request, the DMH has provided the following table to reflect the current status of the short-term projects funded in the Budget Act of 2009 (July).

DMH Project Description	Completion Date	Status
1. Convert 25 Acute Beds at Atascadero to Intermediate Care Beds	June 2009	Complete
2. Add 4 Intermediate Care Beds to Salinas Valley	June 2009	Complete
3. Convert 116 Beds at Salinas Valley to Intermediate Care Beds which are "high custody"	June 2009	On Schedule
4. Double bunk 10 beds at Salinas Valley	February 2010	Complete
5. Convert 44 Beds used for day treatment at Vacaville to Intermediate Care Beds	September 2009	Complete
6. Transfer a prison wing to Vacaville Psychiatric Program and use for 32 Acute Beds	June 2010	On Schedule
7. Convert 36 Beds at Vacaville from Intermediate Care to Acute	October 2009	Complete

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

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

The DMH states that two other large projects are also underway which pertain to the Coleman class of inmate-patients. A 64-bed Intermediate Care Facility addition for Vacaville is scheduled to be completed in August 2012 (CDCR Long-Range Bed Project) and the DMH would begin its activation and the admission of patients four-months after its completion. The DMH budget proposes an increase of $840,000 (General Fund), as discussed below in issue #3, to begin activities associated with this project.

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

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

1. DMH, Please provide an update on key Coleman Court-related activities, and any key concerns with implementation issues.

3. Current Year State Hospital Population Over-Budgeted

Budget Issue. The State Hospital budget for the current-year assumes a caseload of 6,202 patients which is significantly higher than the trend reflected in the actual patient census. As shown in Table 1 below, the most recent patient census reflects a caseload of only 5,727 patients, or 475 patients *less* (7 percent) than provided for in the current-year budget.

Table #1-- DMH State Hospital Patient Caseload: Current Year (2009-2010)

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

At the request of the Subcommittee, the Legislative Analyst's Office (LAO) has updated their analysis from January and is recommending a current-year *reduction* of $10 million (General Fund).

The LAO reduction accounts for patient population decreases for the IST, MDO and NGI categories, but does not include the CDCR category of commitments since these pertain to the Coleman Court and other matters which pertain to correctional inmates. The reduction assumes a $67,242 bed cost which equates to the half-year cost of a bed. This calculation corresponds to the methodology agreed to with the Administration in 2002.

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.

Subcommittee Staff Recommendation— Concur with LAO. Subcommittee staff concurs with the LAO recommendation to reduce by $10 million (General Fund). This reduction may be updated at the Governor's May Revision when additional data is available to do a final adjustment on the current-year.

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

1. DMH, Please provide your analysis of the current-year trends.
2. LAO, Please provide your analysis of the $10 million (General Fund) reduction.

4. Proposed Budget-Year Adjustments for the State Hospitals

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

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

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

Category of Patient	Current Year as Estimated by DMH	Budget Year as Estimated by DMH	Proposed Increase
Sexually Violent Predators (SVPs)	858	920	62
Mentally Disorder Offenders (MDOs)	1,225	1,264	39
Not Guilty by Reason of Insanity	1,238	1,235	-3
Incompetent to Stand Trial	1,189	1,202	13
Penal Code 2684s & 2974s** (Referred for treatment by CDCR)	1,048	1,112	64
Other Penal Code Patients (various)	143	148	5
CA Youth Authority Patients	30	30	0
County Civil Commitments	471	471	0
TOTAL ESTIMATED PATIENTS	**6,202**	**6,382**	**180**

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

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

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

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 Recommendation—Hold Open. It is recommended to hold "open" this issue open pending receipt of the May Revision since patient caseload is anticipated to change considerably.

Further, it is recommended for the Administration to assertively review all State Hospital contracts, operating expenses and equipment needs to reduce expenditures in the May Revision package.

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

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.

5. Office of Patient Rights

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

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

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

Subcommittee Staff Recommendation. It is recommended to adopt trailer bill language to simply strike the reference to the three-year term and to insert the reference for a five-year term.

Question. The Subcommittee has requested the DMH to respond to the following question.

1. DMH, Please provide a brief summary of the contracting process and would it be cost-beneficial to change the term from three-years to five-years?

Outcomes from Senate Subcommittee No. 3: Thursday, March 11th

- Senator Ashburn absent the entire Subcommittee hearing.

Emergency Medical Services Authority (Page 2)

Vote Only: (Pages 3 and 4)

- **Motion.** Approval Vote-Only items (two).
- **Vote: 2-0**

Issue for Discussion: 1. Pharmaceutical Cache (Page 5)

- **Motion.** Deny this proposal for a savings of $448,000 (General Fund).
- **Vote: 2-0**

Mental Health Services Oversight & Accountability Commission (Page 6)

1. Independence of the Commission (Page 9)

- **Motion.** Approved a total of $4.6 million (MHSA Funds) for the Commission and rejected the pro-rata reduction.
- **Vote: 2-0**

DEPARTMENT OF MENTAL HEALTH (Page 11)

VOTE ONLY (Page 13)

- **Motion.** Approved Vote-Only items (two).
- **Vote: 2-0**

ISSUES FOR DISCUSSION

A. State Support (Page 14)

1. Expenditure of Mental Health Services Act Funds for State Support

- **Motion. (1)** Denied the pro-rata reduction for all State departments; (2) Approved Staff Counsel position; and **(3)** Adopted trailer bill language to require the DMH to report on State administration activities as part of their January and May Proposition 63 report.

  Further directed that if a reduction is needed at May Revision to stay within the 5 percent cap, the OAC Commission needs to be consulted and priorities should be established.
- **Vote: 2-0**

B. Community Mental Health Issues (Page 16)

1. Oversight: Federal Concerns with Mental Health Services Waiver

- **Motion. (1)** Adopted trailer bill legislation to require the Administration to provide the Legislature with semi-annual updates on all Medi-Cal Waivers; **(2)** Directed the Administration to meet with constituency groups as soon as feasible to provide more details; and **(3)** Directed the Administration to provide more detailed, *written* information on these Waiver proceedings in the May Revision.
- **Vote: 2-0**

2. Oversight: Implementation of Short-Doyle System (Page 21)

- **Comment.** Subcommittee requested to be kept informed of progress.

3. Medi-Cal Mental Health Managed Care (Page 24)

- **Motion.** Rejected the Governor's proposal to redirect Proposition 63 Funds and to instead, backfilled with General Fund support. Also kept this issue "open" pending receipt of the May Revision since other technical adjustments will be needed at that time.
- **Vote: 2-0**

4. Early and Periodic Screening, Diagnosis and Treatment (Page 26)

- **Motion.** Rejected the Governor's proposal to redirect Proposition 63 Funds and to instead, backfilled with General Fund support. Also kept this issue "open" pending receipt of the May Revision since other technical adjustments will be needed at that time.
- **Vote: 2-0**

C. State Hospital Issues (Page 29)

ISSUES FOR DISCUSSION (Page 31)

1. Oversight: Update on CRIPA (Page 31)

- **No action taken, Subcommittee received information.**

2. Oversight: Update on Coleman Court and DMH Activities (Page 32)

- **No action taken, Subcommittee received information.**

3. Current Year State Hospital Population Over-Budgeted (Page 34)

- **Motion.** Adopted the LAO recommendation to reduce by $10.1 million (GF) in the current-year to account for the patient caseload decrease.
- **Vote: 2-0**

4. Proposed Budget-Year Adjustments for State Hospitals (Page 35)

- **Action.** Held "open" pending receipt of the May Revision but urged the Administration to seek some cost-containment in this area.

5. Office of Patient Rights (Page 38)

- **Motion.** Adopted trailer bill language to amend Section 5370.2 of Welfare and Institutions Code to extend the contract term from 3 years to 5 years.
- **Vote: 2-0**

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

March 18, 2010

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

Room 4203

Committee Staff: Jennifer Troia

Item	Department
0530	Health and Human Services Agency - Office of Systems Integration
4140	Office of Statewide Health Planning and Development
4170	Department of Aging
5180	Department of Social Services

(See Table of Contents on page 2 for More Specific Listing of Issues.)

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.

Agenda

(Vote-Only Items indicated by *)

Vote-Only Agenda

0530 Health & Human Services Agency, Office of Systems Integration (OSI) & 5180 Department of Social Services (DSS)

OSI & DSS Issue 1: Interim Statewide Automated Welfare System (ISAWS) & ISAWS Migration Project

Budget Issue: OSI requests to reduce the budget for the ISAWS Migration project by $75.4 million ($45.2 million GF/TANF) as a result of the completion of implementation activities. In 2009-10, Development and Implementation costs for the ISAWS Migration are budgeted to be $94.9 million, while Maintenance and Operations (M&O) costs are $11.0 million. By contrast, after the Migration is fully implemented in 2010-11, the Governor's budget includes $11.4 million for Development and Implementation (a decrease of $83.5 million) and $19.1 million for M&O (an increase of $8.1 million).

The Governor's budget for 2010-11 also continues $23.9 million ($12.9 million GF/TANF) in full-year funding for ISAWS. OSI has indicated, however, that the ISAWS budget for 2010-11 will be reduced in the May budget revision to instead include a significantly lower amount of closing costs and contingency funding in case of delays in the final stages of the Migration.

Background on ISAWS: ISAWS is one of four consortia within the Statewide Automated Welfare System (SAWS), which is described on page 11 of this agenda. This Migration project is transitioning 35 ISAWS consortium counties to another SAWS consortium called C-IV. After the migration, C-IV will have 13,050 users and include information for approximately 28 percent of clients statewide (according to 2007-08 data). The ISAWS Migration planning phase occurred between July 2006 and June 2008. Implementation began in October 2008, with the actual transition "going live" in three waves during fiscal year 2009-10. The first of these waves took place in November 2009 and the last is scheduled to take place in June 2010. The Migration Project has provided two months of technical support after each of the waves that have happened to date.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the proposed changes to the ISAWS Migration budget for 2010-11. Staff also recommends holding the 2010-11 funding for ISAWS open pending anticipated changes in the May Revision.

OSI & DSS Issue 2: CalWORKs Information Network system (CalWIN)

Budget Issue: OSI requests budget changes and technical adjustments resulting in an increase of CalWIN funding authority by $1.5 million for 2009-10 and $4.2 million for 2010-11. The total proposed 2010-11 budget for CalWIN is $74.3 million ($38.8 million GF/TANF).

Background: Cal-WIN is the automation system that supports the Welfare Client Data System, one of four consortia within the Statewide Automated Welfare System (SAWS). Again, an overview of SAWS is presented on page 11 of this agenda. CalWIN serves 18 counties with approximately 39 percent of the statewide caseload.

The requested adjustments are a result of the following factors:

- As a result of negotiations with the CalWIN vendor in anticipation of contract extension, the price per case increased from $0.67 to $.75. This change accounts for $2.3 million of the requested increase in 2010-11.

- The caseload for the consortium's counties is projected to grow more than previously anticipated (by 5.3 percent, rather than 3.5 percent in the budget year). This accounts for a $1.5 million increase in 2010-11.

- A higher amount of the 2009-10 budget cuts to the aggregate SAWS consortia system were originally allocated to CalWIN than is the case today. Another consortium, C-IV, instead experienced a greater reduction than was originally anticipated. This accounts for the $1.5 million adjustment in the current year.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the proposed budget increases for CalWIN.

4140 Office of Statewide Health Planning

With a total budget of $98.8 million ($126,000 GF) in 2009-10 and a proposed budget of $102.2 million ($75,000 GF) in 2010-11, OSHPD develops plans, policies and programs to assist healthcare systems in meeting Californians' needs (e.g., by ensuring facility safety and investing in professional development).

OSHPD Issue 1: Medical Information Reporting (MIRCal) System

Budget Issue: OSHPD requests budget authority of $343,000 of California Health Data and Planning Special Funds (CHDPF) to transition some of the existing staffing for maintenance and enhancement of the Medical Information Reporting (MIRCal) system from contracted vendor services to three new, permanent state positions. The total CHDPF budget for 2009-10 is $26.2 million (all special fund from health facilities fees). The total MIRCal external contract budget for 2009-10 includes $482,200 of these funds.

Background: OSHPD implemented the MIRCal system in 1998 to collect and disseminate data on patients discharged from California's licensed hospitals, Emergency Departments, and Ambulatory Surgery Centers. Up to five contract staff at a time currently program and administer the system. OSHPD states that it struggles each year with the time it takes to procure and manage a vendor contract and that the state would benefit from a stronger knowledge base among its own staff.

Subcommittee Staff Comments & Recommendation: Staff recommends approval of the requested authority to convert funds for contract staff to three permanent state positions.

OSHPD Issue 2: Song-Brown Program

OSHPD Budget Issue 2: OSHPD requests, for 2010-11, to continue funding the Song-Brown Program with special funds from the California Health Data and Planning Fund (CHDPF), instead of the GF. Total Song-Brown funding is $5 million ($4.7 million for local assistance and $349,000 for state operations). Again, the total CHDPF budget for 2009-10 is $26.2 million (all special fund from health facilities fees).

Background: The Song-Brown Program's goal is to increase the number of family practice physicians, primary care physician assistants, family nurse practitioners, and registered nurses in areas of the state that are medically underserved (e.g., rural and low-income communities). Providers with Song-Brown training and education deliver primary care services through the University of California's teaching hospitals, 61 percent of county facilities, and a number of community health centers.

Subcommittee Staff Comments & Recommendation: To continue to offset GF spending for the Song-Brown program, staff recommends approval of this proposal.

OSHPD Issue 3: Vocational Nurse Education Fund

Budget Issue: OSHPD requests an increase in Vocational Nurse Education Fund (VNEF) expenditure authority of $40,000 in 2010-11 and future years to fund additional scholarship and loan repayment awards. The total VNEF revenue is approximately $165,000 annually (all fee based).

Background: The Vocational Nurse Education Program (VNEP) is one of the programs administered by the Health Professions Education Foundation, which is a non-profit foundation housed at OSHPD. The Legislature created the Foundation to encourage individuals from underrepresented communities to become health professionals. The Foundation's programs are supported by grants, donations, licensing fees, and special funds.

The VNEP, in particular, is supported by a $5 license renewal fee that OSHPD collects from the Board of Vocational Nursing and Psychiatric Technicians. Since its inception, VNEP has awarded 62 scholarships and loan repayments to vocational nurses who agree to work in medically underserved areas of the state for two years. The requested spending authority would allow OSHPD to fund approximately 10-14 additional scholarship and loan repayment awards.

Subcommittee Staff Comments & Recommendation: Staff recommends approval of the request for $40,000 in VNEF expenditure authority.

4170 Department of Aging (CDA)

CDA Issue 1: Medicare Beneficiary Outreach and Assistance Program

Budget Issue: CDA requests, in a budget change proposal, 2010-11 federal funding authority of $672,000 for the second year of its Medicare Improvements for Patients and Providers Act (MIPPA) Beneficiary Outreach and Assistance Program. The first half of the $1.3 million total grant was allocated for expenditure in 2009-10. No state matching funds are required.

Background: The federal government has awarded a two-year, non-competitive grant to CDA. The purpose of the funding is to expand enrollment of California's 4.4 million Medicare beneficiaries in the Prescription Drug Benefit Low Income Subsidy Program (LIS) and Medicare Savings Programs (MSP). Local Area Agencies on Aging (AAA), Health Insurance Counseling Programs (HICAP), and Aging and Disability Resource Centers are conducting the grant-funded work, which varies based on local need.

The federal government requires states to submit quarterly data on the number of low-income subsidy applications by beneficiaries as a result of assistance from these organizations. From July 1, 2009 to January 28, 2010, 1,414 applications for California beneficiaries were submitted. This constitutes 22 percent of the state's two-year goal of 6,475 applications. CDA states that it anticipates achieving the statewide performance benchmarks in time to secure second year funding.

Subcommittee Staff Comment & Recommendation: So that the state will be able to draw down these grant funds from the federal government, staff recommends approval of $672,000 in related 2010-11 federal funds authority for CDA.

CDA Issue 2: Federal Grant for Services to Families Impacted by Alzheimer's Disease and Related Dementias

Budget Issue: CDA requests, in a budget change proposal, federal funds authority of $332,000 (of which $17,000 is state operations and the rest is local assistance) in 2010-11, $333,000 in 2011-12 ($17,000 for state operations), and $106,000 in 2012-13 ($4,000 for state operations). The requested authority for these fiscal years, plus additional funds the Department is seeking for the current fiscal year through a letter to the Joint Legislative Budget Committee, totals $996,132 that the federal Administration on Aging has awarded California under a three-year, competitive demonstration grant.

Federal law requires state grantees to provide a match (cash or in-kind) of 25, 35, and 45 percent in the first, second, and third years of the grant period, respectively. According to CDA, California Alzheimer's Association chapters have agreed to provide these required matches. The Department is not requesting any GF resources for that purpose.

Background: The goal of the federal grant is to replicate an evidence-based supportive services program to assist caregivers of persons with dementia that was initially conducted in New York. The program in New York (called the New York University Caregiver Intervention) included individual and family counseling, as well as support groups and ad hoc telephone counseling, for caregiver spouses. These interventions resulted in substantially reduced or delayed nursing home placements (at an average annual cost of $65,000 nationally in 2006) for individuals with dementia.

CDA estimates that 330 California families will directly benefit from the care consultation and referrals provided by Alzheimer's Association chapters and community service organizations as a result of this grant funding.

Subcommittee Staff Comment & Recommendation: To allow CDA to receive and utilize these federal grant funds, staff recommends approval of this proposal.

DSS Issue 1: CalWORKs- Delay of Work Incentive Nutrition/Pre-Assistance Employment Readiness (WINS/PAERS) and Temporary Assistance Program (TAP)

Budget Issue: DSS proposes, in trailer bill language, to delay implementation of WINS and TAP, two CalWORKs-related programs. The Department also proposes to eliminate PAERS requirements. The proposed delays would extend delays enacted last year in ABx4 4 (Chapter 4, Fourth Extraordinary Session, Statutes of 2009). The proposed changes in WINS implementation dates would also push back approximately $2 million GF costs for automation changes. After those automation changes in the first year, the department estimates costs (countable as Maintenance of Effort [MOE] for the federal Temporary Assistance for Needy Families [TANF] program) of $18 million in the second year of WINS and $28.4 million each year thereafter.

If excess-MOE funds are available when it is implemented, TAP is effectively cost-neutral to the state because funds for the program ($220 million in recipient benefits and $5.3 million in automation expenses) are already included in the CalWORKs budget. GF resources that would otherwise be used to meet the MOE would instead be shifted to fund the solely-state funded TAP (which is not countable as MOE).

Background on WINS and TAP: Under WINS, which was originally authorized in 2008 (AB 1279, Chapter 759, Statutes of 2008), 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 work participation requirements. The related PAERS working group was created to explore options for offsetting a potential increase in the state's CalWORKs caseload (and possible resulting decrease in its federal caseload reduction credit) resulting from WINS. As a result of the proposed delays, the Department would be prohibited from paying WINS benefits prior to October 1, 2012, with full implementation required by April 1, 2013 (instead of existing dates of October 1, 2011 and April 1, 2012).

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 (previously 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 CalWORKs, but without any federal restrictions or requirements. As a result of TAP, California would improve its TANF work participation rate (WPR). 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 three years to delay TAP implementation. This proposal would delay TAP implementation by an additional year, to begin no later than October 1, 2012.

TANF Reauthorization: Congress must take action by September 30, 2010 to reauthorize the TANF block grant. It is important to note, however, that President

Obama's February 1, 2010 budget proposed a one-year extension of TANF (which, if enacted, could result in a one-year delay of the larger reauthorization discussion that stakeholders previously anticipated would happen in 2010).

Subcommittee Staff Comment and Recommendation: Given the potential changes on the horizon at the federal level, staff recommends that the Subcommittee approve the proposed delays of WINS/PAERS and TAP. However, consistent with last year's actions, staff recommends rejecting the proposed deletion of Section (g) PAERS language, as pre-assistance programs may be viable and important options for the state to explore before implementing WINS.

DSS Issue 2: CalWORKs State and County Peer Review Process

Budget Issue: DSS proposes to reduce 2009-10 funding for the state and county CalWORKs peer review process to $37,000 (TANF funds) and to de-fund the program entirely in 2010-11. The 2009-10 budget for the program was $221,000 (TANF) in local assistance funding for the counties. DSS also proposes trailer bill language to suspend the statutory requirement for the Department to implement the process statewide by July 2007 and to instead require its implementation only in the year for which a sufficient appropriation is made in the Budget Act.

Background: A 2006 budget trailer bill (AB 1808, Chapter 75, Statutes of 2006) required DSS to establish a state and county peer review process statewide by July 1, 2007. The purpose was to assist counties in implementing best practices and improving their performances in the CalWORKs program. Given the $221,000 appropriation for 2009-10, the Department anticipated that 18 peer reviews would be conducted. Under this proposal, three reviews would be conducted in 2009-10 and none would occur in 2010-11.

Subcommittee Staff Comments & Recommendation: Staff recommends holding this issue open.

Discussion Agenda

0530 Health & Human Services Agency, Office of Systems Integration (OSI) & 5180 Department of Social Services (DSS)

With a total budget of $251.9 million (OSI Fund, transfers from other mixed sources) in 2009-10 and a proposed budget of $271.6 million in 2010-11, OSI procures and manages automation projects for the Departments of Social Services and Employment Development.

Overview of Statewide Automated Welfare System (SAWS)

Overview of SAWS: The total 2009-10 maintenance & operations (M&O) budget for SAWS is $174.7 million ($93.5 million GF/TANF). These figures include costs for each of the four consortia plus the Welfare Data Tracking and Implementation Project and the impact of a combined $11.6 million ($4.5 million GF) reduction that was part of the enacted budget. These figures do not include SAWS statewide project management or upgrade and replacement projects. As a point-in-time snapshot, those additional costs in 2009-10 were $113.7 million ($66.7 million GF/TANF).

OSI provides state-level project management and oversight for SAWS, which automates the eligibility, benefit, case management, and reporting processes for a variety of health and human services programs operated by the counties, including the CalWORKs welfare-to-work program, Food Stamps, Foster Care, Medi-Cal, Refugee Assistance, and County Medical Services. There are currently four SAWS consortia. After ISAWS finishes its migration into C-IV (anticipated to occur in June 2010, with some close-out funding for ISAWS remaining in 2010-11; see page 3), there will be three consortia systems that each contain information for roughly one-third of the statewide caseload.

Plan for Centralized Eligibility: As proposed by the Governor, a 2009-10 trailer bill (ABx4 7, Chapter 7, Fourth Extraordinary Session, Statutes of 2009) required DSS and the Department of Health Care Services (DHCS), in consultation with stakeholders, to develop a comprehensive plan for a statewide eligibility and enrollment determination process for CalWORKs, Medi-Cal, and food stamps. The Departments are required to submit the plan to the Legislature at least 45 days prior to requesting an appropriation to fund activities associated with the plan.

Subcommittee Staff Comment and Recommendation: This issue is included for informational purposes, and no action is recommended.

OSI & DSS Issue 1: LEADER Consortium Replacement System (LRS)

Budget Issue: OSI requests an increase of $44.3 million as the planning phase of the LRS project ends and the design, development and implementation phase begins. Including the proposed resources, the 2010-11 budget for LRS would be $45.6 million ($23.3 million GF/TANF). This proposal also includes an additional six-month delay of the beginning of the system's development (beyond a six-month delay enacted in the 2009-10 budget). The 2009-10 LRS project planning budget is $1.3 million ($671,000 GF/TANF).

OSI anticipates total average costs for LRS development and implementation of $102.2 million annually, for a total of $408.6 million over four years ($208.6 million GF/TANF, $173.3 million federal funds and $26.7 million county funds) before reaching the M&O phase of the project after December 2014. Although the differing functionalities of the systems make direct comparison difficult, it is worth noting that OSI estimates higher annual operations costs for LRS than those for LEADER.

Background on LEADER: With 2009-10 and 2010-11 M&O costs of $30.7 million ($15.7 million GF/TANF) each fiscal year, LEADER is one of four consortia within SAWS. Los Angeles (LA) County entered into an agreement for Unisys to develop LEADER in 1995 and completed countywide implementation of the system in 2001. The system has been in its M&O phase since that time, with its latest Unisys contract scheduled to expire April 30, 2011. To accommodate the LRS schedule, OSI will seek approval to again extend that contract for four additional years through April 30, 2015.

Background on LRS Project: The Legislature has appropriated a total of $5.3 million ($2.7 million GF/TANF) between fiscal years (FY) 2005-06 and 2009-10 to support the planning process for a new system to replace LEADER. After the February 2009 budget agreement delayed LRS activities for six months, Los Angeles began negotiations for an LRS contract with a vendor in late 2009. Those negotiations are in progress and could result in lower cost estimates. OSI now expects to conclude planning activities at the end of 2010 and to begin design, development, and implementation of the LRS project in January 2011. OSI anticipates that the project could be completed in December 2014.

LA County intends for LRS to replace not only LEADER, but also the Greater Avenues for Independence (GAIN) Employment and Reporting System (GEARS) for its welfare-to-work program, as well as its General Relief Opportunities for Work (GROW) system, and to contain options for other functionalities. GEARS is currently funded with $9.2 million TANF funds, while GROW is funded with $2 million county-only funds.

Need for LRS: According to OSI and LA County, LEADER technology is outdated and cumbersome. LRS will streamline LA's business practices, eliminate duplicative data entry, and minimize errors. OSI also indicates that LRS will expand clients and service providers' ability to apply for benefits or report case changes online. In addition, LRS

will minimize the state's dependency on one vendor's proprietary hardware and software components to run LEADER. The federal government has previously expressed concerns about the state and county's continued non-competitive use of the same vendor; and OSI has indicated that no other qualified vendors have been willing to enter a bid to operate the LEADER system.

Subcommittee Staff Comment & Recommendation: Staff recommends holding this issue open.

Question for OSI/DSS:

1. Please briefly describe the functions of LEADER and GEARS today, and how those functions would change or be streamlined in LRS as you envision it.

2. What is the current status of negotiations with the LRS vendor? (E.g., When do you anticipate that you might have updated cost estimates for the system's development and maintenance? What have you discussed with the vendor about upgrades or changes that may be required in the future?)

OSI & DSS Issue 2: Child Welfare Services/Web (CWS/Web) Project

Budget Issue: OSI requests $1.8 million ($827,000 GF) for 10 new positions to support the continuing development of CWS/Web, a replacement system for the existing CWS/CMS. These 10 positions would be in addition to 12 existing OSI positions and up to another 6 OSI-contract staff currently supporting this phase of the project.

The 2009-10 budget for CWS/Web is $7.1 million ($3.2 million GF). Including the requested funds for OSI staff (and other staff requested by DSS), the 2010-11 budget for the project would increase to $9.4 million ($4.3 million GF). OSI estimates a total cost of $202.8 million ($91.9 million GF) between 2012 and 2014 to complete the implementation of CWS/Web and enter into its M&O phase.

Background on CWS/CMS and CWS/Web: California's CWS system includes a variety of state-supervised, county-administered interventions designed to protect children. Major services consist of emergency response to reports of suspected abuse and neglect, family maintenance or reunification and foster care. CWS/CMS is an automated system that provides case management capabilities for CWS agencies, including the ability to generate referrals, county documents, and case management and statistical reports. The total 2009-10 CWS/CMS project budget is $83.3 million ($38 million GF).

The CWS/CMS system was implemented statewide in 1997, and OSI states that CWS/Web is necessary because the CWS/CMS technology is outdated. In addition, OSI and DSS state that the CWS/Web system is needed to increase efficiency and to comply with federal system requirements (which are tied to federal funding). The CWS/Web project is currently in a planning stage, preparing for a full implementation after development ends in 2014. When CWS/Web is completed, the system will rely on a more modern, web-based technical architecture.

Stated Rationale for Additional Resources: According to OSI, the amount and complexity of work related to the CWS/Web Request for Proposal process is greater than initially anticipated. The requested positions would focus on database administration, security management, development, testing, training, quality assurance, operations and configuration management requirements. Without these resources, OSI states that "the risk that the CWS/Web would ultimately fail to be delivered on time, within budget and in accordance with established requirements would be significantly increased."

Subcommittee Staff Comment & Recommendation: Staff recommends holding this issue open.

(Questions on next page)

Questions for OSI/DSS:

1. Please briefly explain the need for 10 additional staff at OSI to support the planning process for CWS/Web.

2. How will these positions fit in with the project's needs as it moves into development and implementation?

4170 Department of Aging (CDA)

With a total budget of $209.7 million ($33 million GF) in 2009-10 and a proposed budget of $176.4 million ($12.3 million GF) in 2010-11, CDA administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities.

CDA Issue 1: Implementation of Vetoed Funds for Community Based Services Programs (CBSP)

CBSP Update: As outlined below by program, the 2009-10 budget reduced or eliminated, as of October 1, 2009, GF spending for several CBSPs. Through his veto actions, the Governor then eliminated all of the remaining GF resources for these programs, as well as state and local administration funds, as of that same date (also shown below).

Impact of 2009-10 Community Based Services Program Reductions

Program	Original 09-10 GF Allocation	Legislative Action	Governor Veto	Total 09/10 GF Reduction*	Total 10/11 Funding
Alzheimer's Day Care Resource Center	**3,787,000**	-1,200,000	-1,640,000	**-2,840,000**	**0**
Brown Bag	**541,000**	0	-405,000	**-405,000**	**0**
Linkages	**7,935,000**	-2,421,000	-3,958,000	**-6,379,000**	**0**
Respite	**317,000**	-238,000	0	**-238,000**	**0**
Senior Companion	**317,000**	-238,000	0	**-238,000**	**0**
Local Admin. for these CBSPs	**935,000**	-117,000	-157,000	**-274,000**	**0**
State Admin. for these CBSPs	**211,000**	0	-106,000	**-106,000**	**0**

** Note that these numbers reflected nine months of funding reductions because of anticipated time for programs to ramp-down.*

Linkages: Prior to the elimination of its funding, Linkages was expected to serve as a case management program for approximately 5,500 elderly and younger adults who had functional impairments and were at-risk of institutionalization. In May, 2008, the program waiting list included approximately 2,100 people.

Alzheimer's Day Care Resource Centers (ADCRC): Prior to the elimination of this funding, 57 ADCRCs received infrastructure support so that Adult Day Care and Day Health Care Centers could serve 3,200 individuals with dementia.

Brown Bag Program: Prior to the elimination of its funding, the Brown Bag program relied on the assistance of 3,900 volunteers and 600 sites to provide free surplus and donated fruits, vegetables, and other foods to 27,000 low-income seniors. The program's $541,000 local assistance budget was supplemented by $13 million in local matching funds.

Respite Purchase of Services (POS): Prior to the elimination of its funding, the Respite POS program provided temporary relief to caregivers of frail elderly or impaired adults who were at risk of institutionalization.

Local Actions: Local Area Agencies on Aging (AAAs), which administered these programs in the past, have flexibility to continue these or similar programs if they can use federal Older Americans Act and/or other funds. For the Linkages program, AAAs may also be eligible to continue receiving a limited amount of funding from local handicap parking fines. AAAs electing to continue programs similar to these CBSPs using non-state funds are not required to meet state standards for the programs. According to a CDA survey conducted in November 2009:

- 25 AAAs planned to continue some form of ADCRC programs and eight discontinued the program.
- 17 AAAs continued Brown Bag programs and seven discontinued them.
- 17 continued Linkages programs and 16 discontinued them.
- Seven continued Respite programs and 21 discontinued them.
- Three continued Senior Companion programs and 12 discontinued them.

Subcommittee Staff Comment & Recommendation: This Issue is included for oversight and informational purposes.

Questions for CDA:

1. Please describe how the Department has implemented the Governor's vetoes within these programs and how local agencies have responded to date.
2. What, if any, continuing oversight does the Department have over these programs to the extent that they are still operated locally?
3. What data does the Department have on how the programs' former beneficiaries are faring today? Do you know how many clients were referred to other state programs that may provide similar services? How many may have entered institutional care in part because of the loss of these services?

CDA Issue 2: Multi-Purpose Senior Services Program (MSSP)

Budget Issue: CDA requests, in a budget change proposal, the permanent transfer of $20.1 million GF for MSSP from CDA's budget to the budget for the Department of Health Care Services (DHCS). The 2009-10 budget for MSSP state operations and local assistance included a total of $46.6 million ($18.6 million GF).

CDA states that this technical change is necessary because the current division of funds for the program between CDA and the Department of Health Care Services (DHCS) makes its funding unclear to the general public and to legislative entities. In addition, CDA states that the funding split creates unnecessary duplication of work by CDA and DHCS (e.g., the preparation of budget requests).

Background on MSSP: MSSP assists elderly Medi-Cal recipients to remain in their homes. Clients must be at least 65 years old and must be certified as eligible to enter a nursing home. The services that may be provided with MSSP funds include: Adult Day Care, Housing Assistance, Personal Care Assistance, Protective Supervision, Care Management, Respite, Transportation, Meal Services, and other Social and Communications Services. The program, which began in 1977 with eight sites, now has 41 sites and serves up to nearly 12,000 clients per month.

CDA oversees the operations of the MSSP program statewide and contracts with local entities that directly provide MSSP services. As the single state agency authorized to administer the state's Medicaid program, DHCS also has an integral role because the program operates under a federal Medicaid Home and Community-Based, Long-Term Care Services Waiver. In 2006, the Legislature transferred the resources at issue to the CDA budget to enhance the Legislature's ability to oversee the program and to align the program's GF funding with its management. Several other state programs that receive Medicaid funding are overseen by and also have resources budgeted under departments or agencies other than DHCS.

Subcommittee Staff Comment & Recommendation: The continued alignment of the funding and management of MSSP under CDA will best meet the Legislature and public's needs for information about and oversight of the program. Therefore, staff recommends rejecting this proposal. However, staff recommends adopting an alternative technical fix developed by DoF and the Departments. Under this alternative, a new program would be created within CDA's budget for Medi-Cal program funding and Budget Bill Language (for Provision 2 of Item 4170-101-0001) would be revised to authorize the transfer of funds from that new program to DHCS.

(Questions on next page)

Questions for CDA:

1. Please briefly explain the rationale for this request, including a description of CDA and DHCS's respective roles in the operations of the MSSP program.

2. If the requested transfer of funds was approved, would CDA continue to provide the main programmatic oversight of MSSP programs?

5180 Department of Social Services (DSS)

With a total budget of $20.7 billion ($8.7 billion GF) in 2009-10 and a proposed budget of $16.6 billion ($6.9 billion GF) in 2010-11, DSS is responsible for programs that provide aid, service, and protection to children and adults in need of assistance. The Department employs more than 4,000 individuals who oversee the administration of programs like SSI/SSP, CalWORKs, IHSS, child welfare services, and the licensing of community care facilities.

DSS Issue 1: Overview of Trigger Proposals

Budget Issue: The Governor's budget anticipates $6.9 billion of new federal funding across program areas, including health and human services, corrections, and education. If the Director of Finance determines that the federal government has failed to authorize the magnitude of additional funding that the Governor anticipates on or before July 15, 2010, then the Governor proposes to trigger the complete elimination of funding for the CalWORKs, In-Home Supportive Services (IHSS), and Transitional Housing Program Plus (THP+) human services programs, in addition to making other major expenditure reductions and initiating some revenue increases (the rest of which will be discussed during other hearings of the Committee or its relevant Subcommittees). According to the Administration's estimates, if these three human services program trigger proposals took effect for 2010-11, the state would save a total of $2.4 billion GF and forego $4.8 billion federal funds as a result.

Assuming the enactment of the three human services trigger proposals mentioned above, the Governor also proposes to trigger an additional "redirection" of county savings. This trigger proposal, which is in addition to the proposal for other redirections that the Committee discussed on February 2, 2010, would lower the state's and raise the counties' shares of non-federal costs for the Food Stamp program.

According to the LAO, it is reasonable to assume the state will secure some new federal funding and flexibility, but "the chances that the state will receive all of what the Governor seeks from Washington are almost non-existent…The Legislature should assume that federal relief will be billions of dollars less than the Governor wants…"

Subcommittee Staff Comments & Reccomendation: Comments and recommendations for all trigger proposals are consolidated on page 26.

Questions for DOF and LAO:

1. Please briefly outline the Governor's overall trigger proposal.

2. What is your current assessment of the likelihood that the state will (or will not) receive all $6.9 billion in new federal funds that the Governor is seeking?

DSS Issue 2: Trigger Proposal to Eliminate IHSS Program

Budget Issue: The Governor's trigger proposals include the complete elimination of the IHSS program, effective 90 days after notice from the Director of Finance that sufficient federal funds were not authorized. According to the Administration, if this trigger proposal took effect for nine months of 2010-11, the state would save $1.2 billion GF and forego $1.8 billion federal funds.

These estimates assume that current laws governing the IHSS program are still in effect at the time the trigger is pulled (i.e. they do not include the impacts of other IHSS proposals that the Committee discussed on February 2, 2010). These GF savings are also net of $55 million GF costs (growing to $78 million for a full-year) for providing alternative services through the regional centers for the approximately 9 percent of IHSS recipients who have developmental disabilities. The foregone federal funds are predicated on extension through the state's fiscal year of the enhanced Federal Medical Assistance Percentage (FMAP) rate for federal financial participation available for IHSS under ARRA. After expiration of the enhanced FMAP, the Administration estimates $1.8 billion GF savings and $2 billion foregone federal funds annually.

The Administration has not accounted for any potential cost shifts from serving IHSS recipients who would no longer receive in-home supports in Skilled Nursing Facilities (SNFs). According to the LAO, however, if at least 32 percent of non-developmentally-disabled IHSS recipients would enter a SNF in the absence of IHSS (which the LAO states is "very possible"), the proposed elimination of IHSS would result in GF costs, rather than savings. The LAO also estimates that the GF cost shift for replacing IHSS services with other services for recipients with developmental disabilities is significantly greater than the Administration's estimate and would likely be higher than $300 million.

Other 2010-11 Proposals Previously Heard by the Committee: In the absence of the trigger for the proposed elimination of IHSS being pulled, the Governor's Budget proposes to eliminate services to approximately 87 percent of IHSS recipients and to reduce the state's participation in IHSS providers' wages to the state's share of the minimum wage ($8 per hour plus $.60 for benefits). The Committee held a hearing on those proposals on February 2, 2010.

Background on IHSS: The IHSS program has its roots in a 50-year-old cash grants program for individuals who are blind, aged, or who have disabilities and a 30-year-old "homemaker" program that offered domestic help to recipients. Today, the IHSS program provides in-home personal care services to roughly 460,000 qualified individuals who are blind, aged (over 65), or who have disabilities. These individuals usually have income at or below the SSI/SSP grant level ($845 per month for an individual as of October 2009) and assets, except their homes or cars, worth less than $2,000. County social workers determine eligibility for the program after conducting in-home assessments.

IHSS services can include tasks like meal preparation, feeding, bathing, paramedical care, and domestic services. On average, the state spends roughly $12,000 per year for IHSS services (although may also spend other funds for some services that a nursing home resident would not utilize). These services frequently assist program recipients to avoid or delay more expensive and less desirable institutionalizations. According to the LAO, the state spends an average of about $55,000 per year for each nursing home resident who uses Medi-Cal (based on 2006-07 figures).

Impacts & Economic Consequences: This proposal would eliminate supportive services to all of the approximately 460,000 individuals who currently receive them through the IHSS program. For many individuals, the loss of these services could result in immediate need for more expensive institutional placements, such as SNFs. For others, such an institutional placement may occur faster than it would have if they had continued to receive supportive services. Some may remain in their homes and receive continued support from non-IHSS sources, and others may live with unmet needs that place them at risk.

In addition, approximately 385,000 IHSS care providers would lose their IHSS employment. Many of these providers already live in low-income households. The Governor's budget forecasted the state's 2010 unemployment rate to be 12 percent. According to the LAO, job losses of this magnitude could increase that unemployment rate by more than 1 percent. In addition, the LAO estimates that about 60 percent of affected IHSS workers (or 231,000) may qualify for unemployment insurance benefits. Approximately 2,000 to 3,000 county and 80 state staff positions could also be eliminated.

Questions for DSS or DoF:

1. When and how would you anticipate that the IHSS program would be ramped down in the event of the trigger being pulled? When and how would recipients and providers receive notice of the program's elimination?

2. If this trigger proposal took effect, what impacts on IHSS recipients and providers would you anticipate?

3. How do you respond to the LAO's analysis that it is "very possible" that there are a sufficient number of IHSS recipients who would enter a SNF in the absence of IHSS services (32 percent) to indicate that the program's proposed elimination could in fact cost the state GF resources?

4. How do you respond to the LAO's analysis that state cost shifts for serving individuals with developmental disabilities will be significantly higher ($300 million versus the $55 million the Administration estimated)?

DSS Issue 3: Trigger Proposal to Eliminate CalWORKs

Budget Issue: The Governor's trigger proposals also include complete elimination of the CalWORKs program, effective 90 days after notice from the Director of Finance that sufficient federal funds were not authorized. If this proposal took effect in 2010-11, the Administration estimates that the state would save $1.2 billion GF (growing to $2.3 billion GF annually) and forego $3 billion federal funds (growing to $3.8 billion TANF funds annually after the expiration of federal stimulus funds described below).

These estimates assume that current laws governing the CalWORKs program are still in effect at the time the trigger is pulled (i.e., they do not include the impacts of other CalWORKs proposals that the Committee discussed on February 2, 2010). The estimated GF savings also rely on the assumption that the federal TANF Emergency Contingency Fund (ECF) from the American Recovery and Reinvestment Act (ARRA) (currently authorized through September 30, 2010) will be extended with respect to basic assistance costs through the state's 2010-11 fiscal year. They are also net of $590.5 million GF to annually backfill funding for non-welfare programs that would otherwise have benefited from TANF resources.

The federal funds foregone would include California's entire Temporary Assistance to Needy Families (TANF) block grant. The state would also become ineligible for any benefits that would otherwise be available under ECF. During the period of ECF, the federal government pays 80 percent of the costs of certain welfare-to-work expenditures. Under current federal law, California could receive up to $1.8 billion total in ECF funds during federal fiscal years 2009 and 2010. Absent this trigger proposal and other proposed reductions in the Governor's budget and assuming the extension of ECF, DSS estimates that the state would receive $742.5 million ECF funds in 2010-11.

Other 2010-11 Proposals Previously Heard by the Committee: In the absence of the trigger for the proposed CalWORKs elimination being pulled, the Governor's Budget proposes to reduce monthly grant payments to families by 15.7 percent, to reduce the level at which the state reimburses child care providers, and to eliminate the Recent Noncitizen Entrants program as of June 1, 2010. The Committee held a hearing on these proposals February 2, 2010.

Background on CalWORKs: California has had a welfare program in some form since the enactment of the Aid to Dependent Children program in 1911. Today, CalWORKs provides not only temporary cash assistance, but also education, training, child care, and employment programs to families who are unable to meet basic needs (i.e. shelter, food, clothing) on their own. In 2009-10, the average monthly assistance grant for a family of three in high-cost counties is $694. The monthly grant was also $694 twenty years ago in 1989. The maximum allowable CalWORKs and food stamp grants are currently the equivalent of 78 percent of the Federal Poverty Level (FPL) in high-cost counties and 77 percent of FPL in low-cost counties.

Impacts on Families, Counties and the Economy: This proposal would eliminate benefits to all of the 500,000 to 600,000 families (including more than 1 million children) who receive assistance from the program. Counties and advocates project that the elimination of CalWORKs could result in dramatic increases in unemployment, poverty and homelessness among recipient families, as well as costs in other state and local services (e.g. the child welfare, foster care, and education systems). Again, the Governor's budget forecasted an unemployment rate of 12 percent during 2010. According to the U.S. Census Bureau, California had an overall poverty rate of 13.3 percent of the state's population in 2008. The poverty rate was already even higher, at 18.5 percent, for children under 18 years of age.

If the trigger proposal takes effect and the CalWORKs program is eliminated, former CalWORKs recipients may become eligible to apply for county-funded General Assistance (GA) programs for indigent families. As an example, the maximum GA grant in Los Angeles County (called General Relief) for a family of 3 is $450 per month. In some counties, GA offers lower-value vouchers and no cash assistance. The County Welfare Directors Association (CWDA) estimates the potential overall costs to counties if all former CalWORKs recipients could become eligible for GA as $1.9 billion.

It is also well-established that the lowest-income individuals and families spend a higher percentage of their income locally and immediately than do individuals with more disposable income. In addition to these effects on recipient families and their economic activities, as well as local governments, below are examples of others who would be directly impacted by elimination of CalWORKs:

- Employers who might otherwise avert layoffs or expand their workforce via up to 15,000 ECF-supported subsidized employment slots.

- Tens of thousands of local child care providers who provide child care to children whose care is subsidized by the CalWORKs program; and

- An estimated 14,000 county and 170 state employees who work within the state's CalWORKs program.

TANF Reauthorization: Congress must take action by September 30, 2010 to reauthorize the TANF block grant. It is important to note, however, that President Obama's 2010 budget proposed a one-year extension of TANF (which, if enacted, could result in a one-year delay of the larger reauthorization discussion that stakeholders previously anticipated would happen in 2010).

Questions for DSS:

1. When and how would you anticipate that the CalWORKs program would be ramped down in the event of the trigger being pulled? When and how would recipients and providers receive notice of the program's elimination?

(Continued on next page)

2. If this trigger proposal took effect, what would you anticipate would be the impacts on jobs and unemployment? On homelessness among families with children? On their rates of poverty? On other state services and costs? On the overall economy?

3. Are you aware of any other Governor or Legislature in the United States that has proposed the complete elimination of their TANF program?

DSS Issue 4: Trigger Proposal to Eliminate Transitional Housing Program Plus (THP+) for Former Foster Youth

Budget Issue: The Governor's trigger proposals also include the elimination in 2010-11 of all $35.9 million for the THP+ housing and supportive services program. The THP+ program is currently funded with 100 percent GF. The proposed elimination of funding would take effect immediately upon notice from the Director of Finance that sufficient federal funds were not authorized. (The estimate of $35.9 million GF savings assumes that such notice would occur on or before July 1, 2010.)

Background on THP+: THP+ provides up to two years of transitional housing and supportive services to help former foster youth achieve self-sufficiency. There are approximately 1,400 young adults and 168 of their children living in THP+ placements in 52 California counties. Participants receive support from THP+ staff to work toward their county-approved self-sufficiency (e.g., employment or education-related) goals and may live alone or with roommates. The THP+ monthly rate is up to 70 percent of the county's average group home grants for 16 to 18-year-old foster youth.

The federal Fostering Connections to Success Act of 2009 (P.L. 110-351) opened the door for federal financial participation in the costs of foster care services and placements for youth between the ages of 18 and 21. However, THP+ is currently designed to serve foster youth who have emancipated from care (i.e., for whom a judge has terminated the state's jurisdiction); thus, the program is not currently eligible for these federal funds.

Impacts: It is well-documented that foster youth who emancipate from care without continued support at the age of 18 experience higher rates of arrest, incarceration, pregnancy, homelessness, unemployment and a lack of educational achievement (i.e., receipt of a high school diploma) than their peers. In a 2008 survey by the John Burton Foundation, the interviewed THP+ participants experienced a 19 percent gain in employment and a 13 percent increase in hourly wages, in addition to advances in education, health, and housing stability.

Advocates state that many of the 1,400 youth and 168 children currently living in THP+ settings would face immediate homelessness if program funding was eliminated as of

July 1, 2010. In the longer term, the elimination of THP+ funding could also impinge on progress toward reducing the critical challenges faced by former foster youth and result in increases in other state costs (e.g., public assistance and corrections costs).

Questions for DSS:

1. When and how would you anticipate that THP+ would be ramped down in the event of the trigger being pulled? When and how would THP+ providers and participants receive notice of the program's elimination?

2. If this trigger proposal took effect, what would you anticipate would be the impacts on the former foster youth currently living in THP+ settings? On foster youth who emancipate from care in the future? On THP+ providers and staff?

3. What would you anticipate to be the effects on other state services and costs (e.g. public assistance, corrections)?

Subcommittee Staff Comment & Recommendation on Human Services Trigger Proposals: Given the potential for significant state and local government cost shifts, negative impacts on the state's economy and rate of unemployment, and devastating consequences to many of the state's particularly vulnerable children and adults, staff recommends that the Subcommittee reject the Governor's proposals to authorize a trigger for the outright eliminations of the IHSS, CalWORKs, and/or THP+ Programs.

DSS Issue 5: IHSS Anti-Fraud / Program Integrity

Budget Issue: DSS requests $528,000 ($264,000 GF) for six permanent positions to carry out IHSS-related anti-fraud and program integrity activities, and $500,000 ($264,000 GF) for a contract with California State University (CSUS) to assist in the development of a required report to the Legislature. The Department has administratively established these six new positions in 2009-10, and is now seeking 2010-11 authority to continue them permanently. These six positions would be on top of the 42 new IHSS anti-fraud positions authorized by the 2009-10 budget (12 positions at DSS in 2009-10 and 30 positions at DHCS across 2009-10 and 2010-11).

The total budget for IHSS Quality Assurance and Anti-Fraud efforts by DSS and the Counties is $88.3 million ($34.2 million GF), with approximately $3.1 million ($1.6 million GF) for state operations and $85.1 million ($32.6 million GF) for local assistance. Of this total, $54.2 million ($21.9 million GF) were new funds in the 2009-10 budget, including $8.2 million ($4.4 million GF) for the costs of fingerprinting IHSS recipients. These figures do not include the additional costs of IHSS fraud investigations by DHCS.

Background on 2009-10 Program Integrity Provisions: The 2009-10 budget made vast and significant changes in the IHSS program, including expansion of anti-fraud/ program integrity activities. (See the Agenda from the October 28, 2009 Oversight Hearing of Recent Changes in the IHSS Program by the Assembly Budget Committee & Senate Budget Subcommittee #3 for a more comprehensive list.) According to the Administration, these changes will result in an estimated $162 million GF savings. The changes, which included requirements for stakeholder collaboration in their implementation, were:

1. **Criminal background checks** and appeals processes for IHSS providers;
2. The requirement for providers to attend an **orientation**;
3. Authorization to send **targeted mailings** to providers and recipients and to conduct **unannounced home visits**, pursuant to developed protocols and in targeted cases, when there is cause for concern about program integrity;
4. Limits on the use of **P.O. boxes** by providers to receive paychecks;
5. **Training** for social workers on fraud prevention;
6. **Notification** to providers about their clients' authorized hours and service levels;
7. **Fingerprinting** of IHSS program recipients; and
8. **Changes to timesheets**, including fingerprinting and certification after notice of possible criminal penalties for fraud.

These changes were anticipated to take effect at varying points in time over 2009-10 and 2010-11. This Subcommittee has held, jointly with the Assembly Budget Committee, two oversight hearings to address major challenges in the implementation of these changes to date.

DSS State Operations Staff: Not including the requested positions and resources, DSS's total state operations staff for IHSS Quality Assurance and Anti-Fraud efforts consists of 28 positions. Twelve of these positions are new as of 2009-10. According to DSS, all of these 12 new positions have been filled. Six of these 12 staff members are assigned to a variety of program integrity activities (e.g., developing protocols for home visits and targeted mailings, social worker fraud training and data collection). The other six are assigned to the new provider enrollment appeals process. As of early March, 2010, there were approximately 31,000 providers enrolled under the new enrollment procedures. Another 72,137 were in "pending" enrollment status. Finally, 117 had been denied eligibility to enroll in the program. Also as of early March, 14 of the 117 providers who were denied eligibility had appealed that determination.

Also according to DSS, the six additional staff requested in 2010-11 would focus on program changes related to the inclusion of provider and recipient fingerprint information on timesheets.

Background on Required Report: The 2009-10 budget additionally required the Department to convene a stakeholder group to develop a report, by December 31, 2010, to evaluate quality assurance and fraud prevention and detection activities implemented from 2004 to the present. The stakeholder group is required to review annual error reports, information regarding referrals of suspected fraud and subsequent investigations (including cost-benefit information), and information regarding final convictions for fraud. The resulting report must also provide recommendations for early detection and for prevention of errors and fraud.

Subcommittee Staff Comment & Recommendation: Staff recommends rejecting the Administration's proposal for six new positions and holding open the request for $500,000 in authority to contract for support in developing the required report.

Questions for DSS:

1. How is the Department prioritizing the assignments of the 12 new staff authorized in 2009-10 to be dedicated to IHSS program integrity? How much of their work is one-time in nature?

2. What is the current workload for the six of these new staff (out of the 12 authorized in 2009-10) who are assigned to provider enrollment appeals? How many appeals have been filed to date?

(Questions continue on next page)

3. Please briefly describe the current and anticipated functions of the six additional requested positions (on top of the 12 referenced above).

4. How did the Department fund its administrative establishment of these six positions in 2009-10?

5. How did the Department arrive at its estimate of $500,000 as the contract costs for support in providing the required report on anti-fraud efforts to date?

DSS Issue 6: IHSS - *Conlan II* Claims

Budget Issues: DSS requests, in a BCP, $113,000 ($56,000 GF) to establish one new position to review claims filed by IHSS recipients under the *Conlan II* court decisions. DSS also requests to permanently extend one limited-term manager position that would otherwise expire in June 2011 (at an annual cost of $128,000 [$64,000 General Fund]). If these requests are granted, the *Conlan II* unit at DSS would consist overall of one Staff Services Manager and three permanent AGPA positions. DSS states that all of these positions are necessary to meet the provisions of the *Conlan II* court order.

In 2009-10, the Legislature approved DSS's request for the creation of one new position and extension of two additional positions, but rejected the request for a fourth position, to review recipients' claims for reimbursement under *Conlan II.*

Background on *Conlan II* and DSS Workload: *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 has stated that the *Conlan II* cases have resulted in an increasing and permanent workload. In 2009, the Department estimated that the workload could include up to 400 claims per year. The Department now estimates that the annual total may be even higher. The Department estimates that most claims take 12 hours to review (with some taking up to 20 hours).

Subcommittee Staff Comment & Recommendation: Staff recommends holding this issue open.

Questions for DSS:

1) Please briefly summarize the need for the requested staff, including the number and nature of the *Conlan II* claims that are currently awaiting processing by the department and the timeframe in which the department generally processes these claims.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

March 18, 2010 - Actions Taken

(Committee Staff: Jennifer Troia)

0530 Health & Human Services Agency, Office of Systems Integration (OSI) & 5180 Department of Social Services (DSS)

Interim Statewide Automated Welfare System (ISAWS) & ISAWS Migration Project

Approved (2-0) (Ashburn absent) the proposed changes to the ISAWS Migration budget for 2010-11. **Held open** the 2010-11 funding for ISAWS open pending anticipated changes in the May Revision.

CalWORKs Information Network System (CalWIN)

Approved (2-0) (Ashburn absent) the proposed changes to the CalWIN budget.

LEADER Consortium Replacement System (LRS)

Held issue open.

Child Welfare Services/Web (CWS/Web) Project

Held issue open.

4140 Office of Statewide Health Planning

Medical Information Reporting (MIRCal) System

Approved (2-0) (Ashburn absent) the requested authority to convert funds for contract staff to three permanent state positions.

Song-Brown Program

Approved (2-0) (Ashburn absent) the proposal to continue to offset General Fund (GF) spending for the Song-Brown program.

Vocational Nurse Education Fund (VNEF)

Approved (2-0) (Ashburn absent) the request for additional VNEF special fund expenditure authority.

4170 Department of Aging (CDA)

Medicare Beneficiary Outreach and Assistance Program

Approved (2-0) (Ashburn absent) the request for federal funds authority to allow the state to draw down these grant funds.

Federal Grant for Services to Families Impacted by Alzheimer's Disease and Related Dementias

Approved (2-0) (Ashburn absent) the request for federal funds authority to allow the state to draw down these grant funds.

Implementation of Vetoed Funds for Community Based Services Programs (CBSP)

No action taken. This Issue was included for oversight and informational purposes.

Multi-Purpose Senior Services Program (MSSP)

Rejected (2-0) (Ashburn absent) the proposal to transfer program funds to the Department of Health Care Services, but **approved** an alternative technical fix developed by DoF and the Departments of Aging and Health Care Services. The alternative technical fix would create a new program within CDA's budget for Medi-Cal program funding and revise Provision 2 of Item 4170-101-0001 of the Budget Bill.

5180 Department of Social Services (DSS)

CalWORKs- Delay of Work Incentive Nutrition/Pre-Assistance Employment Readiness (WINS/PAERS) and Temporary Assistance Program (TAP)

Approved (2-0) (Ashburn absent) the proposed delays of WINS/PAERS and TAP, but **rejected** the proposed deletion of Section (g) PAERS language.

CalWORKs State and County Peer Review Process

Held issue open.

Trigger Proposal to Eliminate the In-Home Supportive Services (IHSS) Program

Rejected (2-0) (Ashburn absent) the proposal to authorize a trigger that would fully eliminate the IHSS program if the Department of Finance determined that the state would not receive $6.9 billion in new federal funds.

Trigger Proposal to Eliminate CalWORKs

Rejected (2-0) (Ashburn absent) the proposal to authorize a trigger that would fully eliminate the CalWORKs program if the Department of Finance determined that the state would not receive $6.9 billion in new federal funds.

Trigger Proposal to Eliminate Transitional Housing Program Plus (THP+) for Former Foster Youth

Rejected (2-0) (Ashburn absent) the proposal to authorize a trigger that would fully eliminate the THP+ program if the Department of Finance determined that the state would not receive $6.9 billion in new federal funds.

IHSS Anti-Fraud / Program Integrity

Rejected (2-0) (Ashburn absent) the Administration's proposal for six new positions and **held open** the request for authority to contract for support in developing the required report.

IHSS - *Conlan II* Claims

Held issue open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

March 25, 2010

9:30 a.m. *or*
Upon Adjournment of Session
Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item	Department	Page
4260	Department of Health Care Services	
	• Vote Only Issues	4 to 5
	• Medi-Cal Program, Discussion Items	6 to 30
4280	Managed Risk Medical Insurance Board	
	• Healthy Families Program	31 to 36

PLEASE NOTE:
Only those items contained in this agenda will be discussed at this hearing. Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. *Please* see the Senate File for dates and times of subsequent hearings.

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 or by calling 916-651-1505. Requests should be made one week in advance whenever possible.

Thank you.

I. 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. *However*, federal American Recovery & Reinvestment Act of 2009 provides an enhanced federal match of 61.59 percent (from October 2008 to December 30, 2010).

Medi-Cal is at least three programs in one: (1) a source of traditional health insurance coverage for low-income 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 ("dual" eligibles who receive Medicare and Medi-Cal services).

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 the current year is about 7.3 million people and for 20010-11 it is 7.5 million people. Medi-Cal provides health insurance coverage to about 19 percent of California's population, or almost one in every five people (assumes a population of 38.8 million). Most Medi-Cal clients are from households with incomes at or below 100 percent of poverty ($18,310 for a family of three).

The projected Medi-Cal eligible caseload is summarized in the table below.

Summary of Caseload Medi-Cal Eligibles	20010-11 Estimated Eligibles
Families/Children	
CalWORKS	1,467,600
Working Families (1931 b Program)	3,100,000
Pregnant Women	35,900
Children (100 % and 133% programs)	294,500
Aged/Disabled	
Aged	712,700
Blind	23,300
Disabled	1,128,400
Medically Indigent	232,500
Other Various Categories	461,600
Undocumented Persons	67,600
TOTALS	**7,524,100**

Summary of Proposed Budget—Significant Reductions. The Governor proposes total expenditures of $40.3 billion ($12.9 billion General Fund, $25 billion federal Title XIX Medicaid funds, and $2.4 million in other funds) for local assistance the Medi-Cal Program in 2010-11. This reflects a proposed *decrease* of $8.8 billion (total funds) as compared to the revised 2009-10 budget.

This reflects a *net* General Fund increase of $678.2 million, or an increase of about 5.5 percent above the revised current-year level as shown in the chart below.

Medi-Cal Funding Summary *(Dollars in Thousands)*	2009-10 Revised	2010-11 Proposed	Difference	Percent
Local Assistance				
Benefits	$45,752,600	$37,020,500	-$8,732,100	-19.1
County Administration (Eligibility)	$3,116,100	$3,007,400	-$108,700	-3.5
Fiscal Intermediaries (Claims Processing)	$309,900	$302,600	-$7,200	-2.3
Total Local Assistance	**$49,178,500**	**40,330,500**	**-$8,848,000**	**-18.0**
General Fund	$12,232,900	$12,911,100	$678,200	5.5
Federal Funds	$33,653,300	$25,017,300	-$8,636,000	-25.7
Other Funds	$3,292,500	$2,402,100	-$890,400	-27.0

B. Vote Only Issues (Pages 4 through 5)

1. Delay California Discount Prescription Drug Program (CDPDP)

Budget Issue. The DHCS proposes trailer bill language to delay implementation of this new program until 2011-2012 due to continued fiscal constraints. Further, the DHCS proposes to end the program by February 1, 2012 if funding is not provided in subsequent legislation.

Due to budget conditions in 2007-08 and 2008-09, the Governor vetoed funding for this new program. In 2009-2010 funding was not provided and statute was modified to delay implementation. The Governor's January budget for 2010-11 does not contain an appropriation for this new program either.

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. Though implementation of this new program has merit, due to the continued fiscal crisis it is recommended to approve the trailer bill language to delay implementation of this program for 2010-11. Subsequent legislation or budget appropriations could be provided in future years if the design and need for program are warranted.

2. DHCS Staff for Mental Health Supplemental Payments

Budget Issue. The DHCS proposes expenditures of $216,000 ($108,000 Reimbursements from County Mental Health, and $108,000 federal funds) to support two State positions, including a Staff Counsel (three-year limited-term) and an Associate Governmental Program Analyst (permanent) to conduct work regarding the Mental Health Services Supplemental Payment Program authorized in 2009.

The DHCS states the Staff Counsel position will perform legal workload required to establish and implement the program and to ensure it complies with federal law requirements. The other position will administer the actual reimbursement aspects of the program.

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

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

To-date, no federal funds have been received since the State Plan Amendment needed from implementation is now part of the overall Medi-Cal Mental Health Waiver and audit change package being negotiated with the federal CMS. Hopefully this will be reconciled by August 2010. The DMH and DHCS are to keep the Legislature informed of progress.

Subcommittee Staff Comment and Recommendation—Approve. There is no General Fund impact to this proposal and staff is needed to proceed with this new program. No issues have been raised regarding these positions.

C. ISSUES FOR DISCUSSION

1. Governor's Federal Fund Assumptions for Medi-Cal: Several Components

Budget Issues. There are several components to the Governor's January budget for the receipt of federal funds under Medicaid (Medi-Cal Program). These federal fund assumptions for Medi-Cal, along with several others, are tied to the Governor's "trigger" proposal. (The "trigger" mechanism is discussed separately in issue 2 of this Agenda.)

Each of the federal fund assumptions is described below, and *Table 1* (*Page 11*) provides a summary of the dollars. Receipt of these federal funds saves General Fund support. In some instances as noted, the receipt of new additional federal funds will require the State to identify an appropriate State match in order to draw the funds and offset General Fund support.

- **A. Receipt of federal ARRA funds through December 31, 2010.** The federal ARRA enacted by President Obama in 2009 provided increased federal funding for State's from October 2008 through December 31, 2010 (27 months). California is to receive a 61.59 percent federal medical assistance percentage (FMAP), or 11.59 percent *above* our standard level of 50 percent.

  This enhanced funding reduces General Fund expenditures in a corresponding manner. Certain local fund commitments, such as County Realignment expenditures, are also reduced. No issues are raised with this baseline assumption.

- **B. Assume extension of federal ARRA to June 30, 2011.** The Governor's budget assumes the federal government will pass legislation to extend the ARRA for another 6 months to June 30, 2011. The DHCS budget assumes about $1.5 billion in federal funds for this extension which would be used to offset General Fund support in the Medi-Cal Program and other departments. There have been several proposals for federal extension, most recently the Senate included an extension in H.R. 4213 (American Workers, State and Business Relief Act) on March 10. The Governor's "trigger" calculation assumes a total of $2.1 billion (federal funds) for this extension which includes other federal ARRA funds in addition to these Medicaid (Medi-Cal) funds.

  The LAO is on record for concurring to assume this extension for 2010-11.

- **C. Receipt of unexpended federal funds from Hospital Financing Waiver and federal ARRA 61.59 Percent.** California's existing Hospital Financing Waiver, enacted in 2004 through SB 1100 (Ducheny and Perata), is a key Waiver that provides reimbursement to designated safety net hospitals (about 146 hospitals). It is in effect until August 31, 2010.

This Waiver contains provisions for the receipt of $360 million for expansion of Medi-Cal Managed Care through “mandatory” enrollment of seniors and persons with disabilities. This $360 million (federal funds) was left *unexpended* at the time due to the need for considerable health care system changes prior to such implementation. Through the Budget Act of 2009 (July), it was assumed California would obtain these unexpended federal funds pending discussions with the federal CMS.

The DHCS has reached a tentative agreement with the federal CMS to obtain the unexpended $360 million from the Waiver, *plus an additional* $423.8 million to reflect enhanced federal ARRA funding. This $783.8 million (across two-fiscal years) serves as an offset to General Fund support in the Medi-Cal Program.

There are *two key* aspects to this tentative agreement. First, the DHCS has agreed to meet new milestones, as negotiated with the federal CMS, which focus on serving very medically involved individuals. Three demonstration projects (pilots) have been identified for this purpose, as follows:

1. *Implement Disease Management Projects in Los Angeles and Alameda.* This project specifies that at least 19,000 individuals enrolled in Medi-Cal Fee-for-Service who are seniors and disabled individuals living in these counties are to be in a Disease Management Program by no later than August 31, 2010 (Waiver sunsets).

2. *Implement an End of Life Coordinated Care Management Project.* This project specifies that at least 5,000 individuals enrolled in Medi-Cal Fee-for-Service who are seniors and disabled individuals and seriously ill and/or near the end of life are to receive assistance. This pilot is to focus on Butte, Contra Costa, El Dorado and Placer counties.

3. *Implement a Serious Mental Illness Coordinated Care Project.* This project specifies that at least 5,000 individuals enrolled in Medi-Cal Fee-for-Service who are seniors and disabled individuals who are seriously mentally ill are to receive coordinated case management services.

Second, the $783.8 million (across two-fiscal years) in federal funds require a State match for their receipt. As provided for under the Hospital Financing Waiver, California can use “certified public expenditures” (CPE’s) which include all sources of funds available to *government* entities (public) that directly operate health care. In an effort to mitigate demands on State General Fund, California has been utilizing “CPE” from several State-operate programs, as well as from Public Hospitals (as designated). The use of CPE’s has been ongoing since inception of the Waiver.

However, with the newly identified $783.8 million in available federal funds, additional CPE's to match these federal dollars is needed. The DHCS has been working with the federal CMS, as well as the Public Hospitals and others, to discern an approach to identify the appropriate sources. *No resolution has as yet been reached.*

There are two key issues related to identifying appropriate CPE's for this match. First, the DHCS has identified additional State CPE's that can be used for this purpose. The State Programs identified by the DHCS include the following programs:

- AIDS Drug Assistance Program (ADAP) — newly added
- Mental Health Services Act Funds — newly added
- County Medical Services Program — newly added
- Expanded Access to Primary Care — newly added
- California Children Services Program — ongoing
- Medically Indigent Adults, Long-Term Care — ongoing
- Breast and Cervical Cancer Treatment — ongoing
- Genetically Handicapped Persons Program — ongoing

Generally, for the State to claim CPE's for these programs there needs to be clarity that public funds are being expended for health care services and that these funds are *not* otherwise being used to match other federal funds (cannot use funds to match federal dollars multiple times). The federal CMS requires detailed reporting and conducts audits on these funds to ensure the appropriateness of their use.

With respect to the newly added programs, the DHCS has informed Subcommittee staff that use of the ADAP CPE's poses no issues with the operations of the ADAP. They contend there would be *absolutely no impact* to ADAP with respect to the Ryan White CARE Act Funds or the receipt of ADAP Drug Rebate Funds.

The amount of CPE's to be calculated for the Mental Health Services Act Funds (MHSA Funds) has not yet been provided to Subcommittee staff but preliminary DHCS estimates have referenced from $300 million to $500 million. The DHCS is having discussions regarding this calculation. As discussed in the March 11, 2010, Subcommittee hearing, MHSA Funds are primarily continuously appropriated to local County Mental Health Plans and used for various mental health care purposes. It is likely that some portion of these MHSA Funds can indeed be identified for CPE use.

However, there will be a need to ensure that any CPEs meet federal CMS requirements. This aspect will involve working with the County Mental Health Plans and the Department of Mental Health.

Second, the use of more CPE's from the Public Hospitals also needs to be clarified. Presently, CPE's from the Public Hospitals are used extensively under the Hospital Financing Waiver, including drawing federal funds for the Safety Net Care Pool, as well as for federal Disproportionate Share funding. Generally, Public Hospitals do not receive State General Fund support for Medi-Cal purposes and must access CPE's to obtain the federal match, including for inpatient per diem purposes.

Due to the present structure of the Waiver, particularly the cap on the Safety Net Care Pool Funds, *not* all of the available CPE's are being used to match federal funds. In other words, more public expenditures are being spent for which we are not claiming a federal match through the Waiver. Therefore, a portion of these "available" CPEs can be used to draw the newly available federal funds.

However, a balance of what is reasonable to use to assist in obtaining the $783.8 million in additional federal funds needs to be more fully discussed and clarified. This is a complex issue and could have considerable implications for the new 1115 Medi-Cal Waiver which is presently being crafted. It is reasonable to assume that public entities would want to receive an equitable benefit for expending their funds for the federal match.

Also, any additional CPE's require federal CMS approval as referenced previously and Public Hospitals would be at risk in meeting these requirements.

- **D. Assume increase in base FMAP from 50 percent to 57 percent.** The Governor is seeking federal law changes to the formula used to calculate the federal medical assistance percentage (FMAP) which would increase California's baseline from 50 percent to potentially 57 percent. The 57 percent figure used by the Administration is based on an average of what ten other large states receive. As noted in Table 1 below, the January budget assumes $1.8 billion (federal funds) from this proposal. The Administration would use these funds as an offset for General Fund support. This is part of the Governor's "trigger" calculation.

- **E. Enhanced FMAP for Medicare Part D "clawback".** The Governor's January budget assumes receipt of $250 million (federal funds—one time only) by applying the federal FMAP ARRA to California's payment to the federal government for its Medicare Part D "clawback" (States' cost-sharing requirement to the federal government for this prescription benefit). The Administration would use these funds as an offset for General Fund support. This is part of the Governor's "trigger" calculation.

  In mid-February, federal HHS Secretary Sebeilus announced the federal government would be providing States with fiscal relief by applying federal FMAP ARRA to the "clawback" for October 2008 through December 31, 2010. This action provided California with a total of $680.6 million in one-time federal offsets to California's General Fund. The $680.6 million is $430 million *more* of an offset than contained in the Governor's January budget.

If the federal ARRA is extended to June 30, 2010, an *additional offset* of $166.5 million could be obtained (i.e., 11.59 percent for the six months), for a total of $847.1 million.

- **F. Request to change Medicare Part D "clawback" calculation.** The Governor's January budget assumes federal relief of $75 million (ongoing) by making changes to the federal government's formula for calculating the clawback. This requires federal law changes. The Administration would use these funds as an offset for General Fund support. This is part of the Governor's "trigger" calculation.

- **G. Reimbursement to California for Medicare Disability Determination.** The Budget Act of 2009 (July) assumed receipt of $700 million (federal funds-one time) from the federal government for repayment of funds expended through the Medi-Cal Program which should have been the sole responsibility of the federal Medicare Program. All States are affected by this systemic error on the part of the Social Security Administration. This issue continues to be part of the overall federal funding discussion for States, and would require federal law changes.

  The Administration would use these funds as an offset for General Fund support. This is part of the Governor's "trigger" calculation.

- **H. Federal CMS adjustment to State's Family PACT Waiver—more federal funds.** Effective July 2009, the federal CMS reviewed California's existing adjustment within our Family PACT Waiver for individuals otherwise not eligible for Medi-Cal and determined this adjustment should be lower—from 24 percent to 13.95 percent. The effect of this adjustment is that California will receive increased federal funds of $50.8 million in 2009-10 and $ $58.2 million in 2010-11. These additional federal funds serve as an offset to General Fund support. This receipt of federal funds is not part of the trigger calculation.

(Summary Table 1 of federal funds on next page.)

Table 1—Summary of General Fund Savings from Above Federal Fund Assumptions

California's Medi-Cal Program (Title XIX Funds) Description of Federal Component (Dollars in Thousands)	Governor's Revised 2009-10	Governor's Proposed 2010-11	Total General Fund Savings
1. Receipt of federal ARRA thru December 31, 2010 *	**$3,794,472**	**$1,447,788**	**$5,242,260**
• Total DHCS	($2,879,478)	($1,190,873)	($4,070,351)
• Total Other Departments	($914,994)	($256,915)	($1,171,909)
2. Extension of federal ARRA to June 30, 2011 ***	--	**$1,500,700**	**$1,500,700**
• Total DHCS	--	($1,191,000)	($1,191,000)
• Total Other Departments	--	($309,700)	($309,700)
3. Apply federal ARRA to existing Hospital Waiver ***	**$380,268**	**$43,501**	**$423,769**
4. Receipt of unexpended federal funds Hospital Waiver ***	**$360,000**	--	**$360,000**
5. Assume increase in base FMAP from 50% to 57% ***	--	**$1,819,000**	**$1,819,000**
• Total DHCS		($1,445,000)	($1,445,000)
• Total Other Departments		($374,100)	($374,100)
6. Enhance FMAP for Medicare Part D "Clawback" **		**$250,000**	**$250,000**
7. Request to change Medicare Part D "Clawback" ***		**$75,000**	**$75,000**
8. Reimbursement of Medicare disability determinations***		**$700,000**	**$700,000**
9. Federal CMS adjustment for Family PACT Waiver *	**$50,800**	**$58,200**	**$109,000**
TOTALS	**$4,585,540**	**$5,894,189**	**$10,479,729**

***** Federal dollars confirmed for these items.
****** Federal dollars received are $430.6 million *more than* in Governor's January budget.
******* Discussions are continuing on these items.

Subcommittee Staff Comment and Recommendation. As noted above, the federal funding components for the Medi-Cal Program are complex and have nuances. Due to these aspects, it is important to have transparency for the Legislature to be appraised of both funding and policy concerns. The Legislative Leadership has facilitated receipt of federal funds in several areas already and is poised to continue in this role.

As the State's designated entity, the DHCS has the responsibility to secure, track and monitor these federal funds. It is a complex task and a vital role. The work of the DHCS is appreciated.

it is recommended to have the DHCS provide the Subcommittee with a detailed update on the receipt of these federal funds, as well as more clarity regarding the CPE structure, at the May Revision.

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

1. DHCS, Please discuss and explain each component of the anticipated federal funds for the Medi-Cal Program.
2. DHCS, with respect to the Hospital Financing Waiver, when will we have more clarity regarding the use of CPE's and federal CMS approval?
3. DHCS, Are there any other nuances which the Subcommittee should be appraised of?

2. Governor's Proposed Trigger Mechanism

Budget Issues. The Governor's proposed "trigger" mechanism has two key aspects. First, a sweeping Budget Control Section provides broad authority to the Department of Finance (DOF) to make fiscal reductions if the $6.9 billion federal fund target, as defined by the Governor, is not obtained. Second, a comprehensive trailer bill package provides authority to the DOF to drastically alter the Medi-Cal Program if the trigger is pulled. The Budget Control Section and trigger mechanism are described in more detail below.

This discussion will focus on the Administration's trailer bill package as it pertains to Medi-Cal and its potential consequences for the people of California.

First, the trailer bill package would radically reduce Medi-Cal eligibility for various low-income people, most living below the federal poverty level ($18,310 annually for a family of 3), by imposing the existing federal minimum coverage required of States *prior* to the passage of federal Health Care Reform. Millions of Californians, including children, working families, and aged, blind and disabled individuals would be eliminated from health care coverage under the Governor's scenario. People would need to seek episodic care through emergency rooms, clinics and county indigent health facilities.

Second, the trailer bill package would provide DOF authority to eliminate certain benefits, which under federal law, are considered "optional" for States to provide to adults. Table 1 below provides a summary of the DHCS' estimate of the proposed trigger on the Medi-Cal Program.

Table 1: Summary of DHCS Estimate of Trigger Impact to Medi-Cal

Description of Proposal	Persons Impacted *Fully* Implemented	General Fund Reduction for 2010-11
A. Medi-Cal Eligibility Reduction (assumes 1/01/2011):		
1. Rollback 1931 (b) to minimum	-433,582	-$27,375,000
2. Rollback Aged, Blind, & Disabled	-93,396	-$52,287,000
3. Eliminate Medically Needy Program	-42,809	-$290,888,000
4. Eliminate Children's Gateway Pre-enrollment	-676,216 screens	-$8,120,000
5. Eliminate Accelerated Children's Single Point of Entry	-35,925	-$1,461,000
6. Eliminate Medi-Cal Expansion—Former Foster Care	-4,776	-$1,559,000
7. Eliminate Breast & Cervical Cancer Treatment	-9,269	-$20,383,000
8. Eliminate Medically Indigent Adult Long-Term Care	-943	-$11,115,000
9. Eliminate Family PACT Program	-1,600,000	-$64,133,000
TOTAL Proposed Eligibility Reduction	**-2,220,790**	**-$477,321,000**
B. Medi-Cal Benefit Reduction (assumes 6/01/2010)		
1. Eliminate Adult Optional Benefit: Hearing Aids		-$2,691,000
2. Eliminate Adult Optional Benefit: Physical Therapy		-$40,000
3. Eliminate Adult Optional Benefit: Occupational Therapy		-$4,000
4. Eliminate Adult Optional Benefit: Orthotics		-$30,000
5. Eliminate Adult Optional Benefit: Indep Rehab Facilities		-$4,000
6. Eliminate Adult Optional Benefit: Outpatient Heroin Detox		-$61,000
7. Eliminate Adult Optional Benefit: Medical Supplies		-$19,204,000
8. Eliminate Adult Optional Benefit: Prosthetics		-$570,000
9. Eliminate Adult Optional Benefit: Durable Medical Equip		-$24,669,000
TOTAL Proposed Optional Benefit Reduction	**over 223,000**	**-$47,273,000**
TOTAL Proposed Reductions	**-2,220,790**	**-$524,594,000**

The DHCS eligibility figures assume that children who are dropped from 1931 (b) eligibility are redetermined to be eligible for the 100 percent or 133 percent of poverty categories of Medi-Cal. In practice, it is very likely that many children would actually lose coverage since families would need to have their children re-determined which creates a hurdle for continued enrollment.

The Governor's trigger identifies nine "Optional" benefits in Medi-Cal which would be eliminated. The DHCS reduction amounts assume that some expenditure would be shifted to other Medi-Cal services. The Table below displays the DHCS assumptions regarding potential cost shifts to other Medi-Cal provided mandatory services. For example, if hearing aids are eliminated no other Medi-Cal service is available for treatment/assistance. With respect to outpatient heroin detoxification, it is likely that inpatient services would become necessary but this cost is not captured in the assumptions.

DHCS Medi-Cal Optional Benefits-- Trigger	**DHCS Assumption**
1. Eliminate Adult Optional Benefit: Hearing Aids	Assumes no cost shift
2. Eliminate Adult Optional Benefit: Physical Therapy	90 percent shift to mandatory service
3. Eliminate Adult Optional Benefit: Occupational Therapy	60 percent shift to mandatory service
4. Eliminate Adult Optional Benefit: Orthotics	75percent shift to mandatory service
5. Eliminate Adult Optional Benefit: Indep Rehab Facilities	60 percent shift to mandatory service
6. Eliminate Adult Optional Benefit: Outpatient Heroin Detox	Assumes no cost shift
7. Eliminate Adult Optional Benefit: Medical Supplies	30 percent shift to mandatory service
8. Eliminate Adult Optional Benefit: Prosthetics	75 percent shift to mandatory service
9. Eliminate Adult Optional Benefit: Durable Medical Equip	25percent shift to mandatory service

Some of the above categories are quite broad as to what is covered, particularly "Medical Supplies" and "Durable Medical Equipment". The Medical Supplies category includes diabetic supplies, all wound care, infusion supplies, tracheotomy care, and many others. Durable Medical Equipment includes wheelchairs and accessories, oxygen and respiratory equipment, ostomy pouches, and many others.

it should be noted that the Budget Act of 2009 (July) did eliminate ten Optional benefits for adults (not in nursing homes or pregnant), including Adult Dental, acupuncture services, chiropractic services, incontinence creams and washes, optician/optical lab services, optometry services, podiatry services, psychology services, speech therapy and audiology services.

Background-- Budget Control Section 8.26 (Budget Bill, page 646). This control section provides **(1)** broad authority to the Director of Finance to determine by July 15, 2010, if the State has received $6.9 billion in additional federal funds which can be used in lieu of General Fund support for 2010-11; and **(2)** enables the Director of Finance to *adjust appropriations as necessary* in accordance with statute.

Background--Description of Governor's "Trigger" Mechanism. The Governor proposes *overall* reductions of $4.6 billion (General Fund) and revenue adjustments of $2.4 billion (General Fund) in the event the federal government does not provide $6.9 billion in additional federal funding. The Table 2 below provides a listing of the Governor's federal requests which are counted towards this trigger mechanism.

Table 2: List of Governor's Federal Requests Associated with "Trigger" Proposal

Governor's Federal Request	2010-11 Budget Assumption
1. Extend federal ARRA to June 30, 2010 (all health & human srvs)	$2.1 billion
2. Increase FMAP from 50 percent to 57 percent	$1.8 billion
3. Obtain federal ARRA FMAP for Medicare Part D Clawback	$250 million
4. Change Medicare Part D Clawback calculation	$75 million
5. Reimbursement for Medicare Disability Redetermination	$700 million
6. Reimbursement for Special Education mandates	$1 billion
7. Reimbursement for cost of incarcerating undocumented immigrants	$879.7 million
8. Expanded federal funding for Foster Care	$86.9 million
TOTAL	**$6.9 billion**

Subcommittee Staff Comment and Recommendation. First, President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590) on Tuesday, March 23, 2010. Effective upon this date of enactment, States are required to maintain Medicaid (Medi-Cal) eligibility standards, methodologies, and procedures until a Health Insurance Exchange is operational in the State, with minor exceptions. Therefore, the Governor's proposed trigger for Medi-Cal eligibility reduction would violate the MOE provisions.

Second, the proposal is broadly crafted and does not take into consideration the updated receipt of federal funds, such as for the Medicare Part D Clawback for federal ARRA received in February.

Third, many of the Medi-Cal Optional benefits proposed for elimination are "core" benefits which provide medically necessary assistance for individuals with chronic conditions. Elimination would likely result in increased hospitalization, such as with Diabetes, significant concerns with mobility and employment, such as not having access to wheelchairs and Prosthetics. Common sense needs to be applied.

It is recommended to reject the proposed trigger at this time.

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

1. DHCS, Please provide an overview of the proposed trigger regarding Medi-Cal eligibility. How does the federal H.R. 3590, signed by President Obama, interact with the trigger proposal on eligibility? (Please be specific).
2. DHCS, Please provide a brief description of the Optional benefit proposal.

3. Governor's Proposal to Obtain Federal Approval to Establish Limits on Benefits, Expand Cost Sharing & Other Medi-Cal Program Changes

Budget Issue. The Governor proposes trailer bill legislation for the DHCS to negotiate with the federal government to implement various changes to Medi-Cal for a reduction of almost $2.4 billion ($750 million General Fund). No basis for the estimated savings has been provided to the Legislature.

This proposal is part of the Governor's request for "federal flexibility" and would require federal law changes and other federal approvals, including possible Waivers and State Plan Amendments (all requiring federal CMS approval).

The proposed trailer from the DHCS states that cost containment methods shall achieve a reduction of $750 million (General Fund) in 2010-11 and annually thereafter (i.e., ongoing reductions). It states that cost containment methods *may* include, but are *not limited to*, any or all of the following methods:

- Utilization controls, including limits on particular services.
- Increased cost-sharing for Medi-Cal enrollees through co-payments and premiums to the extent allowed by federal law.
- Adjustment to provider rates.

The DHCS would affect these changes based on federal approval. The Legislature would only receive notification of these changes through the Joint Legislative Budget Committee within 30-days prior to implementation.

Further, the proposed language provides the DHCS with the ability to implement these changes without taking *any* regulatory action, by means of an "All-County" letter or similar instruction.

The DHCS contends they have been meeting with both the federal CMS and constituency groups to discuss various cost containment proposals and that additional discussions need to occur before a more developed proposal can be provided to the Legislature for consideration at May Revision.

Background—Federal Law Restrictions on Cost-Sharing. Under federal law, States cannot impose premiums on Medi-Cal enrollees with incomes below the poverty level (100 percent) and can charge only nominal co-pays. For people with incomes between 100 percent and 150 percent of poverty, the State cannot charge premiums and can charge only limited co-pays (i.e., 10 percent of the cost of the service up to a maximum of 5 percent of the family's income). As such, for the vast majority of Medi-Cal consumers, the State cannot charge premiums.

Subcommittee Staff Comment. As noted by the CA Health and Human Services Agency in a January 2010 publication, California operates one of the *least costly* Medicaid programs in the nation. Our Medi-Cal Program utilizes extensive treatment authorization processes for the receipt of services and has some of the lowest Medi-Cal rates in the nation.

The Administration's draft trailer bill language provides sweeping authority to administer Medi-Cal without the involvement or oversight of the Legislature. Only a 30-day notification of changes would be provided to the Legislature with no real opportunity to have a public discourse or to know the human consequences of the changes. In short, the Governor seeks carte blanche authority to operate the Medi-Cal Program.

The affect of modifying the cost-sharing arrangements in Medi-Cal are disconcerting given the very low income level, and potentially could violate the maintenance of effort provisions of the Patient Protection and Affordable Care Act (H.R. 3590) if it affects Medi-Cal eligibility determinations. For example, it could be in violation if a Medi-Cal enrollee is required to pay a premium in order to continue enrollment.

This proposal was discussed by the Senate Budget Committee in its January 26 hearing during the Special Session deliberations and was not adopted. No additional information on the framework of this proposal has been provided.

The Administration states it will be providing more information at the May Revision.

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

1. DHCS, Please provide an update on the Administration's thoughts as to what specific cost-containment is being considered.
2. DHCS, What interaction does this proposal have with the federal Patient Protection and Affordable Care Act (H.R. 3590) ?

4. Implementation of AB 1383—Hospital Quality Assurance Fee (QAF)

Budget Issues. AB 1383, Statutes of 2009, authorized the implementation of a Quality Assurance Fee (QAF) on General Acute Hospitals for the period of April 2009 through December 2010. Implementation of the QAF requires federal CMS approval which is pending.

The Governor's January budget proposes to appropriate these revenues within the Medi-Cal Program. There are *three* budget issues regarding implementation of the QAF.

First, the federal CMS is in the process of evaluating California's model for implementing the QAF. Presently, the DHCS assumes federal approval by May 1, 2010. The Subcommittee should obtain an update on these discussions and whether any substantial changes may need to be made to the QAF model in order to obtain federal approval.

Second, based on estimates as of January 2010, the DHCS anticipates the QAF to generate almost $3.6 billion in revenues across three fiscal years as shown in Table 1, below. The QAF will be deposited into the Hospital Quality Assurance Revenue Fund, where they are available for expenditure until January 1, 2013.

Table 1: Total Estimated Revenues from Hospital Quality Assurance Fees

Fiscal Year and Time Frame	Estimated Quality Assurance Fees (dollars in thousands)
2008-09 (April 2009 to June 2009) *****	$513,920
2009-10 (July 2009 to June 2010)	$2,055,680
2010-11 (July 2010 to December 2010)	$1,028,000
TOTAL Estimated Fees (April 2009 to December 2010)	$3,597,600

*****These funds will be reflected in the 2009-2010 state fiscal year.

Due to the timing of the federal CMS approval, the Subcommittee should obtain an update on the process and timing of the collection of the QAF from hospitals and if there are any concerns from constituency groups regarding implementation of the collection process.

Third, Table 2 below reflects total estimated payments, including federal funds (61.59 percent for ARRA where applicable), to be made by fiscal year as contained in the January budget for Medi-Cal, including State support for implementation

Table 2: Total Estimated Payments by Fiscal Year (as proposed by the DHCS)

AB 1383 Uses	2009-10 (April 2009-June 2010)	2010-11	Total Amount (7 Quarters)
1. Direct Grants to Public Hospitals	$387,500	$155,000	$542,500
2. Hospital Payments-- includes Private and Non-Designated Hospitals, Managed Care Plans and Mental Health Plans	$4,636,380	$1,854,550	$6,490,930
3. Children's Health (off-sets General Fund)		$560,000	$560,000
4. DHCS Staff & Administrative Request	$1,103	$1,335	$2,438
TOTAL Estimated Payments	**$5,024,983**	**$2,570,885**	**$7,595,868**

Each of the proposed expenditures from Table 2 is described below:

- **Direct State Grants to Public Hospitals**. As contained in statute, Public Hospitals are to receive direct grants in support of health care expenditures in an aggregate amount of $310 million (federal fiscal year). Public hospitals include both those operated by Counties and by the University of California system. These grants are *not* considered Medi-Cal payments and cannot be matched with federal funds. This is because these hospitals are now paid at the maximum amount that qualifies for federal matching funds under the existing Hospital Financing Waiver.

- **Hospital Payments.** This reference in Table 2 broadly covers several areas. First, private hospitals (those paying the fee) will receive *supplemental* Medi-Cal payments for inpatient and outpatient hospital and subacute care services. These supplemental payments are in addition to existing Medi-Cal per diem payments. Most of the payments will be made in this area.

  Second, the DHCS will increase Medi-Cal payment rates to Managed Care Plans (Plans) and require them to "pass-through" all of these funds to hospitals. The Plans will receive funds for those hospitals located in their service region as well as funds for hospitals in neighboring counties where there is no Medi-Cal Managed Care. The Plans will then pay *supplemental* payments to these hospitals as directed by the DHCS. The amount a hospital will receive will be based on the number of total Medi-Cal Managed Care days it provides.

  Third, the DHCS will provide payments to County Mental Health Plans to "pass-through" to hospitals providing Acute Psychiatric Services. This is a *supplemental* payment made in a similar manner as done with the Managed Care Plans.

  Fourth, non-designated hospitals (District Hospitals) will also receive *supplemental* Medi-Cal payments for inpatient services. Reimbursement rates for these hospitals are on a per diem basis and are lower than those for private hospitals since non-designated hospitals are not paying the QAF.

- **Children's Health.** The enabling legislation provided for $320 million annually for health care coverage of children. The $560 million represents seven quarters of QAF collection which corresponds to the statute. The $560 million serves as an offset to General Fund support in the Medi-Cal Program for providing services to children. These funds will be matched with federal funds. (Also see MRMIB, Healthy Families Program discussion.)

- **Department of Health Care Services—14 State Staff.** Utilizing an appropriation provided in the legislation, the DHCS has $1.1 million ($537,000 Private Hospital Supplemental Fund from the Hospital Finance Waiver and $566,000 federal funds) available in the current-year to commence with implementation. These funds are to support 3.5 State staff and to contract with two consulting firms (Covington and Burling, and Mercer) for their expertise with hospital financing issues.

For 2010-11, the DHCS requests a total of 14 State staff (two-year limited-term), and no contract funds, for an expenditure of $1.3 million ($463,000 Private Hospital Supplemental Fund, $163,000 Hospital Quality Assurance Revenue Fund, and $709,000 federal funds). The State staff includes the following positions:

(a) Staff Legal Counsel	two positions
(b) Associate Governmental Program Analysts	four positions
(c) Associate Management Auditors	three positions
(d) Associate and Trainee Accounting Analysts	four positions
(e) Office Support	one position

The DHCS states the workload for these staff includes the following key items:

- Participate in Medi-Cal Program changes (i.e., State Plan Amendments) that require negotiations with the federal CMS and resolve ongoing legal issues related to these changes;
- Collect data to develop total QAF amounts imposed on each hospital and to determine different types of payments to each hospital.
- Develop certification forms, fee notices, and prepare payment letters for hospitals.
- Develop a QAF collection database and prepare relevant collection processes and paperwork.
- Perform full-scope audits to reconcile the enhanced payments to Managed Care Plans.
- Calculate and certify the Managed Care payments as actuarially sound pursuant to federal regulations.
- Develop accounting procedures for processing new hospital payment invoices and implement a new federal claiming process.

Background—The Fee. The enabling legislation specifies a three-tier QAF structure which is intended to maximize the number of hospitals that benefit from it and minimize the number of hospitals that do not, while still meeting federal requirements. Certain categories of hospitals, such as designated public, small and rural, most specialty care and long-term care, are exempt from paying the fee.

The fees in statute are as follows:

- $27.25 for every inpatient day of patients enrolled in a Managed Care Plan, *excluding* Medi-Cal;
- $233.46 for every inpatient day of patients covered by Fee-for-Service, *excluding* Medi-Cal; and
- $293.00 for every inpatient day of patients *covered* by Medi-Cal, whether Managed Care or Fee-for-Service.

It should be noted the DHCS may alter the specified QAF amount slightly in order to obtain federal CMS approval. As such, the fee structure may be altered. Fees are to be computed

starting on the effective date of the bill and to continue through December 31, 2010 (i.e., corresponds to existing expiration date of the federal ARRA FMAP amount 61.59 percent).

Background—Use of Fees and Taxes. Taxes and fees assessed on health care providers have become a key component of Medicaid financing in 43 of 50 States. In addition to hospitals, California currently applies provider fees on certain Nursing Facilities and Intermediate Care Facilities for the Developmentally Disabled (ICF-DD), and has also extended an existing State gross premium tax on insurance to Medi-Cal Managed Care Plans (AB 1422, Statutes of 2009). These revenues, coupled with federal matching funds (including enhanced ARRA funds), have been used to increase Medi-Cal reimbursement to providers, to finance quality improvement efforts, and to maintain or expand health care coverage. Federal law restricts the use of provider taxes and fees, and all Medicaid applications require federal CMS approval.

Subcommittee Comment. The DHCS must obtain *federal CMS approval* for several aspects of QAF implementation, including:

- An amendment to the existing Hospital Financing Waiver for the QAF to be applied to participating hospitals;
- The overall QAF fee design and model;
- Distribution of the payments to hospitals; and
- Method of payment to be made to Medi-Cal Managed Care Plans and County Mental Health Plans for the pass-through to hospitals.

It is important to obtain an update from the DHCS to ensure transparency, and to enable the Legislature to work collaboratively with the Administration to secure federal CMS assistance and approval.

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

1. DHCS, Please provide a brief overview of the structure for this Quality Assurance Fee (QAF). and its update regarding progress being made with the federal CMS.
2. DHCS, Please provide an update regarding progress being made with the federal CMS on its approval.

5. Proposed 10 Percent Reduction to Public Hospitals for 2010-11

Budget Issue. The DHCS proposes trailer bill language to *shift* a total of $54.2 million in federal funds from the Safety Net Care Pool, designated for uncompensated care for Public Hospitals and the Los Angeles Medical Services Preservation Fund (L.A. Preservation Fund), to backfill for General Fund support in certain state-operated programs.

The trailer bill language provides that the reduction shall occur for hospital services provided during the period of July 1, 2010 through June 30, 2011. As such, this reduction would be applied under the new, presently being crafted 1115 Medi-Cal Waiver.

Of the $54.2 million shift, almost $30 million would be used for backfill of General Fund support in 2010-11 and the remaining amount of $24.2 million would be expended in 2011-12. The DHCS states this is due to the lag between the date of the service and the date that expenditures are paid.

AB 3X 5, Statues of 2009 (trailer bill), redirected $54.2 million, or 10 percent, as referenced for 2009-2010 (as applied to the existing Hospital Financing Waiver). Therefore the DHCS contends they need to continue this redirection for at least one more year.

The Tables below summarize both fiscal years, along with the existing baseline assumptions

Table 1: Total Redirection for 2009-2010

State Program (Dollars in Thousands)	Existing Redirection (Baseline)	AB 3X 5 Amount (Increase)	Total Amount of Shift for 2009-10
Medically Indigent--LTC	$19,464	$5,100	$24,564
Breast & Cervical Cancer	1,000	--	$1,000
CA Children's Services Program	22,000	32,157	$54,157
Genetically Handicapped Persons	18,000	16,943	$34,943
TOTALS	**$60,464**	**$54,200**	**$114,664**

Table 2: Total Redirection for 2010-2011

State Program	Existing Redirection (Baseline)	Additional Shift for 2010-11 (Increase)	Total Amount of Shift for 2010-11
Medically Indigent--LTC	$8,725	$2,500	$11,225
Breast & Cervical Cancer	$500	--	500
CA Children's Services Program	$22,000	$17,000	39,000
Genetically Handicapped Persons	$18,000	$10,000	28,000
TOTALS (with $24.2 million for 2011-12)	**$49,225**	**$29,500**	**$78,725**

Background—Summary of Existing Hospital Financing Waiver. As a result of federal policy changes, California was required to completely change its method in which Safety-Net Hospitals (about 146 hospitals) are financed under the Medi-Cal Program. The Administration negotiated a five-year federal Waiver with the federal CMS which was completed as of September 1, 2005 and expires as of *August 30, 2010*. This Waiver is to provide over $2 billion in annual reimbursement to hospitals.

The federal requirements for this Hospital Finance Waiver are contained in the *"Special Terms and Conditions"* document which serves as a contract between California and the federal CMS. Senate Bill 1100 (Perata and Ducheny), Statutes of 2005, provides the state statutory framework for implementing it.

Under this Waiver, Public Hospitals certify their health care expenditures (referred to as "Certified Public Expenditures" or CPE) in order to obtain federal funds, and Private Hospitals solely on the state's General Fund to obtain their federal funds. In addition, Public Hospitals use Intergovernmental Transfers (IGT's) on a limited basis to obtain federal matching funds.

The framework of the Waiver is quite complex and consists of several funding mechanisms, including the Health Care Support Fund (i.e., Safety Net Care Pool), Stabilization Funding, Disproportionate Share Hospital (DSH) payments, replacement DSH and replacement Graduate Medical Education payments, Physician Services, Distress Hospital Fund, and Medi-Cal per diem and cost-based payments.

Background—Pending Comprehensive 1115 Medi-Cal Waiver. With the existing Hospital Financing Waiver scheduled to sunset as of August 2010, trailer bill legislation-- AB 4X 6, Statutes of 2009—was adopted to commence with the framework for a new, more comprehensive Waiver for California. The goals of this new Waiver are:

- Strengthening California's health care safety net;
- Reducing the number of uninsured individuals;
- Optimizing opportunities to increase federal financial participation;
- promoting long-term, efficient and effective use of State and local funds;
- Improving health care quality and outcomes; and
- Promoting home and community-based care.

The statute also directs for the Waiver to provide Medi-Cal enrollees with access to better coordinated and integrated care to improve outcomes and help slow the long-term growth in program costs. Among other things, it provides for the more comprehensive enrollment of individuals into specified organized delivery systems, such as managed care, enhanced primary care case management, or a medical home model.

The DHCS has developed a concept paper for the Waiver and is convening extensive workgroups to engage diverse stakeholders in crafting a framework for this Waiver. Considerable work needs to be done over the next several months, including the development of an implementation plan. This plan is to be provided to the fiscal and policy

committees of the Legislature prior to implementation of the Waiver, and at least 60-days prior to an appropriation by the Legislature for this purpose.

Constituency Letters. The Subcommittee is in receipt of numerous letters, including from the CA Hospital Association of Disproportionate Share Hospital Task Force, in strong opposition to the Governor's additional redirection of federal Safety Net Care Pool Funds.

Subcommittee Staff Comment and Recommendation. With the ongoing fiscal crisis clearly there is a need to obtain General Fund relief to maintain core health care treatment programs, such as the California Children's Services, Medically Indigent Long-Term Care, Breast and Cervical Cancer Treatment, and Genetically Handicapped Persons (mainly hemophilia treatment services).

However, it is unclear at this time how the overall structure of the 1115 Waiver is to be crafted, particularly the complexities of the financing. The use of certified public expenditures (CPE's) and other funding sources besides General Fund support should be further clarified prior to adoption of this proposal. Additional transparency would be helpful.

The effect of the Governor's proposal on Public Hospitals and hospitals receiving funds from the L.A. Preservation Fund is that fewer federal funds would be available for uncompensated care provided to medically needy individuals.

It is recommended to keep this issue "open", pending receipt of the May Revision.

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

1. DHCS, Please describe the budget proposal.

6. Proposed 10 Percent Reduction to Private Hospitals for 2010-11

Budget Issue. The Governor also proposes to reduce by 10 percent, or $52 million, the amount Private Hospitals and District Hospitals receive through the Waiver by making adjustments to certain disproportionate share hospital payments, including replacement payments. This issue corresponds to the 10 percent Public Hospital reduction, above.

The trailer bill language provides that the reduction shall occur for hospital services provided during the period of July 1, 2010 through June 30, 2011. As such, this reduction would be applied under the new, presently being crafted 1115 Medi-Cal Waiver.

AB 4X 5, Statutes of 2009 (trailer bill), redirected $52 million (Disproportionate Share Hospital Replacement Fund) to offset General Fund support in the Medi-Cal Program for 2009-2010.

Under the state's Hospital Financing Waiver, hospitals participating in the Medi-Cal Program receive funds from several sources based on a complex formula. A key aspect of this arrangement is that Public Hospitals receive federal funds based on the use of their certified public expenditures and intergovernmental transfers, whereas Private Hospitals and District Hospitals receive a mixture of state General Fund support and federal funds.

The payments the DHCS is proposing to reduce are "replacement" Disproportionate Share and "replacement" Graduate Medical Expenses. When the Waiver was structured, federal funds which the Private and District Hospitals had received were restructured with the intent of the state to ensure that in the aggregate, these hospitals would receive payments equal to what they received in 2004-05 (i.e., prior to the Hospital Financing Waiver).

Constituency Letters. The Subcommittee is in receipt of numerous letters, including from the CA Hospital Association of Disproportionate Share Hospital Task Force, in strong opposition to the Governor's additional redirection of federal Safety Net Care Pool Funds.

Subcommittee Staff Comment. The DHCS proposal would affect the distribution of funds within the upcoming 1115 Medi-Cal Waiver. Therefore, it is recommended to keep this issue "open", pending receipt of the May Revision.

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

1. DHCS, Please describe the budget proposal.

7. Implementation of Medi-Cal Managed Care Tax (AB 1422, Statutes of 2009)

Budget Issues. Among other things, AB 1422, Statutes of 2009, extended the State's existing 2.35 percent gross premium tax on insurance (all types) to Medi-Cal Managed Care Plans. This tax is effective retroactively from January 1, 2009 through to December 31, 2010.

Revenues from this tax are matched with federal funds and will be used for the following:

- Provide a reimbursement rate increase to Medi-Cal Managed Care Plans;
- Provide a reimbursement rate increase to health plans participating in the Healthy Families Program; and
- Fund health care coverage for children in the Healthy Families Program (serves as a backfill to the General Fund). (Discussion under the Managed Risk Medical Insurance Board item.)

Specifically, the enabling legislation requires the State to allocate 38.41 percent of the tax revenue to the DHCS to provide enhanced rates to Medi-Cal Managed Care Plans. The remaining 61.59 percent of the tax revenues to the Managed Risk Medical Insurance Board for essential preventive and primary health care services through the Healthy Families Program.

With respect to Medi-Cal Program impacts, there are *two* key budget issues, including changes to the Medi-Cal Managed Care capitation rates, and the DHCS' trailer bill proposal to extend the sunset date of the tax to June 30, 2011.

With respect to Medi-Cal Managed Care capitation rates, the DHCS needs to adjust the current-year to reflect the tax retroactive date of January 1, 2009, *and* also needs to provide for 2010-11. According to the DHCS, a total of $239.2 million (total funds) is available for this purpose for 2009-10 and a total of $162.6 million (total funds) is available for 2010-11.

The Medi-Cal Managed Care Plans affected by the tax include: (1) Two Plan Model (Local Initiatives); (2) County Organized Health Systems (COHS); (3) Geographic Managed Care; (4) AIDS Healthcare; and (5) SCAN.

The DHCS is also proposing trailer bill language to: (1) extend the existing sunset from December 31, 2020 to July 1, 2011; and (2) amend the applicable percentages for reimbursement to the DHCS due to the sunset of the federal ARRA. The proposed six-month extension would provide an additional $82 million in revenues, and a corresponding $63 million in additional federal funds.

Background—Medi-Cal Managed Care QIF and Federal Changes. In 2005, a "Quality Improvement Fee" (QIF) for Medi-Cal Managed Care organizations was implemented. The fee was 5.5 percent of the total operation revenue of each organization, except for four county organized healthcare systems (COHS) who were federally exempt from payment.

Initially, about 75 percent of the revenues collected from the QIF was matched with federal funds and used for payments to the Medi-Cal Managed Care organizations. The remaining 25 percent was retained to backfill for General Fund support in the Medi-Cal Program.

Effective October 1, 2007, with implementation of the DHCS' new Medi-Cal Managed Care rate methodology, only 50 percent of the revenues from QIF was used to match federal funds and used for payments to these organizations. The remaining 50 percent was retained to backfill for General Fund support in the Medi-Cal Program. Therefore, while the amount these organizations pay is returned to them, they realized no *net* benefit.

Due to federal law changes, States had until October 1, 2009 to modify these fee structures which required application of provider fees or taxes to be more broadly applied (i.e., to include health maintenance organizations and preferred provider organizations). As such, this QIF sunset as of September 30, 2009 and AB 1422, Statutes of 2009 *generally* serves as its replacement.

Subcommittee Staff Comment and Recommendation. The May Revision should provide more clarity regarding the revenues to be generated from implementation of AB 1422, as well as the status of the federal ARRA extension. Therefore it is recommended to adopt the Administration trailer bill language as "placeholder" and to keep issues related to Medi-Cal Managed Care rates "open".

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

1. DHCS, Please provide an update regarding the current-year rate adjustments for Medi-Cal Managed Care Plans due to the gross premium tax revenues. Are there any concerns from the Plans regarding these adjustments?
2. DHCS, Please provide a brief summary of the trailer bill proposal.

8. Newly Qualified Legal Immigrant Adults

Budget Issue. The Governor proposed legislation in Special Session to eliminate full-scope Medi-Cal for newly qualified legal immigrant adults in the U.S. for less than five years for a net reduction of $433,000 (total funds) for 2009-10, and a reduction of $33.4 million (decrease of $53.8 million General Fund and increase of $20.4 million federal funds). This proposal was *not* adopted in the Special Session.

Under this DHCS proposal, 48,600 adults would only be eligible to receive emergency services, prenatal care, state-only breast and cervical treatment, long-term care, and tuberculosis services. Other preventive care, medications for chronic conditions, and related full-scope services would not be reimbursed under Medi-Cal.

Due to federal law changes enacted in 1996, federal matching funds are not provided for non-emergency services for this category of individual. Federal law does require states to provide emergency services and will reimburse for these services if they are identified as being an emergency medical service (according to the attending medical staff).

The DHCS states under their proposal to eliminate full-scope services to these individuals, 56 percent of the cost for services would shift to emergency services and would be partially reimbursed by the federal government.

Subcommittee Staff Comment and Recommendation. California has *always* provided legal immigrant adults with full-scope services in Medi-Cal if they otherwise meet all other eligibility requirements (such as income and residency). Medi-Cal uses 100 percent General Fund support for this purpose, but the State is reimbursed by the federal government for those services identified as being an emergency service.

Enactment of the DHCS proposal would most likely (1) impair people's health, particularly individual's with chronic conditions; (2) result in increased use of hospital emergency rooms; (3) result in increased uncompensated care costs for hospitals and clinics; and (4) shift some costs to County indigent health care programs.

California has incorporated the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) option to obtain federal funds for legal immigrant children and pregnant women by eliminating the previous five-year waiting period. As such, federal funds are now obtained for this population.

It is recommended to leave this issue open until the May Revision.

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

1. DHCS, Please describe the proposal.
2. DHCS, Does your proposal violate the maintenance of effort (MOE) provisions of the federal ARRA, including potential cost-shifting to local governments, or the Patient Protection and Affordable Care Act (H.R. 3590)? If not, why not please?

9. Governor's Proposal: Persons Permanently Residing Under Color of Law (PRUCOL)

Budget Issue. The Governor proposed legislation in Special Session to eliminate full-scope Medi-Cal for individuals designated as PRUCOL for a net reduction of $289,000 (reduction of $465,000 General Fund) in 2009-2010, and $39.6 million (reduction of $63.8 million General Fund) in 2010-11. This proposal was *not* adopted in the Special Session.

Under this DHCS proposal, 17,000 people would only receive emergency services, prenatal care, state-only breast and cervical cancer treatment, long-term care, and tuberculosis services. Other preventive care, medications for chronic conditions, and related full-scope services would not be reimbursed under Medi-Cal.

Due to federal law changes enacted in 1996, federal matching funds are not provided for non-emergency services for this category of individual. Federal law does require states to provide emergency services and will reimburse for these services if they are identified as being an emergency medical service (according to the attending medical staff).

The DHCS states under their proposal to eliminate full-scope services to these individuals, 56 percent of the cost for services would shift to emergency services and would be partially reimbursed by the federal government.

PRUCOL generally means that the immigration authorities are aware of a person's presence and have no plans to deport or remove them from the county. Medi-Cal lists several immigrant statuses that are considered PRUCOL. The various PRUCOL categories are permitted by the Department of Homeland Security to remain in the U.S.

Subcommittee Staff Comment and Recommendation. California has *always* provided full-scope services to these individuals if they otherwise meet all other eligibility requirements.

Enactment of the DHCS proposal would most likely (1) impair people's health, particularly individual's with chronic conditions; (2) result in increased use of hospital emergency rooms; (3) result in increased uncompensated care costs for hospitals and clinics; and (4) shift some costs to County indigent health care programs.

It is recommended to leave this issue open until the May Revision.

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

1. DHCS, Please describe the proposal.
2. DHCS, Does your proposal violate the maintenance of effort (MOE) provisions of the federal ARRA, including potential cost-shifting to local governments, or the Patient Protection and Affordable Care Act (H.R. 3590)? If not, why not please?

10. DHCS Proposal to Implement Mid-Year Status Reporting for 6 Months

Budget Issue. The DHCS proposes a reduction of $4.9 million ($2.5 million General Fund) by rolling back the annual eligibility for Children from 12-months to 6-months as of January 1, 2011. They state if the federal ARRA is extended to June 30, 2011, then this mid-year roll back will *not* occur. Yet the Governor's budget assumes extension of the federal ARRA to June 30, 2011. Therefore, the budget is clearly in conflict.

Background—Existing State Law. Inclusion of children as part of the semi-annual reporting process (every 6-months) was enacted in Assembly Bill 1183, Statutes of 2008 (Omnibus Health Trailer Bill), and became effective as of January 1, 2009. Previously, only annual reporting was required for Children.

The enactment of the federal ARRA in February 2009 provided States with enhanced FMAP for 27 months (October 1, 2008 through December 2010) but a "maintenance of effort" was required. One of the key federal requirements is that states may not have eligibility standards, methodologies or procedures in place that are more restrictive than those in effect as of July 1, 2008. Any state that implemented more restrictive policies since July 1, 2008, had until July 1, 2009, to rescind them. The state would then be *fully* eligible for the enhanced match, retroactive to October 1, 2008.

Adoption of SB 3X 24 (Alquist), Statutes of 2009, among other things, restored annual reporting for Children until the enhanced ARRA federal funds are no longer available. About $10.1 billion (federal funds) was at risk if California did not comply.

Subcommittee Staff Comment and Recommendation. First, President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590) on Tuesday, March 23, 2010. Effective upon this date of enactment, States are required to maintain Medicaid (Medi-Cal) eligibility standards, methodologies, and procedures until a Health Insurance Exchange is operational in the State, with minor exceptions. Therefore, this DHCS proposal would violate these MOE provisions.

Further, independent analyses have shown that annual reporting for Children is cost-beneficial because it assists in assuring uninterrupted health care coverage and provides a medical home for comprehensive coverage (most children are enrolled in Managed Care). Further, it serves to focus limited state dollars on direct health care services versus administrative paperwork and shifting between programs.

It is recommended to reject this proposal and to adopt trailer bill language to restore annual eligibility for children.

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

1. DHCS, Please describe the budget proposal and comment on whether it is in violation.

11. Proposed Changes to Special Needs Trust Recovery

Budget Issue. The DHCS is proposing trailer bill language to amend Section 3605 of the Probate Code and Section 14009.5 of Welfare and Institutions Code to change existing statute and case law (Shewry v. Arnold, from 2004; and Dalzin v. Belshe, from 1997) relating to Special Needs Trust recovery.

The budget assumes savings of $3.6 million ($1.8 million General Fund) through the enactment of the proposed trailer bill language. This savings level is based upon a DHCS estimate of recovery potential from these trusts and recoupment for Medi-Cal expenses.

Subcommittee Staff Comment and Recommendation-- Reject. The Administration has proposed similar changes to statute for the recovery of funds for Medi-Cal expenses from Special Needs Trusts. Most recently a similar proposal was rejected without prejudice by the Joint Budget Conference Committee in 2009. Due to the complexities of both federal and state law, it was recommended for the Administration to proceed with policy legislation.

The DHCS is seeking to substantially change the dynamics of recovery from Special Needs Trusts and should therefore be proceeding with policy legislation so a full discourse can be had with the appropriate policy committees (including both Judiciary and Health). For example, a provision of the DHCS language states:

> "These claims shall *not* be governed by *any* provision of State for federal law pertaining to estate recovery. To the extent that Shewry v. Arnold (2004) 125 Cal.App4th 186 is inconsistent with the provisions of this section, it is expressly superseded."

Such sweeping language is not appropriate for budget trailer bill.

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

1. DHCS, Please describe the trailer bill language and budget proposal.

II. 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 almost $1.1 billion ($128.4 million General Fund) for all programs administered by the Managed Risk Medical Insurance Board for 2010-11 as shown in the chart below.

Summary of Expenditures (dollars in thousands)	**2009-10**	**2010-11**	**$ Change**
Program Source			
Major Risk Medical Insurance Program (including state support)	$65,127	$36,953	-$28,174
Access for Infants & Mother (with state support)	$77,448	$122,195	$44,747
Healthy Families Program (with state support)	$1,142,384	$928,821	-$213,563
County Health Initiative Program	$1,710	$1,789	$79
Totals Expenditures	**$1,286,669**	**$1,089,758**	**-$196,911**
General Fund	$216,983	$128,376	-$88,607
Federal Funds	$779,667	$666,867	-$112,800
Other Funds	290,019	$294,515	$4,496

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

1. Governor's Proposal to Reduce Eligibility in HFP from 250 to 200 Percent

Budget Issue. The Governor proposes legislation to reduce eligibility in the Healthy Families Program (HFP) from 250 percent to 200 percent of poverty for a reduction of $41.9 million ($10.5 million General Fund) in 2009-2010, and $252.4 million ($63.9 million General Fund) in 2010-11.

Under the Governor's proposal, 203,310 children would be dropped from coverage as of May 1, 2010, and an estimated 5,670 children each month (21 percent of new enrollment) would be denied HFP enrollment thereafter. For 2010-11, MRMIB states that at least 206,368 children would be denied enrolled under this proposal.

About 875,000 children are currently enrolled in the HFP (as of March 1, 2010).

The Governor's proposal was part of the Special Session as discussed in the Senate Budget & Fiscal Review Committee hearing of January 26, 2010; it was *not* included as part of the Legislature's package.

Background—Description of Healthy Families Program. The HFP provides subsidized health, dental and vision coverage through managed care arrangements for 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.

A 65 percent federal match is obtained through a federal allotment (Title XXI funds). The HFP is *not* an entitlement program. The MRMIB Board has authority to established waiting lists if necessary.

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	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.
Children enrolled in County "Healthy Kids" programs include children without residency documentation; and children from 250% to 300%.	Not eligible for HFP, including 250% to 300%.	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.

Summary of Past Cost Containment and Fund Shifts. A series of cost-containment actions and fund shifts have been implemented for the HFP over the past two-years. Key changes have included the following:

- **Provider Rates.** Reduced by 5 percent the rates paid to health, dental and vision plans in 2008. This reduction is ongoing.
- **Premiums.** The monthly premiums paid by families for their children's enrollment have been increased in 2005, and twice in 2009. This is discussed in more detail in the next Agenda item, below.
- **Dental Services.** Adopted an annual limit of $1,500 for dental coverage, effective as of November 1, 2008.
- **Copayments for Certain Services.** As of November 2009, copayments were increased for families with incomes from 150 percent to 250 percent as follows:
    - Non-preventive health, dental, and vision services—from $5 to $10.
    - Generic prescription drugs—from $5 to $10.
    - Brand name prescription drugs—from $5 to $15, unless no generic is available or brand name drug is medically necessary.
    - Emergency room visits—from $5 to $15, unless the child is admitted to hospital.
- **Additional Federal Funds—CHIPRA.** The federal Children's Health Insurance Program Reauthorization Act (CHIRPA) of 2009, signed by President Barack Obama, gave States the option of providing coverage for legal immigrant children with less than 5-years in the U.S. and provided 65 percent federal matching funds for this purpose. California had been providing this coverage with 100 percent General Fund support. As such, this federal action saves California about $12 million annually.

- **Obtained Alternative Funding.** First, AB 1422, Statutes of 2009, extended the gross premium tax to Medi-Cal Managed Care organizations (MCO) as previously referenced. Of the amount collected 61.59 percent is to be provided to the HFP. The MRMIB states it is assumed that $239 million will be backfilled by these revenues, assuming an extension of the tax to June 30, 2011 and an extension of the federal ARRA (to June).

  Second, through continued discussions with the CA Families First Commission (First Five), a total of $77.2 million (Proposition 10 Funds) are committed for 2009-2010, and $55.6 million (Proposition 10 Funds) is proposed for 2010-11. According to MRMIB figures, the Proposition 10 Funds for 2010-11 would be $24.4 million more but were adjusted downward due to the Governor's proposal to eliminate children in the 201 percent to 250 percent of poverty category.

  In total, these two alternative funding sources will save *at least* $371.8 million in General Fund support across the two-years.

Subcommittee Staff Comment and Recommendation. First, the historic Patient Protection and Affordable Care Act, H.R. 3590, signed by President Obama requires States to retain current income eligibility levels for children in Children's Health Insurance Programs (Healthy Families in California) that were in place as of June 16, 2009. Therefore, the Governor's reduction would violate the MOE provisions.

Second, a lack of health care coverage results in episodic care, increased emergency room visits and likely absences from school. The cost-benefit of proving health care to children is well documented. Healthy children are more likely to be good students, and to have healthy adult outcomes, including employment.

Third, the HFP receives a 65 percent federal match, utilizes two sources of alternative funding, and requires families to pay premiums and copayments for their children's coverage. Many adjustments have been enacted already to contain, reduce and shift costs due to the economic recession.

Fourth, the Governor's "trigger" for receipt of federal funds had also proposed to eliminate the Healthy Families Program. This issue becomes moot as well due to the federal law as noted.

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

1. MRMIB, Please provide a brief summary of the key actions taken to-date to contain costs within Healthy Families, including the cost-sharing adjustments and use of alternative funds.
2. MRMIB, Please provide a brief explanation of the Governor's proposal to eliminate children with family incomes from 201 to 250 percent of poverty from enrollment in HFP.
3. MRMIB, Is it your understanding that the Governor's proposal to reduce eligibility would violate the MOE provisions as noted?

2. Eliminate Vision Benefit & Increase Premiums Paid by Families

Budget Issues. The Governor proposes legislation to (1) eliminate vision coverage, and (2) increase monthly premiums for families with incomes from 151 percent to 200 percent of poverty effective July 1, 2010. A reduction of $18.1 million ($8.9 million General Fund) is reflected for the vision coverage elimination, and $38.7 million ($12.8 million General Fund) for the premium increase, for a total reduction of $65.8 million ($21.7 million General Fund).

An elimination of vision coverage results in 900,000 children no longer having access to eye exams and glasses. According to the MRMIB, only medically necessary vision-related services, such as eye surgery and treatment for eye injuries, would be covered.

Monthly premiums for families from 151 percent to 200 percent of poverty would be increased by $14 per child, or by 87 percent, for a total of $30 per child per month, with a family maximum of $90 for three or more children.

It should be noted that premiums for this income category have been increased twice in less than one year. First, as of February 1, 2009, premiums were increased from $9 per child per month to $12 per child per month (i.e., $3 more per month). The family maximum was correspondingly increased from $27 to $36 per month. Second, as of November 1, 2009, they were increased yet again.

The Table below provides a summary of the recent premium changes under the HFP and the affect of this proposal.

Governor's Healthy Families Program—Proposed Premium Increases

HFP Subscriber Family Income %	Monthly Premium (February 1, 2009)	Existing Premium (November 1, 2009)	Governor's 2010-11 Proposal
100 to 150 %	$7 per child Maximum of $14	No Change (federal law prohibits)	No Change (federal law prohibits)
151 to 200 %	$12 per child Maximum of $36	$16 per child Maximum of $48	$30 per child Maximum of $90
201 to 250 %	$17 per child Maximum of $51	$24 per child Maximum of $72	Eliminates Eligibility

Background—Discounts Offered for HFP Subscribers. 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.

Further, HFP subscribers can choose a community provider health plan, in most regions of the State, which have lower-cost monthly premiums.

Background—Federal Law Limits Cost-Sharing Amounts Charged. Federal law imposes limits on the total aggregate amount of all cost-sharing, including premiums and co-payments, at a maximum of 5 percent of family income on a monthly basis.

It should also be noted that federal law does not allow for cost-sharing for higher-income families to be less than that imposed on lower-income families. Therefore, if premiums are increased for children in the 151 percent to 200 percent income level, they would have to be less than that paid by families with incomes above 201 percent of poverty, unless this higher income level was also increased.

Further, according to the MRMIB, the federal CMS has previously expressed concerns that the higher the cost-sharing imposed on families becomes (close to the 5 percent threshold), the more likely the federal CMS will be to require the MRMIB and participating Health Plans to more directly track and monitor individual family out-of-pocket expenses. This could become a closely enterprise for the State and for participating Health Plans, if ever required.

Subcommittee Staff Comment. As previously noted, considerable cost containment and alternative funding sources have been identified to save a considerable amount of General Fund support. Elimination of the vision benefit for 900,000 children would only result in children not receiving appropriate health care and potentially having difficulty at school for not being able to see clearly.

Increasing premiums also poses a problem since most HFP families have incurred two premium increases, as well as a co-payment increase, within one year. Concerns with approaching the five percent federal law restriction is also evident.

The HFP will have May Revision adjustments on the natural and it is recommended to keep this issue "open" pending its receipt.

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

1. MRMIB, Please provide a summary of the proposal to eliminate the Healthy Families vision benefit, as well as the proposed increase to premiums.

Diane Van Maren 651-4103
Senate Budget & Fiscal Review

Outcomes from Senate Subcommittee No. 3: Thursday, March 25th

- Senator Ashburn absent the entire Subcommittee hearing.

A. Department of Health Care Services

Vote Only: (Pages 4 and 5)

- **Motion.** Approved these two items.
- **Vote. 2-0**

C. ISSUES FOR DISCUSSION (Page 6)

1. Governor's Federal Fund Assumptions for Medi-Cal: Several Components

- **Action.** None needed at this time but directed the DHCS to **(1)** continue to work with the Public Hospitals regarding the "CPE" issues; **(2)** continue to work with County Mental Health Plans and others with issues related to the Mental Health Services Act Fund; and **(3)** keep Legislative staff appraised of your efforts; and **(4)** report back to this Subcommittee in a *written format* at the May Revision in more detail.

2. Governor's Proposed Trigger Mechanism (Page 12)

- **Motion.** Reject the Governor's proposed "trigger".
- **Vote. 2-0**

3. Governor's Proposal to Establish Limits on Benefits, Expand Cost Sharing & Other Medi-Cal Program Changes (Page 15)

- **Action.** Kept "Open" until the May Revision.

4. Implementation of AB 1383—Hospital Quality Assurance Fee (QAF) (Page 17)

- **Motion.** Approved the DHCS staff and kept "Open" the rest of the issue to receive an update at the May Revision.
- **Vote. 2-0**

5. Proposed 10 Percent Reduction to Public Hospitals for 2010-11 (Page 21)

- **Action.** Kept "Open" pending receipt of May Revision.

6. Proposed 10 Percent Reduction to Private Hospitals for 2010-11 (Page 24)

- **Action.** Kept "Open" pending receipt of May Revision.

7. Implementation of Medi-Cal Managed Care Tax (AB 1422) (Page 25)

- **Motion.** Adopted "placeholder" language to continue the gross premium tax, and kept "Open" the issue of the rates until the receipt of the May Revision for the DHCS to provide more clarity as to how the rates are developed.
- **Vote. 2-0**

8. Newly Qualified Legal Immigrant Adults (Page 27)

- **Action.** Express concerns with the proposal but kept "Open" pending May Revision.

9. Governor's Proposal: Persons Permanently Residing Under Color of Law (PRUCOL) (Page 28)

- **Action.** Express concerns with the proposal but kept "Open" pending May Revision.

10. DHCS Proposal to Implement Mid-Year Status Reporting (Page 29)

- **Motion. (1)** Rejected the Governor's proposal to reinstitute the mid-year status reports and **(2)** adopted trailer bill language to continue "annual" eligibility as required to maintain "maintenance-of-effort" provisions in federal Health Care Reform Law.
- **Vote. 2-0**

11. Proposed Changes to Special Needs Trust Recovery (Page 30)

- **Motion.** Rejected the Governor's proposal. (This is a policy bill issue.)
- **Vote. 2-0**

B. **Managed Risk Medical Insurance Board (MRMIB)**

1. Governor's Proposal to Reduce Eligibility in HFP (Page 32)

- **Motion.** Rejected both the Governor's proposal to reduce Healthy Families eligibility, *and* his Trigger proposal to eliminate it..
- **Vote. 2-0**

2. Eliminate Vision Benefit & Increase Premiums Paid by Families (Page 35)

- **Action.** Expressed grave concerns with this proposal but we will keep it Open pending receipt of the May Revision

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

April 8, 2010

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

Room 4203

Committee Staff: Jennifer Troia

Item	Department
4200	Department of Alcohol and Drug Programs
5160	Department of Rehabilitation
5175	Department of Child Support Services
5180	Department of Social Services

(See Table of Contents on page 2 for More Specific Listing of Issues.)

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.

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Agenda

(Vote-Only Items indicated by *)

Vote-Only Agenda

5160 Department of Rehabilitation (DOR)

With a total budget of $435.6 million ($52.9 million GF) in 2009-10 and a proposed budget of $419.0 million ($56.5 million GF) in 2010-11, DOR works in partnership with consumers and other stakeholders to provide services and advocacy resulting in employment, independent living, and equality for Californians with disabilities.

DOR Issue 1: Electronic Records System (ERS) Project

Budget Issue: DOR requests, in a budget change proposal, an increase of $5.1 million in federal funds authority in 2010-11 to fund the fourth year (out of five anticipated years) of the ERS project. The Department is not requesting GF resources or any new positions associated with this proposal, but does anticipate higher overall project costs as the result of a delay in project completion (largely due to contractor costs).

Background on ERS: ERS is a commercial, off-the-shelf case management system. DOR intends to use ERS in place of its current case management system for the vocational rehabilitation services program, which is called the Field Computer System (FCS). According to the Department, FCS is outdated and unable to integrate with recent software applications, such as Microsoft Word. DOR anticipates that ERS will improve the accessibility and efficiency of its vocational rehabilitation services. ERS-related activities in 2010-11 will include system integration, testing, and implementation.

The vocational rehabilitation services program assists Californians with disabilities to obtain and retain employment and maximize their ability to live independently in their communities. DOR develops, purchases, provides, and advocates for these programs and services, with priority on serving persons with the most significant disabilities.

Anticipated Completion of ERS: DOR originally expected to complete ERS by March 2011. The Department now anticipates that ERS will be completed five months later, in August 2011. According to DOR, the delay is the result of contract approval and budget enactment delays, as well as the impact of state furloughs.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the requested federal funds authority for 2010-11.

DOR Issue 2: Traumatic Brain Injury (TBI) Program

Budget Issue: DOR requests, in a budget change proposal, an increase of $1.3 million ($1.2 million special funds from criminal and vehicular offense fines and $170,000 federal funds) and 2.0 positions to administer the TBI program. This request results from the passage of AB 398 (Monning, Chapter 439, Statutes of 2009), which transitions the TBI program from the Department of Mental Health (DMH) to DOR.

Background: TBI refers to any injury to the brain or its parts sustained after birth from external force, such as a fall or a blast, which results in cognitive, psychological, neurological, or anatomical changes in brain functioning. According to the analysis of AB 398 by the Assembly Health Committee, approximately 350,000 individuals with acquired TBI reside in California.

DMH currently administers the TBI program, which began in 1990 as a demonstration project, with 1.0 allocated staff position. The program funds post-acute care services for persons with TBI, including supported living and community reintegration services, vocational supports and community education. The sponsors of AB 398 believed that DOR's focus and experience would be a better fit for administering the program.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the requested funding and position authority.

5175 Department of Child Support Services (DCSS)

DCSS Issue 1: Mothers' Marital Status Trailer Bill Language (TBL)

Budget Issue: DCSS proposes, through TBL, to amend state law to ensure that the Department of Public Health (DPH) can continue to share information about mothers' marital status with DCSS. DCSS uses this information to meet reporting requirements that are tied to federal incentive funding related to paternity establishment.

Background: The DPH Health Information and Strategic Planning Division maintains and manages vital records (i.e., birth, death, fetal death, adoption, marriage, and dissolution) for the state. State law generally prohibits DPH from sharing data regarding individuals' marital status. However, DPH currently shares this information with DCSS via an Interagency Agreement, and DCSS is mandated to protect the data in compliance with related privacy and confidentiality requirements. The Departments are seeking to have the authority for this sharing of information by DPH with DCSS formalized in statute.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the proposed TBL, with an amendment to add a cross-reference to existing law that protects the confidentiality of the information shared.

Discussion Agenda

4200 Department of Alcohol and Drug Programs (ADP)

With a total budget of $584.5 million ($181.5 million GF) and 327 authorized staff positions in 2009-10, and a proposed budget of $592.4 million ($178.8 GF) in 2010-11, ADP plans, develops, implements, and evaluates a statewide system of alcohol and other drug, as well as problem-gambling, prevention, treatment, and recovery services.

ADP Issue 1: Community-Based Diversion Programs for Drug Offenders

Budget Issue: In recent years prior to 2009-10, ADP provided funding for community-based diversion programs for drug offenders through the Substance Abuse and Crime Prevention Act (SACPA or Proposition 36), Offender Treatment Program (OTP), and county-administered drug court programs. In 2009-10, funding for Proposition 36 was eliminated. The Governor's budget for 2010-11 continues to provide no funding for Proposition 36. The Governor's budget for 2010-11 also proposes to eliminate the remaining $18.0 million GF for OTP. Finally, the Governor's budget proposes to continue $27.9 million GF in funding through ADP for drug court programs.

Background on Proposition 36 and OTP: Proposition 36 passed in 2000 and changed state law so that certain adult offenders who use or possess illegal drugs are sentenced to participate in drug treatment and supervision in the community rather than being sentenced to prison or jail, supervised on probation, or going without treatment. From 2001-02 until 2005-06, Proposition 36 also provided annual appropriations of $120 million GF for related substance abuse treatment programs.

OTP was established by Chapter 75, Statutes of 2006 (AB 1808, Committee on Budget) to serve the same individuals as Proposition 36, but with some programmatic changes to improve treatment outcomes. To be eligible to receive OTP funding, counties are required to provide a ten percent local match to state funds and to meet specified eligibility requirements, including dedicated court calendars and the presence of drug courts that accept felony defendants.

Funding for Proposition 36 and OTP combined reached a high in 2006-07 of $145 million GF. In 2008-09, the total was $108 million GF. However, the 2009-10 budget eliminated all funding for Proposition 36, while continuing $18 million GF, plus $45 million in one-time federal Edward Byrne Memorial Justice Assistance Grant (Byrne-JAG) stimulus funds, for OTP. ADP and the California Emergency Management Agency (CalEMA), which administers the Bryne-JAG funds, have determined that the counties have until March 31, 2011 to expend those stimulus funds. As of mid-March 2010, none of the Bryne-JAG funds for OTP had yet been distributed to the counties. ADP has stated, however, that counties will be able to use the funds to back-bill for services provided from October 2009.

Studies of Proposition 36: Prior to the elimination of funding for the program, the University of California, Los Angeles (UCLA) conducted cost-benefit studies related to Proposition 36. The most recent analysis by UCLA concluded that every $1 of Proposition 36 spending resulted in net savings to state and local governments of $2 to $4. Overall cost savings were largely driven by avoided jail and prison expenditures. More than 30,000 offenders annually entered treatment under Proposition 36, and around one-third completed treatment.

Proposition 36 Sentencing Laws and Impacts of Funding Elimination: Although the 2009-10 budget eliminated state funding for Proposition 36 programs, the sentencing laws created by the Act still remain in place. According to an informal survey conducted by the County Alcohol and Drug Program Administrators Association of California (CADPAAC), far fewer individuals statewide are now receiving treatment than in previous years, individuals are receiving lower levels of care, and the wait to receive treatment is significantly longer.

Background on Drug Court Programs: Generally, drug court programs combine judicial monitoring with intensive treatment services over a period of about 18 months. Individuals who qualify are usually nonviolent drug offenders. As of October 2009, ADP provided funding that supported 135 drug courts in 53 of California's 58 counties. Based on 2008 data from the Administrative Office of the Courts (AOC), ADP estimates that there were a total of 203 drug courts in California at the time. Adult drug courts provide access to treatment for offenders in criminal, dependency, and family courts while minimizing the use of incarceration. Dependency drug courts address substance abuse issues that contribute to removal of children from the care of their parents. Finally, juvenile drug courts incorporate the same underlying components of adult drug courts, while also including additional elements like more intensive supervision.

National studies have documented that drug courts are more effective than traditional criminal prosecution methods. Among their findings are that drug court participation reduces recidivism. ADP also documents, based on 2007-08 data, that every $1 spent on treatment through adult drug courts averts $3 in prison-day costs. At the time, the Department estimated that participants who completed adult drug court programs between 2003-04 and 2007-08 averted approximately $69.4 million in total prison-day costs. In addition, 6,427 days of foster care were avoided due to the successful completion of dependency drug court programs, and 3,565 days in correctional facilities were avoided by juveniles who completed juvenile drug court programs.

Subcommittee Staff Comment & Recommendation: Staff recommends holding open the proposed elimination of funding for OTP. The remaining, related issues are included for context and for informational purposes.

(Questions on next page)

Questions for ADP and CalEMA:

1) What is the status of the $45 million in Byrne-JAG funding for OTP that was authorized in 2009-10? How much has been distributed to the counties to date? What has caused the delays in getting the funds to the counties? Have any problems been rectified?

2) When do you anticipate that counties will provide services paid for by these Bryne-JAG funds? Are some already doing so in 2009-10 in anticipation of receiving these funds?

Questions for ADP, AOC, & CADPAAC:

3) What is happening on the ground as a result of the elimination of funding for Proposition 36 programs? How have the referrals to and the availability of treatment for offenders changed already? How might they change further when stimulus funds for OTP have been spent down and/or if the remaining OTP GF resources are eliminated?

4) How are courts applying the Proposition 36 sentencing laws if or when treatment is unavailable?

5) What might be the fiscal and human consequences to the state of a drastically reduced availability of treatment for offenders? The public safety consequences?

ADP Issue 2: Substance Abuse Prevention & Treatment (SAPT) Funding and Maintenance of Effort (MOE) Requirement

Budget Issue: In 2010-11, ADP estimates that the state will receive $258.8 million ($238.2 million for local assistance and $18.6 million for state operations) in federal SAPT block grant funding. As a condition of receiving these funds, the federal government requires the state to spend $246.2 million to meet its related MOE requirement. The Governor's budget for 2010-11 instead proposes $197.9 million GF for non-federal substance abuse-related expenditures, which falls $48.3 million short of this SAPT MOE requirement. (*Note*: These figures could change in the event that Federal Medical Assistance Percentage [FMAP] policies differ from those assumed by the Governor's budget.)

ADP intends to request a waiver from the federal government for any enacted 2010-11 MOE shortfall. If the federal government does not grant that waiver, the state is at risk of losing one dollar of federal funding for every state dollar below the required level.

Background on SAPT MOE: The federal government establishes the state's MOE based on a two-year average of state expenditures. Federal law and regulations allow for a waiver of MOE requirements when a state faces "extraordinary economic conditions," defined as "a financial crisis in which the total tax revenue declines at least one and one-half percent, and either unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent." 45 C.F.R. 96.134(b).

Prior and Upcoming Waiver Requests: In 2008-09, California fell short of its MOE requirement by $11 million for the first time. In January, 2010, the federal government granted a waiver to the state for this shortfall. The 2009-10 MOE shortfall was much larger at $96.7 million. ADP will apply for a waiver of this shortfall as well.

Subcommittee Staff Comment & Recommendation: This issue is included for informational purposes and no action is required.

Questions for ADP and DOF:

1) Please summarize the state's recent SAPT MOE shortfalls and the status and timing of related waiver requests to the federal government.

2) How likely is it that the state could again receive a waiver for the proposed 2010-11 MOE shortfall of $48.3 million?

5175 Department of Child Support Services (DCSS)

With a total budget of $1.0 billion ($296.3 million GF) and 617 authorized staff positions in 2009-10, and a proposed budget of $1.0 billion ($301.3 million GF) in 2010-11, DCSS oversees child support establishment, collection and distribution services statewide.

DCSS Issue 1: Update on Federal Performance Measures

Budget Issue: The 2007 Human Services budget trailer bill (SB 84, Chapter 177, Statutes of 2007) required DCSS to provide an annual update to the Legislature in the subcommittee process, beginning in 2008, on state and local performance on federal outcome measures, and child support collections. The department will provide this annual update during this hearing.

Background on Child Support Services: 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: Since federal fiscal year (FFY) 2000, the federal government has awarded incentive funding to state child support programs based on specific performance measures. In FFY 2009, the total pool of incentive funds available to states is $504 million. DCSS estimates that California will receive incentive funds of $41.7 million in the state's 2009-10 fiscal year and $40.4 million in 2010-11. The federal government can also penalize states that fall below minimum performance thresholds, up to a maximum penalty of 25 percent of the state's total Temporary Assistance to Needy Families (TANF) block grant. These federal performance measures and minimum thresholds are described below, along with information on California's recent performance.

- **Statewide paternity establishment percentage** 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 plus a two to six percent increase annually if under 90 percent. In 2009, California ranked 4th out of the 32 states for which PEP outcomes were available. This is an improvement from the state's ranking of 8th in the prior year.

(Continued on next page)

Paternity Establishment Percentage	IV-D PEP (measure of entire caseload) FFY 2005 - 86.0% FFY 2007 - 91.3% FFY 2009 - 97.3% Statewide PEP (measure of one year) FFY 2005 – 106.5% FFY 2007 – 106.7% FFY 2009 – 103.4%

- **Percent of cases with a child support order** measures cases with support orders, compared to the total caseload. The minimum federal threshold is 50 percent or a five percent annual increase. In 2009, California ranked 35th out of the 51 states (including the District of Columbia) for which this outcome was measured. This is a decline from the state's ranking of 30th in the prior year.

Percent of Cases with a Child Support Order	FFY 2005 – 80.3% FFY 2007 – 82.1% FFY 2009 – 78.8%

- **Current collections performance** measures the amount of current support collected, compared to the total amount of current support owed. The minimum federal threshold is 40 percent. In 2009, California ranked 45th out of the 51 states (compared with 46th in the prior year).

Current Collections Performance	FFY 2005 – 49.3% FFY 2007 – 51.5% FFY 2009 – 53.4%

- **Arrearage (past due) collections performance** measures the number of cases with child support arrearages for which there are collections during the FFY. The minimum federal threshold is 40 percent. In 2009, California ranked 40th out of the 51 states (compared with 41st in the prior year).

Arrearage Collections Performance	FFY 2005 – 56.0% FFY 2007 – 57.1% FFY 2009 – 59.4%

(Continued on next page)

- **Cost effectiveness** measures the total amount of distributed collections, compared to total program expenditures (expressed as distributed collections per dollar of expenditure). The minimum federal threshold is $2.00. In 2009, California ranked 48th out of the 51 states (although this ranking and the related 2009 cost effectiveness data for California- as reflected below- may be inflated because of a cost offset based on a computation error in the prior year*).

Cost Effectiveness Performance Level	FFY 2005 - $2.15 FFY 2007 - $2.01 FFY 2009 - $2.10*

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 California's performance on each of the five federal measures.

2) How do you explain the state's continuing low performance on collections and cost-effectiveness measures when compared to other states?

3) What are your specific plans to improve upon these outcomes?

DCSS Issue 2: Revenue Stabilization Funding

Budget Issue: The Administration proposes to continue in 2010-11 an augmentation of $18.7 million ($6.4 million GF) that was enacted in 2009-10. This revenue stabilization funding was intended to support LCSAs in maintaining caseworker staffing levels and stabilizing child support collections. In 2009-10, DCSS estimated that these funds would result in increased recoupment of $14.4 million in public assistance costs ($6.6 million GF revenue, and the rest as revenue to federal and county governments). DCSS also expected these funds to result in collection of an additional $70 million in child support payments that would be passed on to custodial parents and their children.

Background on 2009-10 Augmentation: From 2003-04 to 2009-10, state and federal funding for LCSA basic administrative expenses was held flat, with the exception of two one-time increases. According to DCSS, as a result of this relatively flat funding and local increases in the costs of doing business, LCSA staffing levels declined during that time by 1,935 positions (including 517 caseworkers) or 23 percent from a peak in 2002-03, and child support collections decreased. During that same time, the child support caseload statewide declined by about 11 percent (200,000 cases).

The Legislature approved the Administration's request for revenue stabilization funds in 2009-10. ABx4 4 (Chapter 4, Fourth Extraordinary Session of 2009) also contained enacted TBL related to this funding. That legislation required that 100 percent of the new funds be used to maintain caseworker staffing levels. ABx4 4 also specified that revenue stabilization funds should be distributed to counties based on their performance on two key federal outcome measures – Collections on Current Support, and Cases with Collections on Arrears. Finally, ABx4 4 required each LCSA that receives funds to have submitted to DCSS an Early Intervention Plan (EIP) to increase the engagement of non-custodial parents, and required reporting by DCSS to the Legislature on the use and impacts of revenue stabilization funds.

According to a survey DCSS conducted of LCSAs, revenue stabilization funding in 2009-10 has led to retention of 245 caseworkers who may otherwise have been laid off.

Child Support Collections in the First Half of 2009-10: Overall child support collections during the first six months of 2009-10 declined by $3.4 million or three-tenths of one percent when compared with the first six months of 2008-09. The Department estimates that given the recession and high level of unemployment, and based on its assumptions regarding the marginal collections each case worker contributes, the total child support collections during that same time would have dropped by six percent without the work of staff members the LCSAs retained due to stabilization funds.

Specifically with respect to collections that become GF revenue (from cases in which the custodial parent receives public assistance), the first six months of 2009-10 showed an increase of $9.9 million GF ($20.8 million total including collections distributed to the federal government) or 10.8 percent when compared to the same time period in 2008-

09. The Department estimates that without revenue stabilization funds this increase would have been lower—at about $5.3 million GF ($11.1 million all funds) or 5.8 percent.

With respect to non-assistance cases, the first six months of 2009-10 showed a decrease of $24.2 million or 2.8 percent in collections distributed to custodial parents when compared to the same time in 2008-09. The Department estimates that the decrease would have been larger—about $75.2 million or 8.7 percent—without revenue stabilization funds.

Subcommittee Staff Comment and Recommendation: Staff recommends approval of the requested revenue stabilization funds for 2010-11 and recommends that the Subcommittee continue to monitor the use of those funds and the resulting collections going forward.

Questions for DCSS:

1) Please briefly describe how revenue stabilization funds were allocated to LCSAs in 2009-10 and what impact you believe those funds have had on their ability to collect and distribute child support statewide.

2) Please briefly describe the early intervention efforts that LCSAs are engaging in and provide specific examples of how these efforts have proven effective so far.

3) In the budget year and future years, how will you continue to track and assess the effectiveness of the proposed augmentation and resulting revenue increase?

5180 Department of Social Services (DSS)

Please see the March 18, 2010 Agenda for Subcommittee #3 for a summary of DSS's overall budget and activites.

DSS Issue 1: ARRA Food Stamp Automation Simplification Projects

Budget Issue: The 2009-10 budget includes $8.4 million ($5.2 million redirected GF savings associated with ARRA funding, $2.7 million non-ARRA federal funding, and $0.5 million other federal ARRA stimulus funds) to simplify the administration of food stamps through updated technology. Changes include increased availability of online applications to the program, interactive voice response (IVR) systems to conduct outbound calls, and document imaging. The Governor's budget for 2010-11 proposes, via local assistance estimates, another $7.4 million ($3.6 million redirected GF savings associated with ARRA funding, $2.9 million non-ARRA federal funding, and $0.5 million other ARRA funds) for these efforts. These ARRA-related funds are in addition to ARRA resources (all federal funds) for a 13.6 percent food stamps benefit increase.

Background: As a result of ARRA funding, the Department and counties are engaged in several projects to streamline food stamps administration. One of these projects is focused on the expanded availability of online applications and benefits information for recipients. For the C-IV automated welfare system consortium, this means increased investment in and English and Spanish language website located online at: http://www.c4yourself.com. As a result of these and prior efforts, recipients in counties that use C-IV are now choosing to file one-third to more than half of food stamps applications online.

These funds are also supporting the Department and counties' efforts to expand the use of IVR and document imaging. For example, IVR will increasingly be used to make appointment reminder phone calls. Documents like birth certificates or other eligibility-related information will more frequently be stored electronically.

Subcommittee Staff Comments & Recommendation: This issue is mainly included for informational purposes. Staff recommends approval of the proposed 2010-11 funding to continue these simplification efforts.

Questions for DSS:

1) Please briefly summarize the status of these automation projects and their implications for future efforts by the Department and the counties.

2) What impacts are these projects having on access to nutrition assistance? On efficiencies in the administration of the food stamps program?

DSS Issue 2: County Match Requirements for Food Stamps Administrative Costs

Budget Issue: CWDA proposes trailer bill language (TBL) to allow counties, during 2010-11 and 2011-12, to draw down a portion of increasing food stamps administration funding without a county match above and beyond an existing Maintenance of Effort (MOE) requirement. Food stamps administrative costs are generally shared at a ratio of 50 percent federal funds, 35 percent GF, and 15 percent county funds. Apart from this county share, each county has a combined MOE for food stamps administration and CalWORKs that is tied to 1996-97 expenditure levels. The Governor's proposed overall budget for food stamps administration in 2010-11 is $1.2 billion ($485 million GF).

Approximately 3.2 million Californians currently receive food stamps benefits that are 100 percent federally funded. Roughly 32,000 additional individuals receive benefits in the state-funded California Food Assistance Program (CFAP).

Background on County Administration Expenditures: According to 2007-08 data from DSS, 22 counties overmatched their food stamps administration expenditures that fiscal year. When the closeout process was completed, 96 percent of the overmatched funds were reimbursed to those counties (after other counties' allocations required less funding than anticipated-e.g., because of lower than anticipated caseloads). According to DSS, one of those 22 counties overmatched its CalWORKs MOE. CWDA states that since that time, however, the rapid growth in the food stamps caseload has meant that counties are increasingly exceeding MOE requirements.

According to CWDA, the 2010-11 county shares of costs for food stamps administration alone is likely to exceed the CalWORKs/food stamps MOE in all counties; and many counties will be unable to provide the budgeted level of food stamps administration funding above the MOE. The proposed TBL would allow the counties to draw down state funds and a corresponding portion of federal funds that are already included in the Governor's budget, but without providing a match above the relevant MOE level.

Caseload Growth: The average monthly numbers of Californians receiving federal food stamps in recent and upcoming years (according to DSS's annual estimates each November and not including CFAP recipients) are below.

State Fiscal Year	# of Households	# of Individual Recipients
2007-08	850,346	2,138,702
2008-09	1,004,507	2,442,705
2009-10	1,337,016	3,213,770
2010-11	1,575,940	3,752,354

Prior Waiver of Matching Requirements: SB 1344 (Chapter 312, Statutes of 1995) previously waived matching requirements for counties that met specified criteria. That waiver lasted until 1997.

Subcommittee Staff Comments & Recommendation: This issue is included for informational purposes, and no action is recommended at this time.

Questions for DSS and DOF:

1) What impact would this proposal potentially have on enrollment in the food stamp program? On GF costs or the state's ability to meet any relevant federal match requirements?

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

April 15, 2010

9:30 a.m. *or*
Upon Adjournment of Session
Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

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Thank you.

I. Department of Public Health

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 $3.3 billion ($304 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, about $637 million is for state operations and $2.706 billion is for local assistance. The budget for 2010-11 reflects a net decrease of $99.8 million as compared to the revised 2009-10 budget.

Summary of Expenditures for Department of Public Health	2010-11
Public Health Emergency Preparedness	**$104,615,000**
Public and Environmental Health	**$3,067,513,000**
Chronic Disease Prevention and Health Promotion	292,779,000
Infectious Disease	650,846,000
Family Health	1,700,605,000
Health Information and Strategic Planning	25,495,000
County Health Services	21,132,000
Environmental Health	376,656,000
Licensing and Certification Program	**$171,071,000**
Licensing and Certification of Facilities	158,731,000
Laboratory Field Services	12,340,000
Total Program Expenditures	**$3,343,199,000**
Funding Sources	
General Fund	$304,902,000
Federal Funds	$1,753,323,000
Genetic Disease Testing Fund	$117,813,000
Licensing and Certification Fund	$86,523,000
WIC Manufacturer Rebate Fund	$329,901,000
AIDS Drug Assistance Program Rebate Fund	$211,958,000
Water Security, Clean Drinking Water, Beach Protection Fund	$73,487,000
Safe Drinking Water Account of 2006	$21,207,000
Childhood Lead Poisoning Prevention Fund	$22,528,000
Radiation Control Fund	$22,931,000
Food Safety Fund	$6,877,000
Reimbursements	$183,752,000
Other Special Funds (numerous)	$207,997,000
Total Funds	**$3,343,199,000**

B. Vote Only Issues (Pages 4 through 17)

1. Umbilical Cord Blood Banking

Budget Issue. The DPH requests an increase of $471,000 (one-time federal grant funds) to support the collection and storage of publicly donated and ethnically diverse umbilical cord blood in California for use in transplantation. These grant funds are provided through a Congressional Special Initiative grant award and can only be used for this purpose. This is one-time funding and is to be expended in 2010-11.

Of the total federal grant amount, $120,000 would be used to engage a contractor to (1) develop a "Request for Proposal" for the cord blood bank; (2) oversee all implementation and evaluation activities; and (3) monitor the contract with the established cord blood bank. The $120,000 amount is the maximum the federal grant allows for this purpose. According to the DPH, this contractor will consult with the federal Health Resources and Services Administration (HRSA) on the following:

- Developing cord blood collection protocols;
- Assisting with reviewing the contract bids;
- Implementing the contract agreement with the selected cord blood bank;
- Overseeing and managing the grant activities;
- Serve as the subject matter expert for the DPH;
- Providing status reports to HRSA as required; and
- Developing and implementing the grant performance evaluation.

The remaining amount of $351,240 would be used to contract with a selected cord blood bank to collect, process, and store the cord blood from minority populations to diversify the national inventory of umbilical cord blood stem cell units that are available for transplantation.

The DPH states that the cord blood bank's collection and storage fee is a one-time fee inclusive of long-term storage. This is consistent with existing federal requirements. The DPH states that given the high cost associated with cord blood banking, the grant award will only enable collecting a limited number of cord blood units by the selected cord blood bank.

Background—Summary of State and Federal Law. AB 34, Statutes of 2007 (Portantino), established the Umbilical Cord Blood Collection Program for the purpose of collecting and storing umbilical cord blood for use in research and to add genetically diverse cord blood units to the national inventory. It requires, among other things, that any funds available for these purposes to be deposited into the Umbilical Cord Blood Collection Program Fund.

The federal Stem Cell Therapeutic and Research Act of 2005 established a national umbilical cord blood network and authorized funding to collect and maintain cord blood stem cells for the treatment of patients and for research. As of 2009, there are nine banks contracted by the federal Health Resources and Services Administration (HRSA) to collect cord blood for the national inventory. This includes StemCyte, Incorporated located in Arcadia, California.

Subcommittee Staff Comment and Recommendation--Approve. The proposal is consistent with state and federal law. It is recommended for approval.

2. Genetic Disease Testing Program (Prenatal Program and Newborn Program)

Budget Issue. The DPH proposes total expenditures of $95.2 million (Genetic Disease Testing Fund) for local assistance. This reflects a net increase of $472,000 (Genetic Disease Testing Fund) as compared to the current-year. This program is fully fee supported.

The proposed expenditures for each of the programs are outlined below.

Program & Components	Total for 2010-11	Adjustment Over CY
Prenatal Screening:		
Contract Laboratories	$5,090,000	$0
Technologic Support	$13,146,000	$165,000
Systems Development, Equipment & Testing	$6,485,000	$0
Follow-Up Costs	$6,110,000	$1,132,000
Prenatal Diagnostic Centers	$17,426,000	-$765,000
Result Reporting & Fee Collection	$1,310,000	$0
TOTAL for Prenatal	**$49,567,000**	**$532,000**
Newborn Screening:		
Contract Laboratories	$7,429,000	$0
Technologic Support	$23,497,000	$47,000
Systems Development, Equipment & Testing	$4,222,000	$0
Follow-Up Costs	$5,834,000	-$193,000
Newborn Diagnostic Centers	$3,366,000	$86,000
Result Reporting & Fee Collection	$1,290,000	$0
TOTAL for Newborn	**$45,638,000**	**-$60,000**
Total for Genetic Disease Testing Program	**$95,205,000**	**$472,000**

As noted in the Table above, the Prenatal Screening Program reflects net increased costs of $532,000 (Genetic Disease Testing Fund). The DPH states most of these increased expenditures are attributable to costs associated with providing additional testing, follow-up, and diagnostic services associated with the "First Trimester" test expansion implemented in 2009. With the addition of the First Trimester test, women will be able to receive screening services in both trimesters (traditionally it has occurred in the second trimester).

Expenditures for the Newborn Screening Program remain relatively stable and reflect no new policy issues.

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

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. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees.

There are three types of screening tests to pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect. All three of these tests use blood specimens, and generally, the type of test used is contingent upon the trimester.

Women who are at high risk based on the screening test results are referred for follow-up services at State-approved "Prenatal Diagnosis Centers". Services offered at these Centers include genetic counseling, ultrasound, and amniocentesis. Participation is voluntary.

The *Newborn Screening Program* provides screening for all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is $103 dollars. Where applicable, this fee is paid by prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees.

The Newborn Screening Program screens for 76 conditions, including certain metabolic disorders, PKU, sickle cell, congenital hypothyroidism, non-sickling hemoglobin disorders, Cystic Fibrosis and many others. Early detection of these conditions can provide for early treatment which mitigates more severe health problems. Informational material is provided to parents, hospitals and other health care entities regarding the program and the relevant conditions and referral information is provided where applicable.

Repayment of Previous General Fund Loan. The Genetic Disease Testing Fund received two loans from the General Fund in past years in order to maintain solvency. The outstanding principle balance is $4.24 million (General Fund). A loan repayment of $3 million is reflected for 2009, and another payment of $1.2 million is reflected in 2010-11.

Subcommittee Staff Comment and Recommendation--Approve. The budget reflects no new policy issues and is consistent with past expenditure calculations. It is recommended for approval.

3. Blood Specimen Repository—Need for Upgrade

Budget Issue. The DPH is requesting an increase of $677,000 ($576,000 Genetic Disease Testing Fund and $101,000 Birth Defects Monitoring Fund) to fund six State positions (two-year limited-term) to redesign and maintain the central blood repository systems for newborn and prenatal blood specimens as collected under the Genetic Disease Testing Program.

The DPH states these resources are needed to (1) upgrade the storage and retrieval systems for the stored blood specimens; (2) develop regulations pertaining to accessing and sharing of these specimens; and (3) meet the growing volume of blood specimens that have been collected since 1982. California's blood specimen bank is very unique. No other State or international effort approaches its scale in terms of scale, diversity, quality of specimens and number of historic specimens.

The six requested positions include the following:

- Two Research Scientist III, Epidemiologists. These positions will oversee ongoing research for program development that is conducted using the specimen repository to develop, modify and evaluate the Genetic Disease Testing Program. In addition, these positions will develop a comprehensive research request tracking protocol for the Newborn Screening Program specimens.

- Two Research Scientist II, Epidemiologists. These positions will (1) conduct record linkage for the programs' data for using specimens in the repository; (2) update procedures for conducting specimen pulling, shipping, tracking, and return activities; and (3) provide assistance as needed in any other protocol development.

- Laboratory Assistant. This position will provide assistance for locating, pulling, shipping and maintaining the inventory for the Newborn Screening Program specimens needed for program development and evaluation. This position will track workload and processing time on specimen requests to be used in reviewing and analyzing future workload needs.

- Associate Government Program Analyst. This position will be responsible for all administrative functions as they pertain to the re-design and maintenance of an updated central repository. Specifically, this position will (1) design reports for management on infrastructure-related activities; (2) review and analyze data to assess ongoing workload needs for the programs; and (3) provide assistance in reviewing existing laws, policies and procedures on specimen banks and providing feedback as applicable.

Background—Genetic Disease Testing Program and Blood Repository. The Genetic Disease Testing Program consists of the Newborn Screening Program and the Prenatal Screening Program. The program screens about 560,000 newborns and 350,000 pregnant women each year for over 80 genetic and congenital disorders. These screening programs provide screening tests, follow-up, and early diagnosis of disorders that in many cases prevent adverse outcomes, minimize the clinical effects of disorders, and improve health outcomes.

The DPH states that since inception of the Newborn Screening Program in 1982, they have banked blood specimens from screened newborns in freezer storage. This repository, located in Richmond, houses over 15 million specimens and represents an entire generation of Californians.

Additionally, existing State statute requires the DPH to store, analyze and share the Prenatal Screening Program blood specimens for research purposes as of 2003. This repository of frozen prenatal blood specimens is in Long Beach. About 500,000 blood specimens are banked thus far, with another 100,000 prenatal specimens added each year.

These newborn and prenatal specimen banks have been used for a number of purposes. These include: (1) the timely evaluation, improvement, and expansion of these programs; (2) the filling of individual requests of California families with unexplained deaths or health impairments; (3) the provision of evidence for litigation; and (4) understanding of both the prenatal causes of many diseases as well as the genetic etiology of markers found in newborn blood spots, through various collaborative research projects.

Background—Special Funds. SB 1555 (Speier), Statutes of 2006, authorized a $10 fee to be added to the existing fee for prenatal screening to be used for prenatal blood specimen repository functions. Further, existing fees collected under the newborn program can also be used for this purpose.

Subcommittee Staff Comment and Recommendation--Approve. The request makes good policy sense and there is no impact on the General Fund. Sufficient special fund support is available for this purpose. It is recommended for approval.

4. New Safety Requirements for Public Swimming Pools and Spas

Budget Issue. The DPH requests an increase of $402,000 (Recreational Health Fund) to support two State positions (three-year limited-term) and a contract of $151,000 to develop educational materials related to public swimming pools and spas as directed in AB 1020 (Emmerson and Ma), Statutes of 2009.

Through this new program, the DPH will participate in training personnel to enforce the state pool and spa law, and participate in educating pool owners, construction companies, service companies, and the general public about the dangers of drowning and entrapment.

The State staff—two Staff Environmental Scientists—would conduct various activities, including the following:

- Work with various stakeholders to develop guidance on the definition of unblockable drains in state and federal law.
- Work with various organizations on recommended practices and standards to prevent entrapment. Adopt specified standards as appropriate.
- Interact with national testing organizations and manufacturers on approval of performance standards and testing protocol for pool operators and Local Health Jurisdictions.
- Work with Local Health Jurisdictions and pool and spa organizations to assist with development of forms and public notification of the new law and its compliance dates.
- Develop compliance options for pool contractors and owners of public pools and spas.
- Provide technical assistance to Local Health Jurisdictions and the pool and spa industry to eliminate public health and safety hazards related to equipment design, use, and operation.
- Respond to public inquiries on safe and healthy swimming and bathing activities.
- Conduct investigations of entrapment incidents and determine if additional public education is needed or new physical entrapment measures are needed.

The DPH intends to contract with a public safety organization to develop educational materials, technical bulletins, public service announcements, and a training program. The consultant will also be involved to evaluate anti-entrapment devices and provide training on the enforcement of the new standards to local government.

Background—Summary of AB 1020, Statutes of 2009. This enabling legislation, based on federal law enacted in 2007, contains the following key provisions:

- Requires all newly constructed and existing public swimming pools to be equipped with (1) at least two main drains per pump; and (2) one or more anti-entrapment devices or systems as specified.
- Requires DPH to train personnel to enforce the law.
- Requires DPH to educate the public about these requirements and about drowning prevention.

- Requires DPH to issue a form for use by an owner of a public swimming pool to indicate compliance.
- Creates a $6 annual fee on public swimming pool owners for the DPH to defy costs for carrying out specified requirements.

There are about 80,000 public pools in California. The $6 fee on permitted recreational water venues (public pools and spas) is anticipated to generate about $480,000 in revenues. Local health departments will collect the fee and may retain up to $1 of the fee to cover their administrative costs of collecting the fee. The remaining amount will be expended on the program as noted. The fee is scheduled to sunset on January 1, 2014.

Subcommittee Staff Comment and Recommendation--Approve. The proposal is consistent with state and federal law, and no issues have been raised. It is recommended for approval.

5. Convert Information Technology Contracts to State Support

Budget Issue. The DPH is requesting to establish seven State positions—two Systems Software Specialist III's and five Staff Information Systems Analysts— in lieu of existing contracts to conduct information technology work. A net savings of $52,000 (various special funds) is reflected for this proposal.

This DPH request is in response to recent rulings by the State Personnel Board. Specifically, the Service Employees International Union (SEIU) challenged the DPH regarding their use of information technology contracts in lieu of State personnel. As such, the DPH came forward with the above proposal to shift from the use of contractors to permanent state civil service classifications.

It should be noted that the DPH has been phasing-in State civil service positions over a period of time (commencing in 2008-09).

Subcommittee Staff Comment and Recommendation--Approve. This proposal is consistent with the State Personnel Board's ruling. It is recommended to approve it. There is no affect to the General Fund.

6. Infant Botulism (BabyBIG)

Budget Issue. The DPH is requesting an increase of $3.8 million (Infant Botulism Funds) in 2010-11 to begin the several year process to manufacture the next lot of BabyBig. The next lot will be needed in about four to five years.

The DPH states that programmatic efforts required to make the next lot of BabyBig will include: (1) moving the freeze-drying and vialing from Cangene to a replacement federal FDA approved contractor; (2) developing a new toxoid to boost the plasma donors to replace the present 40 year-old and now degraded toxoid; (3) obtaining and report to federal FDA on the stability and potency testing results from the current lot production; (4) continuing the development of faster diagnostics to enable more efficient and accurate use of BabyBig; and (5) fulfilling the statutory mandate to identify sudden infant death cases that result from infant botulism poisoning.

The $3.8 million appropriation would be used for the following consultant and professional services:

- Public Health Foundation Enterprises at $990,000. This contract is for technical and logistical support.
- Emergent BioSolutions, Incorporated at $825,000. This is for new toxoid development.
- Cato Research, Limited at $550,000. This is for regulatory services oversight and project oversight.
- Cato Research, Limited at $279,672. This is for regulatory activities associated with vial transfer.
- Cato Research, Limited at $150,000. This is for deliverables associated with regulatory support.
- Battelle Memorial Institute at $400,000. This is for potency testing.
- Los Alamos National Laboratories at $325,000. This is for new assay development.
- Unknown Contractor at $200,000. This will be for a new freeze-drying facility.
- Baxter Healthcare Corporation at $70,990. This is for stability testing.
- FFF Enterprises at $39,438. This is for distribution.

Background—Infant Botulism. The DHS has an "orphan drug" license from the federal FDA for the Botulism Immune Globulin Intravenous (Baby BIG) which is the only antidote available for infant botulism in the world for infants. The licensure was provided by the federal FDA in 2003 but prior to that, the DHS provided the drug for many years. BabyBIG is made by harvesting and bottling special antibodies from the blood plasma of volunteer donors.

Without treatment, affected infants spend weeks to months in the hospital, much of that time in intensive care. About 100 cases occur in the United States per year. More than one-third

of the cases occur in California. In California, BabyBig saves Medi-Cal about $1.5 million annually. BabyBig is distributed nationwide.

Subcommittee Staff Comment and Recommendation--Approve. No issues have been raised regarding this proposal. It is recommended for approval.

7. Transfer Hearing Officer and Office Technician Positions

Budget Issue. The DPH is requesting to transfer $376,000 ($231,000 General Fund) and 3.5 positions from their Office of Legal and Office of Regulations to the Department of Health Care Services (DHCS) to conduct the involuntary "Transfer or Discharge Appeals" and "Refusal to Readmit" hearings. The DPH does not have the authority to conduct these hearings under federal law. The DHCS does have authority since it is the State's single State agency recipient of Medicaid (Medi-Cal) funding. These hearings are required by federal Medicaid statutes, not State licensing statutes.

This is a technical "clean-up" issue from when the DPH was split out from the Department of Health Services in 2007.

Subcommittee Staff Comment and Recommendation--Approve. No issues have been raised regarding this proposal. It is recommended for approval.

8. Tissue Bank Licensing Program

Budget Issue. The DPH is requesting an increase of $164,000 (Tissue Bank Special Fund) for two State staff—an Examiner I and a Program Technician—to meet workload demands related to tissue bank applications, renewal applications, on-site inspections and investigations to assure that human tissue used for treatment of patients is safe.

There are 522 facilities currently licensed as tissue banks. Existing statute requires the DPH to assure that tissue is collected, tested, processed, stored and distributed in a manner that will prevent the transmission of infectious disease, contamination, or failure of the tissue and donors to have provided necessary consent.

The DPH states that since 2004 there has been rapid growth in newly licensed tissue banks and nearly doubling the number of applications received for first time licensees. This is due to increased use of other tissue such as reproductive (semen, ova, blastula production by in-vitro fertilization) and the introduction of progenitor or stem cells from bone marrow, adipose or sources other than peripheral blood, human donor milk, veins, arteries, cells, such as islet cells for the development of insulin and manufactured skin.

The program currently has three authorized positions and approval of this request will provide for a total of five positions. The positions are fully fee supported.

Subcommittee Staff Comment and Recommendation--Approve. No issues have been raised regarding this proposal. It is recommended for approval.

9. Valley Fever

Budget Issue. The DPH proposes to expend $1 million (General Fund) in 2010-11 for Valley Fever research and related activities. This is a proposed continuation of a one-time only appropriation made in 2009-10.

Existing law provides for the DPH to contract with the Valley Fever Vaccine Project, a non-profit organization, to distribute grants from funds appropriated by the Legislature for Valley Fever research to develop a vaccine. The Legislature has provided one-time appropriations in various fiscal years, including the following:

- $700,000 in 1997-98
- $3 million in 1998-99
- $500,000 in 2001-02
- $350,000 in 2002-03
- $750,000 in 2003-04
- $1 million in 2009-2010

Valley Fever. Valley Fever is an illness that usually affects the lungs. It is caused by a fungus called Coccidioides. Coccidioides lives in the dirt. The spores become airborne when the uncultivated soil is disturbed and are inhaled. It is found in portions of the Sacramento Valley, all of the San Joaquin Valley, desert regions and southern portions of California, much of the Southwest, Northern Mexico and some areas of Central America.

About 150,000 infections occur each year in the United States, although over 60 percent of these infections do not produce symptoms. For some, it may feel like a cold or the flu. For those who become sick, pneumonia-like symptoms, requiring medication and bed rest can result. For those severely affected, meningitis can result. Valley Fever is diagnosed through an antibody blood test or culture.

Subcommittee Staff Comment and Recommendation--Deny. Due to severe fiscal constraints and the need to maintain core programs, it is recommended to *delete* the proposed augmentation of $1 million (General Fund) for 2010-11 for this project.

Donations, rotary club sponsorships, foundation funds and various fund-raising efforts have been used to support the Valley Fever Vaccine Project and their research efforts.

10. State Registrar: Limited-Term Positions

Budget Issue. The DPH is requesting an increase of $478,000 (Health Statistics Special Fund) to fund eight State positions—Program Technicians (two-year limited-term)—to support base vital records operations.

The DPH states that temporary help and overtime are presently being used to meet workload needs and it would be more efficient to utilize two-year limited-term positions.

The DPH states these resources are needed to close the current gap between staffing and workload that has resulted in extended processing times for certified copies and of vital records. Current processing times do not meet national averages which the DPH contends results in personal hardships to people who need their records for military deployment, medical emergencies or to avoid financial hardship.

These positions are to reduce the processing time for issuing certified copies of vital records from an 18-week processing time to about 10 weeks.

Background—State Registrar of Vital Statistics. The DPH is responsible for administering and maintaining California's birth, death fetal death, and marriage records in perpetuity. The DPH has provided the following key statistics:

- Currently maintain 45 million records.
- Registers about 1 million new records each year.
- Issues 3.5 million certified copies of vital records annually.

Subcommittee Staff Comment and Recommendation-- Approve. The DPH has provided detailed workload information for the positions and no issues have been raised. The Health Statistics Special Fund has sufficient to fund these positions. The fund is supported by fees paid by the public for copies of their vital records.

11. Trailer Bill Language to Codify the DPH Vacancy Report

Budget Issue and Subcommittee Staff Recommendation. In the Budget Act of 2007, the Legislative Analyst's Office (LAO) recommended for the Legislature to adopt "Supplemental Report Language" for the Department of Public Health (DPH) to provide the LAO and the fiscal committees of the Legislature with an annual vacancy report by *no later than January 20 of each year*. The purpose of this report was to serve as a tool for monitoring vacancies within the DPH and to facilitate annual budget discussions.

The DPH did provide the vacancy report in 2008 and 2009.

The DPH did not provide the vacancy report for 2010 until an inquiry was sent by the Subcommittee. Subcommittee staff was informed that since the report was crafted under Supplemental Report Language it was not deemed to be required. It took two more inquiries to receive the report, provided on April 12th.

Therefore, it is recommended to adopt uncodified trailer bill language to require the DPH to annual provide this information. The proposed trailer bill language is shown below. This language is identical to the previously adopted Supplemental Report Language.

> "No later than January 20, the Department of Public Health (DPH) shall annually provide a vacancy report effective as of December 1 of the previous calendar year to the Joint Legislative Budget Committee and the chairs of the fiscal committees in both houses. This report shall identify both filled and vacant positions within the DPH by center, division, branch and classification."

C. Issues for Discussion

1. AIDS Drug Assistance Program (ADAP) (Pages 18 to 24)

Budget Issues. The DPH proposes total expenditures of $462.1 million ($158.3 million General Fund, $210.9 million ADAP Rebate Fund, and $92.9 million federal funds) for ADAP. This reflects a *net* increase of $42.2 million (*increase* of $87.5 million General Fund and a *decrease* of $45.2 million ADAP Rebate Fund).

The Table below provides a detailed summary of each ADAP component.

Table: Detailed Comparison of ADAP Adjustments as proposed in January

ADAP Local Assistance Components	2009-10 Revised January	Budget Year	Difference
Basic Prescription Costs	$405,297,000	$456,950,000	$51,653,000
Eliminate Services to Jails	0	-$10,889,000	-$10,889,000
Subtotal of Prescription Costs	**$405,297,000**	**$446,061,000**	**$40,764,000**
Basic Pharmacy Benefit Manager	$12,966,000	$14,782,000	$1,816,000
Administrative Reduction from 2009 (PBM)	-$500,000	-$500,000	--
Eliminate Services to Jails	0	-348,000	-$348,000
Subtotal PBM Operations	**$12,466,000**	**$13,934,000**	**$1,468,000**
TOTAL Drug Expenditures	**$417,763,000**	**$459,995,000**	**$42,232,000**
Local Health Officers: Administration of Enrollment & Eligibility	$1,000,000	$1,000,000	--
Medicare Part D Premiums	$1,000,000	$1,000,000	--
Tropism Assay (for clinical indication)	$133,000	$133,000	--
TOTAL Support and Administration	**$2,133,000**	**$2,133,000**	--
TOTAL EXPENDITURES	**$419,896,000**	**$462,128,000**	**$42,232,000**
General Fund	**$70,849,000**	**$158,311,000**	**$87,462,000**
Drug Rebate Funds	**$256,120,000**	**$210,890,000**	**-$45,230,000**
Federal Funds	**$92,927,000**	**$92,927,000**	**--**

There are *seven issues* regarding ADAP as follows:

- **A. Prescription Expenditure Increase.** The basic prescription expenditure is estimated to increase by $51.6 million (total funds), prior to the Administration's proposed adjustment for elimination of funding to certain counties for incarcerated individuals. The ADAP states that about 88 percent of drug expenditures are for anti-retroviral drugs.

  The Office of AIDS uses a linear regression model with a 95 percent confidence level that uses actual data from January 2006 through July 2009. This is the same model used to project ADAP expenditures as done in 2009.

The Office of AIDS states there are two key reasons for the increases in prescription drug expenditures. First, drug costs are increasing, including anti-retrovirals. Second, caseload has also increased from 35,611 clients in 2008 to about 37,146 clients for 2010-11 (estimated at January), or an increase of 1,535 people over about an 18-month period. The May Revision will provide an update on estimated drug expenditures and client caseload.

- **B. Reduction of $11.2 million to Discontinue ADAP in Jails.** As discussed in Special Session (our January 26th hearing), the Office of AIDS proposes a reduction of $11.2 million ($9.5 million General Fund and $1.7 million in lost ADAP Rebate Fund) by eliminating funding for county jails effective as of July 1, 2010.

  The Administration states that the $9.5 million (General Fund) saved from this action would be *invested* within the ADAP to assist in meeting State expenditures in 2010-11. They note that Local Health Jurisdictions are responsible for inmate care in jails.

  The Office of AIDS administratively began funding county jails for inmates needing AIDS anti-retroviral drugs in 1994 due to the increasing fiscal impact on Local Health Jurisdictions in meeting their mandate to provide medical services to their incarcerated populations. Presently, thirty-six counties receive funding from the State to serve incarcerated individuals in 44 jails, or about 2,027 people.

  The Office of AIDS states the *existing* process for reimbursing these 36 counties is as follows:

  1. Jail pharmacy submits claim of $100 (drug cost) to Pharmacy Benefit Manager.
  2. Pharmacy Benefit Manager submits invoice of $110.05 for payment to State ADAP. This invoice consists of $100 drug cost + $6.00 transaction fee and $4.05 pharmacy dispensing fee.
  3. State ADAP pays Pharmacy Benefit Manager $110.05.
  4. Pharmacy Benefit Manager reimburses Jail pharmacy at $104.05 (drug cost and pharmacy dispensing fee).
  5. State ADAP invoices drug manufacturer $100, and the drug manufacturer pays State a drug rebate of $32 (average rebate for ADAP jail clients) to ADAP.

  The Office of AIDS notes that five counties—San Francisco, Santa Clara, San Diego, Contra Costa and Los Angeles— support their own jail programs. Santa Clara County is able to access 340b federal pricing through their county hospital (Valley Medical Center). As such, other counties may be able to establish relationships through their Local Health Jurisdictions to access this low-cost pricing via hospitals or applicable clinics.

- **C. 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 federal Medicaid law) and *voluntary* supplemental rebates (additional rebates negotiated with 14 drug manufacturers through ADAP Taskforce).

  Generally, for every dollar of ADAP drug expenditure, the program obtains 46 cents in rebates. This 46 percent level is based on an average of rebate collections (both "mandatory" and "supplemental" rebates).

  It should be noted the federal Patient Protection and Affordable Care Act, signed by President Obama in March, makes changes to the federal *mandatory* Medicaid rebate calculation which *may* impact ADAP. Specifically, the federal Medicaid rebate calculation was increased for *both* brand name drugs (from 15.1 percent to 23 percent of "average manufacturer price"), and generic drugs (from 11 percent to 13 percent), effective as of January 1, 2010 (retroactive). The Office of AIDS notes they are *seeking additional information* regarding the increased rebates under Medicaid to discern how ADAP may be affected.

  In addition, California and several other large States negotiate additional supplemental rebates from manufacturers of anti-retroviral drugs through the ADAP Taskforce. The ADAP Taskforce will be meeting in early May to encourage manufacturers of anti-retroviral drugs to implement price freezes and encourage additional supplemental rebates. These negotiations should be helpful.

  The Office of AIDS will update the ADAP Rebate Fund projections at May Revision, including addressing the potential for increased rebates due to the new federal Patient Protection and Affordable Care Act, as well as discussions regarding supplemental rebates.

  If ADAP Rebate Fund revenue is increased, General Fund support may be offset.

- **D. Medicare Part D and "True-Out-Of-Pocket (TrOOP).** California's ADAP interacts with the federal Medicare Part D drug benefit, implemented in 2006. The income level and assets of federal Medicare Part D enrollees determines the level of prescription assistance they receive under the federal program. 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.

  A Medicare Part D enrollee's TrOOP spending— a person's prescription payment obligation during the Medicare Part D coverage gap, or "donut hole"—determines how one advances through the various Part D coverage levels. This rule typically leads to ADAP clients (who are also in Medicare Part D) to remain "stuck" in the Part D coverage gap, and thus shifting more to ADAP coverage for this period.

  The new federal Patient Protection and Affordable Care Act allows for ADAP expenditures to count towards a person's "TrOOP effective as of January 1, 2011. As

such federal Medicare Part D coverage will provide more support, and ADAP will experience savings from this action.

The Office of AIDS states the May Revision will reflect an adjustment for this good federal news, and that a small amount of General Fund savings is likely (possibly $1 million to $2 million or so).

E. Update on Ryan White HIV/AIDS Federal Funding. In April, the federal HRSA informed the DPH of California's award of federal Ryan White HIV/AIDS grant funds. The table below provides a summary.

Component	Purpose	Federal Amount	Increase
AIDS Drug Assistance	ADAP—drug expenditures	$98,809,000	$4,705,000
Base	HIV Care	$34,685,000	$692,000
Minority AIDS Initiative	Local Health Jurisdictions	$936,000	$207,000
Emerging Communities	HIV Care	$175,000	$10,000
TOTAL		$134,605,000	$5,614,000

As noted in the table, the ADAP is to receive an increase of $4.7 million (federal funds) for 2010-11. The Office of AIDS will account for this change at the May Revision.

F. Office of AIDS Request for Application for Pharmacy Benefit Manager (PBM). On March 26, the Office of AIDS released a Request for Proposal (RFP) to provide pharmacy services and claims processing for the ADAP. The existing PBM contract will be expiring in June 30, 2010.

The contract term in the RFP would provide for a 3-year term, with an option of two one-year extensions. According to the RFP, the notice of intent to award is to be made by May 20, 2010. The Office of AIDS has modified some of the administration overhead provisions and anticipates some savings from these actions.

The Office of AIDS should provide an update regarding any *key* changes that are proposed in the RFP.

G. Proposed Use of ADAP as "Certified Public Expenditure (CPE) in Waiver. As discussed in our March 25, 2010 Subcommittee hearing, the DHCS proposes to utilize State CPE from the ADAP, along with other programs, to draw federal funds under the existing Hospital Financing Waiver in the Medi-Cal Program.

For the DHCS to claim CPE, there needs to be clarity that these funds are *not* otherwise being used to match other federal funds (cannot use funds to match federal dollars multiple times). However, the ADAP does recognize a portion of their expenditures for federal purposes in order to obtain federal Ryan White CARE Act funds.

According to the DHCS, the amount of CPE being counted from ADAP is a *maximum* of $144 million. Of this amount, the DHCS states they will be recognizing $65 million for 7 months (i.e., existing Hospital Finance Waiver amendment from February 1, 2010 to August 30, 2010). The DHCS states they have accounted for *all* maintenance of effort (MOE) requirements with the Ryan White CARE Act, as well as with the federal HRSA.

Further, the DHCS testified in the March 25, 2010 Subcommittee hearing there would be *absolutely no impact* to ADAP and that no changes to ADAP systems would be needed.

It is recommended to obtain the Office of AIDS perspective on this issue as the State entity that administers the ADAP.

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 4,000 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.

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 estimated ADAP client enrollment.

ADAP Clients by Coverage Group (2010-11)

Coverage Group	Clients	Percent
ADAP-Only coverage	22,006	59.2%
Medi-Cal coverage	454	1.2%
Private coverage	6,084	16.4%
Medicare coverage	8,602	23.2%
TOTAL	**37,146**	**100 percent**

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 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.

Subcommittee Staff Comment and Recommendation. The ADAP is a core State health care program which has been cost-beneficial to the State. First, due to several anticipated changes forthcoming in the May Revision, it is recommended to keep this issue "open" until such time.

Second, at this time it is recommended to adopt the following placeholder trailer bill language regarding the use of ADAP as a certified public expenditure in the event it is identified to be used for this purpose under a DHCS federal Waiver. (This issue is presently pending in a Waiver amendment to the Hospital Financing Waiver.) The proposed language is as follows:

> " In the event State expenditures for the AIDS Drug Assistance Program (ADAP) are identified by California to be used as a certified public expenditure for the purpose of obtaining federal financial participation under the State's Medi-Cal Program for any purpose, including federal demonstration waivers, the Department of Health Care Services and the Department of Public Health shall ensure the integrity of the ADAP in meeting its maintenance of effort requirements to receive federal funds, and to

obtain all ADAP drug rebates to support the ADAP. The Department of Health Care Services and the Department of Public Health shall keep the policy and fiscal committees of the Legislature informed of any potential concerns that may arise in the event the ADAP is used as a state certified expenditure as noted."

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

1. DPH, Please discuss and comment on each of the seven issues, as identified above.
2. DPH, Are there any other aspects regarding the ADAP that our Subcommittee should be aware of at this time?

2. Department of Public Health's Drinking Water Program: Three Issues

Budget Issues. The DPH has statutory authority to administer California's public Drinking Water Program. The program provides for ongoing surveillance and inspection of public water systems, issues operational permits to the systems, ensures water quality monitoring is conducted and takes enforcement actions when violations occur**.** They oversee the activities of about 8,000 public water systems (including both small and large water systems) that serve more than 34 million Californians.

The DPH is also designated by the federal Environmental Protection Agency (EPA) as the primacy agency responsible for the administration of the federal Safe Drinking Water Act for California.

California's total need for water system infrastructure improvements is in excess of $39 billion, as reported through a needs assessment conducted in 2007. The majority of public water systems care not able to finance necessary improvements on their own and require State and federal assistance.

There are *three budget issues* regarding the Drinking Water Program. These include receipt of federal funds, expenditure of State bond funds, and the need for State staff to manage various water projects. These issues are discussed below.

A. Safe Drinking Water: State Staff Request, and Concern with State Match.

Background. Enacted in 1997, under this program California receives federal funds to finance low-interest loads and grants for public water system infrastructure improvements. In order to draw down these federal capitalization grants, the State must provide a 20 percent match. Further, the State must submit an annual "Intended Use Plan" which describes California's plan for utilizing the program funding.

The program is comprised of five set-aside funds, as well as a loan fund. The set asides are as follows:

- Drinking water source protection (15 percent);
- Technical assistance to small water systems (up to 2 percent);
- Water system reliability/capacity development (2 percent);
- State water system program management activities (up to 10 percent);
- Administrative costs (up to 4 percent).

California will be receiving *increased federal grant funds* due to a change in the federal allocation, and from *increased Congressional funding* (H.R. 2996). Specifically, the Table below provides a summary of the forthcoming federal grant amounts.

With respect to the 20 percent State match, General Fund support was used for a period of time, then a portion of Proposition 13 bonds (until fully expended), then a portion of Proposition 50 bonds, and now a portion of Proposition 84 bonds.

It should also be noted that a portion of the State match has been obtained from local matches (cash) provided by Large Water systems to allow them to access some federal funds. In 2008, a total of $2.3 million was provided through a local match, and in 2009, a total of $6.1 million was provided.

The Table below provides a summary of the federal capitalization grants and State match. The DPH states that Proposition 84 bond funds will be available to serve as a portion of the 20 percent match until 2011-12. Then, additional State sources will be needed—such as other bond funds, local matches, or General Fund support.

Table: DPH Summary of Safe Drinking Water State Revolving Fund Program

State Fiscal Year	20 Percent State Match	Federal Fund Amount	Total Amount
Current Year	$13.3 million ($7.2 million Prop 84) ($6.1 million local—Large Water)	$66.4 million	$79.7 million
2010-2011	$25.4 million (Proposition 84)	$126.9 million	$152.3 million
2011-2012	$13.3million (Proposition 84) $12.1 million *(unidentified)*	$126.9 million	$152.3 million
2012-2013	$25.4 million *(unidentified)*	$126.9 million	$152.3 million
2013-2014	$25.4 million *(unidentified)*	$126.9 million	$152.3 million
2014-2015	$25.4 million *(unidentified)*	$126.9 million	$152.3 million

Proposed Trailer Bill Language—Revenue Bonds. The DPH has proposed trailer bill language for statutory authority to sell revenue bonds to provide the required 20 percent State match to access federal funds under the Safe Drinking Water Program.

Specifically the DPH is requesting an increase of $110,000 (Safe Drinking Water—Administration Account) to hire a consultant to provide assistance to the DPH for the sale of revenue bonds. The revenue stream would be obtained through water rate adjustments over several years.

Considerably more detail is needed in order to discern how the revenue bond sales would be structured. This is why the DPH is seeking an appropriation for a consultant.

The DPH notes several States—New York, Massachusetts, Arizona, Maine, Colorado, Nevada, Ohio and Connecticut—currently use a revenue bond approach.

Request for State Staff. The DPH currently has 45 permanent positions funded under the Safe Drinking Water Program. In addition, the program has 10.5 limited-term positions which expire as of June 30, 2010.

For 2010-11, an *increase of 24.5* (two-year limited term) positions is requested to **(1)** continue support of the Safe Drinking Water Program; **(2)** implement the U.S. EPA Groundwater Rule and State 2 Disinfectant and Disinfectant By-Products Rule; and **(3)** redirect State staff from Proposition 84 bond functions and integrate them into the global Safe Drinking Water Program.

First, the 10.5 limited-term positions within the Safe Drinking Water Program are proposed to be extended for another two-years (from June 30, 2010 to June 30, 2012). These positions have been provided by the Legislature on a two-year limited-term basis since 1999.

Second, 14 limited-term positions established July 1, 2009, pursuant to SB X2 1 (Perata), Statutes of 2008, are proposed to be integrated into the Safe Drinking Water Program from Proposition 84 bond functions. These positions would be used to (1) implement the federal US EPA Groundwater Rule and Stage 2 Disinfectant and Disinfection By-products Rule; and (2) provide technical assistance and administrative support for the increase in projects due to additional federal grants under the Safe Drinking Water Program.

A total of *$3 million* (various special water funds) is requested for the 24.5 limited-term positions. These positions are as follows:

- Sanitary Engineers—various levels 13
- Environmental Scientists—various levels 4
- Accounting, Analysts, and Clerical support 6.4
- Staff Counsel IV 1

Key activities of staff include: (1) review pre-applications and supporting information from public water grant applicants and rank projects; (2) conduct full engineering review of applications; (3) review construction bids for compliance and project costs; (4) conduct mid-point construction inspections; (5) review and approve invoices for payment; (6) assist in program management; (7) develop program financial reports; (8) develop contracts and monitoring performance procedures; (9) conduct activities associated with water capacity development; and (10) provide training and technical assistance on all aspects of the program.

Subcommittee Staff Comment and Recommendation. The Safe Drinking Water Program is a mature program and no issues have been raised regarding the proposed State staff. It is recommended to approve the staff request as proposed (24.5 limited-term positions).

For the $110,000 (Safe Drinking Water— Administration Account) to hire a consultant for the sale of revenue bonds, as well as the proposed trailer bill language, it is recommended to *deny this request without prejudice*.

This concept has merit but should proceed through the policy committee process for a more contemplative approach on how the revenue bonds may be structured, including any opportunities to facilitate access to bond funding streams for disadvantaged communities.

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

1. DPH, Please provide a *brief* summary of the Safe Drinking Water Program.
2. DPH, Please describe the both the trailer bill request *and* the 24.5 limited-term positions.

B. Drinking Water: Reappropriation of Proposition 84 Bonds (SB X2 1)

Budget Issue. Proposition 84, of 2006, provided the DPH with up to $300 million in bond authority for water projects. A spending plan was approved for this in 2007.

As noted above, a portion of Proposition 84 bonds (total of $45.7 million) is expended under the Safe Drinking Water Program for the State's 20 percent match to receive federal funds, and the remaining amount being available for various water projects.

SB X2 1, Statutes of 2008, modified this plan to increase the appropriation in 2008-09 and 2009-2010 (until June 30, 2010) for certain projects.

The DPH is requesting a five-year *reappropriation* of $100.4 million (special funds) pursuant to SB X2 1 (Perata), Statutes of 2008. However, the DPH states that due to sluggish bond sales, they have *not* been allocated sufficient bond proceeds to utilize the appropriation. Specifically, the DOF directed the DPH to suspend authorizing any new grants or obligations for bond projects in 2008.

The DPH did receive some bond proceeds in March 2009, November 2009, and March 2010 and has recently restarted the program. But the impact of the freeze on operations means the DPH cannot meet the encumbrance timeframes specified in SB X2 1.

Further, the DPH notes that, depending on bond sales, full encumbrance is not expected to occur until 2013-14. Therefore, the DPH proposes to *reappropriate funds* to extend its available budget authority as shown in the Table 1 below (last two-columns).

Table 1: DPH Proposal for Reappropriation of SB X2 1, Statutes of 2008 (for Prop 84)

Fiscal Year	SB X2 1 Appropriation (State Operations)	SB X2 1 Appropriation (Local Assistance)	Proposed DPH Reappropriation (State Operations)	Proposed DPH Reappropriation (Local Assistance)
2007-08				
2008-09	$327,000	0	$9,994 actual	0
2009-10	$1,717,000	$98,356,000	$1,500,000	$18,898,787
2010-11		0		$50,313,006
2011-12		0		$10,000,000
2012-13		0		$10,000,000
2013-14		0		$9,678,213
TOTAL	**$2,044,000**	**0**	**$1,509,994**	**$98,890,006**

Authority for *other* Proposition 84 bond funds (i.e., those not related to SB X2 1) are *not affected* by this DPH proposal. The appropriation amounts for the remaining Proposition 84 bonds are shown in Table 2, below.

Table 2: Existing Proposition 84 Appropriation (*non-SB X2 1*) = $134.3 million

Fiscal Year	Proposition 84 (non-SB X2 1) (State Operations)	Proposition 84 (non-SB X2 1) (Local Assistance)
2007-08	$414,000	
2008-09	$1,467,421	$113,500
2009-10	$2,152,000	0
2010-11	$2,154,000	0
2011-12	$2,154,000	$32,154,997
2012-13	$2,154,000	$28,854,997
2013-14	$1,638,616	29,793,250
2014-15	$1,500,000	$29,793,250
TOTAL	**$13,634,037**	**$120,709,994**

A *key* concern of the entire program is the receipt of Proposition 84 bond *proceeds* to commence with projects. As shown in Table 3 below, the DPH has projects identified in various stages that total $194.4 million presently, including an expected "shovel ready " (in two to six months) amount of about $16.2 million.

Yet, proceeds from bond sales for Proposition 84 are very sluggish and presently cash on hand is only about $21.1 million.

The DPH states that March 2010 bond proceeds may increase the $21.1 million (cash on hand), but it is unclear how the March proceeds of $159 million will be split between Proposition 84 program needs and Proposition 50 program needs. The DPH notes that the Department of Water Resources decides the actual split between programs.

Table 3: Proposition 84 Project Obligations Compared to Bond Proceeds Available

Description of Funding Obligation	**Proposition 84 Need**
1. Contract Agreements with Water Systems— 15 projects	$16.9 million
2. Letters of Commitment— 12 letters	$12.2 million
3. Applications in Process—6 applications	$124.3 million
4. New Applications Received—7 applications	$40 million
5. Emergency Grants-- 20	$1 million
TOTALS	**$194.4 million**

However, it would be constructive for the DPH to report back to the Subcommittee *prior* to May Revision on the exact split of the bond proceeds from March, as well as ideas for facilitating the receipt of funds for disadvantaged systems, as directed by SB X2 1.

Background—SB X2 1, Statutes of 2008. The purpose of this legislation is to require the integration of flood protection and water systems to achieve multiple public benefits and to make a portion of the funds authorized by Proposition 84 of 2006 immediately available to the DPH and Department of Water Resources. Additionally, it requires the DPH to give the highest priority water systems that serve disadvantaged and severely disadvantaged communities in the funding for small water system infrastructure improvements.

The DPH was provided 14 limited-term positions (expire as of June 30, 2010) for various aspects of the enabling legislation. These positions are proposed to be extended and will be integrated with the DPH's overall Safe Drinking Water Program (as referenced in the Agenda item above).

Background—Proposition 84, Safe Drinking Water & Water Quality Projects (2006). This act contains several provisions that pertain to the Department of Public Health (DPH). It should be noted that 3.5 percent (annually) of the bond funds are to be used to service the bond costs, and up to 5 percent (annually) can be used for DPH state support expenditures. The remaining amounts are to be used for local assistance. A summary of the provisions for which the local assistance funds can be used is as follows:

- $10 million for Emergency Grants. Section 75021 of the proposition provides funds for grants and direct expenditures to fund emergency and urgent actions to ensure that safe drinking water supplies are available. Eligible project criteria includes, but is not limited to: (1) providing alternate water supplies including bottled water where necessary; (2) improvements to existing water systems necessary to prevent contamination or provide other sources of safe drinking water; (3) establishing connections to an adjacent water system; and (4) design, purchase, installation and initial operation costs for water treatment equipment and systems. Grants and expenditures *shall not exceed $250,000* per project.

- $180 million for Small Community Drinking Water. Under Section 75022 of the proposition, grants for small community drinking water system infrastructure improvements and related actions to meet safe drinking water standards will be available. Statutory authority requires that priority be given to projects that address chemical and nitrate contaminants, other health hazards, and by whether the community is disadvantaged or severely disadvantaged.

  Eligible recipients include public agencies, schools, and incorporated mutual water companies that serve disadvantaged communities. Grants may be made for the purpose of financing feasibility studies and to meet the eligibility requirements for a construction grant.

  Construction grants are limited to $5 million per project and not more that 25 percent of the grant can be awarded in advance of actual expenditures. Up to $5 million of funds from this section can be made available for technical assistance to eligibility communities.

- $50 million for Safe Drinking Water State Revolving Fund Program. As discussed under Agenda issue #1—Proposition 50 implementation, the Safe Drinking Water State Revolving Fund Program enables California to provide a 20 percent state match to draw

down federal capitalization funds. Once the Proposition 50 bond funds are exhausted for this purpose, the Proposition 84 bond funds will be used. This conforms to Section 75023 of the proposition.

- $60 million Regarding Ground Water. Section 75025 provides for grants and loans to prevent or reduce contamination of groundwater that serves as a source of drinking water. Statutory language requires the DPH to require repayment for costs that are subsequently recovered from parties responsible for the contamination. Language in the proposition also provides that the Legislature may enact additional legislation on this provision as necessary.

Subcommittee Staff Comment and Recommendation. It is recommended to approve the reappropriation as proposed due to the sluggish bond proceeds, and to adopt the following Budget Bill Language to ensure the Legislature obtains regular updates regarding expenditures. The proposed Budget Bill Language is as follows (Item 4265-001-0001):

> "The Center for Environmental Health shall provide the fiscal committees of the Legislature with a fiscal update by no later than January 10 and May 14 of each year that provides a summary of *all* Department of Public Health's water bond appropriation authority, bond proceeds, status of project obligations and any other relevant information regarding DPH's safe drinking water program overall."

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

1. DPH, Please provide an update regarding Proposition 84 bonds, including funds affected by SB X2 1.
2. DPH, Specifically, what is presently being done to provide assistance to disadvantaged communities?

C. Drinking Water: Proposition 50 Bonds and State Staff

Budget Issue. The DPH is requesting an increase of $1.8 million (Proposition 50 Funds) to extend 15.5 positions for another two-years (June 30, 2010 to June 30, 2012). These positions were first authorized in 2003 and are supported by the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002 (Proposition 50).

The positions are primarily engineering classifications, along with related environmental scientist classifications and administrative support. The DPH states these positions are necessary to meet workload needs for key activities as follows:

- Review technical "pre-applications" for Proposition 50 funding and rank proposals.
- Create a project priority list based on the priority ranking of the projects.
- Evaluate full project applications and prepare extensive technical report documents for each project.
- Review and evaluate the plans and specifications for each project and conduct construction inspections and a final inspection of each project.
- Review proposal for reduction or removal of drinking water contaminants and participate in demonstration projects such as ultraviolet treatment processes.
- Review and comment on draft environmental documents prepared for drinking water projects.
- Conduct final project inspection and certify completion.
- Conduct program fiscal management and administration.

The Proposition 50 Plan is maintained by the State's Resources Agency. DPH updates its portion of the Plan twice a year to reflect bond cash flow by updating project status information.

The DPH states they have updated their Plan to reflect a longer disbursement period for local assistance funds, and part of this is due to sluggish bond sales.

Background—Proposition 50, Statutes of 2002 & Chapters Applicable to the DPH. Proposition 50 of 2002 provides funds to a consortium of state agencies and departments to address a wide continuum of water quality issues. The DPH anticipates receiving up to $485 million over the course of this bond measure for water projects. Of this amount, $89 million has been expended towards the State's 20 percent match requirement under the Safe Drinking Water Program. The remaining amount is for various water projects as specified in the following key chapters of the proposition.

Chapter 3—Water Security ($50 million). Proposition 50 provides a total of $50 million for functions pertaining to water security, including the following: (1) monitoring and early warning systems, (2) fencing, (3) protective structures, (4) contamination treatment facilities, (5) emergency interconnections, (6) communications systems, (7) other projects designed to prevent damage to water treatment, distribution and supply facilities**.**

Chapter 4—Safe Drinking Water ($435 million total for DHS). Proposition 50 provides $435 million to the DHS for expenditure for grants and loans for infrastructure improvements and related actions to meet safe drinking water standards. A portion of these funds will be used as the state's match to access federal capitalization grants (see table below).

With respect to the other projects, the Proposition states that the funds can be used for the following types of projects: **(1)** grants to small community drinking water systems to upgrade monitoring, treatment or distribution infrastructure; **(2)** grants to finance development and demonstration of new technologies and related facilities for water contaminant removal and treatment; **(3)** grants for community water quality; **(4)** grants for drinking water source protection; **(5)** grants for drinking water source protection; **(6)** grants for treatment facilities necessary to meet disinfectant by-product safe drinking water standards; and **(7)** loans pursuant to the Safe Drinking Water State Revolving Fund (i.e., where by the state draws down 80 percent federal match). In addition, it is required that not less than 60 percent of the Chapter 4 funds be available for grants to Southern California water agencies to assist in meeting the state's commitment to reduce Colorado River water use.

Subcommittee Staff Comment and Recommendation. It is recommended to approve the requested positions and to obtain an update from the DHP on the program.

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

1. DPH, Please provide an update regarding Proposition 50 bonds.

2. DPH, Please provide a brief summary of the budget request.

3. Radiation Protection Program: Two Issues

Budget Issues. The DPH is requesting a total of 13 two-year limited-term staff (to June 30, 2012) to address two issues regarding the Radiation Protection Program.

First, nine Associate Health Physicist positions (two-year limited-term) are proposed to increase the number of radiation machine inspections conducted. Presently, the DPH must register and inspect about 13,000 X-ray machines, including medical diagnostic, therapy accelerators, research machines and others. However, presently they are only able to inspect about 10,000 machines using 33 Health Physicists (about 300 inspections per positions).

These inspections are required by State statute and are intended to:

- Reduce the potential for excessive radiation exposure to individuals from medical and industrial sources;
- Reduce the number of unqualified individuals using radiation machines;
- Provide education to assist users to understand and comply with radiation protection standards; and
- Respond and investigate complaints and perform enforcement activities aimed at prosecuting those facilities and operators in violation of laws and regulations.

The DPH states that with the additional nine Associate Health Physicist positions, they will b able to address the need for the additional 3,000 inspections.

Second, four positions (two-year limited-term) are requested to monitor radioactive materials per existing State statute (Section 115070 of Health and Safety Code), and as required by the federal Nuclear Regulatory Commission (NRC). The requested positions include two Associate Health Physicists and two Office Technician positions. Specifically, the Associate Health Physicists would do the following:

- Annually insect 80 to 120 additional radioactive materials licensees;
- Perform verification of licensee's employees background and communication procedures and policies;
- Inspect locations of increased controls materials, logs of materials receipt, transfer and disposal, licensee radiation detection equipment, and maintenance and calibration records; and
- Annually perform over 50 escalated enforcement activities to ensure that non-compliant facilities and unauthorized operators are identified and stopped from illegal activities.

The requested two Office Technicians would be used for various data collection activities, including maintaining tracking system documents.

Further, the DPH proposes a technical reduction of $2.275 million (Radiation Control Fund) for the current-year, and a *net* reduction of $1.3 million (Radiation Control Fund) for 2010-11.

The current-year reduction reflects adjustments for one-time expenditures related to equipment purposes and training requirements. The $1.6 million cost of the requested 13 positions are accounted for within the net reduction for 2010-11.

Background on Radiation Control Program. The purpose of this program is to protect public health and safety by decreasing excessive and unnecessary exposure to radiation, and reducing the release of radioactive material into the environment. This is accomplished through (1) licensing users of radioactive material, including medical, academic and industrial facilities; (2) registration of radiation producing machines; (3) certification of individuals using radiation sources; (4) inspection of facilities using radiation sources; (5) conducting enforcement actions.

California, along with 33 other States, has an agreement with the federal NRC by which the federal government does not have regulatory authority over certain types of radioactive material. Instead, the State has the authority for oversight but the NRC conducts performance evaluations as part of its function. This State-Federal relationship is known as "Agreement State Program". Therefore, the Radiation Control Program licenses and inspects users of radioactive materials that are subject to both federal and State law.

The federal NRC has instituted additional controls including a National Source Tracking System Program in which the DPH must participate. This program tracks the location of radioactive materials, and adds an additional layer of security and workload to the DPH.

Subcommittee Staff Comment and Recommendation. It is recommended to approve the requested 13 staff (two-year limited-term) as proposed and to obtain an update on the Radiation Protection Program.

Questions. The Subcommittee has requested the L&C Division to respond to the following questions:

1. DPH, Please provide a *brief* summary of the Radiation Protection Program and the budget request.
2. DPH, When will information be forthcoming regarding the Radiation Materials Program reporting?

4. Licensing and Certification— Proposed Licensing Fees for 2010-11

Budget Issue. The Licensing and Certification (L&C) Division develops and enforces State licensure standards, conducts inspections to assure compliance with federal standards for facility participation in Medicare and/or Medi-Cal, and responds to complaints against providers licensed by the DPH.

In 2006, the L&C Program began a transition to migrate from General Fund support to a fee-based program, coupled with applicable federal funding. Only State departments that operate long-term care facilities are appropriated General Fund support for the purpose of licensing and certification activities. Existing statute provides the framework for calculating the annual licensing and certification fees for each of the various health care facilities.

Existing statute requires the L&C Division to annually publish a Health Facility License Fee Report (DPH Fee Report) by February of each year. The purpose of this annual DPH Fee Report is to provide data on how the fees are calculated and what adjustments are proposed for the upcoming fiscal year.

The DPH Fee Report utilizes the requirements of existing statute for the fee calculations, and makes certain "credit" adjustments. The DPH notes that these "credits" are most likely *one-time only* and that when fees are calculated based solely on the statutorily prescribed workload methodology as contained in statute, there *may be significant increases* to fees in the near future.

The *"credits"* are applied to offset fees for 2010-11 and total $14.7 million. They are as follows:

- $8.5 million credit in savings resulting from 2009-2010 employee furloughs.
- $4.2 million credit for miscellaneous revenues for change in ownerships and late fees collected in 2008-09.
- $2 million credit for 2008-09 for internal program savings.

The fees must also take into consideration various incremental cost adjustments for 2010-11, including budget change proposals (to be discussed individually in this Agenda, below), employee retirement and worker's compensation, facility space for field offices and related aspects.

The baseline incremental changes result in *increased costs of $3.6 million* and are as follows:

- Adjustment of pro-rata as directed by the Department of Finance for a net increase of $2.1 million.
- Reallocation of DPH overhead expenditures of $1.4 million.
- Adjustment of $134,000 for employee compensation and retirement.
- Adjustment of $64,000 for lease revenue debt service for staff located at the Richmond Laboratory complex.

The DPH Fee Report of February 2010 proposes a *slight reduction* to fees as shown in the Table below. This decrease results from application of the "credits", primarily from the State employee furloughs, as referenced.

Proposed Licensing and Certification Fee Schedule (January 2010)

Facility Type	Fee Category	2009-10 Fee (Budget Act 2009)	Proposed Fee 2010-11	Difference (+/-)
Referral Agencies	per facility	$3,564.13	$3,536.84	-$27.29
Adult Day Health Centers	per facility	$3,995.61	$3,985.57	-$10.04
Home Health Agencies	per facility	$4,159.42	$4,129.63	-$29.79
Community-Based Clinics	per facility	$600.00	$581.67	-$18.33
Psychology Clinic	per facility	$1,099.99	$1,081.80	-$18.19
Rehabilitation Clinic	per facility	$200.00	$190.00	-$10.00
Surgical Clinic	per facility	$1,918.00	$1,821.97	-$96.03
Chronic Dialysis Clinic	per facility	$2,932.87	$2,897.40	-$35.47
Pediatric Day Health/Respite	per bed	$154.62	$152.23	-$2.39
Alternative Birthing Centers	per facility	$2,430.93	$2,409.10	-$21.83
Hospice	per facility	$1,875.41	$1,844.59	-$30.82
Acute Care Hospitals	per bed	$257.76	$255.10	-$2.66
Acute Psychiatric Hospitals	per bed	$257.76	$255.10	-$2.66
Special Hospitals	per bed	$257.76	$255.10	-$2.66
Chemical Dependency Recovery	per bed	$144.59	$143.86	-$0.73
Congregate Living Facility	per bed	$287.00	$228.57	-$58.43
Skilled Nursing	per bed	$287.00	$228.57	-$58.43
Intermediate Care Facility (ICF)	per bed	$287.00	$228.57	-$58.43
ICF-Developmentally Disabled	per bed	$938.01	$425.20	-$512.81
ICF—DD Habilitative, DD Nursing	per bed	$938.01	$425.20	-$512.81
Correctional Treatment Centers	per bed	$938.01	$425.20	-$512.81

Background on Fee Methodology. Licensing fee rates are structured on a per "facility" or "bed" classification and are collected on an initial license application, an annual license renewal, and change of ownership. The fees are placed into a special fund—Licensing and Certification Special Fund.

The fee rates are based on the following activities:

- Combines information on projected workload hours for various mandated activities by specific facility type (such as skilled nursing home, community-based clinic, or hospital). The DPH notes that workload data from 2008-09 is used to calculate rates for 2009-2010.
- Calculates the State workload rate percentage of each facility type to the total State workload.
- Allocates the baseline budget costs by facility type based on the State workload percentages.
- Determines the total proposed special fund budget cost comprised of baseline, incremental cost adjustments, and credits.
- Divides the proposed special fund cost per facility type by the total number of facilities within the facility type or by the total number of beds to determine a per facility or per bed licensing fee.

The DPH Fee Report provides considerable detail regarding these calculations, as well as useful data on L&C workload associated with the various types of health care facilities, along with clear description regarding the details of the methodology.

Background—Licensing & Certification Division Total Resources. The L&C Division is supported by licensing and certification fee revenue as noted above, as well as various federal funds, and certain reimbursements.

Funding Sources for L&C Division	2009-10	2010-11	Difference
L&C Fees Paid by Facilities	$73,993,000	$86,523,000	$12,530,000
Federal Funds	$60,677,000	$56,526,000	-$4,151,000
Transfers from other State Departments	$8,005,000	$8,005,000	--
Reimbursement from the DHCS for federal certification, Nurses Aide Training and related items.	$3,439,000	$3,292,000	-$147,000
State Citation Penalties Account	$2,149,000	$2,149,000	--
Internal Quality Improvement Account		$818,000	$818,000
Nursing Home Administrator Program	$326,000	$445,000	$119,000
Federal Bioterrorism Funds	$217,000	$217,000	--
General Fund	$221,000	0	-$221,000
TOTAL FUNDS	**$149,027,000**	**$157,975,000**	**$8,948,000**

Subcommittee Staff Comment and Recommendation. As discussed in the DPH Fee Report, certain "credits" are being applied which reduce the fees paid by the various health care facilities. The DPH furloughing of staff for a reduction (credit) of $8.5 million is the most significant reason why fees are being temporarily reduced. However, the affect on L&C Division performance measures for completing required survey work and enforcing quality assurance measures are not readily known. The DPH should provide an update on this aspect.

It should also be recognized that fees may need to be adjusted at the May Revision or subsequent date to reflect any changes that may be forthcoming regarding employee furloughs or other State employee changes. It is recommended to adopt the proposed fee levels pending receipt of the May Revision.

Further, it is recommended to adopt placeholder trailer bill language to require the DPH to provide the fiscal committees of the Legislature with an L&C Division estimate package by no later than January 10 and May 14 of each year. Presently the L&C Division does not provide this level of fiscal detail to the Legislature. It is the understanding of Subcommittee staff that the DPH has been working on the development of such a fiscal estimate package.

Questions. The Subcommittee has requested the L&C Division to respond to the following questions:

1. DPH, Please provide a *brief* summary of the L&C Fees, including the *key* credits and adjustments.
2. DPH, How have the existing furloughs affected the L&C Division workload and survey requirements and quality assurance follow-up?

5. Licensing and Certification—Quality Improvement Activities

Budget Issue. The L&C Division requests one-time expenditure of $800,000 for contracts for quality improvement activities to initiate a "High-Risk Operating Room Department Safety Collaborative" (Collaborative). This Collaborative would focus on assisting hospitals to reduce or eliminate surgical adverse events related to retention of a foreign object, which is the second most frequent preventable adverse event.

Senate Bill 541 (Alquist), Statutes of 2008, among other things, increased certain penalties assessed against hospitals for adverse actions and required these funds to be placed into a special fund to be expended, upon appropriation by the Legislature, to support internal departmental quality improvement activities.

The DPH states that the use of a Collaborative is a new major approach for rapidly improving the quality and efficiency of health care. It focuses on a single technical area and seeks to rapidly spread existing knowledge or best practices related to that technical topic.

California Hospitals will enroll into this Collaborative so that their medical staff can receive training sessions on best practices that are proven to reduce the incidence of retention of foreign objects during surgery. Participant hospitals will establish their baseline for this adverse event and set quarterly goals for including new reduction strategies and method to reduce event rates.

Subcommittee Staff Comment and Recommendation. It is recommended to approve the increase for $800,000 (Internal Department Quality Improvement Account) for quality improvement activities as provided for under SB 541 (Alquist), Statutes of 2008. The DPH should provide an update on the scheduling of the project and anticipated outcomes.

Questions. The Subcommittee has requested the L&C Division to respond to the following questions:

1. DPH, Please provide a brief summary of the proposal and anticipated timing of the contracts and outcomes.

6. Licensing and Certification—Health Facility Reporting (CalHEART)

Budget Issue. The DPH is requesting an increase of $721,000 ($703,000 L&C Fund and $18,000 (Internal Department Quality Improvement Account) for 1.5 positions (limited-term), an interagency agreement, and a contract to develop, implement and maintain the California Healthcare and Event Reporting Tool (CalHEART) web-based portal.

The purpose of CalHEART would be to address reporting needs as contained in State statute. Specifically, Senate Bill 1301 (Alquist), Statutes of 2008, and Senate Bill 1058 (Alquist), Statutes of 2009, both require health facilities to report the DPH regarding certain adverse events (occurring in hospitals) and certain bacterial infection incidences (health facilities).

Presently, these reporting requirements are met by facilities providing the information to the L&C Division by telephone, fax or mail. There is concern this manual process discourages the timely reporting and may delay the L&C Division's ability to investigate incidences in a timely manner.

The 1.5 positions include a half-time Data Processing Manager III (two-year limited-term to June 30, 2012), and one Staff Programmer Analyst (one-year limited-term from January 2011 to December 2012). These positions would work with the contractor and the Office of the Chief Information Officer (interagency agreement at $140,000) to implement the web-based portal.

The DPH would procure a contractor from the California Multiple Award Schedule (CMAS) qualified information technology vendor list to develop the web portal beginning July 1, 2010. A total of $431,000 has been identified for this purpose.

The DPH has provided the following preliminary timetable for this project.

DPH Major Milestones	Estimated Completion Date
Feasibility Study Report (required)	July 2009
Project Approval	July 2010
Complete Requirements Analysis	January 2011
Complete System Design	February 2011
Complete System Development	July 2011
Testing and User Acceptance	August 2011
System Live	September 2011

Subcommittee Staff Comment and Recommendation. The proposal corresponds to the enabling legislation and no issues have been raised.

Questions. The Subcommittee has requested the L&C Division to respond to the following questions:

1. DPH, Please provide a brief description of the budget request and project.

7. Laboratory Field Services— Clinical Laboratory Inspections

Budget Issue. The DPH is requesting an increase of $3.4 million (Clinical Laboratory Improvement Fund) to support 35.5 permanent State positions to implement Senate Bill 744 (Strickland), Statutes of 2009, regarding inspections of clinical laboratories and to address concerns identified in a Bureau of State Audits investigation in 208.

Among other things, SB 744 (Strickland), Statutes of 2009, increased the fee structure based on the volume of testing for licensed laboratories and increased fees for registered laboratories and certified phlebotomists. This new revenue is to be used to enable the DPH's Laboratory Field Services to conduct required biennial inspections, complaint investigations, proficiency testing oversight, enforcement for non-compliance, and phlebotomy certifications.

The DPH states that many of the existing Laboratory Field Services activities have either been minimally performed or not conducted at all due to understaffing and under funding of the program. A Bureau of State Audit investigation also identified many deficiencies in the program which SB 744 was also intended to address.

The DPH notes that 70 percent of diagnoses are based upon laboratory tests. Laboratory mistakes lead to misdiagnoses and inappropriate follow-up treatment. As such, inspections and oversight of laboratories is vital to public health and safety. The number of clinical laboratories continues to increase and there are about 19,500 presently in California, and another 600 outside the State performing testing on California residents.

The 35.5 positions and core functions are described below. The DPH will utilize two existing field offices for this additional staff—one in Los Angeles and the other in Richmond.

- Examiner III, Section Chief (1). This position manages the Los Angeles Office and staff.
- Examiner II, Program Managers (4). These positions shall coordinate initial onsite inspections, biennial inspections, out-of-state licensure, and complaint investigations.
- Examiner I (9). These positions shall conduct initial onsite inspections of the new laboratories, and following up with biennial inspections of newly licensed laboratories. These positions will be shared between Los Angeles and Richmond field offices.
- Examiner I (7). These positions shall conduct biennial inspections of licensed laboratories, including selected laboratories licensed outside of California. These positions will be shared between field offices.
- Examiner I (1). This position shall review and approve phlebotomy training programs in Richmond.
- Program Technicians II (10). These positions shall be assigned to support licensing and registration activities.
- Program Technicians II (3). These positions shall be assigned to review and process phlebotomy renewals and applications.
- Staff Counsel (half-time). This half-time position shall coordinate enforcement actions for non-compliance including failure to comply with inspections, proficiency testing

failures, employment of unlicensed persons to perform testing, phlebotomy competency, and operating without a license after being noticed.

The DPH states that with this new staff in place, they will be able to (1) assure that licensed laboratories are inspected every two years as mandated by law by 2012-13; (2) begin to investigate complaints in a more timely manner; (3) process phlebotomy applications and renewals timely; and (4) approve phlebotomy training programs as required.

The budget request also includes $250,000 (Clinical Laboratory Improvement Fund) for equipment, including moveable storage units and an electronic scanner.

Subcommittee Staff Comment and Recommendation. An extensive workload analysis was provided to the Subcommittee and no issues have been raised. SB 744 increased fees to provide revenues for this purpose and to improve the oversight of clinical laboratories, including the certification of phlebotomists. The DPH proposal appears to be consistent with the enabling legislation.

Questions. The Subcommittee has requested the L&C Division to respond to the following questions:

1. DPH, Please provide a brief summary of the budget request and timing of implementation for all activities.

8. Women, Infants and Children's Supplemental Nutrition Program (WIC)

Budget Issues. The DPH is requesting an increase of $590,000 (federal funds) to support 14 State positions (all permanent, except for one) to address increased WIC participation, accommodate new workload requirements as directed in federal regulations, and to manage the expansion of the WIC Breastfeeding Peer Counselor Program. Eight of these positions are presently funded from a temporary help blanket (federal funds).

The DPH states increased federal funds through the federal American Recovery and Reinvestment Act (ARRA) of 2009, signed by President Obama, and USDA rules regarding WIC food packages, published in 2007, have added new workload for WIC. WIC is also experiencing expansion of the Breastfeeding Peer Counseling Program to include more local WIC agencies. They contend that growth in the number of participants and authorized vendors (such as groceries stores) is expected to continue.

Of the total 14 requested positions, nine are requested to address issues regarding overall WIC Program growth. These positions and key functions are as follows:

- Staff Services and Governmental Program Analysts (7). These positions will be employed to conduct the following *key* functions: (1) provide support to local WIC Agencies through contract management, training and on-site technical assistance to assess operations and quality, and recommend improvements; (2) authorize additional vendors to increase WIC participant access to stores that redeem WIC checks; (3) coordinate and deliver training classes on program, nutrition, and vendor requirements; (4) review and recommend action on WIC food instruments rejected for payment by the State Treasurer's Office and work with affected vendors; (5) develop and maintain a centralized system for tracking all federal reporting deliverables and responses to the USDA and conduct any necessary follow-up regarding technical reviews; (6) provide technical assistance to vendors (over 4,700 now); and (7) conduct policy reviews as directed.

- Health Program Specialist I (1). This position will review, analyze and update program performance measures and outcomes to ensure compliance with federal and state laws and regulations.

- Office Technician (1). This position will provide support functions for various aspects of the training program.

The remaining six requested positions will be used for compliance with federal regulation and to expand the Breastfeeding Peer Support Program. A total of five Public Health Nutrition Consultants, including supervisory, will address issues regarding food package policy, implementation of recent federal regulations, breastfeeding policy development and expansion of the Peer Support Program. An Associate Governmental Program Analyst will provide other administrative support functions related to federal deliverables.

Background on WIC Funding. WIC is funded with federal grants and WIC manufacturer rebate funds such as from baby formula, juice and cereal. As noted in the Table below, California has been receiving increased federal funding for the program.

Summary of WIC Funding. The Table below provides a summary of WIC Program funding for the past three years.

1. Local Assistance	2008-09	2009-10	2010-11
Federal Grant for Food	$766,691,000	$805,025,000	$805,025,000
Federal Grant for Administration	$269,219,000	$282,846,000	$282,846,000
WIC Manufacturer Rebate Fund	$281,214,000	$329,901,000	$329,901,000
Total Local Assistance	**$1,317,124,000**	**$1,417,772,000**	**$1,417,772,000**
2. State Operations			
Federal Grant	$40,440,000	$48,170,000	$52,296,000
Total State Operations	**$40,440,000**	**$48,170,000**	**$52,296,000**
GRAND TOTAL for WIC	**$1,357,564,000**	**$1,465,942,000**	**$1,470,068,000**

It should be noted that the DPH does not provide the Legislature with an estimate package for the WIC Program. As such, fiscal detail is not readily discernable.

Background on WIC Program. WIC is a federally funded program for low-income women who are pregnant or breastfeeding and for children under age five who are at nutritional risk. WIC's objective is to provide nutritious foods, nutrition education, breastfeeding promotion and education, and referrals to health and social services programs.

The DPH has contracts with 82 local WIC agencies to provide nutrition education, referrals to health and social services and food checks to purchase nutritious food.

In California, about 1.440 million WIC participants receive food checks each month. WIC offers over 200 different types of food checks, including checks for milk, eggs, cheese, cereal, and infant formula, that vary based on the needs of the individual participants. There are presently over 4,700 WIC authorized vendors.

Background—WIC's Breastfeeding Peer Counseling Program. The federal USDA provides an annual grant to California for this program which is used to develop and operate breastfeeding peer counseling programs serving 37,500 pregnant and breastfeeding WIC participants. While operation for only three years, California WIC agencies have succeeded in increasing the percentage of infants fed exclusively with breast milk. However, more work needs to be done as illustrated by the following statistics:

- Only 54 percent of the mothers participating in the WIC Program initiate breastfeeding as compared to 75 percent of all California mothers; and
- Only 21 percent of mothers participating in the WIC Program are breastfeeding their infants at six months of age as compared to 42 percent of all California mothers.

The costs savings of breastfeeding include reductions in illness in infants and their associated medical visits and time lost from work by parents. There is also evidence that lack of extended breastfeeding contributes to overweight and obesity later in life. According to WIC, California could avoid $476 million a year in health care costs and lost wages if just 50 percent of mothers breastfed exclusively for six months.

Subcommittee Staff Comment and Recommendation. It is recommended to approve the DPH request for WIC to ensure that WIC participants receive needed food and support services, and so California can more effectively expend its federal grant funds.

In addition, it is recommended to adopt placeholder trailer bill language to require the DPH to submit an estimate package on the WIC Program to the Legislature, as is done with most large programs the State operates. The proposed language is as follows:

> "By no later than January 10 and May 14 of each year, the State Department of Public Health shall provide the fiscal committees of the Legislature with an estimate package for the Women, Infant, and Children Supplemental Nutrition (WIC) Program. This estimate package shall include all significant assumptions underlying the estimate for the WIC's current-year and budget-year proposals, and shall contain concise information identifying applicable estimate components, such as caseload, policy changes, federal fund information, manufacturer rebate information, State positions and organization charts, and other assumptions necessary to support the estimate."

Questions. The Subcommittee has requested the L&C Division to respond to the following questions:

1. DPH, Please provide a *brief* summary of the budget proposal.

II. Department of Health Care Services

A. Vote Only Issue

1. Extend Position for DHCS Waiver Unit

Budget Issue. The DHCS requests to extend an existing, limited-term Associate Governmental Program Analyst for another two years (until June 30, 2012) to provide monitoring and assistance regarding various DHCS federally- approved Medi-Cal Waivers (such as the Home and Community-Based Waiver, Hospital Financing Waiver, and others). Extension of this filled position requires an increase of $100,000 ($50,000 General Fund).

Subcommittee Staff Comment and Recommendation--Approve. The DHCS has provided workload justification to continue this position and Subcommittee staff believes this position can be useful to provide assistance for the upcoming 1115 Waiver which is presently being discussed through various stakeholder forums. It is important to have experienced staff for these Waivers and it is incumbent upon the State to ensure strong management of Waivers to ensure the receipt of federal funds. Therefore, no issues have been raised.

B. Issues for Discussion

1. Genetically Handicapped Persons Program (GHPP)

Budget Issue. The DHCS proposes total expenditures of $83 million ($49.8 million General Fund, $4 million Blood Factor Rebate, $1.2 million Enrollment Fees, and $28 million federal funds) for the GHPP.

This reflects a *net* increase of $6.3 million (increase of $12.7 million General Fund, decrease of $6.9 million federal funds, and increase of $502,000 in Enrollment Fees). as compared to 2009-2010.

The DHCS states that expenditures for individuals with Hemophilia continue to increase, primarily due to the cost of blood factor products. The DHCS utilizes two mechanisms to manage blood factor product expenditures, including a rebate program (both federal rebate and State supplemental rebates), and a soon to be implemented program with pharmacy providers.

The DHCS states that the collection of blood factor rebates is progressing but that *three* blood product manufacturers have *not yet* signed State supplemental rebate contracts. The DHCS states that at least $5.3 million has been collected from the federal rebates for 2009-2010, and that $1.044 million has been collected from the State supplemental portion. These rebates are used to offset General Fund support.

It should also be noted that the DHCS increased enrollment fees under the program as of July 1, 2009. A total of about $1.2 million in GHPP enrollment fees is estimated to be collected which reflects an increase of $502,000 over last year. These enrollment fees are also used to offset General Fund support.

The Table below reflects the DHCS base expenditures for specified diseases.

Table: DHCS Base Expenditure Assumptions for Specified Disease for 2010-11

Diagnosis	Average GHPP-Only Caseload	Average Annual Cost per Case	Total Program Expenditure
Hemophilia	437	$172,300	$75,302,000
Cystic Fibrosis	427	$19,300	$8,238,000
Sickle Cell	308	$4,400	$1,355,000
Huntington's	157	$1,000	$160,000
Metabolic	109	$600	$63,000
Total People	1,438	$59,200	$85,118,000

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 fee and treatment costs based on a sliding fee scale for family size and income.

Subcommittee Staff Comment and Recommendation. The GHPP is a core health care program that provides medically necessary treatment to individuals with specified conditions, often life-threatening, who have often not had access to health care coverage. Often health care coverage has been denied due to their pre-existing condition.

The DHCS will be providing an update on caseload and expenditures at the May Revision. It is recommended to hold this issue "open" pending receipt of the May Revision and to encourage the DHCS to assertively seek participation in the supplemental rebate program by *all* blood factor product manufacturers.

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

1. DHCS, Please provide a brief summary of the GHPP and budget request.
2. DHCS, Please provide an update regarding implementation of the blood factor contracting program. Can anything else be done to have full participation by all blood manufacturers?
3. DHCS, How may the GHPP be affected by the federal Patient Protection and Affordable Care Act, signed by President Obama?

2. State Staff to Conduct Audits of FQHC and RHC Clinics

Budget Issue. The DHCS is requesting an increase of $787,000 ($393,000 General Fund) to support 7 new State positions (two-year limited-term) to conduct field audits of Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) which are associated with payment changes.

The DHCS states these additional positions are needed to address workload needs associated with reimbursing these providers using the Prospective Payment System (PPS) and the number of FQHC/RHC providers which has increased from about 400 in 2001 to over 900 in 2010. Presently the DHCS has six auditors that work on these activities.

Specifically, the DHCS states the requested seven positions would do the following:

- Health Program Auditors III (4 positions). These positions would augment current staff and do the following: (1) Conduct tentative settlements subsequent to cost report acceptance procedures; (2) Monitor differential rates and propose changes as necessary; (3) Conduct field audits and desk reviews for the FQHC/RHC providers, including annual reconciliations, change in scope of service requests, and initial rate setting audits; and (4) Participate in administrative hearings and appeals.
- Health Program Auditors IV (2 positions). These positions would augment current staff and do the following: (1) Conduct enrollment functions not currently done by the DHCS Provider Enrollment Division; (2) Develop regulations, policies and procedures for continued improvement to audit and review protocols; (3) Provide training and technical assistance to providers and other stakeholder groups; (4) Attend formal appeals as an expert witness or subject matter expert; and (5) Conduct the more complex field and desk audits.
- Health Program Audit Manager (1 position). This position provides supervision and conducts more complex tasks related to the above work.

The DHCS states that final audits are completed on about one-third of all FQHC/RHC providers each fiscal year. They contend that if more staff is provided and more audits are conducted a savings of $2.7 million ($1.3 million General Fund) will be obtained. This savings is included in the Governor's January budget for Medi-Cal.

The Fiscal Audits Branch of the DHCS, who is requesting these positions, has a total of 297 staff in several field offices throughout California. As of April 1, 2010, they had 15 overall vacancies.

Background. FQHC/RHC providers are reimbursed by Medi-Cal using a "prospective payment rate (PPS) as required by federal law and enabling state legislation. Among other things, PPS requires that FQHC/RHC providers receive their reimbursement on a per visit basis according to their cost report and for all additional qualifying State programs the FQHC/RHC provides, including "wrap-around payment" (such as Medi-Cal Managed Care, and other services/programs).

The DHCS must analyze and review rate-setting or rate-changing cost reports or any request for reconciliation to validate and verify the costs and services, and if necessary, make audit adjustments to the report. The DHCS calculates the difference between each clinic's final PPS rate and the expenditures already reimbursed (interim rate, Managed Care Plans and Medicare) in order to prepare a final settlement with the clinic.

Subcommittee Staff Comment and Recommendation—Provide Three Positions. There is considerable workload associated with the PPS reimbursement process as presently structured. The DHCS should be pursuing a re-engineering process to better determine how to strengthen existing procedures to streamline its methods, including implementation of regulations.

Due to the fiscal crisis, it is recommended to provide only *three* Health Program Auditor III positions and to delete the remaining positions. The Health Program Auditor III positions will facilitate core functions needed to address the increase in the number of FQHC/RHC providers, and to help prepare for network capacity building which will be necessary with implementation of federal health care reform and the upcoming 1115 Medicaid Waiver.

Further, these positions should be able to identify the cost savings of $2.7 million ($1.3 million General Fund) as identified in the Medi-Cal local assistance estimate as noted.

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

1. DHCS, Please provide a *brief* summary of the budget request.

3. DRA Citizenship—State Staff

Budget Issue. The DHCS proposes to extend four limited-term positions for two-years to: (1) continue implementation of the federal Deficit Reduction Act of 2005 (DRA) citizenship and identity verification, and the transfer of asset rules for Medi-Cal eligibility determination; and (2) implement new Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 requirements regarding citizenship and identify.

The four positions—two Governmental Program Analysts and two Staff Counsels—were established July 1, 2007 and will expire as of June 30, 2010. An increase of $435,000 ($218,000 General Fund) is requested to maintain the positions for another two-years (June 30, 2012).

The DHCS states that continuation of this staff is needed to address ongoing workload associated with DRA implementation and CHIPRA implementation.

Background. The DRA of 2005 changed eligibility requirements by requiring that any person who declares to be a citizen or national of the U.S. must provide acceptable documentation of citizenship and identity, unless they are in an exempt group.

In addition to citizenship and identity requirements, the DRA also mandated changes to Medi-Cal's treatment of asset for eligibility determination purposes. SB 483 (Kuehl), Statutes of 2008, enacted these changes.

The CHRIPA amends the DRA to provide that applicants that declare U.S. citizenship or declare to be a U.S. national must receive full-scope Medi-Cal while they are obtaining citizenship documents if they are otherwise eligible. In addition, as of January 1, 2010, CHIRPA gives the State the option to use electronic verification of a Medi-Cal enrollee's name, Social Security number and citizenship status by the federal Social Security Administration as an alternative means of complying with the DRA.

Subcommittee Staff Comment and Recommendation—Two Positions. Due to the fiscal crisis and vacancy levels at the DHCS, it is recommended to provide only two positions—one Governmental Program Analyst and one Staff Counsel—and deny two positions. A reduction of $218,000 ($109,000 General Fund) would be reflected by this action.

The Medi-Cal Eligibility branch has a total of 111 positions with eight vacancies as of February 1, 2010. The DHCS noted that one of the Governmental Program Analyst positions being requested in this proposal is presently vacant. The DHCS should be able to adjust priority workload within the Eligibility branch to address any remaining DRA citizenship issues, as well as any issues regarding CHIPRA.

Similarly, the DHCS Office of Legal Services has 124.5 positions, including support staff. Due to the amount of legal work to be completed, continuation of one Staff Counsel is recommended. Workload could be prioritized and redirected if needed to complete other legal work as required.

Further, though implementation has required much work by the DHCS, counties and advocacy groups, Subcommittee staff believes a considerable amount of the work has been completed. The DHCS has implemented a process using vital records that provides for citizenship verification for Medi-Cal enrollees born in California, and has issues several "All County Letters" to provide direction.

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

1. DHCS, Please provide an update on key actions taken to implement the DRA requirements of 2005.
2. DHCS, Please provide a *brief* summary of the budget request and need for the positions.

4. Skilled Medical – Request for Backfill due to Federal Disallowance

Budget Issue. The DHCS is requesting an increase of $634,000 (General Fund) for the DHCS' Medical Review Branch to backfill for the loss of federal funds related to nurses, physicians and pharmacists due to a federal disallowance.

The DHCS states the federal Centers for Medicare and Medicaid Services (CMS) has disallowed their claim to obtain an enhanced federal match (25 percent to 75 percent) for certain medical related staff—nurses, physicians and pharmacists.

In their review, the federal CMS deemed that much of the work conducted by the Medical Review Branch was more administrative and not a medical service. Therefore, they agreed to only provide California its baseline federal match of 50 percent to 50 percent (General Fund to federal funds).

Therefore, the DHCS is requesting the General Fund augmentation in order to continue existing support within the Medical Review Branch. Without this backfill, the DHCS contends six positions may have to be eliminated.

Subcommittee Staff Comment and Recommendation—Deny Request. It is recommended to deny the request due to the fiscal crisis and the vacancy level within the Medical Review Branch.

Based on April 1, 2010 information, the Medical Review Branch has 714 positions, including support positions. Of these positions, 639 are filled, leaving 75 positions vacant. As such, the branch should be able to identify on-going savings to adjust for the $634,000 over time.

Further, this branch may also desire to review existing procedures to discern if they can be streamlined.

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

1. DHCS, Please provide a *brief* summary of the budget request.

5. Local Educational Agency Medi-Cal Billing Option Program

Budget Issue. The DHCS is requesting an increase of $1.6 million ($819,000 from local entities and $819,000 federal funds) to support 14 new State positions (two-year limited-term) to perform financial oversight requirements of the "Local Educational Agency" (LEA) billing option provided under the Medi-Cal Program.

The DHCS states that two positions within the Fiscal Audits Branch are presently conducting audits of LEA billing option information but due to workload increases, these additional 14 positions are needed.

Full implementation of the LEA billing option was delayed by the DHCS for almost two-years due to claims and billing problems with the Medi-Cal Fiscal Intermediary (Electronic Data Systems). Because of these technical problems as well as the need to conduct more audits, the federal CMS has deferred $85 million in federal payments for the LEA billing option. The DHCS states that two-years worth of "Cost and Reimbursement Comparison Schedule" forms must be reviewed and validated by the DHCS before federal payment can be obtained.

In addition, the DHCS would utilize the positions to provide training and to improve existing procedures.

The requested staff is as follows:

- Ten Health Program Auditor III positions;
- Two Health Program Auditor IV positions; and
- Two Health Program Audit Manager positions.

As California's lead state agency for the Medicaid Program (Medi-Cal), the DHCS is required to perform financial oversight responsibilities for the LEA billing option to ensure that federal Medicaid funds are being appropriately expended. The DHCS states that if these positions are not provided, the LEA billing option may be in jeopardy and it is very likely the $85 million in deferred federal funds would not be obtained.

Background. There are 485 LEA providers participating in the LEA billion option. The LEA billing option provides the federal share of reimbursement for health assessment and treatment for Medi-Cal eligible children and family members within the school environment.

The billing option program provides early and periodic screening, diagnosis, and treatment services such as physical therapy, occupational therapy, speech and audiology, physician and nursing services, and school health aid services.

Subcommittee Staff Comment and Recommendation. An increase of 14 staff appears excessive yet the DHCS needs to process the forms and conduct the financial audits in order to ensure receipt of the $85 million in federal funds. The LEAs are at risk of losing the $85 million in reimbursement if action is not immediately taken. Therefore, it is recommended to approve the request. The Subcommittee had not received any comments from constituency groups on this issue prior to the release of this Agenda.

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

1. DHCS, Please provide a *brief* summary of the budget request.

Outcomes of Senate Subcommittee #3 for April 15, 2010

A. Department of Public Health

Vote Only: (Pages 4 through 17)

- **Action.** Approved vote only calendar for items 1 through 8, and 10 through 11.
- **Vote:** 3-0

- **Action.** Deleted $1 million (General Fund) for Valley Fever (issue 9 on Agenda).
- **Vote:** 2-1 (Senator Ashburn)

Issues for Discussion (Page 18)

1. AIDS Drug Assistance Program (ADAP) (Pages 18 to 24)

- **Action.** Adopted trailer bill language regarding ADAP and its potential use as a certified public expenditure, and kept the remainder of the item "open".
- **Vote:** 3-0.

2. Public Health's Drinking Water Program: Three Issues (Page 25)

A. Safe Drinking Water: State Staff Request, and Concern with State Match.

- **Action.** Approved requested 24.5 (limited-term) positions, and denied the $110,000 (special funds) for the consultant as well as the proposed trailer bill for revenue bond authority. The issue of the revenue bond mechanism should be discussed in Policy Committee.
- **Vote:** 3-0.

B. Drinking Water: Reappropriation of Proposition 84 Bonds (SB X2 1) (Page 29)

- **Action.** Approved the reappropriation and adopted Budget Bill Language for the Legislature to obtain updated fiscal information (as written in Agenda).
- **Vote:** 3-0.

C. Drinking Water: Proposition 50 Bonds and State Staff (Page 33)

- **Action.** Approved as proposed.
- **Vote:** 3-0.

3. Radiation Protection Program: Two Issues (Page 35)

- **Action.** Approved as proposed.
- **Vote:** 3-0.

4. Licensing and Certification— Proposed Licensing Fees for 2010-11 (Page 37)

- **Action.** Approved the L&C Fees, pending May Revision, and adopted trailer bill language to obtain fiscal detail for the Legislature.
- **Vote:** 3-0.

5. Licensing and Certification—Quality Improvement Activities (Page 40)

- **Action.** Approved as proposed.
- **Vote:** 2-0. (Senator Ashburn abstained)

6. Licensing and Certification—Health Facility Reporting (CalHEART) (Page 41)

- **Action.** Approved as proposed.
- **Vote:** 3-0.

7. Laboratory Field Services— Clinical Laboratory Inspections (Page 42)

- **Action.** Approved as proposed.
- **Vote:** 3-0.

8. Women, Infants & Children's Supplemental Nutrition Program (WIC) (Page 44)

- **Action.** Approved as proposed and adopted trailer bill language to require an estimate package.
- **Vote:** 3-0.

B. Department of Health Care Services (Page 47)

Vote Only Issue (Page 47)

- **Action.** Approved the request position.
- **Vote:** 2-1 (Senator Ashburn).

Issues for Discussion (Page 48)

1. Genetically Handicapped Persons Program (GHPP) (Page 48)

- Held Open, pending May Revision.

2. State Staff to Conduct Audits of FQHC and RHC Clinics (Page 50)

- **Action.** Approved only 3 Health Program Auditor III positions and denied the remaining four positions.
- **Vote:** 2-1 (Senator Ashburn).

3. DRA Citizenship—State Staff (Page 52)

- **Action.** Approved two positions—a Staff Counsel and a Program Analyst—and denied the remaining two positions—a Staff Counsel and a Program Analyst--rest of the request.
- **Vote:** 2-1 (Senator Ashburn).

4. Skilled Medical – Request for Backfill due to Federal Disallowance (Page 54)

- **Action**. Denied the request for $634,000 (General Fund).
- **Vote:** 3-0

5. Local Educational Agency Medi-Cal Billing Option Program (Page 55)

- **Action**. Approved the request.
- **Vote:** 3-0