Senate Budget and Fiscal Review

Subcommittee No. 3, 2011 Agendas

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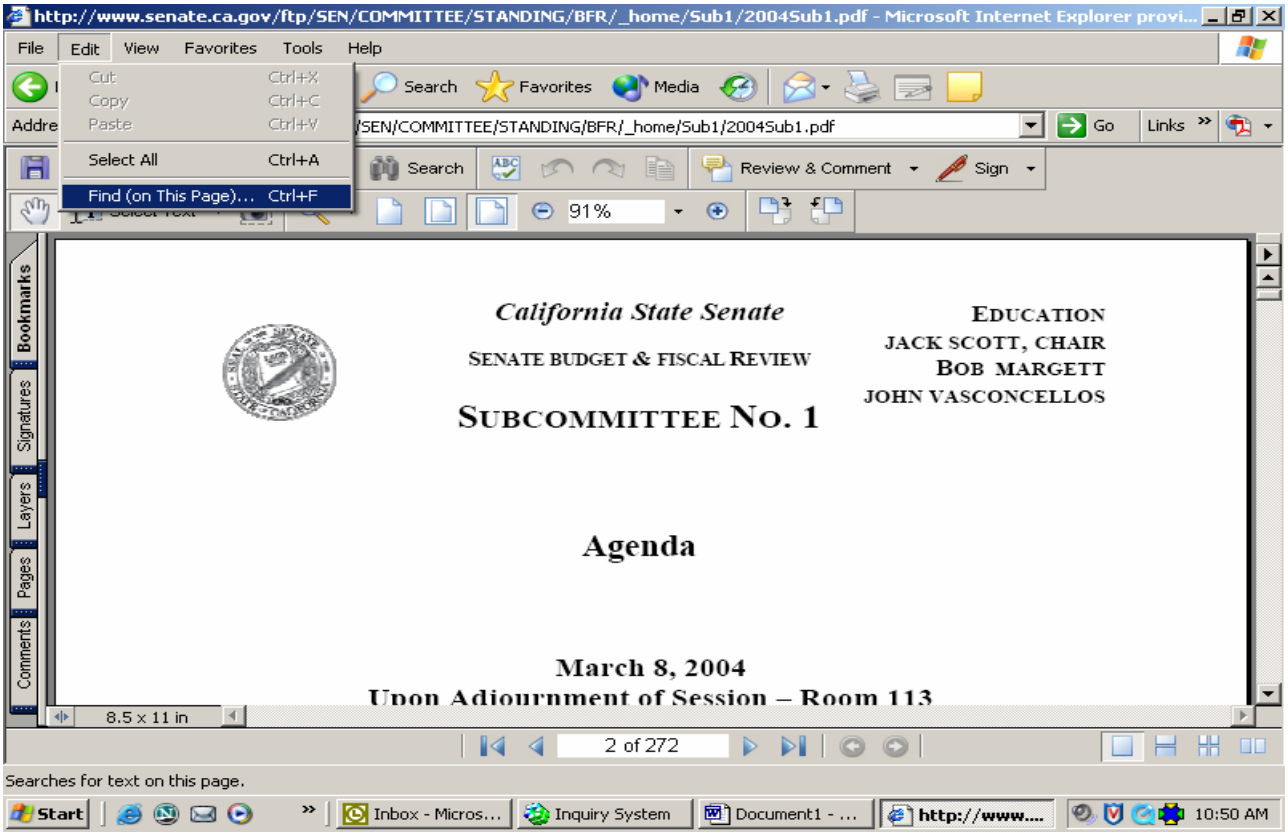

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

January 26th, 2011

10:00 AM or
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item	Department
4120	Emergency Medical Services Authority • Emergency System Registration of Volunteers
4260	Department of Health Care Services • State Support • Medi-Cal Program, including fund redirections
4280	Managed Risk Medical Insurance Board • Healthy Families Program • Pre-Existing Condition Insurance Program (PCIP)

PLEASE NOTE:

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

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

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I. VOTE ONLY CALENDAR (Pages 2 through 4)

1. Emergency Medical Services Authority: Registration of Volunteers

Budget Issue. The budget proposes an increase of $231,000 in Reimbursements (which are federal funds) to extend limited-term positions for an additional two-years in order to continue implementation of California's Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP System). The two positions include a Health Program Specialist and a Staff Information Systems Analyst.

This ESAR-VHP System provides the needed volunteer health professionals necessary to augment a Hospital or other medical facility, staff alternate care sites and field treatment sites, and augment personnel for the State's Mobile Field Hospitals to meet increased patient/victim care needs during a declared emergency.

States are required to meet specified federal ESAR-VHP operational requirements as updated in July 2009.

Key functions of the two positions are the following:

- Implement an enhanced recruitment and retention plan;
- Initiate a regular schedule of drills on the ESAR-VHP System, including drills for volunteer deployment protocols;
- Provide increased training opportunities for system administrators

Staff Comment and Recommendation—Approve. This is an important emergency preparedness program and the positions are justified. No General Fund support is required.

2. Department of Health Care Services: Delete Three Proposals

Budget Issue. The Department of Health Care Services has submitted three proposals that request General Fund augmentations as follows:

- $2.0 million ($948,000 General Fund) to support 17 positions for Health Care Reform.
- $1.2 million ($480,000 General Fund) to support 11 positions to implement a Hospital Diagnosis Related Group System Change.
- $299,000 ($150,000 General Fund) to support 3 positions to continue implementation of privacy operations according to the federal Health Insurance Protection and Accountability Act (HIPPA).

Subcommittee Staff Comment and Recommendation—Deny without Prejudice. Due to the fiscal crisis, it is recommended to delete these three proposals from the budget without prejudice. The General Fund cannot support increased expenditures for State administration at this time.

Further, the Governor's budget summary pages note that State Administration is being reviewed and consolidation and contraction will be occurring.

Therefore, it is recommended to delete these General Fund support requests from the budget *without prejudice* at this time.

3. Department of Health Care Services—Approve Requested Positions

Budget Issue. The Department of Health Care Services has submitted proposals requesting positions which utilize *special fund and federal funds*. These are as follows:

- *Specialty Mental Health Waiver.* Continue two existing positions to continue support of this Waiver which provides over $2.5 billion in funds to California for specialty mental health services. A request of $211,000 (total funds) is requested.
- *Implementation of 1115 Medicaid Waiver (SB 208, Statutes of 2010).* This Waiver, approved by the federal CMS in November 2010, will provide California with $10 billion in funds over a 5-year period. This Waiver provides for the mandatory enrollment of seniors and individuals with disabilities into Medi-Cal Managed Care, restructures Hospital financing arrangements, and provides California with about $500 million annually in General Fund support. A request of $7 million (total funds) is proposed to fund a 39 positions of which 19 will be used to implement Medi-Cal coverage of eligible adult inmates in Inpatient Hospital settings (saves General Fund expenditures).
- *Bridge to Health Care Reform--Implementation of AB 342 (Perez), Statutes of 2010*. This comprehensive legislation, as well as provisions in the 1115 Medicaid Waiver, provides for the receipt of federal funds by counties to provide health care coverage for the Medicaid population of uninsured adults 19 to 64 years with incomes below 133 percent of poverty who are otherwise not eligible. These projects are an integral component of the Waiver. A request of $4.3 million (total funds) is proposed to support 23 positions and external contracts.
- *Medi-Cal Managed Care Inter-Governmental Transfer Staffing.* A total of $257,000 (total funds) is requested for 2.5 positions to managed complex calculations related to Intergovernmental Transfers (IGTs) for Hospitals, and Medi-Cal Managed Care Plans to obtain federal funds. According to the DHCS, in 2009-10, they processed about $221 million in IGT transfers. The federal CMS requires a strict monitoring of these funds and additional staff is needed.
- *California Mental Health Managed Care Program (CalMEND).* A total of $631,000 (total funds) is requested to extend 4 positions to continue work on this project which focuses on how to better serve Medi-Cal individuals with serious mental illness and co-occurring medical problems. These projects when fully implemented will involve over 200 clinical provides and researchers and 1,500 Medi-Cal enrollees.

Subcommittee Staff Comment and Recommendation—Approve. These proposals have been reviewed and no issues have been raised by Subcommittee staff or the Legislative Analyst's Office (LAO). The requested positions either provide assistance in obtaining increased federal fund support and result in General Fund savings. No General Fund support is needed for these positions.

II. Departments for Discussion

Department of Health Care Services-- Medi-Cal Program

A. Overall Background: Medi-Cal Program (Pages 5 through 7)

Purpose. The federal Medicaid Program (Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance.

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.

Estimated Medi-Cal enrollment for the current year is 7.5 million people and for 2011-12 it is 7.7 million people. Medi-Cal provides health insurance coverage to almost 20 percent of Californians and almost 24 percent of insured Californians.

Most Medi-Cal clients are from households with incomes at or below 100 percent of poverty ($18,310 annually for a family of three).

Summary of Governor's Budget for 2011-12. As shown in the table below, the Governor proposes total expenditures of almost $42.5 billion ($13.8 billion General Fund, $26 billion federal Title XIX Medicaid funds, and $2.7 million in other funds) for Medi-Cal in 2011-12.

This reflects a proposed *decrease* of almost $13.2 billion (total funds), or 23.7 percent, as compared to the revised 2010-11 budget. There are several key aspects to this significant reduction as proposed by the Governor.

First is the significant change in federal funding. Both the federal American Recovery & Reinvestment Act of (ARRA) of 2009, and the Education, Jobs and Medical Assistance Act of 2010, provided States with enhanced federal funding for their Medicaid programs.

For California, the enhanced federal funding provided almost $3 billion in General Fund relief within the DHCS Medi-Cal Program for 2010-11. However, the loss of this federal support (enhanced funding ends June 30, 2011) is estimated to increase General Fund support by $2.544 billion in 2011-12.

Medi-Cal Funding Summary *(Dollars in Thousands)*	**2010-11 Revised**	**2011-12 Proposed**	**Difference**	**Percent**
Benefits	$52,686,000	$39,438,600	-$13,247,400	-25.1%
County Administration (Eligibility)	$2,691,300	$2,717,300	$26,000	+1.0%
Fiscal Intermediaries (Claims Processing)	$281,800	$322,200	$40,400	+14.3%
Total-Local Assistance	**$55,659,000**	**$42,478,000**	**-$13,181,000**	**-23.7%**
General Fund	$12,759,100	$13,842,500	$1,083,400	+8.5%
Federal Funds	$37,449,700	$25,974,500	-$11,475,200	-30.6%
Other Funds	$5,450,300	$2,661,100	-$2,789,200	-51.2%

Second is the substantial cost-containment which is being applied to the Medi-Cal Program. The budget proposes over $2.7 billion in reductions for 2011-12 through strategies that include:

- Placing limits on health care services;
- Elimination of certain benefits;
- Cost-sharing through Medi-Cal enrollee copayment requirements;
- Provider payment reductions;
- Mandatory enrollment of seniors and persons with disabilities in Medi-Cal Managed Care; and
- Additional sources of alternative funding (i.e., redirection of Proposition 10 Funds, Hospital Fee extension, increased federal funds through the new 1115 Medicaid Waiver).

The table below provides a summary of proposed reductions and cost shifts by major category. These Administration proposals are all directed at reducing General Fund expenditures in the program.

Summary Chart of Key Medi-Cal Reductions & Cost Shifts in Budget
(General Fund Solutions)

Major Category of Adjustment	Revised 2010-11 General Fund Solutions	Proposed 2011-12 General Fund Solutions
1. Reductions to Medi-Cal Enrollee Benefits (cost-sharing, limits and elimination of services)	-$6.3 million	-$994.4 million
2. Implementation of 1115 Medicaid Waiver**	-$400 million	-$500 million
3. Medi-Cal Provider Payment Reductions	-$11.5 million	-$733.6 million
4. Hospital Fee Extension: January to June 2011	-$160 million	--
5. Redirection of Proposition 10 Funds (June Ballot Measure)	--	-$1 billion
General Fund Solution Amount (reduction)	**-$221.8 million**	**-$3.228 billion**

Footnote: ****Federal CMS approved California's 1115 Waiver in November 2010. The framework of this Waiver is contained in SB 208 (Steinberg), Statutes of 2010, AB 342 (Perez), Statutes of 2010, and federal Terms and Conditions. This savings level is consistent with these documents. Savings are reflected in a Non-Budget Control Item and do not totally accrue to the Medi-Cal Program directly. Some savings, which are due to the receipt of federal funds through the 1115 Medicaid Waiver, are used in certain public health programs and within the Department of Corrections.

Administration's Proposals Need Federal Approval. *All* of the DHCS mandatory copayment, utilization limits, and benefit reductions are contingent on federal approval of State Plan Amendments, and in some cases federal Waivers (mandatory copayments). State Plan Amendments are submitted for federal approval to document that California meets federal requirements set forth in law and regulation.

Federal Waivers allow States to Waive certain federal requirements generally to obtain programmatic flexibility while furthering the purposes of the Medicaid (Medi-Cal) Program. At a minimum, DHCS would need Waivers of federal laws and regulations for:

(1) The types of populations affected (i.e., children, pregnant women, long-term care);

(2) The federal poverty levels affected (including Medi-Cal enrollees with incomes below 100 percent of poverty); and

(3) The level of copay to be charged—both from the nominal pay aspect and the exceeding five percent of family income per month aspect.

The federal government has never approved any State's request for a Waiver regarding mandatory copayments in Medicaid (Medi-Cal).

B. ISSUES FOR DISCUSSION: Medi-Cal (Pages 8 to 34)

A. Budget Issues Regarding Medi-Cal Benefits

Background. The budget proposes various reductions to health care services (Benefits category) provided to Medi-Cal enrollees. The table below provides a summary of these proposed reductions and reflects estimated General Fund reduction amounts (corresponding amounts of federal funds would be reduced as well).

The proposed reductions for Benefits fall into *three categories*: **(1)** limiting access to services; **(2)** requiring mandatory copayments for services; and **(3)** eliminating services. Almost all of these proposals were presented last year and rejected by the Legislature; however due to the State's fiscal crisis, the Administration believes they warrant consideration.

All of these proposed Benefit reductions *require* federal Centers for Medicare and Medicaid (CMS) approval through "State Plan Amendments" (SPAs). *In addition*, all of the mandatory copayment proposals also require federal Waivers which are an additional threshold due to the need to bypass existing federal law.

Summary of Key Reductions to Medi-Cal Benefits (General Fund Component)

Proposed Reduction Issue	Effective Date	2010-11 General Fund Reduction Amount	2011-12 General Fund Reduction Amount
1. Hard Cap: 10 Visits for Physicians & Clinics	09/01/2011	--	-$196.5 million
2. Mandatory Copays for Physicians & Clinics	10/01/2011	--	-$152.8 million
3. Hard Cap: 6 Prescription Outpatient Drugs	10/01/2011	--	-$11 million
4. Mandatory Copays for Pharmacy	10/01/2011	--	-$140.3 million
5. Mandatory Copays for Hospital Services, including (a) Hospital Inpatient, (b) Non-Emergency Room, and (c) Emergency Room.	10/01/2011	--	-$262.8 million
6. Copayment for Dental Services *Revised Calculation*	05/01/2011	-$208,500 *-$4 million*	-$1.3 million *-$27.9 million*
7. Proposed Elimination of Over-the-Counter Cough and Cold Products	06/01/2011	-$97,000	-$2.2 million
8. Eliminate Adult Day Health Care Services	06/01/2011	-$1.7 million	-$176.6 million
9. Limit Enteral Nutrition Products for Adults to Tube Feeding Only (conform with Medicare)	06/01/2011	-$547,000	-$14.5 million
10. Establishes Maximum Annual Dollar Limit for Durable Medical Equipment	10/01/2011	--	-$7.4 million
11. Establishes Maximum Annual Dollar Limit for Medical Supplies	10/01/2011	--	-$1.9 million
12. Establishes Maximum Annual Dollar Limit for Hearing Aid Expenditures	10/01/2011	--	-$507,000
TOTALS (with revised calculation)		**-$6.3 million**	**-$994.4 million**

1. Hard Cap: 10 Visits for Physician Offices and Clinics for Adults

Budget Issue. The budget proposes a "hard cap" of 10 office visits per year for Medi-Cal enrollees in both Medi-Cal Fee-for-Service and Medi-Cal Managed Care programs. A reduction of $392.9 million ($196.5 million General Fund) is assumed from this action.

Trailer bill language is required for enactment and a September 1, 2011 implementation date is assumed. *In addition* to statutory changes, this proposal requires a State Plan Amendment and federal CMS approval.

This hard cap would apply to Adults. Children (21 years and under), pregnant women, and residents in Long-Term Care facilities are exempt.

This proposal affects outpatient primary care and specialty care provided under the direction of a Physician in the following settings:

- Hospital Outpatient Department;
- Outpatient Clinic;
- Federally Qualified Health Centers (FQHCs);
- Rural Health Centers (RHCs); and
- Physician Offices.

DHCS states that a total of 3.3 million office visits were provided and *40 percent*, or 1.3 million office visits, would be above this proposed cap of 10 visits per year.

Subcommittee Staff Comment. Federal law *mandates* the provision of Physician services.

The Administration's "hard cap" does not take into consideration any cost shifts to other services—such as Emergency Rooms and hospitalizations—that would likely occur from this action due to the lack of primary and specialty care which would result.

This proposal would negatively impact people with the greatest need for health care services. Appropriate medical care in the right setting provides for a cost-beneficial program and more positive patient health outcomes.

The fiscal calculation assumes an average cost per visit of $143 in the outpatient setting. It would not take many emergency room visits or hospitalizations to negate the assumed savings from this "hard cap".

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

1. DHCS, Please provide a brief summary of the proposal.
2. DHCS, What happens if a significantly medically needy individuals exceeds this cap?
3. DHCS, Do any other States have similar caps to this?

2. Mandatory Copayments for Physician & FQHC/RHC Office Visits

Budget Issue. The budget assumes a reduction of $305.7 million ($152.8 million General Fund) by implementing *mandatory* copayments of $5 per Physician Office visit and $5 per Clinic Office visit (FQHC and RHC clinics) at the point of service.

These proposals apply to Medi-Cal Fee-for-Service and Medi-Cal Managed Care arrangements. *All* Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women are included. No exemptions.

Trailer bill language is required for enactment and an October 1, 2011 implementation date is assumed. *In addition* to statutory changes, this proposal requires a State Plan Amendment and a federal Waiver which *both* require federal CMS approval.

The Administration's reduction estimate of $305.7 million (total funds) assumes savings from both a rate reduction to Physicians and Clinics, as well as an 8 percent reduction in utilization by Medi-Cal enrollees. Specifically, about $219 million (total funds) is attributable to a rate reduction and about $86 million for less Office Visits.

Under this proposal, the Physician would collect the $5 copayment at the time of service and the providers would be reimbursed their Medi-Cal rate *minus* the $5 copayment.

If the Medi-Cal enrollee does not pay the $5 copayment, the Physician can deny the service.

Currently, Medi-Cal enrollees have a $1 copayment per Office visit. It is a voluntary copayment and services cannot be denied if the enrollee doesn't pay.

DHCS states that the average cost of a Fee-for-Service Physician Office Visit is $82.49 and the average cost of an FQHC or RHC Clinic Visit is $140.16.

Subcommittee Staff Comment. A mandatory copayment for Physician Visits and Clinic Visits would serve more as a deterrent to obtaining preventive medical care services and would make health care access for low-income children, families and people even more problematic.

Appropriate medical care in the right setting provides for a cost-beneficial program and more positive patient health outcomes.

The Administration's proposal does not take into consideration any cost shifts to other services—such as emergency rooms—that would likely occur from this action.

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

1. DHCS, Please provide a brief summary of the proposal.
2. DHCS, How would this policy be applicable to people with chronic health conditions?
3. DHCS, Please explain why a federal Waiver is necessary.

3. Hard Cap: Six Prescription Outpatient Drugs

Budget Issue. The budget proposes a "hard cap" on the *existing* six-prescription per month limit. A reduction of $22.1 million ($11 million General Fund) is assumed from this action.

This hard cap would apply to Adults. Children (21 years and under), pregnant women, and residents in Long-Term Care facilities are exempt.

Trailer bill language is required for enactment and an October 1, 2011 implementation date is assumed. *In addition* to statutory changes, this proposal requires a State Plan Amendment and federal CMS approval.

Medi-Cal would *not pay* for prescriptions beyond the six-prescription per month limit *unless* Medi-Cal deems the drugs to be life-saving, such as those used for the treatment of HIV/AIDS, cancer, hypertension, diabetes, coagulation disorders and mental health disorders.

Background—Existing Six-Prescription Limit. An existing six-prescription per month limit for Medi-Cal enrollees was effective in 1994 and is still in effect. Any prescription beyond this limit must receive "prior authorization" approval by the DHCS. Medi-Cal currently pays for drugs beyond the six prescription limit *after* a prior authorization is approved.

This existing prescription limit is *not* the number of different drugs dispensed in a month, or the number of drugs a recipient is currently taking. Rather, it is the limit of pharmacy drug claim lines submitted within a calendar month. For example, if the same drug is dispensed four times a month, it counts as four of the six prescriptions. There are exemptions to this existing limit, such as cancer drugs, HIV/AIDS, and others.

Subcommittee Staff Comment. *First,* it is presently unclear how the DHCS would make its determinations with regarding to life-saving medications to be exempted from the proposed "hard cap". It is unclear how the DHCS would administer this proposal and how Medi-Cal patients with significant health care needs would not fall through the cracks.

Second, the Administration's "hard cap" does not take into consideration *any* cost shifts to other services—such as Physician visits, clinic visits, or Emergency Rooms—that may occur if appropriate medications are not provided.

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

1. DHCS, Please provide a brief summary of the proposal.
2. DHCS, How would this policy be applicable to people with chronic health conditions?

4. Mandatory Copayments for Pharmacy

Budget Issue. The budget proposes a reduction of $280.6 million ($140.3 million General Fund) by implementing mandatory copayments of $3 per prescription for preferred drugs (generics) and $5 per prescription for non-preferred (brand) at the point of service.

This proposal applies to Medi-Cal Fee-for-Service and Medi-Cal Managed Care arrangements. *All* Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women are included. No exemptions.

Trailer bill language is required for enactment and an October 1, 2011 implementation date is assumed. *In addition* to statutory changes, this proposal requires a State Plan Amendment and a federal Waiver which *both* require federal CMS approval.

The Administration's reduction estimate of $280.6 million (total funds) assumes savings from **(1)** a rate reduction to Pharmacists; **(2)** a 5 percent reduction in the number of prescriptions once the copayment is implemented; and **(3)** a shift of 25 percent from non-preferred (brand) to preferred (generics). This break out is as follows:

- $135.1 million (total funds) from Pharmacy rate reduction.
- $93.6 million (total funds) from a 5 percent reduction in the number of prescriptions.
- $51.9 million (total funds) from the 25 percent shift to preferred (generics).

The Pharmacy would collect the copayment at the point of service, and the Pharmacists would be reimbursed their Medi-Cal rate *minus* the $3 or $5 copayment.

The mandatory copayment means the Pharmacist can deny the Medi-Cal enrollee their prescription medication unless the copayment is made at the point of service. This is the DHCS concept reflected in the 5 percent reduction in the number or prescriptions.

Presently, the average cost of a prescription is $92.

Currently, Medi-Cal enrollees have a $1 copayment per prescription. It is a voluntary copayment and services cannot be denied if the Medi-Cal enrollee doesn't pay.

Subcommittee Staff Comment. The no exemption policy, particularly for children and fragile medically needy individuals will likely result in people not seeking assistance and becoming potentially more medically involved.

The Administration's proposal does not does not take into consideration *any* cost shifts to other services—such as Physician visits, clinic visits, or Emergency Rooms—that may occur if appropriate medications are not provided.

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

1. DHCS, Please provide a brief summary of the proposal and how it would operate.

5. Mandatory Copayments for Hospital Services: Three Issues

Budget Issue. The budget proposes implementation of *three* mandatory copayments related to Hospital Services for a total reduction of $542.1 million ($262.8 million General Fund). These proposals apply to Medi-Cal Fee-for-Service and Medi-Cal Managed Care arrangements.

All Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women are included. No exemptions.

Trailer bill language is required for enactment and an October 1, 2011 implementation date is assumed. In addition to statutory changes, this proposal requires a State Plan Amendment and a federal Waiver which *both* require federal CMS approval.

Under these proposals, the Hospital collects the copayment from the Medi-Cal enrollee as applicable. DHCS would then reimburse the Hospital the Medi-Cal rate *minus* the copayment. As such, it serves as a Medi-Cal rate reduction.

If the Medi-Cal enrollee cannot pay the copayment, as referenced below, then the Hospital *can deny* health care services to the individual. The DHCS notes that Hospitals must still comply with the Emergency Medical Treatment and Active Labor Act. As such, most care still would need to be provided by the Hospitals.

The *three* proposed mandatory copayments related to Hospital Services are as follows:

- *A. Mandatory $100 Copay for Hospital Inpatient Days*. Medi-Cal enrollees would be required to pay $100 per Inpatient Hospital day up to a maximum of $200 per admission.

  This mandatory copayment would apply to *all* Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women. No exemptions would be provided.

  The budget assumes a reduction of $319 million ($151.2 million General Fund) from this action.

  A significant aspect of this proposal is an assumed reduction in Hospital Inpatient admissions. Specifically, a 5 percent reduction is assumed once the copayment is implemented, which is about 30 percent of the proposed reduction.

  It should be noted that only 21 percent of Medi-Cal Hospital Inpatient days are for only one day, with the remaining 78 percent for two or more days. This reflects the more medically needy population. Further, Medi-Cal's treatment authorization system and reimbursement method for Hospital Inpatient days serves to already dissuade frequent use by Medi-Cal enrollees or Hospitals.

- *B. Mandatory $50 Copay for Non-Emergency Room Visits.* Medi-Cal enrollees would be required to pay $50 for Non-Emergency Room use of Emergency Rooms. This mandatory copayment would apply to *all* Medi-Cal enrollees. No exemptions would be provided.

  The budget assumes a reduction of $146.4 million ($73.2 million General Fund) from this action.

  For this calculation, the DHCS assumed a reduction of 8 percent in utilization once the copayment is implemented, which reflects a reduction of $22 million (total funds) in expenditures. The remaining amount—about $125 million (total funds)—would occur from the rate reduction (i.e., offset of the copayment).

  DHCS states the average cost of a Non-Emergency Room visit is $125.94.

  It should be noted that the federal CMS regulations provide for States to charge copayments for Non-Emergency services provided in a Hospital Emergency Room. But the following requirements must be met (Federal Register of May 28. 2010, page 30245):

  - Patient is to receive an appropriate medical examination to determine patient has no emergency;
  - Patient has access to a non-emergency services provider without the imposition of the same cost-sharing requirement;
  - Hospital must coordinate a referral to the non-emergency services provider.

  It is not clear from the DHCS proposal, if the above federal criteria would be met.

- *C. Mandatory $50 Copay for Emergency Room Visits.* Medi-Cal enrollees would be required to pay $50 for Non-Emergency Room use of Emergency Rooms. This mandatory copayment would apply to *all* Medi-Cal enrollees. No exemptions would be provided.

  The budget assumes a reduction of $76.7 million ($38.4 million General Fund) from this action.

  For this calculation, the DHCS assumed a reduction of 8 percent in utilization once the copayment is implemented, which reflects a reduction of $10.8 million (total funds) in expenditures. The remaining amount—about $65.9 million (total funds)—would occur from the rate reduction (i.e., offset of the copayment).

  DHCS states the average cost of an Emergency Room visit is $143.57.

  It should be noted that this mandatory copayment is for *medically necessary* emergency room visits. Clearly, significant medical treatment is required for individuals needing

emergency services and to mandate a $50 copayment, particularly coupled with no exemptions and the low-income level of Medi-Cal enrollees is extreme.

Subcommittee Staff Comment. The Administration's three proposal for mandatory copayments related to Hospitals do not take into consideration any cost shifts to other services that would likely occur from this action, or that people will become more ill and require more services.

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

1. DHCS, Please provide a brief summary of each of the mandatory copayment proposals for Hospital Services, as noted above.
2. DHCS, Please briefly explain why a federal Waiver is necessary for these mandatory copayment proposals.

6. Mandatory Copayments for Dental Services

Budget Issue. The budget proposes a reduction of $417,000 ($208,000 General Fund) in the current-year, and $2.5 million ($1.3 million General Fund) in 2011-12 by implementing mandatory copayments of $5 per Dental Office Visit at the point of service.

This proposal applies to Medi-Cal Fee-for-Service and Medi-Cal Managed Care arrangements. *All* Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women are included. No exemptions.

Trailer bill language is required for enactment and a May 1, 2011 implementation date is assumed. *In addition* to statutory changes, this proposal requires a State Plan Amendment and a federal Waiver which *both* require federal CMS approval.

Under this proposal, the Dental Office would collect the copayment at the point of service, and the Dentist would be reimbursed their Medi-Cal rate *minus* the $5 copayment.

The mandatory copayment means the Dentist *can deny* the Medi-Cal enrollee their dental service unless the copayment is made at the point of service.

The Adult Dental Services benefit, other than certain federally required services, was eliminated from Medi-Cal in 2009 as a cost-cutting measure. As such, most of the copayment reduction pertains to dental services provided to Children, along with pregnant women, and a few Adults in managed care arrangements.

Subcommittee Staff Comment. *First,* it has been well documented that a lack of dental care can lead to serious health care issues. The Administration's proposal does not take into consideration any cost shifts to other services—such as Physician visits, clinic visits or Emergency Rooms—that may occur if appropriate dental care is not received.

Second, a calculation misstep occurred and the amount of the reduction should actually be $9.3 million ($4 million General Fund) in the current-year, *and* $55.8 million ($27.9 million General Fund) in 2011-12.

As such, if adopted, this proposal would provide for a further reduction of $30.4 million (General Fund) off of the Governor's budget.

It should be noted that most of this savings is primarily directed at children having to provide a copayment.

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

1. DHCS, Please provide a brief summary of the proposal and how it would work.

7. Proposed Elimination of Over-the-Counter Cough and Cold Products

Budget Issue. The budget reduces by $194,000 ($97,000 General Fund) in the current-year and $4.4 million ($2.2 million General Fund) in 2011-12 by eliminating "non-prescription" cough and cold products for Adults.

Specifically, these would be so called "over-the-counter" products such as Nyquil, Robitussin, Alka-Seltzer, and similar cough and cold products. Trailer bill language is required for enactment and a June 2011 implementation date is assumed.

Under the DHCS proposal, Medi-Cal enrollees could choose to pay out-of-pocket for these cough and cold products, *or* seek medical attention and obtain a prescription product as medically necessary. Prescription drug products are not affected by this proposal.

Over-the-counter cough and cold products for children would remain unchanged (i.e., available through Medi-Cal).

Subcommittee Staff Comment. The LAO recommends adoption of this proposal.

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

1. DHCS, Please provide a brief summary of the proposal.

8. Proposed Elimination of Adult Day Health Care Services

Budget Issue. The budget assumes elimination of Adult Day Health Care Services (ADHC), effective June 1, 2011, for a reduction of $3.4 million ($1.7 million General Fund) in the current-year, and $353.2 million ($176.6 million General Fund) in 2011-12. Trailer bill language is required for enactment.

Under federal Medicaid law, ADHC services are considered "Optional" benefits for States to provide. California is one of few States that currently offers this service.

ADHC services are a community-based day program providing health, therapeutic and social services designed to serve those at risk of being placed in a nursing home.

There are about 325 active ADHC providers in Medi-Cal who serve about 27,000 average monthly users. The estimated cost per ADHC beneficiary is $1,128 per month, or $13,536 annually.

DHCS states that other Medi-Cal services would still be available if ADHC services were eliminated. Specifically, the following Medi-Cal services, which are similar to ADHC services, would still be available to individuals:

- Home Health Services
- In-Home Supportive Services
- Physical and occupational therapy
- Clinic services that would include dietitian, physician, social worker and nursing services
- Physician Services through the individual's Medical health care provider

Previous cost-containment efforts regarding ADHC services have included the following:

- *Moratorium*. In 2004, a statutory moratorium as directed by the DHCS was placed on the expansion of ADHC providers. This remains in place and only the Director of the DHCS has the discretion to add more providers.

- *Treatment Authorization Reviews (TARS)*. In 2009 onsite treatment authorization reviews were implemented and are anticipated to reduce expenditures by $1.6 million ($824,000 General Fund) in 2011-12.

- *Medical Acuity Eligibility Criteria—Enjoined by Court.* In 2009 trailer bill legislation enacted specific medical acuity eligibility criteria. The intent of this action was to focus ADHC services on the most medically acute individuals. DHCS has estimated this would reduce expenditures by about 20 percent. This action was enjoined by the court (in the case of Brantley v Director Maxwell-Jolly, superseded by Carry Cota, et. Al v Maxwell-Jolly).

- *Limit ADHC Benefits to Three-Days per Week—Enjoined by Court.* In 2009 trailer bill legislation limited the number of days an individual could receive ADHC services to

three days per week, except for individuals with developmental disabilities receiving services through Regional Centers (these individuals were not limited). This action was enjoined by the court (in the case of Brantley v Director Maxwell-Jolly).

Subcommittee Staff Comment. Elimination of ADHC services has previously been rejected by the Legislature.

If this benefit is eliminated, the DHCS should work with ADHC facilities and other providers to transition Medi-Cal enrollees to other medically necessary services.

Further, *if* this benefit is eliminated from the Medi-Cal Program, there would need to be a corresponding reduction in State staff, both within the DHCS (in Medi-Cal, and Audits & Investigations) and the Department of Aging (administers and certifies the program).

The Administration should please provide this information to the Subcommittee since it was not addressed in the proposed budget though elimination of ADHC services is assumed.

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

1. DHCS, Please briefly describe the budget proposal, *and* comment on prior cost-containment proposals regarding ADHC services. What about operating ADHC services under a federal Waiver?
2. DHCS, Please comment on the availability of other Medi-Cal services as referenced if the ADHC benefit is eliminated.
3. DHCS, Please clarify the interaction between ADHC services and the upcoming mandatory enrollment of individuals in Medi-Cal Managed Care—i.e., would services overlap or what exactly--?

9. Limit Enteral Nutrition Products for Adults to Tube Fed

Budget Issue. The budget reflects a reduction of $1.1 million ($547,000 General Fund) in the current-year and $28.9 million ($14.5 million General Fund) in 2011-12 through enactment of trailer bill language to limit Enteral Nutrition products provided to Adults. An implementation date of June 1, 2011 is assumed.

Specifically, these products would only be provided for those Adults who must be tube-fed. Conditions which require tube feeding include, but are not limited to, anatomical defects of the digestive tract or neuromuscular diseases.

DHCS states that Children, pregnant women and individuals in Long-Term Care facilities would be *exempt* from this limitation. DHCS also states that a product *may be exempted* from their proposed limit when used as part of a therapeutic regimen for patients with conditions for which regular good, or standard processed foods cannot be consumed without causing risk to the health of the patient.

Under federal law, Enteral Nutrition products are a Medicaid "optional" benefit. DHCS states this proposal would more closely align Medi-Cal with the current Medicare benefit which limits these products to those individuals who are tube fed.

Currently, Medi-Cal Enteral Nutrition products are covered only when supplied by a Pharmacy provider upon the prescription of a licensed practitioner within the scope of their practice. All Enteral Nutrition products require prior authorization approval before Medi-Cal reimbursement.

Subcommittee Staff Comment. It is unclear from the DHCS proposal what medically needy individuals would be exempted or how this process would be determined and administered.

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

1. DHCS, Please briefly describe the budget proposal and how both the proposed limit and exemptions would be applied.

10. Establishes Maximum Annual Dollar Limit for Durable Medical Equipment

Budget Issue. The budget assumes a reduction of $14.7 million ($7.4 million General Fund) through enactment of trailer bill legislation to cap the maximum expenditures per Medi-Cal enrollee for Durable Medical Equipment (DME). The maximum dollar limit would be $1,604 annually per Medi-Cal enrollee. An implementation date of October 1, 2011 is assumed.

In addition to statutory change, this proposal also requires a State Plan Amendment and federal CMS approval for implementation.

DHCS states this DME limit would apply to Adults (21 years and older) who are *not* in Long-Term Care Facilities or pregnant women. Children (21 years and under) and Pregnant women are exempt.

DME items include ambulation devices (such as walkers), bathroom equipment, decubitus (bedsore) care equipment, hospital beds and accessories, patient lifts, traction and trapeze equipment, communication devices, IV equipment, oxygen and respiratory equipment, and wheelchairs and accessories.

The *only* DME products exempt from the proposed dollar limit are Respiratory and Oxygen equipment.

DHCS contends their proposed DME limit would enable 90 percent of the Medi-Cal population to continue to receive all necessary DME products because they are presently at or below the proposed dollar limit of $1,604 per enrollee. Excluding those exempt from the budget proposal, this 90 percentile consists of about 60,100 Adult DME users with expenditures of $11.7 million (total funds).

In comparison, the DHCS states 6,773 people, or about 10 percent of those needing DME products, would exceed the limit. These individuals have an average cost of $4,666 annually, or *almost 3 times* the amount of the proposed dollar limit. Specifically, this 10 percentile consists of 6,773 Adult DME users with expenditures of $31.6 million (total funds).

Under federal law, DME products are considered a Medicaid “optional” benefit. Medi-Cal has covered DME products since 1988. Medi-Cal requires DME

Subcommittee Staff Comment. This proposal was denied by the Legislature last year.

A key concern with this limit is for people who require a combination of DME products due to their fragile medical state, as well as people who need more costly customized wheelchairs in order to live independently and to be mobile (access to school, work and quality of life issues).

The Administration’s proposal does not take into consideration any cost shifts to other services—such as Physician visits, clinic visits, or emergency rooms—that may occur if appropriate DME products are not provided.

Further, it does not take into account cost shifts to the Department of Developmental Services for the provision of DME products needed for people who are clients of the Regional Center system and entitled to services.

The trailer bill language has not yet been provided by the Administration; however, the proposed language from last year contained a specified dollar amount for the hard cap. As such, legislation would be necessary to change them in the future which is not particularly workable.

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

1. DHCS, Please briefly describe the budget proposal.
2. DHCS, Please briefly describe the people who would be affected by the dollar limit. Do we know why they are higher-need users of these products (or which products)?

11. Establishes Maximum Annual Dollar Limit for Medical Supplies

Budget Issue. The budget proposes a reduction of $3.9 million ($1.9 million General Fund) through enactment of trailer bill legislation to cap the maximum expenditures per Medi-Cal enrollee for certain Medical Supplies. An implementation date of October 1, 2011 is assumed.

In addition to statutory change, this proposal also requires a State Plan Amendment and federal CMS approval for implementation.

DHCS states this DME limit would apply to Adults (21 years and older) who are *not* in Long-Term Care Facilities or pregnant women.

The annual dollar limit would apply to wound dressings, incontinence products, and urinary catheters for Adults *not* residing in Long-Term Care facilities. Children and pregnant women are exempt from the proposed limit.

The table below lists the proposed annual dollar limits. The annual limit is based on State fiscal year, not a calendar year.

Table: Proposal to Limit Medical Supplies

Medical Supply Item to be Capped	Proposed Annual Dollar Limit	People Affected by Limit (10 Percent)
Wound Care	$391	882
Incontinence Supplies	$1,659	9,050
Urologicals--catheters	$6,435	459
TOTAL		10,391

DHCS contends their proposed Medical Supply limit would enable 90 percent of the Medi-Cal population to continue to receive all necessary Medical Supplies because they are presently at or below the proposed dollar limits as shown in the table, above.

In comparison, the DHCS states 10,391 people, or about 10 percent of those needing Medical Supplies, would exceed the limit. These individuals have an average costs as follows:

- $1,191 for Wound Care as compared to $391 proposed limit, or over 3 times the limit.
- $1,872 for incontinence Supplies as compared to $1,659 proposed limit.
- $7,295 for Urologicals as compared to $6,435 proposed limit.

Federal law considers Medical Supplies to be an Optional benefit. Medi-Cal has included Medical Supplies in its program since 1976.

Currently, Medical supplies are a benefit in Medi-Cal when prescribed by a Physician. Certain prior authorization approvals also apply. In addition, the DHCS has authority to contract with providers for certain supplies, including incontinence supplies.

Subcommittee Staff Comment. The Administration's proposal does not take into consideration any cost shifts to other services—such as Physician visits, clinic visits, or emergency rooms—that may occur from this action.

The people who fall outside of the 90 percentile are people who have significant medical conditions. Without these medical supplies it is likely that infections and other more severe medical conditions may occur.

The trailer bill language has not yet been provided by the Administration; however, the proposed language from last year contained a specified dollar amount for the hard cap. As such, legislation would be necessary to change them in the future which is not particularly workable.

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

1. DHCS, Please briefly describe the budget proposal.
2. DHCS, Please briefly describe the people who would be affected by the dollar limit.

12. Establishes Maximum Annual Dollar Limit for Hearing Aid Expenditures

Budget Issue. The budget proposes a reduction of $1 million ($507,000 General Fund) through enactment of trailer bill legislation to cap the maximum expenditures per Medi-Cal enrollee for hearing aid expenditures.

The maximum dollar limit would be $1,510 annually per Medi-Cal enrollee. This includes expenditures for the Hearing Aid, ear molds, and repairs.

An implementation date of October 1, 2011 is assumed. In addition to statutory change, this proposal also requires a State Plan Amendment and federal CMS approval for implementation.

DHCS states the Hearing Aid expenditure limit would apply to Adults (21 years and older) who are *not* in Long-Term Care Facilities or pregnant women.

DHCS contends the expenditure limit would enable 90 percent of the Medi-Cal population to continue to receive Hearing Aids and most servicing of the device because they are presently at or below the proposed expenditure limit of $1,510 per enrollee. DHCS data reflects that 20,600 people would be within the proposed limit.

Medi-Cal reimbursement for Hearing Aids varies but the maximum reimbursement for the device is $884 (monaural) and $1,480 (binaural). In addition to the device, many people also need ear molds.

According to DHCS data, there would be 2,293 people above the proposed expenditure limit. The average amount expended by this 10 percentile group is $1,579 annually, or about $80 higher than the proposed cap.

Federal law considers Hearing Aids to be an Optional benefit. Medi-Cal has included Hearing Aids in its program since 1988.

Hearing Aids are a benefit in Medi-Cal when supplied by a Hearing Aid Dispenser through the prescription of Otolaryngologist or attending Physician.

Subcommittee Staff Comment. Though caps on services are not desirable, the level proposed by the DHCS would enable one to obtain a hearing aid (binaural) with some modicum of adjustment being available.

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

1. DHCS, Please briefly describe the budget proposal, and whom it would affect.

B. Proposed Medi-Cal Provider Payment Reductions

1. Proposed Medi-Cal Provider Payment Reductions *(See Hand Out)*

Budget Issue. The budget reflects a reduction of $18.2 million ($9.4 million General Fund) in the current-year and $1.1 billion ($537.1 million General Fund) in 2011-12 through enactment of Medi-Cal Provider Payment reductions. An implementation date of June 1, 2011 is assumed. In addition to statutory changes, this proposal also requires a State Plan Amendment and federal CMS approval.

The proposed Provider Payment reductions are applicable to *both* Medi-Cal Fee-for-Service and Medi-Cal Managed Care providers.

The Provider Payment reductions vary by Provider Type. As shown in the *Hand Out*, this is due to Provider Payment reductions enacted in prior years (see AB 3X 5 column) which were enjoined by various Court actions and then partially restored (see AB 1183 column). As such, the budget proposes to enact an additional percentage reduction as shown (see "Proposed Additional Reduction" column). The *general* intent of the Provider Payment reductions as contained in the budget is to reflect an overall 10 percent *ongoing* Provider Payment reduction.

Subcommittee Staff Comment. Medi-Cal Provider Payments are some of the lowest in the United States. Federal law requires Medicaid payments (Medi-Cal in CA) to be sufficient to enlist providers so that care and services are available to the extent that such care and services are available to the general public in a geographic region. Concerns regarding Medi-Cal enrollee access to health care services, including various specialists, have been of concern in the past in California.

There is a long history of legal challenges and actions regarding the various methodologies used in developing Medi-Cal Provider Payments, as well as the various reductions which have been enacted over the past few years.

The United States Supreme Court recently agreed to hear California's appeal of a Ninth Circuit Court of Appeals ruling involving Medi-Cal's Provider Payments. This involves three cases — (1) Director Maxwell Jolly v. Independent Living Center; (2) Director Maxwell Jolly v. California Pharmacists Association; and (3) Director Maxwell Jolly v. Santa Rosa Memorial Hospital. It is anticipated the United States Supreme Court will provide its decision by *late Fall* 2011. The key issue is whether the Supremacy Clause of the Constitution confers a private right of action on providers and Medicaid enrollees to challenge rates for compliance with certain federal law.

It should also be noted that a calculation misstep is in the Medi-Cal budget and a 10 percent Provider Payment reduction for Intermediate Care Facilities for the Developmentally Disabled (ICF/DD Facilities) should have been included for a reduction of $41.1 million ($20.5 million General Fund) for these facilities.

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

1. DHCS, Please provide a brief summary, including the aspect of the U.S. Supreme Court hearing California's case and when a ruling may occur.

2. 10 Percent Medi-Cal Payment Reduction to Nursing Homes (Level B's)

Budget Issue. The budget reflects a reduction of $4.6 million ($2.3 million General Fund) in the current-year and $392.9 million ($172 million General Fund and $24 million Quality Assurance Fee) in 2011-12 through enactment of a 10 percent Provider Payment reduction to Nursing Homes (Level B's).

An implementation date of June 1, 2011 is assumed. In addition to statutory changes, this proposal also requires a State Plan Amendment and federal CMS approval.

As referenced below, Nursing Home (Level B) facilities are reimbursed using methodology established under AB 1629, Statutes of 2004. This methodology uses General Fund support, coupled with Quality Assurance Fees (QA Fees), to obtain federal matching funds. As required under the methodology, each Nursing Home has an individual facility specific rate based upon previous cost reports which reflect labor and operations expenditures.

Under existing statute, these Nursing Homes are to receive an average 3.93 percent rate adjustment for 2010-11 and an average 2.4 percent adjustment for 2011-12.

The DHCS states the proposed budget reduction of 10 percent to the Provider Payment would be applied to a Nursing Home's bottom-line, *after* the existing statutory rate adjustments (average of 3.93 and average of 2.4) are calculated.

Background—Nursing Home Reimbursement (AB 1629, Statute of 2004). Certain Nursing Home rates are reimbursed under Medi-Cal using combinations of federal funds, General Fund and revenues collected from Quality Assurance Fees (QA Fee). Use of QA Fees has enabled California to provide reimbursement increases to certain Nursing Homes with *no* added General Fund support.

This existing reimbursement method established under AB 1629, Statues of 2004, requires the DHCS to implement a facility-specific rate system for certain Nursing Homes and it established the QA Fee. Revenue generated from the QA Fee is used to draw federal funds and provide additional reimbursement to Nursing Homes for quality improvement efforts.

The *current* QA Fee structure sunset as of July 31, 2012. If the QA Fee sunsets, over $400 million in General Fund support is at risk.

Summary of Budget Act of 2010 Actions. Through the Budget Act of 2010 and corresponding trailer bill (SB 853, Statutes of 2010), a comprehensive Nursing Home Quality and Accountability package was adopted and contained the following *key* components:

- *Rate Adjustments*. Provides for a two-year rate adjustment of 3.93 percent increase in 2010-11 and up to 2.4 percent in 2011-12 by extending the sunset of the Quality Assurance Fee to July 31, 2012.
- *Quality & Accountability.* Begins to phase-in a Quality and Accountability system by establishing a special fund and a reward system for achieving certain measures. A

comprehensive stakeholder process will be used by the Administration to proceed with implementation of this system and to publish specific information.

A special fund was established for supplemental payments to be made under this system. Penalty collections will also be deposited into this special fund. Supplemental payments for 2011-12 are anticipated to be $50.9 million (total funds).

- *Compliance with 3.2 Nursing Ratio.* Required the State to audit nursing homes for complying with the existing 3.2 nursing hours to patient ratio. Nursing homes who are non-compliant from 5 percent to 49 percent of audited days would be assessed a penalty of $15,000. This increases to $30,000 for those who are non-compliant from 50 percent or more of audited days.
- *Legal Costs and Liability.* Limited legal costs incurred by nursing homes engaged in the defense of legal actions filed by governmental agencies or departments against the facilities. In addition, it limits Medi-Cal reimbursement for liability insurance to the 75th percentile computed on a geographic basis.
- *Expanded the Quality Assurance Fee.* Expanded the Quality Assurance Fee to include Multi-Level Retirement Communities as proposed by the Administration since Medi-Cal pays for over 50 percent of these facilities patients.

Subcommittee Staff Comment. Based on information received to date, it is unknown how the budget proposal may affect quality and accountability aspects at the Nursing Homes or unravel efforts made last year to improve the system overall.

In addition, the Quality Assurance Fee sunsets as of July 31, 2012 and will need to be extended or up to $400 million in General Fund support could be jeopardized. It is unknown how the Administration's proposal could affect this aspect.

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

1. DHCS, Please provide a brief summary of the proposal, including how the reduction would be applied, the interactions with the updated quality assurance changes from last year, as well as how the reduction affects the Quality Assurance Fee.
2. DHCS, Could this proposed reduction be affected by the pending U.S. Supreme Court review regarding California's Medi-Cal reimbursement?

C. Other Issues & Alternative Funding Proposals

1. Proposed Trailer Bill Language: Federal Roger's Amendment Issue

Budget Issue. The Administration proposes a reduction of $6.4 million (General Fund) by extending the sunset date of Section 14091.3 of the Welfare and Institutions Code by one-year (to January 2013).

Specifically, this code section is based on federal law and regulation (known as the Roger's Amendment) that requires State Medicaid Programs (Medi-Cal) to establish separate payment amounts for emergency services and post-stabilization services.

The intent of the law is to establish a basis for Medi-Cal Managed Care Plans to make reasonable payments to Hospitals who are "out-of-network" for these services. Historically, some Hospitals have litigated payments from Managed Care Plans that were high enough for the federal CMS to determine them to be unreasonable for the services provided.

Subcommittee Staff Commend and Recommendation. It is recommended to adopt this proposal.

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

1. DHCS, Please provide a brief summary of the proposal.

2. Two Issues Regarding Medi-Cal Managed Care Tax

Budget Issues. *First*, the Administration proposes to *permanently* establish the existing tax on the total operating revenue of Medi-Cal Managed Care Plans as originally enacted in AB 1422, Statutes of 2009. Existing statute sunsets as of July 1, 2011.

The budget projects revenues of $194.5 million to be generated in 2011-12 from this tax. Revenues from this tax are matched with federal funds and are used to (1) provide a reimbursement rate increase to Medi-Cal Managed Care Plans; and (2) fund health care coverage for children in the Healthy Families Program.

For the Medi-Cal Program, half of the generated revenues, or $97.2 million, will be matched with federal funds to provide for capitation payments. A total of $194.4 million (total funds) is available for this purpose. These funds are necessary in order to keep the participating plans whole.

Second, based upon a revised Fund Condition analysis, it has been determined that an *additional* $89.9 million in Special Fund support is available to *offset* (save) General Fund support in 2011-12 *above* the Governor's proposed January budget.

This is because in 2009-2010, General Fund support was used to provide for a transition period while the new tax revenue was being obtained from the Medi-Cal Managed Care Health Plans. Therefore, there was an unexpended balance in the Special Fund that can be used to offset General Fund for Medi-Cal Managed Care rates. This meets existing statutory requirements for expenditure of these revenues. The table below displays this information.

Summary Table: Children's Health and Human Services Fund (Medi-Cal Managed Care Plan Tax Revenues)			
	2009-10 Prior Year	**2010-11 Current Year**	**2011-12 Budget Year**
Beginning Balance	$0	$152.2 million	$0
Revenues, Transfers, Adjustments	$234 million	$192.3 million	$194.5 million
Total Revenues, Transfers, and Adjustments	**$234 million**	**$344.5 million**	**$194.5 million**
Expenditures:			
MRMIB	$81.8 million	$177.1 million	$97.2 million
DHCS	$0	$77.5 million	$97.2 million
Total Expenditures	**$81.8 million**	**$254.6 million**	**$194.5 million**
Balance Remaining	$152.2 million	$0	$0
Additional Available to Offset General Fund to DHCS		**$89.9 million**	

Constituency Concerns. Managed Care Plans have expressed their support for continuation of the tax established under AB 1422 *but desire a sunset* in lieu of the Administration's proposal for permanently establishing.

They note the federal CMS is presenting reviewing California's methodology for the tax and that federal funding formulas will be evolving in 2014 forward with implementation of the federal Affordable Care Act and reauthorization of the State Children's Insurance Program (Healthy Families in CA).

Therefore, they are seeking a sunset date.

Subcommittee Staff Comment and Recommendation—Modify. *First*, it is recommended for the existing sunset date to be extended of permanently establishing the tax. A new sunset date of January 1, 2014 is recommended (three years).

Second, it is recommended to reduce Medi-Cal by $89.9 million (General Fund) to reflect the availability of Special Fund revenues. (These Special Fund revenues are continuously appropriated.)

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

1. DHCS, Please provide a brief summary of the proposal, including the proposed trailer bill and the potential to use $89.9 million in revenues as an offset to General Fund support.
2. DHCS, Please provide an update regarding any federal CMS concerns regarding the tax.

3. Use of Proposition 10 Reserves to Fund Medi-Cal Services for Children

Budget Issue. The budget proposes to use $1 billion (Proposition 10 Funds) to fund Medi-Cal services for children (aged five and under) to offset General Fund support in the program for 2011-12. A new Special Fund—Proposition 10 Health and Human Services Fund (4260-101-3148) has been established in the Budget Bill for this purpose.

Of the $1 billion (Proposition 10 Funds) for 2011-12, the Department of Finance (DOF) assumes that approximately $233.9 million (Proposition 10 Funds) is obtained from the State Commission and the remaining amount of $766.1 million (Proposition 10 Funds) is obtained from local commission reserves. However the amount obtain from the State Commission and local commissions may be adjusted based upon pending updated information.

In addition, beginning July 2012, fifty percent of local Proposition 10 Funds would be transferred to the new Special Fund to help support Medi-Cal services for children (aged five and under) on an ongoing basis.

As the Administration notes, this proposal requires voter approval. A June 2011 ballot initiative is assumed.

Background. The California Children and Families Program (known as First 5) was created in 1998 upon voter approval of Proposition 10, the California Children and Families First Act. There are 58 county First 5 commissions as well as the State California and Families Commission (State Commission), which provide early development programs for children through age five. Funding is provided by a Cigarette Tax (50 cents per pack), of which about 80 percent is allocated to the county commissions and 20 percent is allocated to the State Commission.

Unspent funds are carried over for use in subsequent fiscal years. According to the DOF, over time, both the State and local fund balances have grown. The DOF contends as of June 30, 2009, county commissions held more than $2 billion in reserves.

County commissions implement programs in accordance with local plans to support and improve early childhood development in their county. While programs vary from county to county, each county commission provides services in three main areas: (1) Family Functioning; (2) Child Development; and (3) Child Health.

Most recently, Proposition 1D was on a special statewide May 2009 ballot to redirect a portion of Proposition 10 Funds to support certain health and human services programs and it was not successful. However, the fiscal crisis has deepened since this time.

Constituency Concerns. County commissions are very concerned that the amount of reserve assumed by the DOF is too high since some County commissions have maintained prudent reserves for their future obligations. In addition they note that any redirection could create job loss and disruption, and eliminate some vital services that have been determined at the local level.

Subcommittee Staff Comment. In previous analyses, the LAO has recommended a redirection of Proposition 10 Funds to support certain health and human services programs. They noted that Proposition 10 was approved by voters during a healthier fiscal period for California, and with the State facing continued hardship with the Great Recession, it would make fiscal sense to prioritize core children's programs.

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

1. Administration, Please provide a brief summary of this proposal, including a discussion of the proposed Proposition 10 Fund shifts. Please explain both the proposed 2011-12 shift as well as the proposed on-going shift.

4. Health Information Technology for Economic & Clinical Health (HITECH) Act

Budget Issues. *First,* the budget reflects an increase of $634.8 million (federal funds) in Medi-Cal from the HITECH Act. These federal funds are available to California as approved by the federal CMS and reflect California's Health Information Technology Planning and Advance Planning document.

These funds are to be used as federal incentive payments for Hospitals, Physicians, and other eligible clinical health care professionals who participate in the Medi-Cal Program. The DHCS has identified 435 Hospitals and more than 10,000 Medi-Cal providers who will quality to receive incentive payments.

DHCS has proposed trailer bill language to structure an incentive payment program for this purpose.

Second, the DHCS is requesting an increase of $2.2 million ($2 million federal funds and $217,000 in Reimbursements from the CA Health Care Foundation) to support 16 positions and specified contract funds to implement this new program. The request includes the following 16 positions and contract funds:

- Staff Services Manager I — 2
- Health Program Auditor IV — 2
- Associate Governmental Program Analysts — 8
- Research Program Specialists II — 4
- External Consulting — $450,000

Background—HITECH Act. This federal Act authorizes the outlay of federal money for, among other things, Medicaid (Medi-Cal) incentive payments to qualified heath care providers who adopt and use electronic health records in accordance with provisions in the Act, including electronic prescribing, submission of information on clinical quality measures, reporting to immunization and disease registries, and exchanging health information to improve the quality of care.

Subcommittee Staff Comment and Recommendation. It is recommended to approve both the increase of $634.8 million (federal funds) in the Medi-Cal Program and the increase of $2.2 million (total funds) for DHCS support in order to proceed with implementation of this new program. *However*, it is recommended to deny the proposed trailer bill (without prejudice) to establish this new program since this should be done through the policy committee process.

Providing for appropriation of the funds beginning in July will enable the DHCS to begin to hire staff and work with contractors while the policy legislation is being finalized.

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

1. DHCS, Please provide a brief summary of this proposal.

Managed Risk Medical Insurance Board (MRMIB)

A. Overall Background (Pages 35 through 36)

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)	**2010-11**	**2011-12**	**$ Change**
Major Risk Medical Insurance Program	$51,527	$37,084	-$14,443
Access for Infants & Mother	$123,953	$122,465	-$1,488
Healthy Families Program	$1,125,440	$1,054,124	-$71,316
County Health Initiative Program	$1,764	$1,773	-$9
Pre-Existing Conditions Plan (PCIP) Program	$217,372	$341,376	$124,004
Totals Expenditures	**$1,520,056**	**$1,556,822**	**-$36,766**
General Fund	$130,801	$267,469	$136,668
Federal Funds	$796,737	$749,563	-$47,174
Federal Funds—High Risk Health Insurance	$217,372	$341,376	$120,004
Children's Health & Human Services Special	$176,841	$97,226	-$79,615
Managed Risk Medical Insurance Fund	$51,527	$37,084	-$14,443
Other Funds	$146,778	$64,104	-$82,674

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 *five programs* as follows:

- Healthy Families Program;
- Pre-Existing Conditions Insurance Program (PCIP).
- Major Risk Medical Insurance Program (MRMIP);
- Access for Infants and Mothers (AIM) Program; and
- County Children's Health Initiative Matching Program (CHIM).

The Governor's budget proposes changes to Healthy Families and the newly created PCIP. As such, these programs are discussed further in this Agenda (See Discussion Issues).

The Major Risk Medical Insurance Program (MRMIP). MRMIP provides health insurance for Californians unable to obtain coverage in the individual health insurance market because of pre-existing conditions. Californians qualifying for the program participate in the cost of their coverage by paying premiums. Cigarette and Tobacco Product Surtax Funds are deposited into a special fund and are used to supplement premiums paid by participants to cover the cost of care in MRMIP. The budget proposes no policy changes for MRMIP. The changes between the two fiscal years reflect technical adjustments from prior years and payments to health plans.

Access for Infants and Mothers (AIM). AIM provides low cost insurance coverage to uninsured, low-income pregnant women. The subscriber cost is 1.5 percent of their adjusted annual household income. AIM is supported with Cigarette and Tobacco Product Surtax Funds deposited into a special account, as well as federal funds to supplement the participant's contribution to cover the cost. The budget proposes no policy changes for AIM.

County Children's Health Initiative Matching Fund Program (CHIM). Established by AB 495, Statutes of 2001, this program provides four counties the ability to obtain federal funds for their Healthy Children's Initiatives by providing local funds to match the federal dollars. The budget proposes no policy changes for CHIM.

B. Background on Healthy Families Program (Pages 37 through 38)

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 age 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: Summary of Eligibility for 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 (AIM).	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 funds to county projects as approved by the MRMIB. Counties provide the match for the federal funds. Conforms to existing law.

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 Budget Appropriation. A total of $1.044 billion ($264.8 million General Fund) is proposed for 2011-12 to provide health care coverage to an estimated 916,029 children. This proposed funding level reflects a series of cost-containment proposals as shown in the table below.

Table: Proposed Reductions to the Healthy Families Program

Budget Proposals	Effective Date	2010-11		2011-12	
		GF	Total	GF	Total
Eliminate Vision Coverage	June 1, 2011	-$900,000	-$2.6 million	-$11.3 million	-$32.3 million
Increase Premiums	June 1, 2011	-$1.9 million	-$5.3 million	-$22.2 million	-$63.3 million
Increase Co-Pays for Emergency Room Visits & In-Patient Hospital Stays	October 1, 2011	0	0	-$5.5 million	-$15.9 million
Subtotal Subscriber Changes		**-$2.8 million**	**-$7.9 million**	**-$39 million**	**-$111.5 million**
Managed Care Plan Tax	July 1, 2011	0	0	-$97.2 million	-$97.2 million
Total Proposals		**-$2.8 million**	**-$7.9 million**	**-$136.2 million**	**-$208.7 million**

Each of these issues is discussed in detail below.

C. Issues for Discussion on Healthy Families (Pages 39 through 46)

1. Proposed Elimination of Vision Coverage in Healthy Families

Budget Issue. The budget eliminates Vision coverage as presently provided for children enrolled in Healthy Families for a reduction of $2.6 million ($900,000 General Fund) in 2010-11, and $32.3 million ($11.3 million General Fund) in 2011-12.

The Administration assumes enactment of legislation by March 1, 2011 for implementation to be effective by June 2011. Families need to be notified of the elimination of the coverage and the contracts with the Vision Plans would need to be closed-out.

This proposal also requires federal approval of a State Plan Amendment for implementation.

Currently, HFP provides Vision coverage through a separate Vision Plan, as done in the employer-based insurance market. There are three Vision Plans for HFP subscribers to choose from, including (1) Vision Service Plan (VSP); (2) EyeMed Vision Care; and (3) SafeGuard vision. About 900,000 children are presently enrolled in a Vision Plan.

According to the MRMIB, Vision Plan coverage includes the following services:

- Case History
- Evaluation of the health of the visual system including:
    - External and internal examination
    - Assessment of neurological integrity
    - Biomicroscopy of the anterior segment of the eye
    - Screening of gross visual fields; and
    - Pressure testing through tonometry.
- Binocular function test
- Diagnosis and treatment plan, if needed
- Corrective lenses, limited to once each twelve consecutive month period
- Contacts are covered with prior authorization and under certain conditions, such as cataract surgery.

If Vision coverage is eliminated as proposed by MRMIB, only a *more limited set* of sensory Vision services would be available. The HFP Health Plan benefit includes some preventive vision services, including some vision testing, eye refractions to determine the need for corrective lenses, and dilated retinal eye exams.

California's Knox Keene Act requires Health Plans to "provide benefits for the comprehensive preventive care of children 16 years of age or younger.." that comply with recommendations for preventive pediatric health care, as adopted by the American Academy of Pediatrics; these sensory Vision screenings are to be performed at ages 3 to 6, 8, 10, 12, 15 and 18 years.

Further, medically necessary services for the treatment of eye illnesses or eye injuries would also be provided under the HFP Health Plan benefit.

Subcommittee Staff Comment. Elimination of separate Vision coverage would mean that only a more limited set of sensory Vision services would be available. Annual eye exams and glasses would not be covered by Health Plans as they are covered under the HFP Vision Plan (as is comparable under the employer-based insurance market).

There may be other options available for reducing Vision Plan expenditures that could be explored, such as cost containment with eye-glass frames or the like.

The LAO recommends approval of the Administration's proposal to eliminate the Vision benefit due to the State's fiscal condition since it is not a required benefit of the federal Children's Health Insurance Program (HFP in CA).

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

1. MRMB, Please briefly describe the proposal.
2. MRMIB, Please discuss the differences in Vision services provided under the Vision Plan and as provided under the Health Plan.
3. MRMIB, Are other options for reducing Vision Plan expenditures available?

2. Proposed Increases to Premiums

Budget Issue. The budget significantly increases the monthly premiums paid by families with incomes from 151 percent up to 250 percent for a total reduction of $5.3 million ($1.9 million General Fund) in 2010-11, and a reduction of $63.3 million ($22.2 million General Fund) in 2011-12.

The Administration assumes enactment of legislation by March 1, 2011 for implementation to be effective by June 2011. A State Plan Amendment must also be approved by the federal CMS for this purpose.

This federal approval is necessary for two purposes: **(1)** To ensure California conforms to federal requirements regarding family cost sharing (premiums and copays cannot exceed 5 percent of family income); and **(2)** To ensure the proposed premium increases would not violate federal maintenance of effort (MOE) provisions as contained in the federal Patient Protection and Affordable Care Act (Affordable Care Act) of 2010.

The table below provides a summary of the proposed premium changes. It should be noted that premiums were increased in 2005 and twice in 2009.

Table: Proposed Monthly Premium Increases

HFP Subscriber Family Income %	Existing Monthly Premium	Proposed Budget Increase to Premiums	Proposed Revised Monthly Premium (effective June 1, 2011)
100 to 150 % (Category "A")	$7 per child Family Maximum of $14	No change Federal law prohibits	No change Federal law prohibits
151 to 200 % (Category "B")	$16 per child Family Maximum of $48	$14 per child Family Maximum of $42	$30 per child Family Maximum of $90
201 to 250 % (Category "C")	$24 per child Family Maximum of $72	$18 per child Family Maximum of $54	$42 per child Family Maximum of $126

Monthly premiums for families from 151 percent to 200 percent of poverty (Category B) 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.

The increase to Category B families results in an expenditure reduction of $35.7 million ($12.5 million General Fund) to HFP.

Monthly premiums for families from 201 to 250 percent of poverty (Category C) would be increased by $18 per child, or by *75 percent*, for a total of $42 per child per month, with a family maximum of $126 for three or more children.

The increase to Category C families results in an expenditure reduction of $27.6 million ($9.7 million General Fund) to HFP.

Background: Federal Maintenance of Effort (MOE) Requirement *(See Hand Outs)*. The Affordable Care Act of 2010 requires States to retain current income eligibility levels, including processes and procedures for enrollment, for children in Children's Health Insurance Programs (HFP in CA).

As noted in the hand out package, two federal CMS letters—one to California and the other to Georgia—raise question as to whether increases to premiums may potentially violate these federal MOE provisions. At risk to California is over $750 million in federal funds within the HFP, as well as over $26 billion in federal funds within the Medicaid Program (Medi-Cal).

Background: Federal Law Limits Cost-Sharing Amounts Charged to 5 Percent. 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.

According to 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 require 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.

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.

Subcommittee Staff Comment. First, federal CMS approval of the viability of any premium increases should be explored and clarified by the RMMIB.

Second, the proposed premium increases are substantial for low-income families. The Category B premiums reflect an increase of 87 percent, and the Category C premiums reflect an increase of 75 percent. Other premium adjustments may be an option if further direction can be obtained from the federal CMS.

Further, it should be noted that the Administration's cost savings estimate for the premium increases to families do not assume any reductions to caseload. Due to the level of increase, it seems likely that some families will drop HFP coverage due to cost.

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

1. MRMB, Please provide a brief summary of the proposal.
2. MRMIB, What is the viability of the federal CMS to approve any premium increases within the context of California meeting its MOE provisions.
3. MRMIB, Are other options potentially available?

3. Proposed Increases to Copayments to Conform to Medi-Cal Program

Budget Issue. The budget proposes a reduction of $15.9 million ($5.5 million General Fund) by increasing HFP copayments to conform to a similar proposal within Medi-Cal, as noted above. An October 1, 2011 implementation date is assumed.

This reduction includes the following two proposals:

- Emergency Room visits which do not result in hospitalization or outpatient observation would increase from $15 to $50; and
- Hospital Inpatient days would have copay of $100 per day (maximum of $200 per stay).

This proposal requires federal approval through a State Plan Amendment, as well as a federal Waiver (to be done by the DHCS through the Medi-Cal Program as previously referenced).

Background on Copayments. In addition to monthly premiums, families must also provide copayments for their children to receive services. Copayments count towards the federal cost-sharing calculations of five percent of monthly family income.

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-- $5 to $15, unless no generic is available or brand name drug is medically necessary.
- Emergency room visits—from $5 to $15, unless child is admitted to hospital.

Subcommittee Staff Comment. Existing statute and HFP regulation have a cap of $250 annually on the amount of out-of-pocket copayments. It is up to families to track this information and if the cap is reached, the family informs the HFP that it has been reached.

The MRMIB notes that the $250 annual copayment cap would not be modified under this proposal in order to meet the existing federal requirement of not exceeding 5 percent of a family's income in all cost-sharing arrangements (meaning premiums and copays collectively).

This issue should conform to actions taken in Medi-Cal.

D. Issue for Discussion: Pre-Existing Condition Insurance Program

1. Request for Resources for California's Pre-Existing Condition Insurance Program

Budget Issue. MRMIB requests an increase of $3.5 million (federal funds) to support 28 positions to continue implementation and operation of California's Pre-Existing Condition Insurance Program (PCIP) as recently authorized in both federal and State statute.

California received federal approval in August 2010, along with an allocation of $761 million (federal funds) to operate a high risk health insurance pool (PCIP in California). The federal Department of Health and Human Services (DHHS) will reimburse MRMIB for administrative expenses and claims for covered medical services that are in excess of the premiums collected from enrollees in the PCIP.

PCIP is to provide health care coverage for eligible individuals through December 31, 2013, with a final closeout period that will run from January 1, 2014 through June 30, 2014.

The requested $3.5 million (federal funds) would support 28 permanent positions, and provide for $629,000 in external contract expenditures. The requested positions are as follows:

- 4 Staff Services Analysts Manager I
- 6 Associate Governmental Program Analysts
- 5 Research Program Specialists
- 2 Staff Services Analysts
- 3 Associate Accounting Analysts
- 2 Staff Program Analysts
- 1 Legal Staff Counsel IV
- 1 Legal Staff Counsel III
- 1 Legal Assistant
- 1 Information Officer
- 1 Associate Personnel Analyst
- 1 Associate Management Auditor

Key responsibilities and functions of these positions include:

- Administer an eligibility system, including establishing policies and procedures for enrollment, disenrollment and appeals;
- Develop and operate subscriber service functions, including plan enrollment, providing customer service, and conducting marketing and outreach;
- Oversee all aspects of premium administration;
- Develop and maintain program regulations;
- Conduct various contractual and legal activities, including Administrative Vendor contracts, health plan contracts, matters related to subpoenas, appeals and hearings, and Public Record Act requests.

- Ensure compliance with federal program requirements, including routine monitoring and identification of compliance risks, internal monitoring, data reporting, and federal DHHS requirements.

The $629,000 (federal funds) for external contracts would be for certain expertise including actuarial services, legal services and auditing services.

Background—Establishing CA's PCIP. The federal Patient Protection and Affordable Care Act of 2010 established a *temporary* federal high risk pool program (June 2010 through December 31, 2003) and provided States flexibility to operate their own program.

SB 227 (Alquist), Chapter 31 of 2010 and AB 1887 (Villines), Chapter 32 of 2010 required the MRMIB to establish and administer California's program. Implementation was contingent on an agreement with the federal government and receipt of adequate federal funds for this purpose. The legislation prohibits the use of any State funds for this new federal program.

PCIP is governed by terms of a contract with the federal Department of Health and Human Services which was approved in August 2010. An allocation of $761 million (federal funds) was provided for California to operate the program.

PCIP offers health coverage to *medically uninsurable* individuals 18 years or older who live in California. It is available for people who did not have health coverage in the 6-months prior to applying. PCIP uses a preferred provider network that has contracted health providers in all 58 counties statewide. Monthly premium costs are based on the applicant's age and the region where the applicant lives.

Subcommittee Comment and Recommendation-- Approve. It is recommended to approve the $3.5 million (federal funds) and the 28 positions. MRMIB states that by the nature of the program phasing-out, the positions will also phase-out as of June 30, 2014.

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

1. MRMIB, Please provide a brief summary of the key aspects of the program and this request.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

January 27, 2011

9:30 AM or
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

Staff: Jennifer Troia

Item	Department
0530	Office of Systems Integration (Health & Human Services Agency)
5180	Department of Social Services

PLEASE NOTE:

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

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

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Agenda

(Vote-Only Items indicated by *)

Item Department **Page**
Issue

Background Information:
Department Overviews

Office of Systems Integration (OSI): With a total budget of $212.1 million (OSI Fund, transfers from other mixed sources) in 2010-11 and a proposed budget of $183 million in 2010-11, OSI procures and manages automation projects for the Departments of Social Services and Employment Development.

Department of Social Services (DSS): With a total budget of $21.0 billion ($8.6 billion GF) in 2010-11 and a proposed budget of $16.6 billion ($8.7 billion[1] GF) in 2011-12, 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, In-Home Supportive Services (IHSS), child welfare services, and the licensing of community care facilities.

[1] Note that this figure does not display the impact of nearly $1 billion of the $1.5 billion proposed reduction to CalWORKs, as those funds would still pass through DSS's budget before being transferred to the Student Aid Commission.

Vote-Only Agenda

0530 Office of Systems Integration (OSI) (& DSS)

OSI (& DSS) Issue 1: Los Angeles Eligibility, Automated Determination, Evaluation and Reporting (LEADER) Replacement System (LRS)

Budget Issue: OSI requests a decrease of $7.0 million in the 2010-11 budget for LRS as a result of contract finalization. The total 2010-11 budget for LRS, which includes six-months of design, development, and implementation, would thus be $38.4 million ($14.3 million GF/TANF). OSI also proposes an increase of $37 million ($12.6 million GF/TANF) for a full year of project design, development, and implementation in 2011-12. Including these proposed funds, the 2011-12 budget for LRS would be $75.5 million ($27 million GF/TANF).

OSI anticipates total costs for LRS development and implementation of $370.2 million over four years ($137.7 million GF/TANF, $205.7 million federal funds and $26.8 million county funds) before reaching the Maintenance & Operations (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 $63.5 million annual operations costs for LRS ($24.9 million GF/TANF) or about double the costs for LEADER.

Background on LEADER: With 2010-11 M&O costs of $30.7 million ($15.7 million GF/TANF), LEADER is one of four consortia within the Statewide Automated Welfare System (SAWS). The system that is being replaced by LRS has been in its M&O phase since 2001, with its latest Unisys contract scheduled to expire on April 30, 2011. To accommodate the LRS schedule, OSI is seeking approval to again extend that contract for additional years.

Background on LRS Project: According to OSI and Los Angeles (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.

Planning activities are currently wrapping up and design, development, and implementation of the LRS project is scheduled to begin shortly. OSI anticipates that the project could be completed in December 2014.

Subcommittee Staff Comment & Recommendation: Staff recommends approving the proposed 2011-12 funds for LRS.

5180 DSS

DSS Issue 1: CalWORKs - Work Incentive Nutrition Supplement (WINS) Program

Budget Issue: DSS proposes, in trailer bill language, to repeal statutes requiring the department to create and implement the WINS program. Based on preliminary estimates, the department anticipates that after automation changes costing $2 million GF in the first year of implementation, costs (countable as Maintenance of Effort [MOE] for the federal Temporary Assistance for Needy Families [TANF] program) for WINS would be $18 million in the second year and $28.4 million each year thereafter.

Background on WINS: 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 per month supplemental food benefit to working families who are receiving CalFresh benefits but are not receiving CalWORKs assistance, if they are participating in sufficient hours of paid employment to meet the TANF work participation rate (WPR). As a result, the state would improve its WPR as measured by the federal government. A related 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) that could result from WINS. As a result of enacted implementation delays, the Department is prohibited from paying WINS benefits prior to October 1, 2012, and is required to fully implement the program by April 1, 2013.

Subcommittee Staff Comments & Recommendations: Staff recommends approval of another one-year delay in the timeline for WINS implementation, rather than an outright repeal of the statutes authorizing the program. This allows for additional time to consider the benefits and costs of the program in light of any further communications with the federal government regarding the state's WPR and any other changes in TANF policies.

DSS Issue 2: CalWORKs - Temporary Assistance Program (TAP)

Budget Issue: DSS proposes, in trailer bill language, to repeal statutes requiring the department to create and implement TAP. Based on preliminary cost estimates, after automation changes of $5.3 million GF, if excess-MOE funds are available when it is implemented, TAP is effectively cost-neutral to the state because funds needed for the program ($220 million in recipient benefits) 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). However, according to the Department, TAP could also result in a revenue loss to the state because of an associated loss of public assistance cost recoupment through child support payments.

Background: 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 WPR. To date, implementation complexities, largely due to challenges with child support automation and rules, have prevented TAP from moving forward. As a result, trailer bill language was adopted four years in a row to delay TAP implementation. The Department reports no new progress in overcoming those challenges to implementing TAP.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the proposed repeal of the statutes authorizing the TAP program.

DSS Issue 3: CalWORKs - State and County Peer Review Process

Budget Issue: DSS proposes trailer bill language to continue the inactive status of the CalWORKs state and county peer review process in 2011-12. The process was suspended for 2010-11, but the Department is currently required to implement it statewide no later than July 1, 2012. This proposal would extend that deadline for statewide implementation by two years to July 1, 2014.

Background: A 2006 budget trailer bill (AB 1808, Chapter 75, Statutes of 2006) Originally 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. Prior to last year, eight peer reviews were conducted (three in 2008 and five in 2009).

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the proposed trailer bill language to delay the required statewide implementation of the peer review process.

DSS Issue 4: CalFresh Nutrition Education (CNE) Unit

Budget Issue: DSS requests, in a budget change proposal, $350,000 (withheld federal funds) to make three existing limited-term staff positions (one Staff Services Manager and two Associate Governmental Program Analysts) into permanent positions in the CNE.

Background: The CNE's goals are to educate low-income CalFresh-eligible individuals regarding healthy lifestyles and how to best use limited food budgets. Its total budget includes $246 million ($129 million for a state share, which is paid by school districts, county health departments and other local entities). DSS contracts with two partners, the

University of California-Davis (UCD) and the California Department of Public Health (DPH) to carry out the CNE program. For 2006 through 2008, the federal government disallowed some costs of the program as a result of fraud and embezzlement discovered to have been perpetrated by a UCD employee. The CNE Unit was established in 2009-10 with limited-term positions to provide increased oversight of the CNE program and its contractors.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the requested positions, which will be federally funded.

Discussion Agenda

0530 Office of Systems Integration (OSI)
5180 Department of Social Services (DSS)

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

Budget Issue: OSI requests $2.1 million ($951,000 GF that is reflected in the DSS budget) for four additional staff and additional contract resources to support its project management role in the development of the new CWS/Web system. These four positions would be in addition to 29 existing OSI positions and another ten OSI-contract staff currently supporting this phase of the project.

DSS requests, in a budget change proposal, $304,000 ($139,000 GF) for the extension, for an additional two years, of three limited-term staff who support the child welfare program-side of the project's development. These three staff (in a manager, office technician, and legal counsel position) would be in addition to three existing DSS positions supporting this phase of the project.

Including the requested positions, the total 2011-12 budget for the project would include $13.2 million ($6.0 million GF). OSI estimates a total cost of $351.2 million ($165.5 million GF) for the project over the decade between 2006-07 and 2016-17. Of this amount, the one-time costs to implement the project are estimated to be $215.3 million ($97.5 million GF), with maintenance and operations costs of $135.9 million ($68 million GF). According to the current project schedule, the project will be fully implemented by the Fall of 2015.

Background: 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. The Child Welfare Services/Case Management System (CWS/CMS) is the existing 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 CWS/CMS system was implemented statewide in 1997, and OSI has stated that CWS/Web is necessary because the CWS/CMS technology is outdated. In addition, OSI and DSS report that the CWS/Web system will increase efficiency and better 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.

According to OSI and DSS, the requested positions are needed to keep pace with critical quality assurance, design, and development tasks. Without the requested resources, OSI indicates that it will be difficult to keep the project on time and within its budget.

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

Questions for OSI & DSS:

1) Please briefly describe the status of the CWS/Web project development and its current and anticipated staffing. What is the rationale for requesting these additional positions at OSI and at DSS at this time?

2) If these positions are not approved, what consequences would result? Please provide specific examples.

5180 Department of Social Services (DSS)

DSS Issue 5: CalFresh - Electronic Benefit Transfer (EBT) for Farmers' Markets

Budget Issue: DSS requests, as part of its local assistance estimates, $1.6 million ($788,000 GF) to provide EBT services (point-of-sale devices, service, and transaction fees) to over 700 new farmers' markets in 2011-12.

Background: Of the 800 farmers markets in California, 111 markets are currently equipped to accept EBT at 280 locations. Enacted last year, AB 537 (Arambula, Chapter 435, Statutes of 2010) allows, but does not require, groups or associations of produce sellers to operate as Food and Nutrition Service (FNS) agents by accepting EBT.

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

Questions for DSS:

1. Please briefly describe the provisions of AB 537 and the Department's plan for implementing those provisions.

2. How many of the roughly 700 farmers' markets that currently do not use point-of-sale devices can reasonably be expected to begin doing so during the budget year?

CalWORKs Overview

CalWORKs provides cash assistance and welfare-to-work services to families whose income is inadequate to meet their basic needs for shelter, clothing, and other essentials. The 2010-11 budget for CalWORKs includes $5.8 billion ($2.3 billion GF). Based on August, 2010 data, the program serves around 575,000 families with about 1.1 million children.

Eligibility: To be financially eligible for CalWORKs, a family's income must be below a specified income level (for example, $1,203 per month for a family of three) and they must meet set limits on their other assets (e.g., no more than $2,000 in savings). Grants vary by family size and county of residence. If an adult has reached the five-year limit on his or her aid, the family's grant is reduced by the amount attributable to the adult, and the children continue to receive aid in a program known informally as the "CalWORKs safety net" (approximately 9 percent of all CalWORKs cases). Children with parents who are ineligible to receive CalWORKs assistance (approximately 35 percent of all CalWORKs cases) receive a "child-only" grant throughout their time on aid. As an example, a parent who is undocumented would be ineligible to receive aid.

Assistance: Currently, the maximum monthly grant for a family of three is $694 in higher-cost counties (the equivalent of approximately 76 percent of the Federal Poverty Level when combined with CalFresh benefits). Once on aid, a family may remain eligible despite having some additional earnings because of an "earned income disregard," which does not count certain earned income when determining the family's grant. Generally, able-bodied adults are limited to 60 months of cash aid, while children are not subject to such time limits. Under reforms passed as part of the 2009-10 budget, these time limits for adults are scheduled to change, as of July 1, 2011, to 48 months and then a "sit out" period of at least one year before eligibility for an additional 12 months begins.

Work Requirements: Federal law generally requires that states ensure that at least 50 percent of families with adult recipients be working either 20, 30, or 35 hours per week, depending on the age of the youngest child and whether there are one or two parents in the household. Failure to meet the net federal work participation rate may result in federal financial penalties for the state. Able-bodied adults who are required to participate receive child care and other services to help them work, obtain training, or find work.

Governor's 2011-12 Proposals: The Governor's budget proposes a total of approximately $1.5 billion GF savings as a result of the major reductions to CalWORKs described in the rest of this agenda. This amounts to a 50 percent reduction in net GF costs for CalWORKs compared to the workload budget. To achieve a majority of these savings, $946.8 million of federal TANF block grant funding would be transferred from DSS to the Student Aid Commission to offset a like amount of GF costs for CalGrants. While some TANF funds have been used for programs other than CalWORKs itself in prior years, the scale of this proposed transfer is unprecedented.

The Governor also proposes trailer bill language to repeal a number of reforms to the CalWORKs program that were enacted as part of the 2009-10 budget and which are scheduled to take effect July 1, 2011. These reforms include the change to the time limits

on adults' eligibility for CalWORKs benefits described above, additional reviews of clients' circumstances ("self-sufficiency" reviews) by case workers, and increases in sanctions for non-compliance with welfare-to-work requirements. The Department estimates that taken together, these reforms would have saved $104.9 million GF in 2011-12 [$134.9 million GF savings in the CDSS budget offset by $34 million GF costs in the Department of Education (CDE) budget for increased child care costs].

DSS Issue 6: Proposals to Extend Reduction of County Block Grant Funding (Single Allocation) & Continue County Flexibility to Move Funds Between Specified Accounts

Budget Issue: The Governor's budget proposes to extend a reduction of $376.9 million GF to the counties' "single allocation" for CalWORKs (block grant funding for Administration, Child Care, and Employment Services).

The 2009-10 Budget Act (Chapter 4, Statutes of 2009, Fourth Extraordinary Session, AB X4 4) included similar sized reductions for 2009-10 and 2010-11, but also included corresponding short-term reforms to the CalWORKs program (described below). The Governor's current proposal does not include the main policy changes in effect during those years, and is instead an unallocated reduction. According to DSS, counties would therefore "need to re-prioritize the use of the single allocation funds to serve clients in the most efficient and effective manner." The Governor's budget does, however, propose to continue flexibility that counties have had in 2009-10 and 2010-11 to redirect funding for Substance Abuse and Mental Health Services to and from CalWORKs Employment Services funding.

Background on Policies Connected to Prior Reductions: Under AB X4 4, counties may provide time-limit exemptions to adults who have been granted good cause due to lack of supportive services, and may exempt families with young children (i.e., 12-23 months or if two or more children are under the age of six) from welfare-to-work requirements. The Welfare Data Tracking Implementation Project (WDTIP), which counties use to track time on aid, reported that in the quarter ending in September 2010, 46,000 families were granted exemptions that may have resulted from these policies. AB X4 4 also contained statutory provisions like those in the Governor's proposal that allow counties greater flexibility to redirect mental health and substance abuse funding.

Anticipated Impacts: Because the Governor's budget does not offer any direction as to how counties should implement this very large reduction to funding for CalWORKs administration and for welfare-to-work services, including child care and other education and employment-related services, it is very difficult to predict which families and children would be affected by this proposal and in what ways. In general, there will be significantly less funding available for the supports that assist families in obtaining and keeping employment.

LAO Alternative: The LAO's alternative CalWORKs proposals for the Legislature's consideration include the possibility of a reduction to the Single Allocation that is deeper than the one proposed by the Governor's budget. The LAO suggests that such a reduction

should again be accompanied by participant exemptions, or some other form of increased flexibility for counties.

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

Questions for DSS:

1. Please summarize the impacts of the 2009-10 and 2010-11 reductions to the single allocation to date (on clients, counties, and the overall CalWORKs program). How does the department envision that the results of the proposed reduction would differ or be similar?

2. The proposed reduction does not include the corresponding CalWORKs policy changes that were included in the prior reductions. Why not? And how would implementation and the savings estimates change if those policies were again included?

3. How many counties took advantage of the flexibility to move substance abuse and mental health funding to and from other purposes? What, if any, have been the consequences to the availability of treatment when it may be needed to remedy barriers to employment or education?

DSS Issue 7: CalWORKs Proposal to Establish 48-month Time Limit On Aid to Children and Adults

Budget Issue: The Governor's budget proposes savings of $832.9 million GF/Temporary Assistance to Needy Families (TANF) to establish, effective July 1, 2011, a 48-month time-limit on the receipt of CalWORKs cash assistance and supportive services. This new time limit would apply retroactively and would apply to both adults and children, with some narrow exceptions for children whose parents continue to meet federal work participation requirements. Previous months of cash aid would count toward the time limit, even if the adult participant had been exempted from welfare-to-work requirements or was temporarily disabled at the time.

Current Time Limits: Currently, able-bodied adults who are eligible to receive CalWORKs assistance are limited to 60 months of cash aid. Under reforms passed as part of the 2009-10 budget, these time limits for adults are scheduled to change, as of July 1, 2011, to 48 months, and then a "sit out" period of one year before eligibility for an additional 12 months begins. If an adult recipient reaches the existing 60-month time-limit, the family's aid is reduced by the portion of the grant that was attributed to the adult and the family's child or children may continue to receive cash assistance until the age of eighteen in what is known as the "CalWORKs safety net".

Children of adults who are not eligible to receive CalWORKs assistance (e.g., parents who are undocumented or who have been convicted of certain felonies) receive cash aid in what are known as "child-only" cases, and there is no time limit on their aid during childhood.

Caseload Characteristics & Anticipated Impacts: The Governor's budget assumes that 115,000 low-income families with 234,000 children would lose all CalWORKs assistance as of July 1, 2011 as a result of this proposal. A more detailed breakdown based on 2011-12 caseload projections is below:

> There are 313,200 CalWORKs assistance families with an eligible adult (including cases in which the adult has been sanctioned or is exempt for other reasons). In 42,900 of these cases (with 77,000 children), the family has been receiving aid for 48 months, but the adult has not yet reached the existing 60-month time limit. The Department estimates that 26,500 of these families (with 47,600 children), would lose all aid on July 1, 2011. The remaining 16,400 families are assumed to meet work requirements and continue to receive aid in the safety net (for children only).
>
> There are around 52,300 families (with 127,600 children) in safety net cases after the parent(s) timed off of aid. The Department estimates that 36,600 of these families, (with 87,800 children), would lose all aid on July 1, 2011. The remaining 15,700 families are assumed to meet work requirements and would continue to receive aid in the safety net.
>
> There are 214,600 families projected to receive CalWORKs assistance in child-only cases. The Department estimates that 51,900 of these families (with 98,600 children) would lose all aid on July 1, 2011. The Department estimates that none of these families would continue to receive aid for children only, as it does not expect the adults (mainly undocumented parents) to meet work requirements or other criteria.

According to the Department, adults who would time off of CalWORKs aid at 48 months under the Governor's proposal would not be eligible for General Assistance (GA) under California law. However, at this point it is less clear whether children who would lose CalWORKs assistance as a result of the Governor's proposals would be eligible for some form of assistance at the local level. GA benefits vary significantly from county-to-county, but are generally significantly less than the cash assistance and welfare-to-work services provided by CalWORKs. As an example, the maximum GA grant in Los Angeles County (called General Relief) for a family of 3 was $450 per month in 2010.

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

Questions for DSS:

1. Please briefly describe the proposal.

(Continued on next page…)

2. Studies have indicated that the families who remain on aid the longest are often the families with adults who have the greatest barriers to employment (e.g., physical or mental health challenges, less work experience, etc.) Many are already living below the poverty line, and unemployment in the state is over 12 percent. What can we expect to happen when 115,000 of these families lose all assistance on July 1? To the families and their children? To the counties' and other areas of the state's budget (e.g. child welfare services and foster care)? To the economy?

3. How would the savings from this proposal change if the state continued to recognize exemptions to time limits on adults' aid (i.e., exemptions that have already been granted in the past and those that would otherwise be expected to occur in the future)? If the time limits were shortened only for adult recipients?

DSS Issue 8: Proposal to Reduce Grants by 13 percent

Budget Issue: The Governor's budget proposes $14 million GF savings in 2010-11 and $405 million in 2011-12 from reducing CalWORKs grants by 13 percent, effective June 1, 2011 (based on enactment in March).

Background & Anticipated Impacts: In 2010-11, the maximum monthly CalWORKs assistance grant for a family of three in high-cost counties is $694 and in low-cost counties is $661. The maximum monthly grant was also $694 (in real dollars, before adjusting for inflation) twenty years ago in 1989. This proposal would impact all families receiving cash assistance through CalWORKs. The Department estimates that by the 2011-12 budget year, 5,300 families would lose all CalWORKs assistance.

For a family of three, the Governor's proposal would reduce maximum monthly grants for basic necessities from $694 to $604 in high-cost counties and from $661 to $575 in low-cost counties. For families with no other income who also receive CalFresh (food stamp) benefits (which may increase slightly as a result of the families' reduced income under this proposal), this would place their household incomes at approximately $1,090 or 71 percent of the Federal Poverty Level (FPL) (from the current $1,155 or 76 percent of the FPL).

Grant Level Comparisons: According to the Department, CalWORKs grants (before the proposed reduction) are the second highest TANF grants in the ten most populous states and the fourth highest in the nation overall. After the 13 percent proposed reduction, the Department states that California's grant level would be the ninth highest in the nation. After adjusting for housing costs, however, the Center on Budget & Policy Priorities found that California's current grant levels were lower than those in 20 other states.

LAO Alternative: The LAO points out that the Legislature has never reduced CalWORKs grants by more than 6 percent at any one time, and suggests that the Legislature might consider phasing in the Governor's proposed reduction over two years. As a result, the 2011-12 GF savings would decrease, but the savings would grow to the same level over time.

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

Questions for DSS:

1) Please briefly describe the proposal and its anticipated impacts.

DSS Issue 9: LAO Alternative Proposals to Modify Earned Income Disregard & Subsidized Employment Program

Budget Issue: The LAO recommends that the legislature consider simplifying the "earned income disregard" for CalWORKs families to a flat 50 percent of all income earned. The resulting savings could be $200 million GF annually. The LAO also recommends that the Legislature consider expanding the state's subsidized employment program for CalWORKs recipients (established by Chapter 589, Statutes of 2007, Niello).

Background & Anticipated Impacts: Under current law, California does not count the first $225 of earned income or unearned disability-based income and 50 percent of each dollar earned beyond $225 when calculating a family's monthly grant. The policy is intended to create additional incentives for families to earn income. As a result of the proposed change to the income disregard policy, about 16,500 families who currently earn below $225 would have their grants reduced by 50 percent of their earnings, and around 125,500 who currently earn above $225 would have their grants reduced by $112. Approximately 5,600 families with incomes above $1,200 per month would lose all cash assistance.

Under AB 98's subsidized employment policies, counties can receive a match from the state that is capped at 50 percent of the maximum grant costs. When a CalWORKs recipient then receives subsidized wages, his or her grant is reduced (in part offsetting the cost of the subsidy). During 2009-10 and part of 2010-11, AB 98 was suspended while federal stimulus funds for subsidized employment were available. The federal program at the time covered 80 percent of the costs for approximately 20,000 subsidized jobs for CalWORKs recipients (with employers and local entities' contributions countable for the state's 20 percent match). However, this enhanced federal funding for subsidized employment expired in September, 2010; and the statutes created by AB 98 again took effect.

Subcommittee Staff Comment & Recommendation: This item is included for informational purposes and no action is required at this time.

Questions for LAO and DSS:

1) Please briefly describe these alternative proposals and their impacts.

2) What are some advantages and disadvantages of achieving savings by modifying the earned income disregard as proposed?

DSS Issue 10: Proposal to Lower the Age at which Children are Eligible for Child Care (Stage 1 Impacts)

Budget Issue: The Governor's budget proposes $34.0 million GF savings from eliminating Stage 1 child care for 11 and 12-year-olds and lowering the limit on age-related eligibility to the age of ten. The expected overall Stage 1 child care expenditures for 2011-12 are approximately $649 million.

Background & Anticipated Impacts: California offers subsidized child care to parents currently participating in CalWORKs (Stage 1); and families transitioning off of (Stage 2) or no longer receiving aid (Stage 3). DSS administers Stage 1 child care, while CDE administers Stages 2 and 3, as well as subsidized care for families with exceptional need who have not been CalWORKs recipients. After adjusting for the reduction to the CalWORKs single allocation (described on page 10), 51,200 children are expected to receive Stage 1 child care in 2010-11. Without that reduction, the caseload would have been larger. As a result of this proposed change in age eligibility, approximately 4,300 children from 2,500 families would lose Stage 1 child care services.

Subcommittee Staff Comment & Recommendation: Subcommittee #1 will consider the impacts of this proposal and other child care-related proposals on Stages 2 and 3 of CalWORKs child care, as well as non-CalWORKs subsidized child care. Staff recommends holding the Stage 1 impacts of these proposals open as those discussions also occur.

Questions for DSS and DOF:

1) Please briefly describe the proposal.

2) How might families and other state or county services (e.g., the juvenile justice or child welfare systems) be impacted by this proposal?

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

Outcomes from the January 27, 2011
Human Services Hearing

0530 Office of Systems Integration (OSI) [& Department of Social Services (DSS)]

OSI (& DSS) Issue 1: Los Angeles Eligibility, Automated Determination, Evaluation and Reporting (LEADER) Replacement System (LRS)

Voted 2-1 (Emmerson no) to approve the proposed funding for LRS.

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

Voted 3-0 to hold these issues open.

5180 DSS

DSS Issue 1: CalWORKs - Work Incentive Nutrition Supplement (WINS) Program

Voted 2-1 (Emmerson no) to approve an additional one-year delay to the implementation of the WINS program.

DSS Issue 2: CalWORKs - Temporary Assistance Program (TAP)

Voted 3-0 to approve the proposed repeal of the statutes authorizing the TAP program.

DSS Issue 3: CalWORKs - State and County Peer Review Process

Voted 3-0 to approve the proposal to delay the required statewide implementation of the peer review process by another two years.

DSS Issue 4: CalFresh Nutrition Education (CNE) Unit

Voted 3-0 to **approve** the requested positions, which will be federally funded.

Voted 3-0 to hold all of the following issues open:

DSS Issue 5: CalFresh - Electronic Benefit Transfer (EBT) for Farmers' Markets

DSS Issue 6: Proposals to Extend Reduction of County Block Grant Funding (Single Allocation) & Continue County Flexibility to Move Funds Between Specified Accounts

DSS Issue 7: CalWORKs Proposal to Establish 48-month Time Limit On Aid to Children and Adults

DSS Issue 8: Proposal to Reduce Grants by 13 percent

DSS Issue 10: Proposal to Lower the Age at which Children are Eligible for Child Care (Stage 1 Impacts)

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

February 1st, 2011

1:00 PM

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item	Department
	Vote Only Calendar
4265	Department of Public Health
4260	Department of Health Care Services
4440	Department of Mental Health
	Issues for Discussion
4265	Office of AIDS, Department of Public Health • AIDS Drug Assistance Program
4440	Department of Mental Health • Proposal on Proposition 63 and Realignment • Community Mental Health • State Hospitals • Other Programs and Administration
4265	Department of Public Health • Every Woman Counts Program • Women Infant and Children's Supplemental Food (WIC) Program • Other Federal Grant Programs

PLEASE NOTE:
Only those items in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings. Issues will be discussed in order as shown in the Agenda unless otherwise directed by the Chair. Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible. Thank you.

Vote Only Calendar:

A. Department of Public Health (Pages 2 to 6)

1. Genetic Disease Testing Program

Budget Issue. The budget proposes total expenditures of $94 million (Genetic Disease Testing Fund) for 2011-12 which reflects a net decrease of $1.2 million. The reduction reflects minor technical adjustments. No policy changes have been proposed.

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

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

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

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended to approve as budgeted.

2. Federal Affordable Care Act: Pregnant and Parenting Teens

Budget Issue. The budget proposes an increase of $2 million (federal funds) to link an evidence-based Positive Youth Development case management intervention to school-based care services for pregnant and parenting teens. No State match is required

Of this amount, (1) $221,000 is for State support for two limited-term positions (February 2011 to February 2014); and (2) $1.8 million is for local assistance.

DPH states the purposes of these funds are to:

- Conduct activities to improve and increase capacity of services currently offered by the State, including the Adolescent Family Life Program (AFLP) administered by the DPH and the California School Age Families Education (Cal-SAFE) administered by the Department of Education;
- Provide Local Health Jurisdictions funds for implementation and administration of this program; and
- Conduct assessments and monitoring for compliance of appropriate interventions.

Both the AFLP and Cal-SAFE programs stipulate that the two programs will collaborate and coordinate services in order to deliver a seamless non-duplicative system of care focusing on adolescent health and repeat teen pregnancy prevention. This federal grant will provide comprehensive assistance for this purpose.

Background. The Pregnancy Assistance Fund for Support of Pregnant and Parenting Teens and Women was established through provisions of the federal Patient Protection and Affordable Care Act of 2010. California was awarded federal grants through a competitive process. The purpose of these funds is to strengthen support services to pregnant and parenting teens.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended to approve as budgeted. No General Fund implications.

3. Lupus Surveillance in California

Budget Issue. The budget proposes an increase of almost $1.1 million (federal funds) in State support to support Lupus surveillance activities. Of this amount, $788,000 will be used for external contracts and $285,000 will be used to support the equivalent of 2.3 State staff.

DPH will be working with the University of San Francisco and Kaiser Permanente on this project to analyze data to better define the incidence and prevalence of Lupus as specified in the federal grant application.

California was awarded these federal grant funds from the federal Centers for Disease Control (CDC) through a competitive process.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended to approve as budgeted. No General Fund implications.

4. Federal Affordable Care Act: Tobacco Cessation

Budget Issue. The budget proposes an increase of $120,000 (federal funds) in State to support contracted services to implement initiatives to reduce tobacco use among populations disproportionately affected by tobacco, including people affected by mental illness, and substance abuse. This grant funding supplements an existing federal grant.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended to approve as budgeted. No General Fund implications.

5. Sodium Reduction in Communities

Budget Issue. The budget proposes an increase of $412,000 (federal funds) to support activities designed for rural communities to create healthier food environments to reduce sodium intake through public health application and implementation of population-based sodium reduction strategies. This is a federal grant from the federal CDC.

Of this amount, (1) $309,000 is for Shasta County to address specified sodium reduction functions; and (2) $103,000 is for a contract with the University of San Francisco to assist with training and technical assistance.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended to approve as budgeted. No General Fund implications.

6. Federal ARRA: Communities Putting Prevention to Work

Budget Issue. The budget proposes an increase of $255,000 (federal funds) to collect baseline and follow-up behavior data for Los Angeles, San Diego, and Santa Clara counties that are funded under the federal Communities Putting Prevention to Work federal grant.

Of the total amount, (1) $102,000 is for a Research Scientist II (two-year limited-term); and (2) $153,000 is for a contract with University of California Davis.

Specifically, these resources are to be used to measure these communities' evidence-based interventions in order to lead to improvements in public health policies, practices and behaviors within three to six years, ultimately leading to improved health and longer lives for Californians.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended to approve as budgeted. No General Fund implications.

7. Implementation of AB 2300 regarding Genetic Counseling Licensure

Budget Issue. The budget reflects an increase of $67,000 (Genetic Disease Testing Fund) to establish the Genetic Counselor Licensure Program as contained in AB 2300 (Emmerson), Statutes of 2010.

AB 2300 (Emmerson), Statutes of 2010, requires the DPH to license Genetic Counselors who meet specified requirements beginning July 1, 2011. In addition, it requires DPH to issue temporary Genetic Counselor licenses, valid for 24 months, to a person who meets all the requirements for licensure except passage of an examination.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended to approve as budgeted. No General Fund implications.

8. Federal Affordable Care Act: Personal Responsibility Education Program

Budget Issue. The budget reflects an increase of $6.5 million (federal funds) to implement and sustain comprehensive prevention education activities in populations with high teen birth rates, sexually transmitted disease infections, and HIV rates.

Of the total amount, (1) $555,000 is for five positions to plan, implement, monitor and support the grant program; and (2) $6 million is for local assistance to establish the program. Local assistance funds will be provided to community-based non-profit organizations.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended to approve as budgeted. No General Fund implications.

9. Accountability Payment System-- Contract

Budget Issue. The budget proposes an increase of $1 million (Reimbursements from Department of Health Care Services) to contract with California's Medicare Quality Improvement Organization (QIO) as directed by in SB 853 (Committee on Budget), Statutes of 2010.

The purpose of contracting with the QIO is to support quality improvement activities in Nursing Homes (Level B) as referenced in the statute, including the development, collection, analysis and reporting of performance data.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended to approve as budgeted. No General Fund implications.

Vote Only Calendar:

B. Department of Health Care Services (Pages 7 through 8)

1. Family Health Programs—Three Programs

Budget Issue. The budget proposes technical fiscal adjustments and caseload adjustments to three distinct programs within Family Health. These are as follows:

- *Genetically Handicapped Persons Program (GHPP).* Total expenditures of $92 million ($87.8 million General Fund, $4 million Rebate Fund, and $197,000 Enrollment Fees) are proposed for 2011-12. This reflects technical fiscal adjustments and caseload only.

- *California Children's Services Program (CCS).* Total expenditures of $298.1 million ($140.5 million General Fund and $157.7 million federal funds) are proposed for 2011-12. This reflects technical fiscal adjustments and caseload only.

- *Child Health & Disability Prevention (CHDP) Program.* Total expenditures of $2.5 million ($2.5 million General Fund, and $8,000 Children's Lead Poisoning Prevention Funds) are proposed for 2011-12. This reflects technical fiscal adjustments and caseload only.

Background—Genetically Handicapped Persons Program (GHPP). The Genetically Handicapped Persons Program (GHPP) provides comprehensive health care coverage for persons with specified genetic diseases including Cystic Fibrosis, Hemophilia, Sickle Cell Disease, Huntington's Disease, Joseph's Disease, metabolic diseases and others. GHPP also provides access to social support services that may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions.

Persons eligible for GHPP must reside in California, have a qualifying genetic disease, and be otherwise financially *ineligible* for the CCS Program. GHPP clients with adjusted gross income above 200 percent of poverty pay enrollment fees and treatment costs based on a sliding fee scale for family size and income.

Background: CA Children's Services Program (CCS). The CA Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children with specific medical conditions, including birth defects, chronic illness, genetic disease and injuries due to accidents or violence. The CCS services must be deemed to be *"medically necessary"* in order for them to be provided.

The CCS is the oldest managed health care program in the state and only one focused specifically on children with special health care needs. It depends on a network of specialty physicians, therapists and hospitals to provide this medical care. By law, CCS

services are provided as a separate and distinct medical treatment (i.e., carved-out service).

CCS was included in the State-Local Realignment of 1991 and 1992. As such, counties utilize a portion of their County Realignment Funds for this program.

CCS enrollment consists of children enrolled as: **(1)** CCS-only (not eligible for Medi-Cal or the Healthy Families Program); **(2)** CCS and Medi-Cal eligible; and **(3)** CCS and Healthy Families eligible. Where applicable, the state draws down a federal funding match and off-sets this match against state funds as well as County Realignment Funds.

Background: The Child Health & Disability Prevention Program (CHDP).
The CHDP provides pediatric prevention health care services to (1) infants, children and adolescents up to age 19 who have family incomes at or below 200 percent of poverty, and (2) children and adolescents who are eligible for Medi-Cal services up to age 21.

CHDP services play a key role in children's readiness for school. All children entering first grade must have a CHDP health exam certificate or equivalent.

This program serves as a principle provider of vaccinations and facilities enrollment into more comprehensive health care coverage, when applicable, via the CHDP gateway.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this estimate package for these three programs. No policy changes are proposed and all fiscal adjustments reflect baseline changes associated with caseload and technical adjustments.

Vote Only Calendar:

C. Department of Mental Health

1. Legal Resources Request

Budget Issue. The budget requests an increase of $2.1 million (General Fund) for legal services to be performed by the Attorney General's Office (AG's Office) for DMH regarding health education and welfare work and all new tors and condemnation work.

This budget proposal lacks fiscal detail and justification for the need of the $2.1 million (General Fund) request. This request simply reflects the amount which was denied by the Legislature last year regarding legal work at the DMH.

Background. Historically, the AG's Office has provided legal representation to the DMH for litigation and court appearances. In September 2009, the AG's Office informed the DMH of policy changes that would substantially reduce the amount of legal services provide by the AG's Office to the DMH as a result of reduced resources within the AG's Office.

In spring 2010, the DMH requested 6 new Legal positions for total expenditures of $3.1 million (General Fund). As recommended by the Legislative Analyst's Office (LAO), only $1.2 million (General Fund) was approved, along with Budget Bill Language requiring the AG's Office to provide certain legal representation for the DMH.

DMH states that the funds are needed in 2011-12 since the AG's Office needs resources from the DMH to perform the work.

Legislative Analyst's Office Recommendation—Reject without Prejudice. Similarly to last year, the LAO has questions regarding this proposal and are still awaiting responses from the DMH. The LAO recommends denying this proposal without prejudice.

Subcommittee Staff Recommendation—Deny. The Assembly (Subcommittee #1) took action denying this proposal without prejudice as recommended with the LAO. As such, it is recommended to conform to the Assembly's action. This proposal can be re-evaluated at a later date contingent upon receipt of information by the LAO and their analysis of the proposal.

Issues for Discussion:

A. Office of AIDS, Department of Public Health

AIDS Drug Assistance Program: Two Issues

Overall Budget Issues. ADAP is a subsidy program for low and moderate income persons living with HIV/AIDS who could not otherwise afford them (up to $50,000 annual income). Eligible individuals receive drug therapies through participating local pharmacies under subcontract with the ADAP Pharmacy Benefit Manager (PBM).

There are several intertwined issues regarding AIDS Drug Assistance Program funding for 2011-12. These key issues are as follows:

- 1. Base-line estimate for ADAP; and
- 2. Proposed premium for ADAP clients for a net reduction of $16.8 million.

1. Baseline Estimate for ADAP (Pages 10 through 14)

Comparison of Current-Year & Budget Year. Over 42,000 people living with HIV/AIDS are estimated to receive drug assistance through ADAP in 2011-12, or an increase of 2,700 Clients over the current year.

The budget estimates expenditures of $518.5 million which reflects a *net* increase of $40 million as compared to the revised current year.

The *net* increase of $40 million in program costs is primarily due to **(1)** projected increases in prescription drug costs; **(2)** projected increase of 2,700 clients; and **(3)** updated utilization information. No issues have been raised by the LAO or Subcommittee staff regarding these adjustments.

The budget reflects several fund shifts, as compared to 2010-11, as follows:

- Increase of $92.5 million in General Fund
- Increase of $28.9 million in AIDS Drug Rebate Funds
- Reduction of $76.3 million in Reimbursements (DHCS 1115 Medicaid Waiver)
- Reduction of federal Ryan White CARE Act supplemental funds (one-time)

Table: Governor's Estimated Expenditures for Current Year and Budget Year

Fund Source	Revised Current Year	Proposed Budget Year	Difference
General Fund	$71.4 million	$163.9 million	+$92.5 million
AIDS Drug Rebate Fund	$228.1 million	$257 million	+$28.9 million
Federal Funds—Ryan White	$102.7 million	$97.6 million	-$5.1 million
Reimbursements from Medicaid Waiver	$76.3 million	--	-$76.3 million
Proposed New Premiums (Non-add here for it offsets expenditures)	--	($16.8 million)	($16.8 million)
TOTALS	**$478.5 million**	**$518.5 million**	**$40 million**

Discussion of Funding Sources & General Fund Shifts. Historically, three funding sources have supported ADAP, including General Fund support, the AIDS Drug Rebate Fund and federal Ryan White Care Act Funds. Both the AIDS Drug Rebate Fund and federal funds are used as offsets to General Fund support when applicable. As noted below, there is an annual federal maintenance of effort (MOE) requirement for General Fund support.

At present, the AIDS Drug Rebate Fund reflects a reserve of only $9.6 million, or a 3.7 % reserve margin. This reserve level is considerably below the 5 percent reserve which is normally considered prudent by the DOF. Any update of revenues for this Fund will not be available until the Governor's May Revision.

Through the federal Ryan White CARE Act, California received two supplemental grants (one-time only) in 2010 above the base amount for a total of about $5.1 million. It is likely that California will receive a small supplemental grant for 2011, possibly in the $2 million to $3 million range. The Administration states this would be updated at the Governor's May Revision.

A new resource available to support ADAP is federal funds available from the State's 1115 Medicaid Waiver administered by the Department of Health Care Services. Federal funds are available through this Waiver since General Fund expended within the ADAP can be counted as "State certified public expenditures" (State CPE) and are used to obtain federal funds through the Waiver financing mechanism.

For the current year, a total of $76.3 million (Reimbursements from DHCS—federal funds) was identified in this manner. *However*, the Administration has *not* yet reflected the amount specifically available to ADAP through the Waiver for 2011-12.

Cost Savings from New Pharmacy Benefit Manager Contract-- $4 million. The new recently awarded PBM contract (to Ramsell Holding Company) which will be effective July 1, 2011, contains two administrative changes. These changes pertain to how transaction fees are reimbursed to the PBM.

Due to the timing of the Governor's January budget process and the award of the contract, the savings resulting from these changes are not reflected in the budget.

As such, a reduction of $4 million (General Fund) can be taken to reflect these savings.

Availability of Other Programs. There are *three* public programs in which some individuals with AIDS may choose to enroll. Two of these programs are new, and one needs to be updated to be more effective. All three programs offer considerable cost-savings to the ADAP yet *no projected savings* in the ADAP budget have yet to be estimated for this affect. These include the following programs.

- CARE/HIPP. Federal law authorizes this Health Insurance Premium Payment (HIPP) program under the Ryan White Comprehensive AIDS Resources Emergency Act. This program provides premium payment assistance for eligible people for various insurance policies including: private insurance; COBRA; Cal-COBRA; and others. Eligible individuals are low-income California residents unable to work full time due to HIV-AIDS related health problems that are either receiving or in the process of applying for disability benefits. The income and asset limits are 400 percent of poverty and assets of $6,000. The monthly health insurance premium must be less than $700 per month. The private insurance plan must have prescription coverage as well.

  Current caseload is about 174 cases.

  It should be noted that CARE/HIPP is administered by the DPH and that there is considerable State discretion in modifying the program criteria administratively. Further, the framework of this program has not been updated recently and it needs to be to reflect changes.

  Constituency interests have conveyed to the Administration specific ideas as to how changes could be administratively implemented to update CARE/HIPP and make it more responsive and viable to the people it is intended to serve.

- Pre-Existing Condition Insurance Program (PCIP). As discussed in Subcommittee on January 26th, California received federal approval and an allocation of $761 million (federal funds) to operate a high risk health insurance pool. PCIP offers health coverage to *medically uninsurable* individuals 18 years or older who live in California. It is available for people who did not have health coverage in the 6-months prior to applying. PCIP uses a preferred provider network that has contracted health providers in all 58 counties statewide. Monthly premium costs are based on the applicant's age and the region where the applicant lives. PCIP is to provide health care coverage for eligible individuals through December 31, 2013,

- Low-Income Health Program. Under the recently approved 1115 Medicaid Waiver, administered by the Department of Health Care Services, Counties can access additional federal funds to provide for health care to low-income individuals who previously were not eligible for Medi-Cal. These projects are commencing and it is reasonable to assume some ADAP expenditures will shift to this program on the natural.

Background: 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).

Background: Federal HRSA Maintenance of Effort for Ryan White CARE Act. The federal HRSA requires States to provide expenditures of at least one half of the federal HRSA grant award. For example, California's 2010 HRSA grant award is $134.6 million; therefore, the MOE for 2010-11 is $66.8 million. As noted in the above fiscal chart, a total of $71.4 million in General Fund support was provided to meet this MOE amount.

In addition, California and several other large States negotiate additional supplemental rebates from manufacturers of anti-retroviral drugs through the ADAP Taskforce.

Background—ADAP is Cost-Beneficial to the State. 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 following actions are recommended:

- Reduce by $4 million General Fund to reflect the transaction processing savings. (This reduction is presently not reflected in the Governor's budget.)
- Increase by $3 million federal funds, and reduce by $3 million General Fund, in anticipation of receipt of additional Ryan White CARE Act funds. This adjustment can be modified if necessary at the May Revision.
- Reduce by $70 million (General Fund) and increase by $70 million (federal funds) to reflect ADAP's share of the Safety Net Care Pool Funds made available under the 1115 Medicaid Waiver for this purpose. (A similar action was done in the current-year.)
- Direct the Office of AIDS to work immediately with Stakeholders to recast the CARE/HIPP expand enrollment and potentially shift ADAP expenditures to other payers.

- Director the Office of AIDS to work within the Administration and encourage linkage with the PCIP and Low-Income Health Program to provide more comprehensive care for individuals with HIV/AIDS and to reduce potential expenditures within ADAP.

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

1. Office of AIDS, Please provide a *brief* description of the *baseline* ADAP budget.
2. Office of AIDS, Please comment on the viability of the three programs above and potential enrollment of individuals with HIV/AIDS. What tangible follow-up can be here?
3. Office of AIDS, Please address the CARE/HIPP Program issue—Are changes needed?

2. Significant Monthly Premiums Proposed for ADAP Clients (Pages 15 to 17)

Budget Issue. The budget proposes changes to ADAP's cost-sharing by instituting a monthly premium estimated to generate $19.7 million in revenue from ADAP clients. These revenues are offset by $2.9 million in expenditures for administrative costs associated with the monthly premium.

Therefore, a net reduction of $16.8 million in program expenditures is assumed from this effort. Trailer bill language is required for this action and a July 1, 2011 implementation date is assumed.

The Administration would *significantly* change the existing ADAP client cost-sharing by requiring *all* clients above 100 percent of poverty to pay monthly premiums based upon a percent of gross income. There are four categories of ADAP clients and the cost-sharing reflects differences based on this aspect.

"ADAP-Only" clients (60 percent of program) and "ADAP-Medi-Cal" clients (1 percent of clients) would have the *highest* premium payment.

"Medicare Part D" clients (22 percent of clients) and "Private Insurance" clients (16 percent of clients) would have a *smaller* premium payment. The Administration states these clients generate considerable funding for ADAP as the program is able to collect full drug rebate funds on their prescriptions even though the program is only paying a co-pay for their drugs. In addition, some co-pays for this population are already being paid under their other coverage.

The table below summarizes the share-of-cost assumptions.

Table: Administration's Cost-Sharing Methodology

Annual Income Level	Share Of Cost
100% of poverty and below	None
101% to 200% ($10,831 to $21,660)	5 percent of gross income
201% to 300% ($21,601 to 32,490)	6 percent of gross income for Private Insurance 7 percent of gross income for *all other* ADAP Clients
Over 300% to ADAP maximum ($32,491 to $50,000 maximum)	6 percent of gross income for Private Insurance 10 percent of gross income for all other ADAP Clients

The Administration has provided the two tables below to illustrate the application of their monthly premium proposal on ADAP client categories. As noted,

Table: Comparison for: ADAP-Only Clients & Medi-Cal-ADAP Clients

Income	Poverty Level	Current Total Share of Cost	Current Monthly Cost	Newly Proposed % of Gross Income Share of Cost	Newly Proposed Annual Amount	Newly Proposed Monthly Amount
$30,000	201-300%	$0	$0	7%	$2,100	$175
$40,000	301-400%	$0	$0	10%	$4,000	$333
$50,000	>401%	$4,126	$344	10%	$5,000	$417

Table: Comparison for: Private Insurance ADAP & Medicare ADAP Clients

Income	Poverty Level	Current Total Share of Cost	Current Monthly Cost	Newly Proposed % of Gross Income Share of Cost	Newly Proposed Annual Amount	Newly Proposed Monthly Amount
$30,000	201-300%	$0	$0	6%	$1,800	$150
$40,000	301-400%	$0	$0	6%	$2,400	$200
$50,000	>401%	$4,126	$344	6%	$3,000	$250

The ADAP cost sharing is to generate $19.7 million in revenues with an offset of $2.9 million, or 17 percent of the cost, for administration of the premiums. The $2.9 million figure is an estimate but assumes a processing cost of $10 for each client per month. Presently, there is a $6 processing cost associated with the current cost-sharing.

Background: ADAP Eligibility and Current Cost-Sharing. Eligible individuals receive drug therapies through participating local pharmacies under subcontract with the Pharmacy Benefit Manager (PBM) (Ramsell Holding Company is the State's PBM for ADAP)

Individuals are eligible for ADAP if they:

- Reside in 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.

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 (2011-12)

Coverage Group	Clients	Percent
ADAP-Only coverage	25,387	60.2
Medi-Cal coverage	519	1.2
Private coverage	6,730	16.0
Medicare coverage	9,541	22.6
TOTAL	42,178	100%

ADAP clients with incomes between $43,400 (401 percent of poverty as of April 1, 2010) and $50,000 are charged monthly co-pays for their drug coverage which is established annually at the time of enrollment or recertification.

The current cost-sharing formula is based on twice the client's individual income tax liability, minus any health insurance premiums paid by the individual. The final amount due can vary greatly depending on the client's tax deductions, that are used to reach their final income tax liability (based on tax return). This amount is then split into 12 equal monthly payments which are collected at the Pharmacy at the time the client picks up their medication

The client's payment is then credited and the amount the Pharmacy bills the ADAP Pharmacy Benefits Manager is adjusted to account for this credit.

Subcommittee Staff Comment. The ADAP premium proposal is extreme. The level of premium proposed is substantially beyond the level of income for individuals enrolled in the program. Further, Subcommittee staff believes the federal law cited as a reference for the proposed cost sharing actually pertains to *all* cost sharing arrangements provided under the Ryan White Act, and not just for ADAP clients. The administrative costs of the premium are also quite questionable.

The consequences of people going without treatment would be dire. When individuals are unable to obtain appropriate treatment, drug-resistant strains of HIV can develop. Rates of transmissions could subsequently increase because the viral loads of those individuals not receiving treatment would drop.

ADAP is the payer of last resort and saves funds in the Medi-Cal Program. It literally keeps people alive.

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

1. Office of AIDS, Please provide a brief description of the proposal and how it would operate.
2. Office of AIDS, What may the consequences of this approach be?

B. Department of Mental Health: Community Mental Health

1. Proposition 63 Fund Redirection & Realignment Proposal (Pages 18 to 25)

Overall Budget Issue. The budget calls for a vast realignment of government services. The component applicable to community mental health services consists of *three* core components.

First, it redirects $861.2 million (Mental Health Services Act Funds from Proposition 63) from Counties on a *one-time* basis to backfill for General Fund support in 2011-12 for three specified programs:

(1) Mental Health Managed Care ($183.6 million);

(2) Early and Periodic Screening, Testing and Treatment Program ($579 million); and

(3) AB 3632—mental health services to special education students ($98.6 million).

Second, it realigns these programs to the Counties in 2011-12, and proposes a dedicated revenue source for this purpose (June ballot). These revenues, coupled with matching federal Medicaid funds, would be used to support these programs in future years.

Third, it proposes to generate *additional* revenues for the *1991 Realignment* of programs, including for mental health. In essence, revenues presently generated for the 1991 Realignment have been relatively flat for many years (no growth allocation) while caseload and service needs have grown. As such, the intent is to more equitably allocate additional revenues across the 1991 Realignment accounts.

The Administration states their proposal is a work in progress and they are having considerable discussions with various constituency groups to refine the proposal.

Key aspects of this proposal are discussed below.

Issue: The Mechanics for Proposition 63 Redirection are Important. There are several aspects to this issue.

First, $861.2 million (Mental Health Services Act (MHSA) Funds) would be redirected from local Proposition 63 funds allocated to Counties. It is *undetermined* at this time how the Administration intends to redirect or transfer these funds from which MHSA accounts, and therefore from which local services.

The Administration states their intent is to work with the Counties and other constituency groups to determine which transfer approach will least impact local services. *However*, there will be a considerable affect at the local level from this redirection. Funds for services will be less.

It is critically important to work with the Counties and other constituency groups to ensure appropriate *cash-flow* for local services and to ensure the preservation of core mental health services. Therefore, the fiscal mechanics of this redirection are a key to its success.

Second, trailer bill language is proposed which would amend the Non-Supplantation and Maintenance-of-Effort (MOE) provisions of Proposition 63 to provide for the redirection of the $861.2 million. The Administration intends for this legislation to be a 2/3 vote, and *not* a ballot measure. (In 2009 Proposition 1E which redirected MHSA Act Funds to support General Fund relief was denied by voters.)

They note that since a dedicated revenue source would be forthcoming to support the realigned programs in 2011-12 (June Ballot measure), the $861.2 million redirection would be *one-time* and serve as a transition while the new dedicated revenue source became available. As such, the intent is to not supplant and to provide a more robust revenue source. Details on this trailer bill language are still forthcoming.

Third, a related aspect of the MOE provision in Proposition 63 pertains to State General Fund support. California's MOE as determined by a federal Court ruling is $557.9 million. This was the level of General Fund support provided in 2003-04 when the MHSA Act was approved by voters. Expenditures for Mental Health Managed Care and EPSDT are included within this MOE calculation. Therefore the proposed trailer bill language and financing mechanism will need to address this aspect as well.

Issue: Discussion on Programs to be Realigned to Counties. Three programs are designated to be realigned to the Counties: (1) Mental Health Managed Care; (2) EPSDT; and (3) AB 3632.

All three of these programs are federally mandated. Mental Health Managed Care and EPSDT are Medicaid programs (Medi-Cal in CA). These two programs are presently funded using State General Fund support, County Realignment Funds (from 1991 changes), and to a limited degree, local MHSA Funds. These various fund sources are used to obtain federal matching Medicaid funds.

Both of these programs operate under a designated federal Medicaid Waiver for the provision of specialty mental health services in California. The federal CMS provides guidance, direction and requirements as federal law, regulation and direction warrant.

In general, federal law requires Medi-Cal services to be provided state-wide with any eligible individual receiving comparable services. Medi-Cal enrollees are entitled to services. These aspects are not normally waived by the federal CMS.

The Department of Health Care Services (DHCS) is California's designated Medicaid entity and serves as the conduit with the federal CMS on all Medicaid issues. All financial agreements and service delivery requirements, including reimbursement

methodologies, audit and settlement requirements, provisions of services, and beneficiary protections, are all negotiated between the federal CMS and DHCS.

Therefore, if Mental Health Managed Care and EPSD are realigned to the Counties, considerations and discussions are needed on how the State and Counties will manage responsibilities for various federal requirements. A key aspect of this discussion will be financial risk arrangements. It should be noted that presently, State statute (from 1994) provides for Counties (individually) to return the Mental Health Managed Care Program to the State. Though a few Counties have discussed this aspect, none have actually done so.

In addition, policies would need to be developed over the next several years regarding transitions which pertain to (1) California's 1115 Medicaid Waiver recently approved by the federal CMS in November 2010; and (2) the federal Affordable Care Act of 2010 and the expansion of Medicaid. These issues require discussion but can be addressed at a later time.

Further, a nuisance to the EPSDT Program is a cost settlement process in which actual expenditures are settled (closed-out) from prior years. In the past, the Department of Mental Health has requested increased General Fund support for this purpose at the May Revision. Amounts have varied over the years but have been in the tens of millions range. The DMH states that 2008-09 cost settlements will be forthcoming at the upcoming May Revision. Cost settlements for other prior years (2009 and 2010) would still need to be resolved.

Under AB 3632, Counties provide mental health services to special education pupils. This too is a federally mandated program through special education (federal IDEA of 1976) which guarantees disabled children the right to a free appropriate public education, including necessary services for a child to benefit from their education. In 1984 (AB 3632, Brown) the Legislature generally assigned County Mental Health Departments the responsibility for providing mental health services since schools generally were not. This was determined to be a State reimbursable mandate to Counties.

Funding for AB 3632 has been a patchwork provided through State reimbursable mandate, some General Fund support, and a portion of federal special education funds (from 2004 forward). State reimbursable mandate funds have *not* kept pace with expenditures and the past Administration vetoed $133 million (General Fund) related to prior-year mandate claims. This has resulted in multiple lawsuits and has created uncertainty over the responsibility for providing these required and medically necessary mental health services. The federal mandate is on the schools, yet State law directs services to be a State reimbursable mandate to the Counties.

Both the Legislative Analyst's Office (LAO) and mental health constituency groups have raised concerns as to whether AB 3632 should be realigned to the Counties. The LAO articulates the following specific concerns:

- *Misaligns Responsibility.* The LAO contends K-12 schools should be responsible for this federal education mandate and they know of no other State that outsources a federal education mandate to non-education entity. A restructuring is warranted to have services linked more closely with education outcomes. Federal law requires that schools ensure students receive necessary services.
- *Inappropriate Use of Proposition 63 Funds.* State mandate reimbursements must be general purpose funds that Counties can use for any activity (Proposition 4 of 1979). Proposition 63 funds must be used for mental health services.
- *Outstanding Amount Owed to Counties.* The LAO estimates that due to pending AB 3632 claims from prior years that at least $260 million will be needed to keep the State mandate active (due to veto and related aspects) in 2011-12.

Some constituency groups have echoed similar concerns to those raised by the LAO. In addition, Counties contend that it makes no sense to redirect $98.6 million from local Proposition 63 funds for a State reimbursable mandate since that would mean the Counties are reimbursing themselves.

Issue: Interaction of 1991 Realignment Revenues. The Administration states that the 1991 Realignment for mental health generates about $1.1 billion (Sales Tax and Vehicle License Fee). Under this realignment proposal, growth revenues obtained through the June Ballot taxation extension would provide for a more stable, dedicated revenue stream. The actual allocation of these revenues awaits later clarification.

Issue: State Administration Cap of 5% and Need for Local Flexibility in MHSA. The MHSA allows for up to *5 percent of total annual revenues* to be expended on State support, including the Mental Health Services Oversight and Accountability Commission (OAC), Department of Mental Health, Mental Health Planning Council and many other State entities.

According to the DMH, the budget proposes total State Administrative expenditures of $49.7 million. The DMH notes however that based on *updated* MHSA Fund revenues, the existing budget for 2011-12 would *exceed the 5 percent cap by $11.5 million*. They contend that the May Revision will provide an update and probably propose an adjustment.

It should be noted that the DMH State Administration expenditures alone are $34.6 million (MHSA Fund) for 2011-12, or almost 70 percent of the total State Cap. These funds support over 147 positions, along with various contract funds.

Over the past several years, concerns have been raised by the LAO, constituency groups and the Office of State Evaluations and Oversight (OSAE) regarding the intensive oversight and regulatory structure the State has implemented regarding the allocation of MHSA Funds to Counties for local expenditures.

In light of the Governor's Realignment proposal, and the need to reduce regulations and provide for services closer to the people, Subcommittee staff recommends to lower the State Administrative Cap from the existing 5 percent to 3.5 percent. The lowering of this cap will provide for more MHSA Funds to go to local communities. In future years, this percentage could conceivably be lowered further.

The Administration can work expediently with Counties and other constituency groups to determine how the current MHSA regulatory structure can be streamlined to facilitate flexibility at the local level and to improve cash-flow for mental health program services. These conversations should be occurring in light of the Governor's proposal.

The level of administrative support within the DMH will need to be considerably reduced on the natural, due to the State Cap of 5 percent being over committed by $11.5 million for 2011-12. Other State departments which utilize MHSA Funds will also be considerably impacted, partially due to the over-commitment of funds at this time, as well as this suggestion to lower the cap to 3.5 percent.

Subcommittee staff would recommend for the valuable MHSA Oversight Commission (22 staff at $4.5 million MHSA) to be held harmless from any reduction at this time.

Background: Proposition 63, Statutes of 2004 (Mental Health Services Act). 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.

The MHSA allows for up to *5 percent of total annual revenues* to be expended on State support, including the Mental Health Services Oversight and Accountability Commission (OAC), Department of Mental Health, Mental Health Planning Council and many other State entities.

Background: Mental Health Managed Care (Adults) and Existing Waiver. California provides "specialty" mental health services under a comprehensive federal Waiver that includes outpatient specialty mental health services, such as clinic outpatient services, 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. County Mental Health Plans contract with local providers to provide services.

California's Waiver for this program and for EPSDT (one Waiver) is set to expire as of June 30, 2011. This Waiver provides about $2 billion in funding. The DHCS is presently working for a renewal of this Waiver.

This program is funded using a combination of predominately County Realignment Funds, some General Fund support, and federal matching funds (50 percent and is drawn from the Counties and the State's contribution). State General Fund support for Mental Health Managed Care has been reduced considerably over the past years from about $226 million (General Fund) in 2008 to only $131 million in 2010.

The budget for 2011-12 proposes State support of $183.6 million (to be funded with the Proposition 63 redirection). Most of this increase is due to the loss of enhanced federal ARRA funds which sunset as of June 30, 2011, and an increase in the number of Medi-Cal enrollees.

Background: Early and Periodic Screening, Testing & Treatment (Children). Most children receive Medi-Cal services through EPSDT. Specifically, EPSDT is a federally mandated program that requires States to provide Medicaid (Medi-Cal) recipients under age 21 any health or mental health services 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 plan. Examples of mental health services include a family therapy, crisis intervention, medication monitoring, and behavioral management modeling.

California has expanded the EPSDT Program at the direction of the courts due to litigation regarding access to services, and provision of services. Cost containment measures have been enacted in the past several years to reduce expenditures while maintaining services.

EPSDT is presently funded with State General Fund, federal funds (50 percent), and a portion of County Realignment Funds, along with voluntary use of local Proposition 63 Funds.

The budget for 2011-12 proposes total expenditures of $1.3 billion. Of this total amount, $579 million is proposed from the Proposition 63 redirection, $146.8 million is County Funds (County Realignment and Proposition 63 Funds), and $730.7 million is federal reimbursement.

Background: 1991 Realignment – Mental Health Services. Among other things, the Bronzan-McCorquodale Act realigned certain mental health services to the Counties. The Mental Health Subaccount receives revenues originating from Sales Tax and Vehicle Licensure Fees. About $1.1 billion (continuous appropriation) is presently available for the following services:

- *Community-Based Mental Health Services.* Counties are the provider of mental health services for County Patient with serious mental illness not eligible for Medi-Cal, as well as for Medi-Cal enrollees who require specialty mental health services.
- *State Hospital Services for County Patients.* Counties contract with the Department of Mental Health for State Hospital beds for County Patients who are civilly committed. At present, only 375 beds at the State Hospitals are designated for this purpose. (Due to the development of community-based services.)
- *Institutions for Mental Disease (IMDs).* The IMDs, administered by independent contractors, generally provide short-term nursing level care to seriously mentally ill.

Subcommittee Staff Comment and Recommendation. The Administration's Realignment proposal and shift of Proposition 63 Funds has merit and considerable work is continuing with various constituency groups to provide more detail as discussed under each of the issue sections above.

It is recommended to keep the local assistance component of this proposal "open" and to request the Administration to provide the Subcommittee with additional information as it becomes available.

With respect to the State Administrative Cap, it is recommended to adopt placeholder trailer bill language to reduce the 5 percent to a maximum of 3.5 percent. A 3.5 percent cap would provide a total of $26.7 million (MHSA Funds) for 2011-12 based on existing revenues. It is recommended for the MHSA Oversight Committee to be held harmless from this reduction.

Further detail will be needed from the Administration on their suggestions for possibly prioritizing the $26.7 million at the 3.5 percent State cap level.

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

1. Administration, Please provide an overview of the Proposition 63 redirection and Realignment proposal.
2. Administration, Please provide an update regarding constituency discussions.
3. Administration, What key next steps are being considered?

2. Early and Period Screening, Testing and Treatment: Proposed Trailer Bill

Budget Issue. The Administration is proposing trailer bill legislation to permanently establish the Performance Improvement Projects (PIPs) established as a cost containment measure within the EPSDT Program. The Administration assumes a reduction of $12.1 million (General Fund) from this action.

The Administration's language also provides other "clean-up" to the original language by broadening the PIP projects and requiring different data reporting requirements.

PIPs were established through trailer bill legislation enacted in 2008 as a cost containment measure. The PIPs were established in lieu of more drastic proposals which would have significantly limited active Day Treatment programs and related services for children with serious emotional disturbances.

Subcommittee Staff Comment--Modify. It is recommended to adopt placeholder trailer bill language to extend the sunset for three years and to leave the other changes proposed by the Administration for a later discussion. A sunset extension will enable constituency groups to provide additional perspective regarding the outcomes of these projects and to subsequently make changes at a later date.

(It should be noted that the assumed reduction from this proposal is contained within the EPSDT estimate. Therefore, this cost containment is assumed within the numbers provided regarding the Proposition 63 transfer and realignment proposal discussed above.)

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

1. DMH, Please provide a brief description of the proposal and the intent of the trailer bill legislation.
2. DMH, How have the EPSDT PIP's been working?

C. Department of Mental Health: State Hospitals

Background and Description of State Hospital Patient Population. 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.

A total patient caseload of 6,342 patients is assumed for 2011-2012. This includes 5,558 patients at the State Hospitals and 766 patients at the two acute psychiatric programs. Of the total patient caseload, only 471 patients are civil commitments.

Patients admitted to State Hospitals are generally either **(1)** civil commitments; or **(2)** judicial commitments. These referrals come from County Mental Health departments, the courts, and the CA Department of Corrections and Rehabilitation (CDCR).

The patient population served by State Hospitals has evolved substantially from the early 1990's, when most of the patient population was civil commitments to the present where over 92 percent are penal-code related patients.

As structured through the State-Local Realignment statutes of 1991/92, County Mental Health Plans contract for State Hospital beds for civil commitments when applicable. 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.

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.

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 $1.220 billion ($1.140 billion General Fund) for 2010-11. *This represents an increase of about $516 million in General Fund support, or an 83 percent General Fund increase in only six-years.*

The DMH contends these increased expenditures are attributable to: **(1)** compliance with 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.

1. Proposed Budget Year Adjustments for Long-Term Care (Pages 29 to 30)

Budget Issue. The budget proposes total expenditures of almost $1.285 billion ($1.160 million General Fund), excluding lease revenue bonds, which reflects *a net decrease* of $25.8 million (decrease of $25.7 million General Fund) as compared to the current-year. The patient population is estimated to be a total of 6,342 patients with 5,558 patients residing in the State Hospitals and 766 inmate patients at the Acute Psychiatric Program (Vacaville and Salinas).

The following *key adjustments* from the current-year to the budget are as follows:

- Baseline Reductions from 2010-11 are Continued in 2011-12. Two baseline adjustments are reflected in the *revised* current-year for the State Hospitals and are carried into the budget year as baseline reductions.

  First, a reduction of $58 million ($55.3 million General Fund) was done through Control Section 3.90 which was a "workforce cap" allocation made by the Department of Finance. It reflects a 5.5 percent reduction. To manage this reduction, the State Hospitals increased their salary savings rate to 11.8 percent by holding some positions vacant.

  Second, another baseline reduction of $19 million (General Fund) was done through Control Section 3.91 regarding State employee contracts and administrative actions.

- *California Medical Facility at Vacaville—Expansion of Psychiatric Program.* An increase of $7.5 million (General Fund) is requested to support 80 new positions (76.2 personnel years) to increase the capacity of the Vacaville Psychiatric Program (Vacaville).

  Of the 80 positions, 53 positions are Level-of-Care and 27are Non-Level-of-Care. The Level-of-Care positions include Clinical staff, such as Staff Psychiatrists and Rehabilitation Therapists, as well as Registered Nurses. The Non-Level-of-Care includes Custodians, Office Technicians, Cooks, Accounting Personnel, and others.

  The DMH is requesting to increase the capacity at Vacaville in order to accelerate the activation schedule for 64 beds in the Intermediate Treatment Program as desired by the Coleman Court.

  In 2010-11, the DMH received all of their requested positions (30 staff) to begin Phase I activation. DMH contends that an accelerated activation is now necessary and an additional 80.3 positions are needed to meet the September 2011 schedule.

Background—Coleman Court Requires More Mental Health Beds. Pursuant to Coleman v. Schwarzenegger an order was issued in October 2004 pertaining to the unidentified needs of CDCR Mental Health Program Inpatient Services. The Coleman Special Master directed the Administration to submit short-term and long-term plans to address the mental health bed capacity need. One aspect of the CDCR plan is to have additional mental health beds at Vacaville.

According to the DMH, Vacaville has a total of 218 Inpatient Beds in the Acute Psychiatric Program and 114 beds in an Intermediate Treatment Program. *However,* an additional 64 beds for high custody Intermediate Treatment Program are to be constructed and activated by no later than September 2011.

The additional 64-beds are to be constructed on VDVR property adjacent to the CA Medical Facility in Vacaville. The construction of these beds is to be completed by September 2011. By adding these beds, CDCR will partially achieve the Court's directed increased in bed capacity and avoid a possible order by the federal Court.

Subcommittee Staff Comment and Recommendation. It is recommended to approve the proposal.

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

1. DMH, Please provide a brief summary of the *each* of the key budget adjustments as referenced above.
2. DMH, Will a May Revision update be forthcoming regarding the State Hospitals?

2. Update on Hospital Security at State Hospitals

Oversight Issue. Due to a number of assaults on State Hospital staff and patients, including a fatality, the State Hospitals have been analyzing risk management data to better understand and address the significant increase in violence and examine the changing demographic of its patient population.

At this time, the State Hospitals are in the process of identifying and prioritizing resources that would further enhance the safety and security of all individuals and staff.

DMH states some actions have already been taken to improve security and safety, including some of the following:

- Construction and installation of temporary observation kiosks inside the S-Unit Courtyard and inner T-Circle at Napa State Hospital (completed January 15, 2011).
- Removal of certain patio walls in program areas where individuals can be easily hidden from sight (Napa State Hospital).
- Tree trimming and excessive ground cover removal to improve line-of sight and remove opportunities where individuals can be hidden.
- Established grounds presence teams that can heighten supervision and security of the grounds. Additional, these teams can also be available to conduct hospital wide searches.
- Implemented various policy changes and issued directives regarding patient risk assessment tool, new supervision requirements, various employee trainings and other measures.

In addition, DMH anticipates their process will also involve discussion and action in the following areas:

- *Electronic Key Control Boards*. This particular system would enable the facility to institute measures to better manage and control access to the secure areas of a facility.
- *Personal Alarm System.* Replace older alarm systems with newer personal alarms.
- *Fence Alarm System.* Identify and replace outdated alarms and shakers.
- *Install Additional Video Monitoring Equipment.* Identifying the need for a campus wide integrated system to be installed that offers pan, tilt and zoom capabilities, throughout State Hospital grounds.

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

1. DMH, Please provide an update as to key actions which have been taken-to-date and security and safety measures being contemplated.

3. Capital Outlay for the State Hospitals

Budget Issue. The DMH has two capital outlay requests regarding fire alarms and fire sprinklers at Napa State Hospital and Metropolitan State Hospital. These are as follows:

- Fire Alarm at Napa State Hospital. DMH requests an increase of $2.2 million (General Fund) to replace the existing fire alarm systems in several buildings at Napa. This request is for preliminary plans and working drawing phases only. Construction will be funded through a future budget request.

  DMH states that all of the fire alarms in the State Hospitals are in need of upgrades. Napa is designated to be the first one since it is experiencing the greatest number of problems and failures.

- Fire Sprinklers at Napa and Metropolitan State Hospitals. DMH requests an increase of $2.1 million (General Fund) to install fire sprinklers in the skilled nursing facilities within Napa and Metropolitan State Hospitals in order to comply with new federal regulations.

  The federal CMS issued new regulations that require Long-Term Care facilities to be equipped with sprinkler systems by August 13, 2013. These fire sprinkler installations will require review and approval by the Office of Statewide Health Planning (OSHPD).

Subcommittee Staff Comment and Recommendation. The Assembly (Subcommittee #1) has approved these two capital outlay requests. The LAO is recommending to deny without prejudice" these proposals due to questions regarding the cost of contingencies that appear to be built into these proposals. The LAO is awaiting responses to these questions from the DMH.

It is recommended to presently approve these requests due to the evident fire, life, safety concerns of these proposals. However, the DMH needs to respond promptly to the LAO requests. Further, if the LAO has recommendations at a later date, this issue can be reopened for discussion.

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

1. DMH, Please provide a brief summary of the two capital outlay proposals and why they are necessary this year.
2. DMH, If these proposals are not funded, what are the implications please?

D. Department of Mental Health: Sex Offender Evaluations

1. Evaluations for Sex Offender Commitment Program (Pages 33 to 35)

Budget Issue. DMH proposes an increase of $6.7 million (General Fund) for conducting evaluations of potential Sexually Violent Predators (SVPs) as referred to them by the CA Department of Corrections and Rehabilitation (CDCR).

The requested *increase is 60 percent more* than the existing appropriation amount of $11.3 million (General Fund) for the current year.

DMH contends that recent policy changes at the CDCR will increase the number of referrals for evaluations. Specifically, the DMH bases the $6.7 million (General Fund) request on the following assumptions:

- An estimated 3,900 *additional* referrals from CDCR to DMH for 2011-12
- 3,900 referrals x $125 per initial clinical screening = $487,500
- Assume 20 percent of the 3,900 referrals, or 780 people, will require an evaluation at $4,000 per evaluation = $3.120 million
- Two Independent Evaluations are required so it is a total of $6.240 million
- Total estimate is the initial clinical screening and the evaluations = $6.7 million (GF)

DMH states the estimated 3,900 increase in additional referrals is based upon policy changes at the CDCR which may increase the number of parole violators returned to custody and then re-referred to the DMH for the SVP evaluations. These CDCR policy changes include the following:

- Active GPS monitoring of sex offenders;
- Lifetime parole for all sex offenders; and
- Increased sex offender monitoring in communities.

As such DMH states that more referrals will occur.

Background-- DMH Responsibilities. When the DMH receives a referral from the CA Department of Corrections and Rehabilitation (CDCR), the DMH is responsible for the following key functions:

- *Screening*. The DMH screens referred cases to determine whether they meet legal criteria pertaining to SVPs to warrant clinical 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 pursue 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—Sexually Violent Predator Act. Enacted in 1995 (AB 888, Rogan), this act created a new civil commitment for "Sexually Violent Predators" (SVPs). The DMH is responsible for the implementation and administration of the SVP Program. This program is impacted by change which has occurred in the form of amended statutes, court decisions, changes in the methods of risk prediction and increased expectations for contract evaluators to be better prepared to conduct evaluations and provide court testimony.

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 registering as a sex offender is subject to assessment using the State-Authorized Risk Assessment Tool for Sex Offenders (SARATSO), a tool for predicting the risk of sex offender recidivism.

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

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to provide an increase of $2.8 million (General Fund), in lieu of the DMH request of $6.7 million (General Fund). The $2.8 million provides for a 25 percent increase for 2011-12.

The DMH has not provided sufficient detail as to how the volume of anticipated evaluations was determined. Only one month—July 2010—was cited as having a high volume of evaluation requests. Projecting a high volume based on one month's of experience does not provide adequate validity to an estimate. Further, the DMH needs to better address contract costs in this area through exploration of other cost-containment measures. There is a history of wide variance in projecting costs for this program.

It should be noted that the LAO recommended to "deny without prejudice" this proposal since the DMH has not yet fully responded to information requests.

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

1. DMH, Please provide a brief summary of the proposal.
2. DHM, What is being done to ensure a competitive bid process with contracts and what other cost-containment may be feasible here?

E. Department of Public Health: Various Programs

1. Every Woman Counts (EWC) Program (Pages 35 to 37)

Budget Issue. The budget proposes total expenditures of $65 million ($27.8 million General Fund, $22.1 million Cigarette and Tobacco Product Surtax Funds, $10.7 million Breast Cancer Control Account, and $4.4 million federal funds) to serve about 393,000 clients for 2011-12.

This reflects a net increase of $22.3 million ($18.4 million General Fund) and 138,000 clients as compared to the revised current year. Most of this increase -- $11.7 million ($7.7 million General Fund)—results from the increased caseload.

The budget proposes a re-appropriation of $10.6 million (General Fund) from the current year to 2011-12 as a result of a five-month delay by the DPH in implementing certain program reforms adopted in the Budget Act of 2010.

The table below provides a summary of these estimated expenditures for 2011-12.

Every Woman Counts -- Category	Estimated Total Expenditures
Office visits and consultations	$14.7 million
Screening Mammograms	$19.4 million
Diagnostic Mammograms	$5.9 million
Diagnostic Breast Procedures	$7.4 million
Case Management	$15.4 million
Other Clinical Services	$8.6 million
Subtotal of Service Categories	**$71.5 million**
Cost Containment on Services (Budget Act of 2010)	
• Tiered Case Management ($50 and $0)	-$9.2 million
• Radiology Rate Adjustment	-$840,000
Total Services Categories	**$61.5 million**
Local Assistance Contracts	**$3.5 million**
TOTAL Expenditures	**$65 million**

Background. The EWC program, administered through the DPH, provides breast and cervical cancer screening services to low-income individuals. Generally, to be eligible for services, a person must have no health care coverage, have a family income below 200 percent of the federal poverty level, and be 40 years of age or older.

Under EWC, breast cancer screening includes clinical breast exams, mammograms, and diagnostic work ups. It also provides cervical cancer screening and diagnostic services to women aged 25 and over who meet similar eligibility criteria.

Cancer treatment is not covered by this program. If a cancerous condition is found, treatment services are available through Medi-Cal, or other referrals are made.

Previous Management Concerns. Through 2009 and 2010 budget deliberations, various program management and operations issues were identified within the EWC Program. The following entities conducted various reviews of the program: (1) Bureau of State Audits; (2) Office of Statewide Evaluations and Audits (OSAE) within the Department of Finance; and the Legislative Analyst's Office (LAO).

Various issues were discussed through the budget process and the DPH implemented some improvements. It is unknown at this time if the DPH intends to implement additional management measures in 2011.

Subcommittee Staff Comment and Recommendation-- Approve. The DPH should provide an update on changes instituted to improve program management and operations since last year.

It is recommended to approve the estimate for this important program.

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

1. DPH, Please provide an update on *key* changes to the EWC that have occurred during 2010 to make the program more efficient and cost-effective.
2. DPH, Please provide a brief summary of the budget proposal.

2. Women, Infant, Children's Supplemental Food (Pages 38 to 39)

Budget Issue--Local Assistance Funding. The budget proposes total expenditures of $1.448 billion($1.220 billion federal funds and $227.7 million Manufacturer Rebate Funds) for WIC local assistance which reflects an increase of $132.8 million (federal funds) for 2011-12.

DPH states that about 1,520,500 WIC participants will access food vouchers in 2011-12. An estimated $62.43 is the monthly average participate cost for food.

Of the total federal grant amount, $919.8 million is for Base Food and $300.9 million is for Nutrition Services and Administration. The $227.7 million in Manufacturer Rebate Funds are continuous appropriated and must be expended on food.

Background on WIC Funding. DPH states that California's share of the national federal grant appropriation has remained at about 17 percent over the past 5 years. Federal funds are granted to each State using a formula specified in federal regulation to distribute the following:

- **Food**. Funds for food that reimburses WIC authorized grocers for foods purchased by WIC participants. The USDA requires that 75 percent of the grant must be spent on food. WIC food funds include local Farmer's Market products.
- **Nutrition Services and Administration.** Funds for Nutrition Services and Administration (NSA) Funds that reimburse Local WIC Agencies for direct services provided to WIC families, including intake, eligibility determination, benefit prescription, nutrition, education, breastfeeding support and referrals to health and social services, as well as support costs.

  States are to manage the grant, provide client services and nutrition education, and promote and support breastfeeding with NSA Funds. Performance targets are to be met or the federal USDA can reduce funds.

- **WIC Manufacturer Rebate Fund.** Federal law requires States to have manufacturer rebate contracts with Infant Formula providers. These rebates are deposited in this special fund and must be expended prior to drawing down Federal WIC food funds.

Background on WIC Program. WIC is 100 percent federal fund supported. It provides supplemental food and nutrition to low-income women (185 percent of poverty or below) who are pregnant and/or breastfeeding, and for children under age five who are at nutritional risk. WIC is not an entitlement program and must operate within the annual grant awarded by the USDA.

WIC participants are issued paper vouchers by Local WIC Agencies to purchase approved foods at authorized stores. Examples of foods are milk, cheese, iron-fortified cereals, juice, eggs, beans/peanut butter and iron-fortified infant formula.

The goal of WIC is to decrease the risk of poor birth outcomes and improve the health of participants during critical times of growth and development. The amount and type of food WIC provides are designed to meet the participant's enhanced dietary needs for specific nutrients during short but critical periods of physiological development.

WIC participants receive services for an average of two years, during which they receive individual nutrition counseling, breastfeeding support and referrals to needed health and other social services. From a public health perspective, WIC is widely acknowledged s being cost-effective in decreasing the risk of poor birth outcomes and improving the health of participants during critical times of growth and development.

Subcommittee Staff Comment and Recommendation. It is recommended to approve their budget as proposed. No issues have been raised by the LAO or Subcommittee staff.

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

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

3. Women, Infant, Children's Supplemental Food Program—State Support

Budget Issue. The DPH requests an increase of $2.3 million (federal funds) to support 20 positions to support vendor management, expand WIC's Breastfeeding Peer Counseling Program; and to improve administration and financial reporting.

The DPH states the positions are needed to do the following key activities:

- Manage the increased activities associated with growth in WIC Vendors and complexity in monitoring and providing assistance to WIC Vendors in order to comply with new federal requirements;
- Expand WIC's Breastfeeding Peer Counseling Program;
- Maintain compliance with federal and State financial requirements and ensure accountability and transparency for federal funds; and
- Provide administrative (personnel and accounting) support to accommodate the requested positions.

DPH notes that recent federal requirements to update the Food benefits require changes in program policies and operations and training for local WIC Vendors, WIC Agencies and participants. In addition, new federal and State regulations mandate that all new WIC Vendor applications must be reviewed and processed within 90-days which has added considerable workload.

The requested 20 positions are as follows:

- Nutrition Consultant, Supervisor 1
- Nutrition Consultant II 2
- Staff Services Manager I 1
- Research Program Specialist 2
- Associate Governmental Program Analyst's 10
- Senior Accounting Officer 1
- Associate Accounting Analyst 1
- Associate Personnel Analyst 2

The requested positions are to be organized to focus on the following specific functions:

- 8 positions for WIC Vendor authorization, consultation and monitoring;
- 7 positions for Breastfeeding Peer Counseling Program;
- 2 positions for maintaining compliance with State and federal requirements; and
- 3 positions for administrative support in personnel and accounting.

Subcommittee Staff Comment and Recommendation. No issues have been raised by the LAO or Subcommittee staff. There are no General Fund implications.

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

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

4. Maternal, Infant and Early Childhood Home Visiting Program

Budget Issue. The budget requests an increase of $14.3 million (federal funds) to implement a new Maternal, Infant and Early Childhood Home Visiting (Home Visit) Program as directed in the federal Affordable Care Act of 2010.

Of the total amount, $10.2 million (federal funds) is for local assistance, and $4.1 million is for State support including 36 positions.

The local assistance funds of $10.2 million are to be allocated to Local Health Jurisdictions for implementation and administration of the Home Visiting Program. DPH states these funds will be used to the following activities:

- Hire and train local professional and paraprofessional staff;
- Provide local Home Visiting services to eligible families;
- Coordinate referrals for eligible families with other community services;
- Conduct program communication and coordination with local partners; and
- Conduct program administration and evaluation.

The DPH states the 36 positions (five-year limited-term) will administer a complex State-based Home Visiting Program and will need to do the following:

- Provide program management and evaluation;
- Develop and implement fiscal reporting, compliance policies and procedures; and
- Ensure grant requirements and program objects are fulfilled.

Background. The Affordable Care Act established a home visiting grant program for States to administer and provided federal grant funds for this purpose. DPH states the initial grant award is available for 27 months and the subsequent grant awards will be available for 24 months. These grant funds cannot be used to supplant any existing funding.

Federal guidelines require services that:

- Promote improvements in maternal and prenatal health, infant health, child health and development;
- Facilitate child development outcomes, school readiness, and the socioeconomic status of eligible families; and
- Reduce child abuse, neglect and injuries.

Subcommittee Staff Comment and Recommendation. No issues have been raised by the LAO or Subcommittee staff. There is no General Fund impact.

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

1. DPH, Please provide a brief summary of the budget request, including how the funds will be allocated to the Local Health Jurisdictions.

5. Performance Management and Public Health Infrastructure

Budget Issue. The budget proposes an increase of $2.1 million (federal funds) to support 15 positions (five-year limited-term) and to provide for a contract with a facilitator to establish a Performance Management Office. No State match is required.

The purpose of this new Office is to support the development of performance management components on a department-wide basis. Specific activities would include:

- Assessing and improving State and local public health information systems, policies and workforce skills to meet federal initiatives;
- Improve business practices and processes;
- Incorporate performance metrics into programs and enhance and improve the quality and efficiency of DPH programs;
- Facilitate cross-departmental coordination of other performance management activities;
- Facilitate the development of task flow analysis tools for program performance;
- Measure, monitor and report regularly to the federal Centers for Disease Control (CDC) the results of various activities with Local Health Jurisdictions.

The requested 15 positions are as follows:

- Research Scientists –Epidemiologists 3
- Health Program Specialists 7
- Associate Information Technology Specialist 1
- Associate Analysts 2
- Support Staff 2

In addition, a total of $150,000 (federal funds) is designated for a facilitator contract.

These federal grant funds were provided to California from the federal CDC and are intended for public health infrastructure to assess and improve the capacity of public health programs.

Subcommittee Staff Comment and Recommendation. No issues have been raised by the LAO or Subcommittee staff. There is no General Fund impact.

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

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

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Tuesday, February 1 (Room 4203) 1:00 PM

VOTE ONLY CALENDAR

- **A. Department of Public Health "vote only" are Pages 2 through 6.**
- **Action.** Approve as proposed.
- **Vote:** 3-0 for Items 1,4,5,7. **Vote:** 2-1 for Items 2,3,6,8.

- **B. Department of Health Care Services "vote only" are Pages 7 through 8.**
- **Action.** Approve as proposed.
- **Vote:** 3-0

- **C. Department of Mental Health "vote only" on Page 9.**
- **Action.** Deny.
- **Vote:** 3-0

ISSUES FOR DISCUSSION (Starts on Page 10)

A. Office of AIDS, Department of Public Health

AIDS Drug Assistance Program: Two Issues

1. Baseline Estimate for ADAP (Pages 10 through 14)

- **Action. (1)** Reduce by $4 million General Fund to reflect savings from the new PBM contract; **(2)** Increase by $3 million federal funds by assuming an increase in Ryan White Funds *and* reduce General Fund by the same amount; and **(3)** Shift $70 million (federal funds) from the Safety Net Care Pool to ADAP and reduce General Fund by the same amount.
- **Vote:** 3-0

Chair also strongly urged the Office of AIDS to work with constituency groups to proceed with changes to CARE/HIPP and to see how we can encourage enrollment of ADAP individuals and others into some of these full-coverage health plan programs as referenced to help them with their medical needs.

2. Significant Monthly Premiums Proposed for ADAP Clients (Pages 15 to 17)

- **Action.** Rejected proposal.
- **Vote:** 2-1 (Senator Emmerson)

B. Department of Mental Health: Community Mental Health

1. Proposition 63 Fund Redirection & Realignment Proposal (Pages 18 to 25)

- **Action.** Adopted placeholder trailer bill language to *lower* the Cap from 5 percent to 3.5 percent, and to leave the Oversight Commission harmless from reduction.
- **Vote:** 3-0

  Left **"open"** the Local Realignment and redirection of Proposition 63.

2. Early and Period Screening, Testing and Treatment: Trailer Bill (Page 26)

- Left Open since the need for language did not make sense.

C. Department of Mental Health: State Hospitals (Page 29)

1. Proposed Budget Year Adjustments for Long-Term Care (Pages 29 to 30)

- **Action.** Approved.
- **Vote:** 2-1 (Senator Emmerson)

2. Update on Hospital Security at State Hospitals (Pages 31)

- No action necessary.

3. Capital Outlay for the State Hospitals (Pages 32)

- **Action.** Approved.
- **Vote:** 3-0

D. Department of Mental Health: Sex Offender Evaluations

1. Evaluations for Sex Offender Commitment Program (Pages 33 to 35)

- **Action.** Increased by $2.8 million (General Fund), *in lieu* of the DMH request of $6.7 million. The $2.8 million provides for a 25 percent increase.
- **Vote:** 3-0

E. Department of Public Health: Various Programs

1. Every Woman Counts (EWC) Program (Pages 36 to 37)

- **Action.** Approved.
- **Vote:** 2-0 (Senator Emmerson abstained)

2. Women, Infant, Children's Supplemental Food (Pages 38 to 39)

- **Action.** Approved.
- **Vote:** 3-0

3. Women, Infant, Children's Supplemental Food—State Support (Page 40)

- **Action.** Approved.
- **Vote:** 3-0

4. Maternal, Infant and Early Childhood Home Visiting Program (Page 41)

- **Action.** Approved.
- **Vote:** 3-0

5. Performance Management and Public Health Infrastructure (Page 42)

- **Action.** Approved.
- **Vote:** 3-0

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

February 3, 2011

9:30 AM or
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

Staff: Agnes Lee (OSHPD, CDA, DOR)
Jennifer Troia (DSS)

Item	Department
4140	Office of Statewide Health Planning & Development (OSHPD)
4170	Department of Aging (CDA)
5160	Department of Rehabilitation (DOR)
5180	Department of Social Services (DSS)

PLEASE NOTE:

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

Issues will be discussed 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 at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible. Thank you.

Agenda

(Vote-Only Items indicated by *)

Item Department Page

Vote-Only Agenda

5160 Department of Rehabilitation (DOR)

DOR Issue 1: Electronic Records System (ERS)

Budget Issue: DOR requests, in a budget change proposal, an increase of $1.3 million in federal fund authority in 2011-12 to fund the fifth and final year activities of the ERS project. DOR indicates that staffing needs would be covered by existing DOR staff. There is no General Fund requested.

Background: 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.

DOR received funding in 2010-11 for the ERS for system development, integration, data conversion, testing, and implementation. The budget change proposal requests expenditure authority for unspent federal funds that were dedicated to this project. The federal funds were not used due to project delays. DOR indicates that ERS will be fully implemented in summer 2011.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the budget change proposal.

DOR Issue 2: Department of Mental Health (DMH) Partnership

Budget Issue: DOR requests, in a budget change proposal, a permanent augmentation of $216,000 from the Mental Health Services (MHS) fund and 1.0 permanent position (associate governmental program analyst). This would maintain the interagency agreement between the DOR and the DMH and allow DOR to leverage an additional $798,000 in federal funds related to vocational rehabilitation programs. There is no General Fund requested.

Background: After the Mental Health Services Act (MHSA) was enacted in 2005, DOR and DMH entered into an interagency agreement for vocational rehabilitation services. The partnership was intended to implement the provisions of the MHSA that relate to assisting persons with severe psychiatric disabilities to obtain employment and necessary independent living skills. Since 2005-06, DOR began to receive MHS funds and positions for these activities on a limited term basis. Specifically, the DOR has assisted in the solicitation, identification, development, and design of cooperative programs and contractual agreements with county mental health and education agencies. DOR indicates there is an ongoing need to provide training and technical assistance to the cooperative programs.

Subcommittee Staff Comment & Recommendation: Staff recommends denying the proposal without prejudice. Currently, the Governor's budget proposal exceeds the administration cap for MHSA funds (see Subcommittee #3 hearing agenda for February 1, 2011 related to Department of Mental Health). Thus, further information is needed from the Department of Mental Health regarding the possible re-prioritization of the MHSA administrative funds.

4170 Department of Aging (CDA)

CDA Issue 1: Medicare Beneficiary Outreach and Assistance Program

Budget Issue: CDA requests, in a budget change proposal, an additional one-time federal funding authority of $1.1 million for local assistance and $17,000 for state operations in 2010-11 and $1.1 million for local assistance and $9,000 for state operations in 2011-12 to utilize federal funding for the Medicare Improvements for Patients and Providers Act (MIPPA) for Beneficiary Outreach and Assistance Program. There is no General Fund requested.

Background: The federal government has awarded another two-year, non-competitive grant to CDA (MIPPA II grant). The purpose of the funding is to expand enrollment of California's 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. CDA also received a two-year grant (MIPPA I) in 2009.

CDA indicates that the performance goal for the MIPPA II grant is 10,834 applications and estimates that the grant will generate at least $400 million in prescription drug cost savings to Medicare beneficiaries throughout the state.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the budget change proposal.

CDA Issue 2: Senior Community Service Employment Program (SCSEP)

Budget Issue: CDA requests, in a budget change proposal, $497,452 in additional ongoing federal expenditure authority due to an increase in the baseline level of grant funding for the SCSEP. There is no General Fund requested.

Background: The SCSEP provides subsidized part-time community service training positions to low-income individuals age 55 and older with poor employment prospects. The

program provides a variety of supportive services to participants including personal and job-related counseling, job training, and job referral.

CDA administers the funds through 15 local Area Agencies on Aging (AAA). The additional federal funds would provide an additional 45 participant training slots.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the budget change proposal.

CDA Issue 3: New Freedom Transportation Grant

Budget Issue: CDA requests, in a budget change proposal, increased reimbursement authority to spend $400,000 from the California Department of Transportation (Caltrans) to utilize a federal New Freedom Mobility Management grant. Specifically, CDA requests $100,000 for 2010-11 (through the Section 28.5 process), $200,000 for 2011-12, and $100,000 for 2012-13. In addition, CDA requests a 2-year limited-term staff services manager I position to implement the grant activities for the grant period. There is no General Fund requested.

Background: CDA proposes to use this federal grant to work with the 33 local Area Agencies on Aging (AAA) to develop and implement a statewide strategy to fill the need of older adults and adults with disabilities for accessible transportation services and systems that enable them to remain in their communities in the least restrictive setting possible. According to CDA, the state-level position will assess each AAA's capacity to apply for the New Freedom grants locally. The position will also work with CDA and AAA staff to establish both state and local level ongoing transportation expertise that can be sustainable in the future. Caltrans requires a detailed implementation plan that includes specific tasks and requires quarterly implementation reports to make sure the goals and objectives of the grant are on schedule.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the budget change proposal.

CDA Issue 4: Long-Term Care Ombudsman Program

Budget Issue: CDA requests, in a budget change proposal, to shift funding for the Long-Term Care Ombudsman Program from the Federal Citations Penalties Account Special Deposit Fund to a combination of funding from the State Health Facilities Citation Penalties Account ($1.188 million) and the Skilled Nursing Facility Quality and Accountability Fund ($1.9 million). The CDA also proposes a statutory change to Health and Safety Code Section 1417.2 to specifically include funding the Long-Term Care Ombudsman Program as an allowable use of the State Health Facilities Citation Penalties Account . There is no General Fund requested.

Background: The Office of the State Long-Term Care Ombudsman, which oversees 35 local Ombudsman programs, is located within CDA. These local Ombudsman offices and their approximately 1,000 certified volunteers identify, investigate, and seek to resolve complaints and concerns on behalf of approximately 296,000 residents of long-term care facilities, including Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs), and Residential Care Facilities for the Elderly (RCFEs).

Over the past several years, the budget has included short-term funding solutions for the program. In 2008-09, General Fund support for the program was eliminated. Since then, the program has received support on a short-term basis including Federal Citations Penalties Account Special Deposit Funds and some General Fund. CDA indicates that the budget proposal will provide a more stable funding source than the Federal Citations Penalties Account Special Deposit Fund. The program also receives about $3.3 million in federal funds for local assistance.

The State Health Facilities Citation Penalties Account consists of moneys collected from civil penalties imposed on health facilities. The Skilled Nursing Facility Quality and Accountability Fund consists of moneys used to make certain payments to skilled nursing facilities.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the budget change proposal and related statutory change.

4140 Office of Statewide Health Planning and Development (OSHPD)

OSHPD Issue 1: Healthcare Reform Healthcare Workforce Development

Budget Issue: OSHPD requests, in a budget change proposal, an increase of $256,000 in 2011-12 and $224,000 in 2012-13 from the California Health Data and Planning Fund (CHDPF) and $58,000 in federal funds in 2011-12 and 2012-13 to establish 4.0 two-year limitedterm positions to perform healthcare workforce development activities in response to the passage of federal healthcare reform. There is no General Fund requested.

Background: According to OSHPD, its Healthcare Workforce Development Division supports healthcare accessibility through the promotion of a diverse and competent workforce while providing analysis of California's healthcare infrastructure and coordinating healthcare workforce issues. OSHPD indicates that federal healthcare reform includes opportunities for health workforce planning and development efforts needed to meet the increased demand for healthcare services in California. OSHPD requests one position to facilitate a strategy for comprehensive health workforce planning and three positions to prepare applications for Health Professional Shortage Area, Medically Underserved Area, and Medically Underserved Population designation and enable the state to maximize opportunities to receive federal funding designed to increase access to healthcare.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the budget change proposal.

OSHPD Issue 2: CalREACH

Budget Issue: OSHPD requests, in a budget change proposal, an increase of $322,000 from multiple special funds and 2.0 two-year limitedterm positions in 2011-12 and $834,000 and 0.5 permanent position in 2012-13 for the creation of the Responsive Electronic Application for California's Healthcare (CalREACH) electronic application and monitoring system. There is no General Fund requested.

Background: OSHPD indicates that the proposal will enable its Healthcare Workforce Development Division (HWDD) and the Health Professions Education Foundation to develop a technology solution that centralizes eligibility and allows applicants to submit applications for scholarships, loan repayments, and grants online. The system would also allow applicants and program staff the ability to manage and track applications and contracts. The foundation is a public nonprofit foundation housed in OSHPD that was statutorily created to increase access to health care in underserved communities by providing financial aid.

In 2009-10, the HWDD and foundation received over 4,000 applications, made nearly 1,000 awards, and awarded over $18 million in funds. OSHPD currently processes these applications and monitors these funds manually.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the budget change proposal.

OSHPD Issue 3: Hospital Seismic Safety

Budget Issue: OSHPD requests, in a budget change proposal, an increase of $337,000 in 2011-12 and $321,000 in 2012-13 from the Hospital Building Fund and 2.0 two-year limited-term positions to implement enacted legislation related to general acute care hospital requests for an extension to the seismic safety deadlines for retrofit or replacement of specific hospital buildings due to planning approval delays. There is no General Fund requested.

Background: Current law requires that all general acute hospitals meet stringent seismic safety standards within specific timeframes. OSHPD is responsible for enforcing compliance of these standards and must approve all hospital construction required to achieve them. SB 608 (Chapter 623, Statutes of 2010), allows OSHPD to grant two separate extensions for hospitals to meet requirements due to local planning delays.

According to OSHPD, the following hospitals (based on current information) may pursue SB 608 extensions:

- Tehachapi Hospital, Tehachapi
- Marin General Hospital, Greenbrae
- St. Jude Medical Center, Fullerton
- Stanford Hospital, Palo Alto
- Sutter Medical Center of Santa Rosa- Chanate, Santa Rosa
- Methodist Hospital of Southern California, Arcadia
- California Pacific Medical Center-California West, San Francisco
- St. Luke's Hospital, San Francisco

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the budget change proposal.

OSHPD Issue 4: Healthcare Workforce Clearinghouse

Budget Issue: OSHPD requests, in a budget change proposal, an increase of $454,000 from the Health Data and Planning Fund and 1.0 position in 2011-12 and $77,000 in ongoing years to fund the development and administration costs associated with Year 3 of the Healthcare Workforce Clearinghouse program. There is no General Fund requested.

Background: Current law authorized OSHPD to establish a clearinghouse designed to serve as a central repository of healthcare workforce and education data. The program is responsible for the collection, analysis, and distribution of information on the educational and employment trends for healthcare occupations in the state.

In 2008-09, $389,000 and 3.5 positions were approved for clearinghouse administration costs. Subsequently, $1,499,000 and 9 positions for 2009-10 and $2,688,000 and 12 positions for 2010-11 were approved for clearinghouse project costs. OSHPD indicates that this budget change proposal would provide for costs for year 3 of the project, primarily to meet increased data and reporting requests resulting from federal healthcare reform.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the budget change proposal.

OSHPD Issue 5: Deferment of General Fund Loan Repayment

Budget Issue: The Governor's budget proposes to defer $32 million in General Fund loan repayments to two special funds within OSHPD. This includes a $20 million repayment to the Hospital Building Fund and $12 million repayment to the California Health Data and Planning Fund. As a result, the state would receive $32 million in GF relief during the 2011-12 budget year. The proposal includes budget bill language to delay the repayment to the Hospital Building Fund.

Background: In 2008-09, $20 million was loaned from the Hospital Building Fund to the General Fund. In 2010-11, the loan repayment date was extended to June 1, 2012. The

budget proposes to now extend the loan repayment date to July 1, 2012. OSHPD indicates that the fund balance in the Hospital Building Fund can withstand the deferment of the loan repayment.

In 2008-09, $12 million was loaned from the California Health Data and Planning Fund to the General Fund. There is no specified repayment date, although OSHPD anticipated receiving the $12 million loan repayment in 2011-12. OSHPD indicates that the fund balance in the California Health Data and Planning Fund can withstand deferment of the loan repayment from 2011-12 to 2012-13.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the proposal to defer the General Fund loan repayment, including the proposed budget bill language.

OSHPD Issue 6: Song-Brown Program Funding

Budget Issue: The Governor's budget proposes to fund 50 percent of the Song-Brown base program ($2.1 million) and 100 percent of the Song-Brown Registered Nurse Program ($2.9 million) from the General Fund. The remaining 50 percent of the Song-Brown base program is proposed to be funded from the California Health Data and Planning Fund.

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.

According to OSHPD, the California Health Data and Planning Fund (CHDPF) has an estimated fund balance of $8.4 million at the beginning of 2011-12. OSHPD indicates that the CHDPF can support the Song-Brown program by another $5 million without affecting current CHDPF activities, including budget change proposals for 2011-12.

Subcommittee Staff Comment & Recommendation: Staff recommends denying the $5 million General Fund for the Song-Brown program and approving instead $5 million from the CHDPF to support the program.

5180 Department of Social Services (DSS)

DSS Issue 1: Staffing Requests for the Disability Determination Services Division (DDSD)

Budget Issue: DSS requests, in a budget change proposal, $20.5 million (100 percent federal funds) to establish 245 new positions to process Social Security and SSI disability claims. The additional staff members would mainly be located in a new San Diego office and an expanded Roseville office.

Background: Disability claims have recently been increasing nationwide by 12 to 14 percent, and the federal government expects this trend to continue for several more years. In 2008 in California, the DDSD processed 349,000 disability claims. That number jumped to 397,000 in 2009 and 412,000 in 2010. According to the Department, the requested positions are needed to keep pace with the growing workload associated with processing these applications for benefits and for conducting continuing disability reviews (CDRs). The Department also indicates that ten percent of CDRs result in decisions to discontinue SSA/SSI benefits, which leads to GF cost avoidance (as a result of the SSP portion of SSI/SSP benefits that would otherwise be paid).

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the requested positions, which are fully federally funded and which will assist the state's population of individuals who are elderly, blind, or who have disabilities in promptly receiving benefits for which they are eligible.

DSS Issue 2: Request for Funding to Relocate the Los Angeles (LA) Branch of the DDSD

Budget Issue: The Department requests, in a budget change proposal, $540,000 ($270,000 GF) for annualized increased rent costs related to the relocation of the LA branch of the DDSD to a site that meets the state's seismic criteria. The Department of General Services' Real Estate Services office identified the need for this move.

Background: Currently, the LA branch occupies approximately 20,866 square feet at a rental rate per square feet of $1.78. The projected rental rate for relocation to a similar-sized space that is seismically compliant at current market rates is $4.00 per square foot, resulting in $45,000 of increased lease costs per month beginning in 2011-12. One-time costs in the amount of $633,750 (redirected GF) have also been placed in an Architectural Revolving Fund for this relocation. The lease for the current office space expired on April 30, 2009; however, a soft-term lease extension was negotiated and lasts through April, 2012. The Department is in the process of looking for an alternative space and the relocation is projected for early in the 2011-12 budget year.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the requested funds related to the relocation.

Discussion Agenda

4170 Department of Aging (CDA)

CDA Issue 5: Proposal to Eliminate the Multipurpose Senior Services Program (MSSP)

Budget Issue: The budget proposes to eliminate the MSSP program for 2011-12 savings of $19.9 million GF. This would also result in the state losing $19.9 million in federal funds.

Background: 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. CDA oversees the operations of the MSSP program statewide and contracts with local entities that directly provide MSSP services. The program operates under a federal Medicaid Home and Community-Based, Long-Term Care Services Waiver. The program has 41 sites statewide and serves approximately 11,789 clients per month.

In 2008-09, the budget reduced funding for the MSSP program. According to CDA, this resulted in MSSP sites serving 10 percent fewer clients, leaving slots vacant.

LAO Comment: The LAO indicates that if the budget includes significant reductions to the In-Home Supportive Services (IHSS) program, the Legislature should consider maintaining the infrastructure of MSSP to continue assisting some of the highly impaired IHSS recipients who are also MSSP recipients. The LAO also recommends achieving savings in MSSP by reducing the budget by at least $5 million General Fund. The LAO recommends that the department begin negotiations with the federal government to reduce operational costs associated with MSSP.

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

Questions for CDA:

1) What are the impacts to persons who would lose MSSP services?

2) Why doesn't the budget include costs associated with an increase in nursing home costs?

3) Please explain what steps would be involved in closing down the MSSP sites.

Question for LAO:

1) Please describe your recommended alternatives.

5180 Department of Social Services (DSS)

Supplemental Security Income/State Supplementary Program (SSI/SSP)

DSS Issue 3: Proposal to Reduce SSI/SSP Grants to Individuals to the Federal Minimum

Budget Issue: The Governor's budget proposes savings of $15 million GF in 2010-11 and $177 million GF in 2011-12 from reducing, effective June 1, 2011, the state's participation in SSI/SSP grants for individuals who are elderly, blind, or who have disabilities to the minimum required by federal law. Savings include those resulting from grant reductions in the Cash Assistance Program for Immigrants (CAPI) and California Veterans Cash Benefit programs, as those grant levels tie to the grants for SSI/SSP. As in the past, approximately 108,000 Non-medical Out-of-Home Care, Restaurant Meal Allowance, and Title XIX Medical Facilities recipients are excluded from this reduction.

Background & Anticipated Impacts: Based on 2010-11 caseload data, there are approximately one million individual recipients of SSI/SSP (not including couples in which both individuals are recipients). As a result of the proposed grant reduction, the maximum grant most of these individual SSI/SSP beneficiaries could receive would be reduced from $845 per month to $830 per month. At this grant level, individuals who receive the maximum grant and have no other income would have incomes equivalent to approximately 92 percent of the Federal Poverty Level (FPL). Approximately 8,500 recipients would become ineligible for the program.

The applicable federal law that limits reductions states can make to SSP benefit levels without penalty is a maintenance-of-effort (MOE) requirement. If a state did reduce SSP benefits below its MOE, the state would lose all federal Medicaid funding.

Recent grant changes: In the February, 2009 special session, a 2009 federal Cost of Living Adjustment (COLA) was rescinded effective May 1, 2009, and grants were reduced 2.3 percent ($20 for individuals and $35 for couples) effective July 1, 2009. Grants were then further reduced, effective October 1, 2009, by $5 for individuals and $82 for couples. After this change, couples' maximum grants of $1,407 per month have been at the MOE floor (around 116 percent of FPL). Also, as a result of AB X4 8 (2009-10 budget trailer bill), no state SSP COLAs will be automatically granted.

There was no federal COLA for the SSI portion of the grants in 2010. An estimated .2 percent federal COLA is, however, expected to take effect on January 1, 2012.

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

Question for DSS:

1) Please briefly describe this proposal and its anticipated impacts.

IHSS Overview
For Background Purposes

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. With a 2010-11 budget of $5.4 billion ($1.2 billion GF), today's 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 standardized in-home assessments and periodic reassessments. The assessment system relies on "functional index" rankings for a number of activities of daily living and weighted average scores of those rankings. Rankings range from 1 (independent, not served by the program) to 5 (cannot perform the task, with or without assistance).

IHSS services can include tasks like meal preparation, feeding, bathing, paramedical care, and domestic services. The maximum number of monthly hours a beneficiary can receive is 283. On average, the state spends roughly $13,000 per year for each IHSS client's services. IHSS 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).

Recent Changes to the IHSS Program: The 2009-10 and 2010-11 budgets included multiple changes to the IHSS program that were estimated to save over $600 million GF. Some of these changes have, however, been enjoined by courts from taking effect and are still the subject of pending litigation. Statutory changes that are in effect include:

- Increases in "out-of-pocket" costs for consumers (made by eliminating what was called the "share of cost buy-out");
- Sweeping anti-fraud reforms, including new background checks and fingerprinting of providers, timesheet verifications, limited use of P.O. boxes for providers to receive checks, unannounced visits to ensure that services are being delivered, and additional funding for state and local fraud detection staffing;
- An across-the-board reduction of 3.6 percent in recipients' authorized hours;
- Upon federal approval, enhanced federal funding for IHSS from establishing a sales tax on support services and the receipt of matching funds for the use of the revenues obtained pursuant to the tax. (IHSS providers will receive a supplementary payment that is equal to the portion of their gross receipts that is newly subject to taxation.);

- An expanded list of criminal record exclusions that prevent an individual from being an IHSS provider, except in certain circumstances when a recipient may provide informed consent; and

- Reductions in funding for Public Authorities that administer registries of qualified providers and provide other services.

Changes to the IHSS program made in 2009-10 and 2010-11 that are not currently in effect include:

- A reduction - to $9.50 per hour plus $.60 per hour for health benefits - of the maximum level of IHSS provider wages in which the state will participate; and

- Elimination of eligibility, subject to applicable exemptions, for:

    - Domestic and related services provided to individuals with a functional index ranking below 4 for each service; and

    - All services for individuals with a functional index score below 2.

The Governor's 2011-12 Proposals: The Governor's budget proposes to reduce IHSS expenditures by an additional $486 million GF. The major proposals include, effective July 1, 2011, a larger across-the-board reduction in hours of service for recipients, the elimination of specified services, and the requirement for a physician's certification of need. These proposals are outlined in greater detail in the remainder of this agenda. It is important to note that the savings associated with each proposal is dependent on interactions with the other proposals; and each would therefore change in tandem with changes in another. Also, given that IHSS is paid for in part by federal Medicaid funding, changes in the program may also be subject to scrutiny by the federal government and/or the courts based upon their compliance with federal Medicaid, as well as other state and federal disability-related, laws.

DSS Issue 4: Proposal to Further Reduce Hours of IHSS Services Provided

Budget Issue: The Governor's budget proposes savings of $127.5 million GF in 2011-12 from reducing, effective July 1, 2011, the hours of IHSS services that recipients receive by an additional 8.4 percent. There would be a corresponding loss of $192 million in federal funds. Coupled with a 3.6 percent reduction already in effect for the budget year (which is made permanent as part of this proposal), the total ongoing reduction to recipients' hours would equal 12 percent. These savings estimates account for related administrative, systems change, and other state operations costs.

Background on Prior Reductions: As a part of the 2010-11 budget agreement, the Legislature and Governor reduced, effective until July 1, 2012, the hours of service available to each IHSS recipient by 3.6 percent (known as an "across-the-board" reduction). There were no specified exceptions to the reduction, although recipients retained any appeal rights that existed prior to the reduction. Recipients are able to direct how the reduction is applied to their authorized hours and types of services.

A 12 percent reduction to the hours of service provided to IHSS recipients also took place earlier-- in 1992-93. Recipients at the time were given an opportunity to apply for an IHSS care supplement if they believed they would be at serious risk of out-of-home placement due to the reduction or would not have the ability to summon emergency assistance. County social workers reviewed those requests for supplemental care.

Anticipated Impacts of the Proposed Reduction: Building upon the policies underlying the 1992-93 reduction, the Governor's current proposal includes a process for individuals to be granted exceptions from the policy--in whole or in part--if their applications for supplemental care are approved. The applications would be given to each recipient along with the notice of action (NOA) that informs them of the reduction policy. Recipients who apply within a specified time after that NOA would receive aid pending a determination of the outcome of their supplemental care request. Based in part on precedent from 1992-93, the Department estimates that 435,600 of the estimated 456,000 IHSS recipients in 2011-12 would experience reductions to their services as a result of this proposal. On average, those recipients would lose 6.7 hours of IHSS services per month. The Department anticipates that 5 percent of recipients would apply for supplemental care and have hours fully restored, while another 13 percent would apply and have their hours partially restored.

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

Questions for DSS:

1) Please briefly summarize the impacts and implementation of the 3.6 percent reduction that is currently in effect and this proposal for an additional 8.4 percent reduction to individuals' authorized hours.

(Continued on next page)

2) What are the proposed criteria and processes by which counties would determine whether or not to grant a supplemental care application?

3) What analysis has the Administration conducted to determine whether this reduction would comply with federal and state Medicaid and disability-related laws?

DSS Issue 5: Proposal to Eliminate Domestic & Related Services for Specified IHSS Recipients

Budget Issue: The Governor's budget proposes $235 million GF savings from eliminating domestic and related IHSS services for recipients who live in shared living arrangements, and another $1.6 million GF savings for eliminating those services in cases where the recipient is a child under the age of 18 living with an able and available parent who is his or her IHSS provider. The savings estimates account for administration costs of $10.3 million ($3.6 million GF) associated with the policy changes, but do not include related automation costs. There would be corresponding losses of $351.7 million and $2.4 million in federal funds, respectively.

Background: Domestic and related services include housework, meal preparation, meal clean-up, laundry, shopping, and errands. Currently, if IHSS recipients who share their homes with other individuals have some of these needs met in common by their households, the social worker who determines their eligibility for IHSS services can pro-rate or reduce the authorized hours of IHSS services related to those activities.

According to the LAO, Washington State recently enacted a restriction on domestic and related services for individuals who lived with their IHSS providers. The state's Supreme Court determined, however, that the policy violated federal requirements regarding the equal treatment of Medicaid beneficiaries.

Anticipated Impacts: The Department estimates that approximately 300,000 individuals who live in shared environments and around 7,000 children who live with parents who are also their IHSS providers would be impacted by these proposals. Individuals in shared living arrangements who already had their services hours pro-rated to account for their housemates' responsibilities would lose an average of 14 hours of domestic and related services per month. Those who live with others and have non-pro-rated hours today would lose an average of 17 hours of domestic and related services per month. The Department anticipates that around 145,000 impacted recipients will appeal the proposed reduction, and that 20 percent of those individuals will receive a full restoration of the services. According to the Department, approximately 48 percent of IHSS recipients live with their IHSS providers, and 62 percent of IHSS recipients have relatives who serve as an IHSS provider.

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

Questions for DSS:

1. Please briefly describe the proposal.

2. How and when would the new policy be implemented for existing IHSS recipients? For new recipients?

3. What are the exceptions that would prevent some or all of an individual's services from being eliminated and the process by which those exceptions would be evaluated and implemented?

4. What analysis has the Administration conducted to determine whether this reduction would comply with federal and state Medicaid and disability-related laws?

DSS Issue 6: Proposal to Require Physician Certification to Qualify for IHSS Services

Budget Issue: The Governor's budget proposes $120.4 million GF savings from eliminating all services, effective July 1, 2011, for IHSS recipients who do not obtain a certificate from a physician (or other medical professional, as the Department determines is appropriate) verifying their need for IHSS services. These savings figures account for the Department's estimate of the time it will take for social workers to process the receipt of the certificates, but do not include any associated automation costs or Medi-Cal costs. There would be a corresponding loss of $180.4 million in federal funds.

Background & Anticipated Impacts: The Department estimates that around 10 percent or 42,000 current and new IHSS recipients would not obtain a physician's certification and would therefore lose all IHSS services (an average of 65 hours per month after the impacts of the Governor's other proposals are taken into account) in 2011-12.

According to the LAO, a number of counties already choose to include information from physicians in their assessments of eligibility for the IHSS program. In those cases, however, the physician's assessment of need is not a condition of eligibility, but rather one piece of information that is taken into consideration. The Department also indicates that a doctor's prescription is already required within the IHSS program if individuals receive what are known as "paramedical" services, and that a form of medical certification is currently required for the category of services called "protective supervision" as well.

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

Questions for DSS:

1) Please briefly describe the proposal and its anticipated impacts.

(Continued on next page)

2) What are medical professionals being asked to certify under this proposal? For example:

    a. Are they indicating that an individual would need out-of-home care immediately in the absence of IHSS services (versus that the individual would likely need such an acute level of care in the near future without those services)?

    b. Are they indicating that an individual needs each IHSS service that has been authorized by a social worker for that individual-- or more generally that the individual may struggle to perform some activities of independent daily living?

3) What is the basis for assuming that 10 percent of IHSS recipients would not obtain a physician's certification? And are those individuals assumed to be individuals with a particular level of need for assistance (e.g., the highest needs or lowest needs)?

4) How easy or difficult does the Administration anticipate that it will be for IHSS recipients to obtain appointments with physicians or other medical professionals if needed to meet this requirement? And at what costs to the Medi-Cal program?

5) What analysis has the Administration conducted to determine whether this reduction would comply with federal and state Medicaid and disability-related laws?

DSS Issue 7: Request for IHSS State Program Staff

Budget Issue: The Department requests, in a budget change proposal, $2.5 million ($1.2 million GF) for 23.5 new positions (9 permanent and the rest limited-term) and contract funding to implement recent budget-related changes to the IHSS program.

Rationale for Requesting the 23.5 Positions: As described on page 13 of this agenda, the 2009-10 and 2010-11 budgets included major reforms to the IHSS program. In 2009-10, the budget included 42 new, related state positions that were authorized for 2009-10 and 2010-11 (12 positions at DSS and 30 at the Department of Health Care Services). The Department requested an additional six anti-fraud/program integrity positions related to the 2009-10 changes in 2010-11; however, that request was denied by the Legislature. No new DSS staff positions were previously requested or authorized in connection with the changes to the IHSS program included in the 2010-11 budget (i.e., a temporary 3.6 percent across-the-board reduction in service hours, new provider criminal background exclusions and notifications of consumers, and enhanced federal funding from an extension of the sales tax and corresponding supplemental provider payment to the provision of IHSS services).

This request for additional staffing includes:

1. Two limited-term positions to assist with implementation of the 3.6 percent across-the-board reduction in hours;

2. Eight and a half limited-term positions to assist with implementation of new provider exclusion rules (including four legal staff);

3. Three permanent and four limited-term positions to assist with implementation of the new provider sales tax and supplemental payment policies; and

4. Six permanent positions to assist with implementation of new fingerprinting requirements.

Additional Background on Fingerprinting of IHSS Consumers: Among the IHSS program changes made in 2009-10 were the requirements, beginning April 1, 2010, to fingerprint IHSS consumers and to include consumer and provider fingerprints on timesheets. Under AB X4 19 (Chapter 17, 4th Extraordinary Session, 2009), the fingerprinting of consumers must take place in prospective consumers' homes at the time of their initial assessment for eligibility. Current consumers (approximately 460,000) were to be finger imaged at their next reassessment, conducted annually and also in the home. The statutes included exemptions for minors and those physically unable to provide fingerprints due to amputation. They do not require or specifically authorize a picture image to be taken of the consumer. Finally, the statutes require DSS to consult with county welfare departments to develop protocols to carry out these requirements.

The Department reports that it conducted six pilots in 2010 to determine the viability of mobile imaging devices that could be used to fingerprint IHSS consumers. Also according to the Department, the Administration is awaiting a response from the federal government regarding the state's Implementation Advance Planning Document that includes these policy changes. Last year, this Subcommittee voted to repeal the requirements for fingerprinting consumers and including fingerprints on timecards. However, the final 2010-11 budget did not include that repeal, and the policies remain in statute.

Subcommittee Staff Comment & Recommendation: Staff recommends:

1) Rejecting any positions that are requested in order to support implementation of fingerprinting IHSS consumers as a condition of eligibility and/or including fingerprints on timecards;

2) Repealing the underlying statutory requirements for consumer fingerprinting and the inclusion of fingerprints on timecards; and

3) Rejecting without prejudice the remaining positions requested to assist with implementation of recent changes to the IHSS program.

(Questions on next page)

Questions for DSS:

1) The 3.6 percent across-the-board reduction is already in effect. What is the continuing workload associated with implementation that leads to this request?

2) What are the responsibilities of the 12 new staff authorized in the 2009-10 budget? Now that some of the previously enacted policies are underway, can those positions be used to fulfill some of the responsibilities described in this request?

3) What is the status of implementation for the recipient and timecard fingerprinting requirements? What are the total costs included in the budgets for DSS and the Office of System's Integration related to those provisions? What savings does the Administration attribute directly to those provisions?

4) If some or all of the requested positions are not authorized, what would be the consequences for IHSS recipients and the program's implementation and budget?

DSS Issue 8: Request for IHSS Automation System State Staff

Budget Issue: The Department requests, in a budget change proposal, $467,000 ($233,000 GF) for an additional one-year extension of four (out of eight) existing limited-term positions to support development of the Case Management Information Payrolling (CMIPS) II automation system.

Background on CMIPS II & Rationale for Related Position Requests: CMIPS is the automated, statewide system that handles payroll functions for all IHSS providers. The current vendor (Electronic Data Systems, which is now Hewlett Packard) has operated the CMIPS system since its inception in 1979. The state has been in the process of procuring and developing a more modern CMIPS II system since 1997. According to the Department, the most recent delay in the project's scheduled completion date was due to the changes to the IHSS program enacted in 2009-10 (again, see the IHSS Overview on page 13). The newest anticipated completion date is March, 2012. The Department indicates that the continuation of the requested positions is necessary to ensure continuity of knowledge and meet a heavy programmatic workload during the final phases of the system's development.

Subcommittee Staff Comment & Recommendation: Staff recommends rejecting these positions without prejudice.

Questions for DSS:

1) Please briefly describe the need for the requested positions.

2) If some or all of the requested positions are not authorized, what would be the consequences for IHSS recipients and the program's implementation and budget?

DSS Issue 9: Proposal to Eliminate Funding for IHSS Advisory Committees

Budget Issue: The Governor's budget proposes to eliminate, effective July 1, 2011, $1.6 million GF (all GF in the program) for local IHSS Advisory Committees. As a result, the Department indicates that the Advisory Committees would change from being mandated by the state to being discretionary at the local level. The Department also indicates that counties would be able to draw down federal matching funds if they are able and willing to fund the Advisory Committees at the local level. The total 2010-11 funding for the Advisory Committees includes $3.1 million ($1.6 million GF and $1.4 million federal funds).

Background: Among other provisions, AB 1682 (Chapter 90, Statutes of 1999) requires counties to establish advisory committees that submit recommendations to their respective county boards of supervisors regarding the delivery of IHSS in their counties. SB 288 (Chapter 445, Statutes of 2000) also created specific requirements regarding the composition of the advisory committees (e.g., that a current or former IHSS consumer must be included).

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

Questions for DSS and DOF:

1) Please briefly describe the proposal and its anticipated impacts.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

Outcomes from the February 3, 2011
Human Services Hearing

4140 Office of Statewide Health Planning and Development (OSHPD)

OSHPD Issue 1: Healthcare Reform Healthcare Workforce Development

Voted 3–0 to approve the budget change proposal

OSHPD Issue 2: CalREACH

Voted 3–0 to approve the budget change proposal

OSHPD Issue 3: Hospital Seismic Safety

Voted 3–0 to approve the budget change proposal

OSHPD Issue 4: Healthcare Workforce Clearinghouse

Voted 3–0 to approve the budget change proposal

OSHPD Issue 5: Deferment of General Fund Loan Repayment

Voted 3–0 to approve the proposal to defer the General Fund loan repayment, including the proposed budget bill language.

OSHPD Issue 6: Song-Brown Program Funding

Voted 3–0 to deny the $5 million General Fund for the Song-Brown program and approve instead $5 million from the CHDPF to support the program.

4170 Department of Aging (CDA)

CDA Issue 1: Medicare Beneficiary Outreach and Assistance Program

Voted 3–0 to approve the budget change proposal

CDA Issue 2: Senior Community Service Employment Program (SCSEP)

Voted 3–0 to approve the budget change proposal

CDA Issue 3: New Freedom Transportation Grant

Voted 2–1 (Emmerson no) to approve the budget change proposal

CDA Issue 4: Long-Term Care Ombudsman Program

Voted 3–0 to approve the budget change proposal and related statutory change

CDA Issue 5: Multipurpose Senior Services Program (MSSP) Elimination

Held issue open.

5160 Department of Rehabilitation (DOR)

DOR Issue 1: Electronic Records System (ERS)

Voted 3–0 to approve the budget change proposal

DOR Issue 2: Department of Mental Health (DMH) Partnership

Voted 3–0 to deny without prejudice

5180 DSS

DSS Issue 1: Staffing Requests for the Disability Determination Services Division (DDSD)

Voted 2-1 (Emmerson no) to approve the requested positions.

DSS Issue 2: Request for Funding to Relocate the Los Angeles (LA) Branch of the DDSD

Voted 2-1 (Emmerson no) to approve the requested funds related to the relocation.

DSS Issue 3: Proposal to Reduce SSI/SSP Grants to Individuals to the Federal Minimum

Held issue open.

DSS Issue 4: Proposal to Further Reduce Hours of IHSS Services Provided

Held issue open.

DSS Issue 5: Proposal to Eliminate Domestic & Related Services for Specified IHSS Recipients

Held issue open.

DSS Issue 6: Proposal to Require Physician Certification to Qualify for IHSS Services

Held issue open.

DSS Issue 7: Request for IHSS State Program Staff

Voted 2-1 (Emmerson no) to:

1) Reject any positions that are requested in order to support implementation of fingerprinting IHSS consumers as a condition of eligibility and/or including fingerprints on timecards;

2) Repeal the underlying statutory requirements for consumer fingerprinting and the inclusion of fingerprints on timecards; and

3) Reject without prejudice the remaining positions requested to assist with implementation of recent changes to the IHSS program.

DSS Issue 8: Request for IHSS Automation System State Staff

Voted 3-0 to reject without prejudice the requested positions.

DSS Issue 9: Proposal to Eliminate Funding for IHSS Advisory Committees

Held issue open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

February 8, 2011

1:00 PM

Room 4203
(John L. Burton Hearing Room)

Staff: Agnes Lee (DCSD, DCSS)
Jennifer Troia (ADP, DSS)

Item	Department
4200	Department of Alcohol & Drug Programs (ADP)
4700	Department of Community Services & Development (DCSD)
5175	Department of Child Support Services (DCSS)
5180	Department of Social Services (DSS)

PLEASE NOTE:

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

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

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

Agenda

(Vote-Only Items indicated by *)

Item Department Page

Department Overviews

Department of Alcohol & Drug Programs (ADP): With a total budget of $606.1 million ($190.4 million GF) in 2010-11 and a proposed budget of $630.4 million ($222.1 million GF) in 2011-12, ADP directs and coordinates: 1) substance abuse prevention services, 2) substance abuse treatment and recovery services, 3) the licensing of treatment facilities and programs, and 4) problem gambling-related services.

Department of Community Services and Development (DCSD): With a total budget of $407 million in 2010-11 and a proposed budget of $259.8 million in 2011-12, DCSD provides a range of services to low-income Californians, including energy assistance (e.g. weatherizing homes) and community services programs. There is no General Fund budgeted for this department.

Department of Child Support Services (DCSS): With a total budget of $1.1 billion ($335.2 million GF) in 2010-11 and a proposed budget of $1.0 billion ($328.3 million GF) in 2011-12, DCSS provides child support order establishment, collections and distribution services.

Vote-Only Agenda

0530 Office of Systems Integration (OSI)
5180 Department of Social Services (DSS)

OSI Issue 1 & DSS Issue 1: Child Welfare Services (CWS)/Web Project

Budget Issue: OSI requests $2.1 million ($951,000 GF that is reflected in the DSS budget) for four additional staff and additional contract resources to support its project management role in the development of the new CWS/Web system. DSS requests, in a budget change proposal, $304,000 ($139,000 GF) for the extension, for an additional two years, of three limited-term staff who support the child welfare program-side of the project's development.

For additional background, please see the agenda for this Subcommittee from January 27, 2011.

Subcommittee Staff Comment & Recommendation: Staff recommends rejecting these positions without prejudice.

4200 Department of Alcohol & Drug Programs (ADP)

ADP ISSUE 1: Problem Gambling Treatment Services Program

Budget Issue: The Governor's budget proposes $5 million in special fund expenditure authority to continue implementation, data collection, and evaluation of a Problem Gambling Treatment Services Pilot Program that serves problem and pathological gamblers and their affected family members. Correspondingly, the Department requests, in a budget change proposal, $183,000 for the two-year extension of two existing, limited-term positions and $817,000 in funding to contract for a public awareness campaign, provider training, training materials, data analysis, and evaluation. The remaining $4 million in requested funds are for Local Assistance and would be allocated by a competitive award process to local governments, public universities, and/or community organizations for treatment programs gamblers and their families. No General Fund resources are requested.

Background: The Department's Office of Problem Gambling provides education and raises awareness about the warning signs of problem gambling. The Office's goals include the establishment of a statewide treatment program that includes a broad spectrum of treatment services and evaluations that lead to an understanding of best practices. The proposed funding would extend for an additional two years an existing, three-year pilot program that supports these goals. At the end of the five-year pilot program, ADP plans to produce evidence-based practices and outcome data regarding the efficacy of the program.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the requested special fund authority.

ADP ISSUE 2: Driving Under the Influence (DUI) Programs

Budget Issue: The Department requests to continue $96,000 in contract dollars from the DUI Licensing Trust Fund for three years to develop a work plan, subsequent follow-up studies, and assessments based on the final recommendations provided at the completion of the existing DUI Descriptive Program Study. No General Fund resources are requested.

Background: In an effort to improve the delivery of services to offenders utilizing its DUI programs, ADP requested and received approval of a 2009-10 budget change proposal to use $96,000 from the DUI Trust Fund to conduct a two-year review of its current program structure. San Diego State University (SDSU) was awarded a two-year contract to gather data on currently licensed DUI programs across California and provide recommendations. The Department now seeks to continue the current funding in order to act on the findings of that first study. The Department states that future studies derived from continued funding will provide measurable client outcomes, enhance DUI program performance, and assist with the continued reduction of barriers to client treatment needs and referrals.

Subcommittee Staff Comment & Recommendation: Staff recommends approving the requested contract funds.

ADP Issue 3: Drug Medi-Cal (DMC) Complaint Investigations

Budget Issue: The Department requests $156,000 for the extension of 1.0 limited-term Staff Counsel III position through 2012-13. The requested position would be funded from the Residential and Outpatient Program Licensing Fund (ROPLF) and reimbursements of federal Medicaid funds from the Department of Health Care Services. The Governor's budget includes $4.5 million overall from the collection of fees in support of existing licensing and certification activities.

Background: The number of complaints related to services funded by the DMC program has grown from 28 in 2005-06 to projected figures of 55 in 2010-11 and 63 in 2011-12. ADP indicates that there is a sufficient fund balance in the ROPLF special fund to cover the ongoing cost of this request, and that there is a continuing need for this position to support the projected complaint workload in a timely manner and with appropriate confidentiality, consideration of program clients, due process protections for the regulated business, coordination with outside enforcement agencies, and fiscal integrity of the program.

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

ADP Issue 4: Strategic Prevention Framework – State Incentive Grant

Budget Issue: The Department requests an increase of $1.9 million in annual federal expenditure authority for five years and position authority for 1.5 five-year limited-term positions. These resources would support the administration, coordination, and implementation of a federal grant award for the Strategic Prevention Framework - State Incentive Grant (SPF-SIG). ADP received notice of the award on October 4, 2010. There are no General Fund resources requested.

Background: The SPF-SIG program provides funding to increase the use of data from public health research to guide planning and lead to the selection of evidence-based programs to prevent substance-abuse related problems. ADP initially applied for the federal SPF-SIG funding in 2008, but that request was denied. Because the Department did not anticipate this more recent award, it did not continue work to prepare for the use of the grant funds. This budget change proposal is intended to facilitate the state's acceptance of the federal funding and to allow for project planning and implementation work to resume as quickly as possible. The state's deliverables under the grant include a completed statewide needs assessment, strategic plans, and outcome data.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the requested federal fund authority and limited-term positions.

ADP ISSUE 5: California Access to Recovery Effort (CARE) Program

Budget Issue: The Department requests a four-year extension of four limited-term positions and expenditure authority to continue the federally-funded CARE program. Through this federal grant, the State will receive $3.3 million per year for four years. Approximately $772,000 of this funding will be for State Support (i.e., provider and client outreach, marketing, training and technical assistance, data collection and evaluation) and $2.5 million will provide treatment vouchers for youth and young service members and veterans (ages 18 to 25) returning from Iraq and Afghanistan and in need of treatment and recovery support services at the local level.

Background: This proposal would allow for continuation of the state's CARE program for a new four-year term (from September 2010 through October 2014). According to the Department, the CARE program is the state's implementation of a federal grant program run by the Substance Abuse and Mental Health Services Administration and called Access to Recovery (ATR). ATR is an initiative to "allow people in need of substance abuse treatment to make individual choices in their path to recovery that reflect their personal needs and values." To date, the CARE program has served youth in Butte, Los Angeles, Sacramento, Shasta, and Tehama counties. The Department indicates that 11,600 youth and young service members and veterans will be served in the next four years through this federal grant funding.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the requested resources.

4700 Department of Community Services and Development (DCSD)

DCSD Issue 1: Managing Expenditure of Federal Funds

Budget Issue: DCSD proposes budget bill language in Items 4700-001-0890 and 4700-101-0890 to allow the department to augment its budget with unexpended federal funds without being subject to the Section 28.00 process.

Background: Over the last several years, DCSD has annually requested a federal fund augmentation through the Section 28.00 process since many of the department's federal grants cross over different state fiscal years. DCSD indicates that this process has limited its flexibility in managing the federal grants. According to DCSD, the situation was exacerbated by major staffing changes and a significant influx of American Recovery and Reinvestment Act of 2009 (ARRA) funds. Thus, the department is proposing budget bill language to provide more flexibility to the department, bypassing the Section 28.00 process for augmentation of federal funds.

Subcommittee staff asked the LAO to draft an amended version of the budget bill language which would establish some formal review by the Legislature yet provide the department with more flexibility than the Section 28.00 process.

Subcommittee Staff Comment & Recommendation: In order to maintain legislative oversight, staff recommends approval of the following budget bill language which requires notification to the Legislature, to replace the proposed DCSD budget bill language:

> "4700-001-0890 (Provision 2)- Any unexpended federal funds from Item 4700-001-0890, Budget Act of 2010 (Ch. 712, Stats. 2010), shall be in augmentation of Item 4700-001-0890 of this act and not subject to the provisions of Section 28.00. *The Department of Finance shall provide written notification of the augmentation to the Joint Legislative Budget Committee within 10 days from the date of the Department of Finance approval of the augmentation. The notification shall include: (a) the amount of the augmentation, (b) an identification of the purposes for which the funds will be used, and (c) an explanation of the reason the funds were not spent in 2010-11."*
> "4700-101-0890 (Provision 3)-- Any unexpended federal funds from Item 4700-101-0890, Budget Act of 2010 (Ch. 712, Stats. 2010), shall be in augmentation of Item 4700-101-0890 of this act and not subject to the provisions of Section 28.00. *The Department of Finance shall provide written notification of the augmentation to the Joint Legislative Budget Committee within 10 days from the date of the Department of Finance approval of the augmentation. The notification shall include: (a) the amount of the augmentation, (b) an identification of the purposes for which the funds will be used, and (c) an explanation of the reason the funds were not spent in 2010-11.* These funds shall be used for local assistance for the programs for which they were originally budgeted."

5175 Department of Child Support Services (DCSS)

DCSS Issue 1: California Child Support Automation System (CCSAS)

Budget Issue: DCSS requests, in a budget change proposal, a reduction of $19.3 million ($6.6 million GF) and a shift of contract funding to support 11.0 new permanent positions to continue management and operation of the CCSAS.

Background: The CCSAS is an automation system that provides centralized case management, including locating and collecting payments from non-custodial parents and disbursing payments to custodial parents. The table below and on the next page summarizes the budget request:

CCSAS Budget Proposal for 2011-12	
Description	Dollars in Thousands
State Operations:	
• Staff and benefits	$927
• Operating expenses & equipment	$73

• Project hardware/software	$1,708
Total DCSS State Operations	$2,708
Local Assistance	
• Business partner contract expiration	-$13,224
• Child Support Enforcement (CSE) maintenance and operations services	$3,731
• Shift help desk contract to state staff	-$1,000
• Application hosting & migration services	-$14,110
• Various consultant contracts	-$90
• Wide area network	$553
• Local technical support	$2,106
Total DCSS Local Assistance	-$22,034
TOTAL PROJECT COSTS	**-$19,326**

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the budget change proposal.

5180 Department of Social Services (DSS)

DSS Issue 2: CalFresh - Electronic Benefit Transfer (EBT) for Farmers' Markets

Budget Issue: DSS requests, as part of its local assistance estimates, $1.6 million ($788,000 GF) to provide EBT services (point-of-sale devices, service, and transaction fees) to over 700 new farmers' markets in 2011-12.

For additional background, please see the Agenda for this Subcommittee from January 27, 2011.

Subcommittee Staff Comment & Recommendation: In light of the Administration's stated intention to revisit the estimates associated with this request at the May Revision, staff recommends rejecting the currently requested resources without prejudice.

DSS Issue 3: CalWORKs - Temporary Assistance Program (TAP)

Budget Issue: DSS proposes, in trailer bill language, to repeal statutes requiring the department to create and implement TAP. Based on preliminary cost estimates, after automation changes of $5.3 million GF, if excess-MOE funds are available when it is implemented, TAP is effectively cost-neutral to the state because funds needed for the program ($220 million in recipient benefits) 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). However, according to the Department, TAP could also result in a revenue loss to the state because of an associated loss of public assistance cost recoupment through child support payments.

Background: 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 work participation rate. To date, implementation complexities, largely due to challenges with child support automation and rules, have prevented TAP from moving forward. As a result, trailer bill language was adopted four years in a row to delay TAP implementation. The Department reports no new progress in overcoming those challenges to implementing TAP.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee rescind its prior action to approve the Administration's proposal to repeal the statutes underlying TAP, and instead approve placeholder trailer bill language for an additional one-year delay in the program's implementation.

DSS Issue 4: Staffing Requests Related to Recent Legislation

Budget Issue: DSS requests, in a budget change proposal, $270,000 ($217,000 GF) for positions associated with recently enacted legislation, as described below.

1) **AB 2418** (Chapter 468, Statutes of 2010): $96,000 for one limited-term consultant position.

   This legislation revised the definition of "Indian child" for the purposes of Indian child custody proceedings to include an unmarried person who is over 18 years of age but under 21 years of age, and who is either a member of an Indian tribe or eligible for membership in an Indian tribe. The Department states that the requested position would assist with implementation of associated new processes and requirements; however, the bill was not considered to have a fiscal impact that warranted its review by the Senate Appropriations Committee.

2) **AB 973**: (Chapter 440, Statutes of 2010): $55,000 ($37,000 GF) and 0.5 limited-term analyst position.

   AB 973 revises, until January 1, 2013, the requirements that must be met before prospective adoptive parents may take a drug-exposed newborn into temporary custody from the hospital. The bill was not considered to have a fiscal impact that warranted its review by the Senate Appropriations Committee.

3) **AB 1048/1983**: $50,000 GF and 0.5 limited-term accounting officer position.

   AB 1983 (Chapter 587, Statutes of 2010) creates the Safely Surrendered Baby Fund check-off on the personal income tax form. Additionally, AB 1048 (Chapter 567, Statutes of 2010) extends the period during which a person may safely surrender a baby at designated sites, and requires new annual reports to the Legislature. The Senate Appropriations Committee analysis did not anticipate any state support costs at DSS for AB 1983 and anticipated approximately $32,000 in 2011-12 costs for AB 1048's reporting requirements.

4) **AB 2084**: $69,000 GF and 1.5 licensing analysts.

   AB 2084 (Chapter 593, Statutes of 2010) requires licensed child day care facilities to: a) serve only low fat or nonfat milk to children ages two or older; b) limit juice to not more than one serving per day of 100% juice; c) serve no beverages with added sweeteners, either natural or artificial; and d) make clean and safe drinking water readily available and accessible for consumption throughout the day. These provisions become operative on January 1, 2012, and the bill requires DSS to inspect the facilities for compliance during regularly scheduled inspections. The Senate Appropriations Committee analysis indicated anticipated state costs of $150,000 GF annually.

Subcommittee Staff Comment & Recommendation: Staff recommends rejecting the requested positions for implementation of AB 2418 and AB 973, and rejecting without prejudice the requested positions for AB 1084/1983 and AB 2084.

DSS Issue 5: Proposal to Continue Suspension of a Confidential Intermediary Program for Sibling Contact (AB 2488)

Budget Issue: DSS proposes savings of $3.0 million ($1.7 million GF) in avoided state operations and local assistance costs from continuing to suspend implementation of AB 2488 (Chapter 386, Statutes of 2006, Leno). The Administration's proposed trailer bill language would suspend the statewide program for an additional two years and would delete intent language regarding continued implementation at the local level to the extent possible.

Background: AB 2488 created a confidential intermediary program intended to facilitate contact between siblings in the circumstance that at least one of them was adopted. In 2008-09, the Governor vetoed funding for implementation of AB 2488, stating that implementation of the program would be delayed for one year as a budget balancing reduction. The Legislature subsequently delayed program implementation to July 1, 2010 and then July 1, 2011 (except to the extent that its provisions can continue to be implemented locally).

Subcommittee Staff Comment & Recommendation: Notwithstanding the merits of fully implementing AB 2488, staff recommends approving trailer bill language for an additional one-year suspension of its provisions. Staff also recommends rejecting the Administration's proposed deletion of language regarding the Legislature's intent for continued implementation to the extent possible.

Discussion Agenda

Human Services Realignment Proposals

4200 Department of Alcohol & Drug Programs
5180 Department of Social Services

Realignment Issue 1: Proposal to Realign State-Supported Substance Use Treatment Programs

Budget Issue: The Governor's budget proposes, beginning in 2011-12 and continuing through full implementation of realignment in 2014-15, to realign to the counties $184 million in funding and primary program responsibility for specified substance-use treatment programs. The Governor's budget identifies tax revenues for counties in lieu of this amount of General Fund resources to support these programs. The proposal does not include realignment of responsibility for licensure or certification of treatment programs. The Administration's intention is for this movement of funding and responsibilities to enable counties to implement creative models of integrated services within the context of other public safety realignment proposals (which are being reviewed by Subcommittee #5), as well as for other low-income persons receiving treatment services.

Background on Programs Included: The largest program included in this proposal is the state's **Drug Medi-Cal (DMC) program**, with funding of $130.7 million GF and corresponding federal funds. The DMC program provides medically necessary substance use disorder treatment services for eligible Medi-Cal beneficiaries. The DMC program includes outpatient drug free, narcotic replacement therapy, and day care rehabilitative services, as well as residential services for pregnant and parenting women. Youth ages 12 to 21 who are covered under the Early and Periodic Screening and Diagnosis and Treatment program may also receive these services. The DMC caseload is anticipated to grow by 36,121 to include 322,437 individuals in 2011-12.

This proposal also includes **non-DMC perinatal (before and after-pregnancy) and other state-funded treatment programs**, with funding of $25.7 million GF. Of the funds for non-DMC perinatal treatment programs, $5.1 million support existing residential programs known as Women and Children's Residential Treatment Services (WCRTS). There are currently eight of these programs in the state.

ADP currently contracts with 57 counties, and in some cases directly with treatment providers, for the provision of these DMC and non-DMC treatment services.

The proposal also includes $26.8 million GF for **drug court programs**, which are generally administered by the counties with state oversight. By and large, drug court programs combine judicial monitoring with intensive treatment services over a period of around 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 more intensive supervision.

It is worth noting that this proposal does not include funding for community-based diversion programs through the Substance Abuse and Crime Prevention Act (Proposition 36) or Offender Treatment Programs. Funding for these programs was eliminated in 2009-10 and 2010-11, respectively, and is not restored in the Governor's budget.

Federal Requirements: In 2011-12, ADP estimates that the state will receive $256.3 million in federal Substance Abuse Prevention & Treatment (SAPT) block grant funding ($236.2 million for Local Assistance and $18.1 million for State Support). As a condition of receiving these funds, the federal government requires the state to spend $207 million to meet its related Maintenance of Effort (MOE) requirement. The federal government establishes this MOE based on a two-year average of state. States that violate the MOE lose one dollar of federal funding for each state dollar below the required spending level (although federal law does allow for the waiver of MOE requirements when a state faces "extraordinary economic conditions"). The federal government also requires the state to identify a single state agency for administering federal substance abuse-related funds. ADP currently serves as that agency.

In addition, recently enacted federal health care reforms impact the provision of alcohol and other drug treatment across the nation. First, effective in 2010, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Parity Act) requires specified health plans to provide substance use-related benefits on parity with physical health benefits (e.g., deductibles, co-payments, and limits on visits cannot be any more restrictive than for other medical treatments). Among other health plans, the Parity Act applies to Medicaid managed care plans. Second, federal health care reform (the Affordable Care Act) will significantly expand the number of beneficiaries to whom the Parity Act and other Medicaid rules apply.

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

Questions for ADP:

1) Please describe the realignment proposal and how the Administration anticipates that substance use treatment in the state would likely change or not change as a result.

2) How and when would major programmatic, governance and funding-related decisions in light of realignment be made? What roles would federal law require the state to retain? What flexibility could be given to counties under this proposal?

3) How does the Administration anticipate that this proposal would impact the individuals served by treatment programs?

4) The state currently contracts with some counties for the services provided in the Narcotic Treatment Program and with some providers directly. Reportedly, not all counties have wanted to more directly provide these services in the past. How would this program fit into the realignment proposal? Similarly, the Women and Children's Residential Treatment Services program currently has eight providers in different regions of the state. How would this program fit into the realignment proposal?

5) Do you anticipate that the state will be able to count expenditures under the realigned programs toward its federal SAPT MOE?

Realignment Issue 2: Proposal to Realign Child Welfare Services (CWS) and Adoptions Programs

Budget Issue: The Governor's budget proposes, beginning in 2011-12 and continuing through full implementation of realignment in 2014-15, to realign to the counties $1.6 billion in funding and primary program responsibility for California's Child Welfare Services (CWS) system. The proposal includes child abuse prevention and adoptions programs, as well as emergency response to allegations of abuse and neglect, supports for family maintenance and reunification, and out-of-home foster care services for approximately 50,000 children. The proposal does not, however, include changes related to the automation system for child welfare services case management and data collection or the licensing of residential placements for children.

The total CWS budget includes $4.2 billion ($1.6 billion GF). The non-federal costs in each program are shared by the state and counties, with the highest county share of 60 percent in the foster care program and the lowest of 25 percent in the Adoptions Assistance Program (AAP). These non-federal sharing ratios were established as part of the 1991 realignment and were intended to incentivize permanency for children and families. Under the Governor's proposal, all $1.6 billion of state costs (currently GF) would be replaced by $1.6 billion in tax revenues to the counties.

Background on Programs Included: The state's **CWS system** investigates allegations of child abuse and neglect and provides case management and support services to children and their families. Statewide, hotline calls alleging child abuse and neglect are received for approximately one-half million children each year.

When children cannot safely remain in their homes because of abuse or neglect, the **foster care** component of the CWS system provides out-of-home placements. Roughly eighty percent of placements are in family settings (e.g., the home of a foster family or relative), while eight percent are in group homes and the remainder are in other settings. In each placement, the caregivers or providers receive monthly grant payments for care and supervision of the child, ranging from an average of $600 per month in kinship guardianship settings to over $5,000 per month in group home settings.

The **adoptions** programs proposed for realignment include: 1) the Relinquishment (or Agency) Adoptions Program, which provides services to facilitate the adoption of children in

foster care, and 2) the Independent Adoptions Program, which serves birth parents who provide consent for the adoption of their children and adoptive parents. Adoption services are provided through state district offices, 28 county agencies, and a variety of private agencies. About 7,000 children are adopted from foster care annually.

The **Adoptions Assistance Program (AAP)** provides average monthly cash grants of just over $800 to around 90,000 families with children whose circumstances may have otherwise presented barriers to adoption (e.g., children over the age of three, who are members of a sibling group being adopted together, or who have adverse parental backgrounds such as a history of drug addiction or mental illness). Nearly all children adopted from foster care are eligible for and receive AAP benefits.

Background on Current Governance Structure of CWS Programs: The federal government provides significant funding for the costs of the CWS and AAP programs mentioned above. Correspondingly, federal law and regulations establish programmatic requirements and goals, and the federal government reviews the outcomes of the state's program and service delivery. Among the state's federally supported programs, the CWS system is generally considered to be one of the more highly regulated by the federal government.

The federal government also requires that each state have a single state agency that is responsible for implementation of CWS programs. In California, the state Department of Social Services is that agency and is responsible for oversight of the CWS programs. However, the counties administer the programs and interact with children and families more directly. The Administration states that the proposed shift of funding and responsibility to counties is intended to be accompanied by flexibility for counties to operate the programs and better serve vulnerable children.

Note Regarding Special Education-Related Placements: The $1.6 billion GF provided for CWS programs also includes about $72 million for the board and care of children who have been designated as **"seriously emotionally disturbed"** and placed in out-of-home care in connection with their special education programs. Although the funding for these residential services is budgeted under CWS, the program's structure (created by AB 3632, Chapter 1747, Statutes of 1984) does not give DSS or county welfare agencies a direct role or responsibility in making these placements or managing the children's cases. The residential placement costs are shared 40/60 between the state (GF) and counties. Subcommittee #1 will be examining the Administration's overall realignment proposal related to AB 3632 programs. The LAO has recommended that the responsibility and funding related to the care of these children be realigned to school districts, rather than counties.

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

Questions for DSS:

1) Please describe the realignment proposal and how the Administration anticipates that the operation of CWS and adoptions programs would likely change or not change as a result.

2) How and when would major programmatic, governance, and funding-related decisions in light of realignment be made? What roles would federal law require the state to retain? What flexibility could be given to counties under this proposal?

3) How does the Administration anticipate that this proposal would impact the children and families served by the CWS and adoptions programs?

Realignment Issue 3: Proposal to Realign Adult Protective Services (APS)

Budget Issue: The Governor proposes, beginning in 2011-12 and continuing through full implementation of realignment in 2014-15, to realign to the counties the entire $55.1 million in state funding and the primary program responsibility for APS. The total 2010-11 budget for APS programs statewide is $130.7 million (including $64.7 million federal funds and $10.9 million county funds).

Background: APS programs, which are currently mandated statewide, respond to reports of elder and dependent abuse on an emergency response basis. The programs also provide needs assessment, case management, and other critical services (e.g. emergency shelter care) to persons aged 65 and older who are functionally impaired, unable to meet their own needs, and victims of abuse, neglect, or exploitation. Currently, APS programs are administered by 58 local APS agencies with oversight provided by DSS. The Governor states that the transfer of this entire program will give counties full flexibility to determine the appropriate level of services and priorities for their communities.

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

Questions for DSS:

1) Please describe the realignment proposal and how the Administration anticipates that the operation of APS programs would likely change or not change as a result. Would some APS responsibilities continue to be mandatory?

2) What, if any, role would the state retain related to the administration or oversight of APS programs?

3) How does the Administration anticipate that this proposal would impact the individuals served by APS programs?

5175 Department of Child Support Services (DCSS)

DCSS Issue 2: Proposal to Suspend County Share of Child Support Collections

Budget Issue: The Governor's budget proposes to suspend the county share of child support collections, estimated to be $24.4 million, in 2011-12. Under the proposal, this amount would instead benefit the General Fund. The department also proposes trailer bill language to implement the proposal. The Governor's budget also maintains the "revenue stabilization" funding of $18.7 million ($6.4 million GF) that counties receive to maintain caseworker staffing levels in order to stabilize child support collections.

Background: Child support payments from non-custodial parents are collected and distributed to either families or governments. Collections made on behalf of families who have not received public assistance are distributed to custodial parents. Collections made on behalf of families who have received public assistance are retained by the government to repay past welfare costs. These assistance collections are shared by the federal, state, and county governments. Prior to the implementation of the automated State Disbursement Unit (SDU), collections were sent to the counties first, and then the counties would send the state and federal share of collections to the state. Subsequent to implementation of the SDU, the collections are received at the state level and the county share of collections is transferred to the counties. According to DCSS, current statute does not reflect the current collections system (as it reflects the system prior to the SDU). There are no statutory requirements regarding the use of the county share of collections once they are transferred to the county treasurer's office. Based on a DCSS survey of counties in 2009-10, most counties transfer their share of collections to the local welfare agency to offset the county share of welfare costs. Los Angeles County and San Diego County reinvest the collections into the local child support program, and other counties transfer the funds to their county general funds.

Revenue Stabilization Funds: In the Governor's 2009-10 budget proposal, the department proposed an augmentation of $18.7 million ($6.4 million General Fund) for local child support agencies (LCSAs) to maintain revenue generating caseworker staffing levels in order to stabilize child support collections. Due to flat levels of funding for LCSAs' basic administrative expenses and local cost increases, local revenue generating caseworker staffing levels had declined in recent years. According to DCSS, this had contributed to declines in child support collections. The Legislature approved the request but directed that 100 percent of the new funds be used to maintain revenue caseworker staffing levels. Based on data for 2009-10, DCSS indicates that the revenue stabilization funds led to the retention of 245 staff who would otherwise have been laid off.

LAO Comments: Because many counties use their share of collections to support their CalWORKs program, the LAO believes the Legislature should discuss this proposal in the context of the other proposed CalWORKs reductions.

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

Questions for DCSS:

1) Please explain the impacts of the proposal on counties and various county programs.

Questions for LAO:

1) How should the DCSS proposal be considered in the context of other CalWORKs proposals?

5180 Department of Social Services (DSS)

Child Welfare Services

DSS Issue 6: Continuation of Unallocated Veto Reduction

Budget Issue: When he signed the amendments to the 2009-10 budget contained in ABx3 1 (Chapter 1, 3rd Extraordinary Session, Statutes of 2009) in July 2009, the Governor used a line-item veto to make an unallocated reduction of $80.0 million GF to CWS and foster care programs. After the Administration allocated the vetoed funding across programs, the total cut to CWS was $133.5 million, including $53.5 million in federal fund losses corresponding to the General Fund reductions. The Legislature restored the vetoed funds in the 2010-11 budget that it sent to Governor Schwarzenegger; but he again vetoed the funding. Governor Brown's 2011-12 budget continues an unallocated reduction of the same amount.

Implementation of the Reductions: The Department indicates that it adopted guidelines for implementing the veto that focused on the preservation, to the extent possible, of the core CWS program (e.g., county child welfare workers), direct services provided to children and families, and federal funding and mandates. Still, according to the Department, the veto and current fiscal challenges at the local level have lead to a reduction of roughly 19 percent in the total number of direct service child welfare social workers from the middle of 2008 to the end of 2010 (not including data from all counties). Less training is available for new social workers. And many counties have reduced or eliminated services, including voluntary Family Maintenance Services that served as a resource for helping to keep children at home with their families, the Supportive and Therapeutic Options Program (STOP), and the Kinship Support Services Program (KSSP).

Last year, the counties similarly reported a loss statewide of more than 500 front-line social workers who investigate emergency reports of abuse and neglect, help families stay together or be reunited, and work to find children permanent homes so that they do not remain in foster care unnecessarily. The most recent analysis of social worker caseloads conducted by the LAO in 2007-08 estimated that in counties representing 98 percent of the foster care caseload, social worker caseloads already exceeded the minimum (not optimal) standards established by a study conducted in response to the requirements of SB 2030 (Chapter 785, Statutes of 1998). Social worker caseloads at the time were estimated to be less than 80 percent of the minimum standard in counties representing 48 percent of the caseload.

According to the counties, statewide performance data last year also indicated that reports of abuse and neglect were less likely to be timely investigated. Foster children were being moved between homes more frequently; and the percentage of children getting timely health examinations was steadily decreasing.

Subcommittee Staff Comment & Recommendation: This item is included for informational purposes, and no action is required at this time.

Questions for DSS:

1) Please describe how the funding reductions that resulted from the veto were allocated in 2010-11 and how they are anticipated to be implemented in the 2011-12 budget.

2) What are the expected impacts on children and families? On other areas of the state and counties' budgets?

DSS Issue 7: Proposed Reduction in Funding for Transitional Housing Program Plus (THP-Plus)

Budget Issue: The Governor's budget proposes $19 million GF savings from a reduction of that size to the funding for THP-Plus. Absent the proposed reduction, the projected costs for THP-Plus would have been $35.8 million GF. The Department states that the basis for the size of the reduction is an estimate of the costs that would otherwise be incurred by serving youth ages 18 and 19 in THP-Plus, and that the reduction is proposed "in light of the passage of" Assembly Bill (AB) 12 (Chapter 559, Statutes of 2010). The Department estimates that the proposed reduction will result in a loss of 650 beds or slots.

Background on THP-Plus and Emancipation from Foster Care: THP-Plus provides up to two years of transitional housing and supportive services to help former foster youth achieve self-sufficiency. Last year, there were approximately 1,400 young adults and 168 of their children living in THP-Plus placements in 52 California counties. Participants receive support from staff to work toward self-sufficiency (e.g., employment or education-related) goals and may live alone or with roommates. The THP-Plus monthly reimbursement rate is up to 70 percent of the county's average group home grants for 16 to 18-year-old foster youth. To date, THP-Plus has served former foster youth who have emancipated from care (i.e., for whom a judge has terminated the state's jurisdiction) and for whom federal financial participation in the costs of care and services was not an option.

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 (e.g., receipt of a high school diploma) than their peers. In a 2008 survey by the John Burton Foundation, the interviewed THP-Plus 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.

Upcoming Changes to the Foster Care System for 18 to 21-Year-Olds: Prior to the enactment of the federal Fostering Connections to Success & Increasing Adoptions Act (FCSA, Public Law 110-351, enacted in 2008), Title IV-E of the federal Social Security Act did not allow for federal funding of the costs of foster care for children over the age of 18 (or in some very limited circumstances, the age of 19). Among a number of other major policy changes related to child welfare and adoptions assistance programs, the FCSA for the first time included a state option to continue providing Title IV-E reimbursable foster care, adoption, or guardianship assistance payments for the benefit of youth between the ages of 18 and 21. The FCSA also expanded the list of foster care placement options available to this population.

AB 12 created the statutory framework for California to opt into this newly available federal funding stream. Under the provisions of that bill, the extension of foster care benefits past age 18 will be phased-in over three calendar years (i.e. for age 18, then 19, then 20) beginning on January 1, 2012. In order to receive foster care, Kinship-Guardianship Assistance Program (Kin-GAP), Adoptions Assistance Program (AAP) or CalWORKs benefits after age 18, youth in California who meet other requirements must agree to reside in an eligible placement and be in one of the following circumstances: 1) completing high school or equivalent program (i.e. GED); 2) enrolled in college, community college or a vocational education program; 3) participating in a program designed to remove barriers to employment; 4) employed at least 80 hours a month; or 5) unable to do any of the above because of a medical condition. THP-Plus housing (called "THP-Plus foster care") will be one allowable supervised foster care placement for 18 to 21-year-olds who opt to remain in foster care when that choice becomes available to them.

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

Questions for DSS:

1) What are the anticipated impacts of the proposed reduction in funding for THP-Plus? In particular:

    a. Would youth currently living in THP-Plus placements be likely to lose their housing and supportive services earlier than they otherwise would have?

    b. Would fewer youth who are emancipating in 2011-12 have the option to receive services or supports than in the past (particularly since the provisions of AB 12 that extend the availability of foster care to 18 to 21-year-olds will not take effect until January 1, 2012, and will then apply only to 18-year-olds during the last six months of the 2011-12 budget year)?

DSS Issue 8: Other Staffing Requests for the Children's Division

Budget Issues: In addition to the funding related to recent legislation described earlier in this agenda, DSS requests, in budget change proposals, the following augmentations to staffing in its Children's Division, totaling roughly $3 million ($1.6 million GF):

1) $1.6 million ($867,000 GF) to authorize 11 (seven permanent and four two-year, limited-term) positions and temporary help funding for the implementation of Assembly Bill 12, the California Fostering Connections to Success Act (AB 12);

2) $837,000 ($279,000 GF) to authorize seven positions to perform field monitoring of county child welfare and CalWORKs programs;

3) $295,000 ($203,000 GF) to authorize three positions to conduct file reviews, prepare summaries and reports, provide technical assistance to counties, and manage public information related to child fatalities and near fatalities resulting from abuse and/or neglect;

4) $199,000 ($147,000 GF) to make one previously approved limited-term manager position permanent and add a second limited-term position for implementation of the federal Fostering Connections to Success and Increasing Adoptions Act (FCSA); and

5) $101,000 ($64,000 GF) to establish one two-year, limited-term position to analyze an increased number of Financial Audit Reports that will be submitted to the Department by group homes in the wake of a recent lawsuit.

Background on Positions Related to the FCSA and AB 12: The FCSA (Public Law 110-351, enacted on October 7, 2008) made a number of significant reforms to promote permanency and improved outcomes for foster and adopted children through policy changes in six key areas: 1) support for kinship care and family connections, 2) support for older youth, 3) coordinated health services, 4) improved educational stability and opportunities, 5) incentives and assistance for adoption, and 6) direct access to federal resources for Indian Tribes. The 2009-10 and 2010-11 budgets included resources for implementation of various FCSA provisions, including one of the limited-term positions that is a subject of this request. As described above, AB 12 is legislation that was enacted to allow California to take advantage of newly available federal financial participation under the FCSA for the care of foster youth ages 18 to 21, as well as assistance payments to relative guardians of children who have exited the foster care system.

Background on Field Monitoring Positions: According to DSS, its monitoring of counties' uses of social service program funding is currently being accomplished through federal audits, as well as various internal controls and desk audits performed at the state level. The Department indicates that these practices have been cited repeatedly as insufficient by the Bureau of State Audits (BSA) and the federal Office of the Inspector General and Administration for Children and Families (ACF). ACF has now directed the Department to take corrective action to comply with monitoring requirements in the Code of Federal Regulations, and the state is facing potential sanctions if ACF considers its corrective

actions insufficient. The potential sanctions apply to several programs, the most critical of which are Temporary Assistance to Needy Families (TANF) and Title IV-E child welfare services. To avoid the sanctions, the Department states that it needs 7.0 positions to perform field monitoring of county programs.

Background on Positions Related to Child Fatalities: The Department states that the requested positions are needed to perform duties associated with case-specific reviews of the circumstances surrounding fatalities/near fatalities of children known to the state's Child Welfare Services system. The staff would conduct electronic file reviews, prepare incident summaries, participate in county critical incident review team briefings, prepare mandated reports and analyses, maintain a website for public access to child fatality related information, and work with the counties to improve their reporting of child fatalities/near fatalities resulting from abuse and/or neglect. The Department made a very similar request last year, which the Legislature denied.

Background on Group Home Financial Audit Reports: As the result of a recent court order, the rates paid to group homes for children in California increased by approximately 32 percent. Correspondingly, the Department indicates that approximately 116 additional non-profit corporations per year will be required to submit annual (rather than triennial) financial audit reports that are required for entities that receive more than $500,000 in federal funding. These audit reports will be submitted to the Department, and the Department is then required to review them within a specified time.

Subcommittee Staff Comment & Recommendation: Staff recommends rejecting these positions without prejudice.

Questions for DSS:

1) Please briefly describe these staffing requests and your highest priorities among them.

2) How might the proposed position needs change in the context of the Administration's child welfare services realignment proposal?

3) What would be the consequences if these positions were not authorized?

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

Outcomes
February 8, 2011 Hearing

0530 Office of Systems Integration (OSI)
5180 Department of Social Services (DSS)

OSI Issue 1 & DSS Issue 1: Child Welfare Services (CWS)/Web Project

Voted 3-0 to reject the requested positions without prejudice.

4200 Department of Alcohol & Drug Programs (ADP)

ADP ISSUE 1: Problem Gambling Treatment Services Program

Voted 3-0 to approve the request.

ADP ISSUE 2: Driving Under the Influence (DUI) Programs

Voted 3-0 to approve the request.

ADP Issue 3: Drug Medi-Cal (DMC) Complaint Investigations

Voted 2-1 (Emmerson no) to approve the request.

ADP Issue 4: Strategic Prevention Framework – State Incentive Grant

Voted 3-0 to approve the request.

ADP ISSUE 5: California Access to Recovery Effort (CARE) Program

Voted 3-0 to approve the request.

4700 Department of Community Services and Development (DCSD)

DCSD Issue 1: Managing Expenditure of Federal Funds

Voted 3-0 to approve budget bill language which requires notification to the Legislature (as shown on the hearing agenda for February 8) to replace the proposed DCSD budget bill language.

5175 Department of Child Support Services (DCSS)

DCSS Issue 1: California Child Support Automation System (CCSAS)

Voted 3-0 to approve the request.

5180 Department of Social Services (DSS)

DSS Issue 2: CalFresh - Electronic Benefit Transfer (EBT) for Farmers' Markets

Voted 3-0 to reject the requested resources without prejudice.

DSS Issue 3: CalWORKs - Temporary Assistance Program (TAP)

Voted 2-1 (Emmerson no) to rescind the Subcommittee's prior action to approve the Administration's proposal to repeal the statutes underlying TAP, and instead approve placeholder trailer bill language for an additional one-year delay in the program's implementation.

DSS Issue 4: Staffing Requests Related to Recent Legislation

Voted 3-0 to reject the requested positions for implementation of AB 2418 and AB 973, and to reject without prejudice the requested positions for AB 1084/1983 and AB 2084.

DSS Issue 5: Proposal to Continue Suspension of a Confidential Intermediary Program for Sibling Contact (AB 2488)

Voted 3-0 to approve trailer bill language for an additional one-year suspension of AB 2488 provisions. Also, rejected the Administration's proposed deletion of language regarding the Legislature's intent for continued implementation to the extent possible.

Human Services Realignment Proposals

4200 Department of Alcohol & Drug Programs
5180 Department of Social Services

Realignment Issue 1: Proposal to Realign State-Supported Substance Use Treatment Programs

Held issue open.

Realignment Issue 2: Proposal to Realign Child Welfare Services (CWS) and Adoptions Programs

Held issue open.

Realignment Issue 3: Proposal to Realign Adult Protective Services (APS)

Held issue open.

5175 Department of Child Support Services (DCSS)

DCSS Issue 2: Proposal to Suspend County Share of Child Support Collections

Held issue open.

5180 Department of Social Services (DSS)

Child Welfare Services

DSS Issue 7: Proposed Reduction in Funding for Transitional Housing Program Plus (THP-Plus)

Held issue open.

DSS Issue 8: Other Staffing Requests for the Children's Division

Voted 3-0 to reject the requested positions without prejudice.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

February 10, 2011

10:00 AM or
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item	Department	
0530	CA Health & Human Services Agency	Vote Only
4300	Department of Developmental Services Developmental Centers Community Services	

PLEASE NOTE:

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

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

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

Vote Only Calendar (Pages 2 through 5)

0530 CA Health and Human Services (CHHS) Agency

1. Health Information Exchange Staffing at CHHS Agency

Budget Issue. The budget requests $369,000 (federal funds) to extend three limited-term positions to continue implementation of the Health Information Exchange. These positions include a Staff Services Manager I; Staff Services Manager II, and a Staff Counsel III.

Key functions include the following:

- Develop statewide health information exchange that is governed and implemented cooperatively by the public and private sectors, the goals of which are to address specified health outcomes that include individual and population health status elevation, prioritizes meaningful use requirements;
- Develop and enforces policy guidance requiring all statewide health information exchange participants to comply with a common set of privacy and security guidelines and policies;
- Develop and enforce vendor-agnostic statewide technical guidance requiring all statewide health information exchange participants to comply with a common set of protocols and standards;
- Coordinate an integrated approach with Medi-Cal and State public health programs to enable information exchange and support monitoring of provider participation in health information exchange as required for Medi-Cal meaningful use incentives.

CHHS Agency states these positions are presently being used to manage implementation of California's Health Information Exchange grant and in developing and managing issues related to the Health Insurance Portability and Accountability Act (HIPAA), including issues pertaining to privacy and security rules.

The CHHS Agency received a four-year $38.7 million federal grant for California's Health Information Exchange. The majority of these funds are to be available in the first two-years of the grant, based on the State's performance in spending funds and building health information exchange capacity.

Under California's Operational Plan, the CHHS Agency is the federal grantee and retains responsibility for administering the federal grant and ensuring all federal grant deliverables are met. CHHS Agency is to coordinate electronic health activities in the State and work with stakeholders, State departments, and the Legislature to support and recommend policy needs for health information technology in California.

"Cal eConnect" (CeC) is California's "Governance Entity" which is a non-profit responsible for meeting the requirements CHSS Agency sets in contract and subsequent amendments. CeC was selected through a Request for Information process.

According to the CHHS Agency, new deliverables will be added to support the next phase of activities as the project proceeds. Generally, CeC will be responsible for establishing ground rules by which health information can be exchanged appropriately among clinicians, hospitals, health plans, patients, and government agencies. The CHHS Agency positions work closely with the CeC.

Background: Health Information Technology for Economic and Clinical Health Act. Under HITECH, California's eligible providers and hospitals may be eligible for up to $4 billion in federal "Electronic Health Record" (EHR) incentive payments. Of this amount, up to $1.4 billion is expected to be administered by the DHCS Medi-Cal EHR Incentive Program.

To receive these payments eligible providers and hospitals must meet federal "meaningful use" requirements which are expected to increase in three specified stages over a five year period. Stage 1 requirements will apply to federal fiscal year 2010-11 and 2011-2012 and are currently being crafted in a federal rule making process. Stages 2 and 3 will apply to federal fiscal years beyond 2012.

It should be noted that the DHCS Medi-Cal Program is engaged in a planning process to coordinate the role of Health Information Exchange activities in improving health outcomes for Medi-Cal enrollees and is in the process of drafting a "Planning-Advance Planning Document" to guide its implementation of "meaningful use" and incentive payments to providers.

Background: Senate Bill 337 (Alquist), Statutes of 2009. Among other things, this statute requires the CHHS Agency to develop a Plan to ensure that health information technology capabilities are available, adopted and utilized statewide so that patients do not experience disparities in access to the benefits of this technology due to their age, race, ethnicity, language, income, insurance status geography or other factors.

In addition, it established the California Health Information Technology and Exchange Fund for purposes related to health information technology and exchange. Federal grant funds are to be deposited in this Fund, along with funds received from sources other than the General Fund. The CHHS Agency is also charged with identifying future funding sources in addition to federal funds and exclusive of General Fund support.

Subcommittee Staff Recommendation—Approve. The request is consistent with California's federal grant application and plan, as well as enabling State statute. No issues have been raised by the Legislative Analyst's Office (LAO) or Subcommittee staff.

2. Additional Health Information Exchange Support

Budget Issue. The CHHS Agency is proposing to establish a two-year limited-term Associate Governmental Program Analyst (AGPA) position to support the Deputy Secretary's operational activities coordinating and leading the California health information and technology exchange program (as discussed under item 1, above). An increase of $99,000 (federal funds) is requested for this two-year AGPA position.

The CHHS Agency contends this position is needed to provide assistance to the Deputy Secretary to provide research assistance; track and oversee assignments; review correspondence; screen appointment requests; and arrange for meetings.

Previously, resources were redirected from another section within CHHS Agency to provide support. However, due to its own program demands that section of CHHS Agency cannot continue to provide assistance to the Deputy Secretary.

Subcommittee Staff Recommendation—Deny. It is recommended to deny this request since it lacks workload justification, and other core positions have been provided for core health information exchange support (as discussed under item 1, above).

The Assembly Budget Subcommittee #1 denied this request. The Subcommittee staff recommendation conforms to this action.

3. Aging and Disability Resource Connection Federal Grant Support

Budget Issue. The budget requests an increase of $604,000 (federal funds) and extension of a Staff Services Manager II (to September 2012) to continue support and administration of two new federal grants focused on strengthening Aging and Disability Resource Connection services ADRC) in California.

The position will provide grant oversight and administration of program outcomes as required under the federal grants.

Of the total amount, $504,000 (federal funds) is for external contracts. These funds will be used to do the following:

- To expand the current ADRC hospital care transition programs to diverse and underserved communities at four ADRCs. The goal of this program is to reduce hospital readmission rates and to secure funding from partner hospitals for continuation of transition coach positions.
- To develop, pilot test and evaluate a comprehensive set of long-term options counseling standards with four local partner organizations and to establish uniform ADRC criteria and a designation process to enable continued ADRC expansion.

Two new federal grants will enable California to build on the initial investment in the Aging and Disability Resource Connection (ADRC) model by strengthening ADCR protocols, technical tools and services developed under previous grants.

Background: Aging and Disability Resource Connection (ADRC) Programs. These programs provide a coordinated entry point into the long-term care system for older adults and people with disabilities. Since 2004, California has launched sever ADRC partnerships covering 10 counties. This model uses the existing resources and expertise of local Area Agencies on Aging (AAA) and Independent Living Centers (ILC), while eliminating service and program overlaps. Through integration and partnership, ADRCs offer consumers a more coordinated system of long-term supports.

The federal Administration on Aging and Centers for Medicare and Medicaid Services (CMS) are recognizing the critical role of ADRCs in the long-term care continuum by directing federal funds to strengthen these services.

Subcommittee Staff Recommendation—Approve. This request is consistent with the federal grants and past State practices. No issues have been raised by the LAO or Subcommittee staff.

Department of Developmental Services

A. Overall Background (Pages 6 through 7)

Purpose and Description of Department. The Department of Developmental Services (DDS) administers services in the community through 21 Regional Centers (RC) *and* in state Developmental Centers (DC) for persons with developmental disabilities as defined by the provisions of the Lanterman Developmental Disabilities Services Act.

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

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

Individuals with developmental disabilities have a number of residential options. Almost 99 percent receive community-based services and live with their parents or other relatives, in their own houses or apartments, or in group homes (various models) that are designed to meet their medical and behavioral needs.

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

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

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

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

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

Agnews Developmental Center was closed to resident occupancy in 2010. DDS submitted its plan for the closure of Lanterman Developmental Center to the Legislature in 2010. DDS states that Lanterman Developmental Center is proceeding with a gradual transition of residents.

Summary of Governor's Budget. The budget proposes total expenditures of $4.454 billion ($2.395 billion General Fund) for the DDS, for a *net* decrease of $316.1 million (decrease of $110.1 million General Fund) over the revised current year for the entire developmental services system.

The budget reflects a net reduction of 6.6 percent overall as compared to the revised current-year, and a net reduction of 4.4 percent in General Fund expenditures.

The table below summarizes this information by program area.

Summary Table of Department of Developmental Services (DDS)

Program Component	Revised 2010-11 Total Funds	20011-12 Total Funds	Difference
Community Services	$4,126,757,000	$3,797,294,000	-$329,463,000
Developmental Center Program	$607,565,000	$618,127,000	+$10,562,000
Headquarters Support	$35,796,000	$38,607,000	+$2,811,000
TOTAL, All Programs	**$4,770,118,000**	**$4,454,028,000**	**-$316,090,000**
Regional Center Consumers	244,108	251,702	+7,594
Developmental Center Residents	1,979	1,783	-196

B. Governor's Proposed Reductions for 2011-12

The Governor proposes enactment of major cost-containment measures in 2011-12 to achieve a reduction of $750 million (General Fund), or an overall reduction to the Developmental Services System of *over* $1.169 billion (total funds).

As presently proposed, most of this reduction would occur in the Purchase of Services allocation provided to Regional Centers to obtain needed services and supports for people with developmental disabilities living in the community.

The table below provides a summary of the Administration's proposals.

$750 million General Fund Reduction to Developmental Services System

Governor's Proposals to Reduce by $750 million GF	**2011-12 General Fund**	**2011-12 Other Funds**
1. Alternative Funding through Fund Shifts		
Federal certification of Porterville Developmental Center	-$10 million	$10 million
More federal funds by expanding special federal 1915 (i) plan	-$60 million	$60 million
Continue redirection of Proposition 10 Funds for Early Start	-$50 million	$50 million
Use of federal "Money Follows the Person" Grant	-$5 million	$5 million
Subtotal: Alternative Funding through Fund Shifts	**-$125 million**	**$125 million**
2. Expenditure Reductions & Cost Containment		
Unspecified Reductions and Cost Containment, including Purchase of Services Standards	-$533.5 million	Undetermined but over -$470 million
Continue 4.25 percent payment reduction on RC Providers	-$76 million	-$66.9 million
Continue 4.25 percent reduction to RC Operations	-$15.5 million	-$7.2 million
Subtotal: Expenditure Reductions & Cost Containment	-$625 million	-$544.1 million At least
TOTAL General Fund Reduction	**-$750 million**	**-$419.1 million At least**

C. Issues for Discussion: Developmental Centers (Pages 9 to 14)

1. Adjustments to Developmental Centers—Revised Current Year & 2011-12

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

The DDS operates four Developmental Centers (DCs) — Fairview, Lanterman, Porterville and Sonoma. Porterville is unique in that it provides forensic services in a secure setting. In addition, the department leases Canyon Springs, a 63-bed facility located in Cathedral City. This facility provides services to individuals with severe behavioral challenges.

Overall Budget. The table below provides a summary of the revised current-year and budget year totals as proposed by the Administration. As noted below, there are adjustments reflected in both the current-year and budget year.

According to the information below, the average cost of a DC resident in 2010-11 is about $307,000, and for 2011-12 it is *$346,678* or $39,678 more per resident in the budget year.

Summary of Current Year & Budget Year for Developmental Centers

Developmental Centers	2010 Budget Act	Revised 2010-11	CY Difference	Proposed 2011-12	CY to BY Difference
Total Funding	$646,091,000	$607,565,000	-$38,526,000	$618,127,000	+$10,562,000
State Positions	6,237	6,211	-26	5,922	-289
Average Population	1,979	1,979	0	1,783	-196
Funds					
General Fund	$314,909,000	$282,785,000	-$32,124,000	$323,992,000	+$41,207,000
Federal Funds	$330,784,000	$324,408,000	-$6,386,000	$293,763,000	-$30,645,000
Lottery Fund	$398,000	$372,000	-$26,000	$372,000	--

A. Revised Current Year Adjustments. The revised 2010-11 reflects a *net* reduction of $38.5 million (total funds) and 27 positions as compared to the Budget Act of 2010 (October). DDS states the *key* changes for the *revised current year* are as follows:

- **Control Sections 3.90 and Control Section 3.91—Workforce Cap Plan and Contract Administrative Actions.** A combined reduction of $49.2 million ($16.9 million General Fund) was done to comply with salary reductions and statewide employee compensation adjustments from changes to collective bargaining agreements. In addition, related adjustments to operating expenses were also to occur.

- **Control Section 3.60—Retirement Adjustment.** The Department of Finance directed a statewide adjustment for State employee retirement expenditures. This resulted in an increase of $10.2 million ($5 million General Fund) for the Developmental Centers.

- **No Population Adjustment Reflected (Hand Out).** Subcommittee staff notes that the revised current-year has not been adjusted to reflect further population decreases. January data from the DDS shows that the actual census at the Developmental Centers has been *less* than estimated in the current-year for the *entire* year to-date (i.e., from July 2010 to January, 2011). The DDS revised current-year still assumes an average of 1,979 residents at the DCs.

  Subcommittee staff believes this assumptions needs to be recalculated to reduce staff and expenditures.

B. Budget Year Adjustments. The budget reflects a net increase of almost $10.6 million (increase of $41.2 million General Fund) as compared to the revised current year.

DDS states *key* changes for 2011-12 are as follows:

- **Loss of Federal Enhanced Funds from Federal ARRA Sunset.** DDS states an increase of $32.5 million (General Fund) is needed to backfill for the loss of federal enhanced funds obtained through the Medi-Cal Program due to the sunset of the American Recovery and Reinvestment Act (ARRA) effective June 30, 2011.

- **Lanterman Developmental Center Closure.** DDS proposes to *redirect* 88 positions (49 Level-of-Care positions and 39 Non-Level of Care positions) *and* $15 million ($6.6 million General Fund) that would be eliminated due to the population reduction at Lanterman to provide assistance with the transitioning of residents during the closure process.

  Subcommittee staff believes a partial redirection is warranted for the transition but not to the level proposed by the DDS. Additional information is necessary.

- **Population Adjustment.** As previously noted, Subcommittee staff believes both current-year *and* budget-year population adjustments are needed to realign resources.

  As noted in the table below, the actual census for the current-year has been below the estimated fiscal level *all* year to-date. Presently there are 41 fewer DC residents than estimated for the current year (1,939 residents compared to 1,979 residents).

  Further, this lower current-year population level should lower the base going into 2011-12 even further. DDS is only reflecting a reduction of $4.8 million ($2.6 million General Fund) based on 196 fewer DC residents. Subcommittee staff believes an additional reduction is warranted.

Facility & Resident Population	**Actual Census (January 26,2011)**	**Current Year Budget (Not Revised)**	**Proposed 2011-12**	**Difference Current Year & 2011-12**
Canyon Springs	47	56	55	-1
Fairview	407	413	386	-27
Lanterman	347	340	235	-105
Porterville	541	557	532	-25
Sonoma	596	613	575	-38
Total Average Population	**1,938**	**1,979**	**1,783**	**-196**

- **Porterville Developmental Center "Medicaid Certification" (Fund Shift).** Porterville has a Secure Treatment Program for about 260 individuals who have been judicially committed. Although many are Medi-Cal eligible, the State does *not* receive federal Medicaid (Medi-Cal) funds for this program due to lack of certification by the federal CMS. This is because the federal CMS requires certain treatment programming.

  DDS assumes a reduction of $10 million (General Fund) by obtaining federal funds for 90 residents in the Secure Treatment population. This fund shift is included as part of the $750 million (General Fund) reduction for 2011-12.

  However, in recent discussions with DDS, Subcommittee staff believes a $13 million (General Fund) reduction is achievable at Porterville for an *additional savings of $3 million (General Fund).* This is based on a revised estimate of the Medi-Cal eligible population at Porterville.

Subcommittee Staff Comment and Recommendation. *First*, it is recommended to direct the DDS to provide Subcommittee staff with an updated DC resident population projection for *both* the current year and 2011-12, including applicable staffing adjustments. This information needs to also include Lanterman. This information will be discussed in the Senate Budget Committee hearings next week.

Second, it is recommended to approve a $13 million (General Fund) reduction, and increase of $13 million (federal funds) to reflect the updated information regarding Porterville Developmental Center. This will save an additional $3 million (General Fund) as compared to the Governor's budget.

Questions. The Subcommittee has requested the DDS to respond to the following questions regarding *both* the revised current year adjustments and the 2011-12 adjustments:

1. DDS, Please provide a brief summary of the current-year adjustments.
2. DDS, Will revised DC population information be forthcoming?
3. DDS, Please provide a brief description of Porterville and the federal fund shift.

2. Capital Outlay: Developmental Centers Automatic Fire Sprinklers

Budget Issue. DDS requests an increase of $2 million (General Fund) for Preliminary Plans and Working Drawings to design a project to install automatic fire sprinklers in 13 buildings which house Nursing Facility and General Acute Care consumers in three Developmental Centers—Fairview, Porterville and Sonoma—in order to comply with federal requirements.

DDS states that the Developmental Centers have not had major fire/life safety upgrades since 1982. The fire systems at several of the Developmental Centers are over 50 years old, unreliable, and subject to breakdowns, failures, and false alarms.

DDS estimates total completion cost of the upgrade to be federally compliant is $13.4 million (General Fund). Construction costs would be reflected in 2012-13. Overtime, the cost of the fire sprinkler system would be 50 percent reimbursed through federal financial participation (Medi-Cal), which is collected through the "bed rate". This reimbursement process is amortized over the life of the sprinkler system.

The Department of Public Health (DPH) who reviews fire/life safety requirements for the federal CMS has informed DDS that it will terminate federal Medicaid (Medi-Cal) certification and federal financial participation if compliance is not achieved by August 13, 2013. Without compliance, DDS is subject to lose significant federal funds.

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

1. DDS, Please provide a brief summary of the project and when it may be completed. Are federal funds at risk?

3. Capital Outlay: Fairview Developmental Center Fire Alarm System

Budget Issue. DDS requests an increase of $8.6 million (General Fund) through a "re-appropriation" for the construction phase of the Fairview Fire Alarm System Upgrade.

The fire alarm system upgrade was approved in the Budget Act of 2008 with $9 million (General Fund) for Preliminary Plans ($597,000), Working Drawings ($565,000) and Construction ($8.5 million). The system was approved to meet the current fire codes in consumer-utilized buildings at Fairview.

DDS states the outdated fire alarm system at Fairview DC affects the safety and quality of life of individuals living and working in the DC. For example, routinely fire and policy personnel are dispatched to living units to silence loud audible fire alarms. A complete upgrade of the system is necessary since replacement parts are no longer available for this 1970's system.

DDS states that there were several delays in completing the upgrade and this is why the re-appropriation is needed.

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

1. DDS, Please provide a brief summary of the project and why it is needed.

4. Sonoma Developmental Center Medical Gasses and Oxygen

Budget Issue. DDS requests an increase of $2.65 million (General Fund) for the Construction phase of this medical gasses and oxygen piping project.

This project was approved in the Budget Act of 2007 to address health and safety needs at Sonoma. The estimated costs included: Preliminary Plans ($381,000), Working Drawings ($423,000), and Construction ($4.8 million).

The project will install a new piping system to supply additional oxygen, medical air and suction, and a new oxygen storage tank. This will eliminate the use of portable suction machines and hazardous portable oxygen cylinders. Complete installation will bring Sonoma up to the current technology.

Sonoma is the only Developmental Center without a permanent piping oxygen outlet.

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

1. DDS, Please provide a brief summary of the project and why it is needed.
2. DDS, When is the project to be completed please?

D. Issues for Discussion: Community Services (Pages 15 to 30)

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

Regional Centers also purchase services for consumers and their families from approved vendors and coordinate consumer services with other public entities.

Generally, Regional Centers pay for services only if an individual does not have private insurance or they cannot refer an individual to so-called "generic" services that are provided at the local level by the state, counties, cities, school districts, and other agencies. For example, Medi-Cal services and In-Home Supportive Services (IHSS) are "generic" services because the RC does not directly purchase these services.

Regional Centers purchase services such as **(1)** residential care provided by community care facilities; **(2)** support services for individuals living in supported living arrangements; **(3)** Day Programs; **(4)** transportation; **(5)** respite; **(6)** health care; and many other types of services. Regional Centers purchase over 100 different services on behalf of consumers and are the payer of last resort.

Regional Center Expenditures Have Experienced Rapid Growth. The Legislative Analyst's Office (LAO) states that between 1999-2000 and 2009-2010, total expenditures for Regional Centers have more than doubled. The LAO believes the increase in costs is attributable to several factors. New medical technology, treatments, and equipment have broadened the scope of services available to the developmentally disabled. Other factors include increased life expectancy of consumers, increased diagnosis of autism and the comparatively higher costs of treating autism.

Background on Reductions from 2009 and 2010 *(Hand Out)*. In 2009 the prior Administration proposed a $334 million (General Fund) reduction. The Legislature restored $234 million (General Fund) of this amount in its February 2009 budget, thereby reducing expenditures by only $100 million (General Fund).

As part of this February action, the Legislature directed the DDS to convene a diverse "workgroup" to assist in developing a collaborative approach in identifying cost reductions and efficiencies. A total of 15 proposals were identified through this process and trailer bill language was developed which was discussed and amended in this Subcommittee.

Unfortunately, the State's fiscal status deteriorated further and the Legislature was compelled by the prior Administration to reduce by another $234 million (General Fund) to achieve their original proposal of reducing by $334 million (General Fund).

In addition to the $334 million (General Fund) reduction, with a corresponding federal fund decrease, the prior Administration vetoed an additional $50 million (General Fund) from the Early Start Program and directed the CA First Five Commission (Proposition 10 Funds) to provide supplemental support.

The *Hand Out* provides a summary prepared by the DDS in 2009 of the various reductions—about 25 different proposals.

It should be noted that some of these proposals did not achieve any savings, and other proposals achieved more savings than originally projected.

DDS states that the Regional Center Estimate package for 2011-12 incorporates all of these changes as part of their baseline process.

Background on Community Services Funding for 2011-12. As shown in the table below, a total of $3.797 billion ($2.047 billion General Fund) is proposed for 2011-12 to serve a total of 251,702 consumers.

Summary of Community Services Funding

Category	Revised 2010-11	2011-12	Difference
Regional Center Operations	$516,608,000	$523,827,000	+$7,662,000
Purchase of Services (POS)	$3,554,048,000	$3,766,870,000	+$212,822,000
Early Start—Other Departments	$20,095,000	$20,095,000	--
Prevention Program	$36,300,000	$20,003,000	-$16,297,000
System Wide Cost Containment	0	-$533,501,000	-$533,501,000
TOTAL Expenditures	**$4,126,608,000**	**$3,797,294,000**	**-$329,314,000**

This reflects a *net decrease* of $329.5 million ($153.1 million General Fund) compared to the revised current year. This net reduction reflects the following *key* proposals:

- Loss of Enhanced Federal ARRA Funds. An increase of $163.1 million (General Fund) is reflected due to the sunset of enhanced federal funds made available through the federal American Reinvestment and Recovery Act for Medi-Cal.
- Caseload and Utilization. An Increase of $165.8 million ($62.9 million General Fund) is reflected for 7,998 additional consumers and for increased utilization of services.
- Impacts of Reductions in Other Departments. An increase of $70.1 million ($54 million General Fund) is provided to reflect pending reductions in other departments that are considered “generic resources” and Regional Centers would therefore need to purchase the service.

This includes: **(1)** $5 million to reflect the reduction of the maximum monthly SSP grant to aged/disabled individuals to the maintenance-of-effort floor effective as of June 1, 2011; **(2)** $32.1 million to reflect the elimination of Adult Day Health Center services in Medi-Cal; and **(3)** $33 million to reflect costs associated with proposals regarding Medi-Cal co-payments. Subcommittee staff notes that these issues will be adjusted as necessary contingent upon actions taken in various departments.

- Continuation of Prior Years Cost Containment. As noted above about 25 different cost containment measures were permanently implemented in 2009 and 2010. Fiscal adjustments made for these issues are reflected in the baseline budget presented by the DDS.

- Continuation of 4.25 Percent Reduction to Regional Center Operations. A decrease of $22.7 million ($15.5 million General Fund) in Operations is assumed by extending the 4.25 percent reduction for one-year (through June 30, 2011).

- Continuation of 4.25 Percent Reduction to Payments to Providers. A decrease of $142.8 million ($76 million General Fund) in Purchase of Services is assumed by extending the 4.25 percent reduction on Provider Payments for one-year (through June 30, 2011).

- Continuation of Proposition 10 Funding for the Early Start Program. The budget assumes continuation of $50 million (Proposition 10 Funds) from the State Commission to support the Early Start Program (birth to 3 years of age). This has been provided the last two-years. These funds offset General Fund support and are counted towards the $750 million (General Fund) reduction amount.

- New System Wide Cost Containment & Statewide POS Standards. A decrease of $533.5 million (General Fund) is proposed by the DDS.

  This is literally the difference between the $750 million General Fund reduction "target" and those reductions which have already been identified for cost-shifts and savings (See Table on Page 8, above).

  Though DDS states this $533.5 million (General Fund) reduction would be "system wide", *most of the reduction would come from the Regional Center system.*

  Further, due to the availability of federal funds through Medi-Cal, this level of General Fund reduction would also result in a reduction of *at least* $470 million in federal funds, for a total of over $1 billion in total funds from this action alone.

- Package of Trailer Bill Language Proposals. The Administration is proposing substantial trailer bill language in response to the Bureau of State Audits report of 2010, as well as in response to audits recently conducted by the DDS.

  DDS states that components of this language *will save* General Fund and will count towards the $750 million (General Fund) reduction amount. *DDS is presently reviewing data and assumptions to discern what level of General Fund reduction can be achieved from these proposals.*

The trailer bill language proposals address the following topics:

- Regional Center contracts for direct services.
- Regional Center dispute resolution and third-party liability.
- Regional Center audits.
- Regional Center conflicts of interest
- Regional Center accountability and transparency

- New Federal Funds through DDS 1915 (i) State Plan Amendment. An increase of $60 million in federal funds to offset General Fund support is assumed by adding additional consumers and their related expenditures into the State's 1915 (i) State Plan Amendment as permitted under the federal Patient and Affordable Care Act of 2010. This savings is being applied towards the Administration's $750 million (General Fund) system wide reduction.
- New Federal Funds through "Money Follows the Person" Project. An increase of $5 million (federal funds) to offset General Fund support is assumed by using the "Money Follows the Person" (also known as California Community Transitions) federal grant. This savings is being applied towards the Administration's $750 million (General Fund) system wide reduction.

(Individual discussion items begin on the next page.)

1. New System Wide Cost Containment Proposal & Statewide POS Standards

Budget Issue. The Administration assumes a reduction of $533.5 million (General Fund) is achieved through implementation of Statewide Standards for the Purchase of Services, as well as through increased accountability and transparency as proposed through a series of trailer bill language proposals. (Discussed separately under Issue 2, below).

It is *unknown* what dollar reduction is to be achieved through the implementation of Statewide Standards for the Purchase of Services. But it is expected that most of the Administration's $533.5 million reduction would occur from this component.

DDS proposes *sweeping trailer bill language* to commence with Statewide Purchase of Services Standards which would add Section 4648.8 to the Welfare and Institutions Code as follows:

> Section 4648.8. Notwithstanding any other provision of law to the contrary:
>
> (a) To provide uniformity and consistency in the services, funding and administrative practices of Regional Centers throughout the State while ensuring consistency with Lanterman Act values and maintaining the entitlement to services, and to increase cost effectiveness, the DDS, with input from stakeholders, shall develop standards for Regional Centers to use when purchasing services for consumers and families.
>
> In developing these standards, DDS shall consider eligibility for the service; duration; frequency and efficacy of the service; services providers qualifications and performance; rates; parental and consumer responsibilities and self- directed service options. DDS shall also consider the impact of the standards, coupled with prior reductions in the service area, on consumers, families, and providers.
>
> DDS shall submit the standards to the Legislature by _____ with draft statutory language necessary to implement required changes. DDS shall include specific cost savings estimates associated with the standards.
>
> (b) Standards developed pursuant to this section may vary by service category and:
>
> (1) Establish criteria and limits on the type, scope, amount, duration, location, and intensity of services and supports purchased by Regional Centers for consumers and their families.
> (2) Prohibit the purchase of specified services.
> (3) Change payment rates.
> (4) Impact family and consumer responsibilities.

(c) In developing these standards, DDS shall consider provisions for limited individual exceptions to ensure the health and safety of the consumer or to avoid out-of-home placement or institutionalization.

(d) Standards developed pursuant to this section shall not:

(1) Endanger a consumer's health or safety.
(2) Compromise the State's ability to meet its commitments to the federal Centers for Medicare and Medicaid Services (CMS) for participation in the Home and Community-Based Services Waiver or other federal funding of services for persons with developmental disabilities.

DDS Process for Stakeholder Involvement in POS Statewide Standards. Under the Administration's proposal, DDS intends to have a Stakeholder process to *provide input* to the development of recommendations for POS Statewide Standards. DDS would then submit the standards to the *Legislature by June* (no specific date provided), along with "draft" statutory language necessary to implement required changes.

To begin the Stakeholder process, DDS made an anonymous online survey available on January 27th to solicit ideas on POS Statewide Standards. This survey is available until February 15th. DDS is seeking responses from consumers, family members, service providers, Regional Center staff, advocates and others. (DDS notified 40 Stakeholder Organizations).

Eight subject area Workgroups, consisting of 30-35 members each (1/3 family members, 1/3 providers, and 1/3 community and State advocates), will be convened at the end of February. The survey information will be provided to these Workgroups. DDS states the Workgroup process will take about *two-months* to complete. The Workgroups will include these subject areas:

- Behavioral Services
- Day Program, Supported Employment, and Work Activity Program Services
- Early Start Services
- Health Care and Therapeutic Services
- Independent Living and Supported Living Services
- Residential Services
- Respite and Other Family Supports
- Transportation

DDS states they will conduct *Public Forums* in May 2011 to present the *draft* of the Statewide POS Standards once the input from the eight Workgroups is obtained. Three Public Forums will be convened (Sacramento, Bay Area and Southern California).

DDS will then present the POS Statewide Standards to the *Legislature*, along with draft statutory language and related fiscal information. This is to occur sometime in *June* 2011.

Background on the Purchase of Services (POS). The table below provides a summary of the budget categories used for POS, not including community placement plan funds. This table reflects baseline funding *prior to the application* of the $533.5 million reduction.

Summary of Purchase of Services Categories *Prior* to $533.5 million GF Reduction

Service Category	2011-12 (Total Funds)	2011-12 (General Fund)
Community Care Facilities (CCFs)	$852,691,000	$474,965,000
Medical Facilities	$23,251,000	$23,251,000
Day Programs	$786,182,000	$410,424,000
Habilitation Services	$143,396,000	$95,153,000
Transportation	$228,921,000	$143,776,000
Support Services	$756,788,000	$414,378,000
In-Home Respite	$256,773,000	$141,393,000
Out-of-Home Respite	$59,430,000	$35,704,000
Health Care	$92,859,000	$82,801,000
Self-Directed Services	$0	$0
Miscellaneous	$486,798,000	$325,471,000
Quality Assurance Fees—ICF-DD	$7,936,000	$7,936,000
Total Baseline *(Prior to allocation of $533.5 million reduction)*	**$3,695,025,000**	**$2,155,252,000**

Subcommittee Staff Comment—Considerable Concerns. Subcommittee staff believes the overall $750 million General Fund reduction, and the backing-in to the as yet unidentified $533.5 million (General Fund) reduction, is *not* fully feasible due to several factors.

First, significant reductions have occurred within the Developmental Services system over the past several years. These reductions have included some eligibility changes, significant changes to services, increasing family cost-sharing, reducing rates, and related actions. As such, reductions of the magnitude that are proposed is not achievable if the Lanterman Act is to be maintained.

Second, in reviewing the POS budget categories noted above, there are some categories—such as Community Care Facilities, and other residential options—that will be difficult to reduce by very much.

Third, the continued reductions to "generic" services, such as Medi-Cal, IHHS and others, makes it more difficult for the Community-Based System to achieve savings. Costs increase in the Developmental Services System when "generic" services are not available.

Fourth, the proposed trailer bill is sweeping and provides little oversight by the Legislature. Development of Statewide POS Standards, which is a considerable undertaking, should involve a more comprehensive process.

Fifth, a significant amount of funding for Community Services is provided through the federal Medicaid Program. California has the Home and Community-Based Waiver which includes over 90,000 people with developmental disabilities. In addition, the 1915 (i) State Plan Amendment and the Money Follows the Person Grant also have federal requirements for the receipt of funds. It is unknown how the Statewide POS Standards would be viewed by the federal CMS or what requirements they may have.

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

1. DDS, Please provide a summary of the budget process and the concept behind developing Statewide Standards for the Purchase of Services.
2. DDS, How will the department aggregate and utilize the survey input received, and how will data be shared across the various Workgroups that are to be established? How will information be provided to the Legislature on the progress and outcomes of these Workgroups?
3. DDS, Would the Administration be providing additional trailer bill or policy bill language to the Legislature in June as part of your process?
4. DDS, How would the DDS and DHCS (State's Medicaid Agency) be working with the federal CMS to discern what federal limits or requirements would be necessary due to the Home and Community-Based Waiver requirements?

2. Package of Trailer Bill Proposals on Regional Centers

Budget Issue. DDS is proposing a package of trailer bill legislation to address substantial issues raised through a Bureau of State Audits Report (dated August 2010), as well as subsequent concerns identified by the DDS in their audits of certain Regional Centers and providers.

DDS states they are analyzing the fiscal effect of their proposals and intend on identifying cost-savings and cost-avoidance aspects which will be applied to offset their system wide $533.5 million (General Fund) reduction figure.

This package of trailer bill language addresses the following topics:

- A. Regional Center contracts for direct services.
- B. Regional Center dispute resolution and third-party liability.
- C. Regional Center audits.
- D. Regional Center conflicts of interest
- E. Regional Center accountability and transparency

A. Regional Center Contracts for Direct Services (85%). *First,* this language would require, notwithstanding any other provision of law, *all* Regional Center contracts or agreements with Service Providers in which rates are *determined through negotiations* between the Regional Center and the Service Provider shall expressly require that at least 85 percent of the Regional Center funds be spent on direct services. Direct service expenditures are those costs associated with the services being offered by the Provider. Funds spent on direct services shall not include any administrative costs. The language also defines the term administrative costs.

DDS notes that the 85 percent direct services requirement would *not* be applicable to services that have established rates as contained in existing State statute and regulation. It applies to *negotiated* contracts.

Second, it requires, notwithstanding any other provision of law, *all* contracts between the DDS and the Regional Centers have at least 85 percent of all funds be spent on direct services. For the purpose of this component, a direct service includes Service Coordinators, assessment and diagnosis, monitoring of consumer services and clinical services. Funds spent on direct services shall not include any administrative costs. The language also defines the term administrative costs.

Third, it requires Service Providers and Contractors, upon request, to provide Regional Centers with access to any documents, books, papers, computerized data consumer records or related information pertaining to the Service Providers' and Contractors' *negotiated* rates.

B. Regional Center Dispute Resolution and Third Party Liability. *First*, this language would authorize the DDS or Regional Centers to institute legal proceedings against a Third Party payer (insurance carrier) as a result of an injury in which the Third Party payer is liable. The language underscores that DDS and Regional Centers are the payers of last resort when Third Party payment is liable.

Second, the language provides for the DDS or Regional Center to recover the reasonable value for services provided as stated. It provides for the powers and duties of the DDS in recouping these amounts and is intended to parallel similar Third Party payer language as contained within the Medi-Cal Program, administered by the DHCS.

Third, it establishes procedures for the enforcement of a lien by the DDS or Regional Center upon a judgment or ward in favor of a consumer for a Third Party injury.

C. Non-Governmental Entity Audits. *First,* this language restricts Regional Centers from using the same accounting firm more than five times in every 10-year period.

Second, it requires non-governmental entities receiving payments from Regional Centers to contract with an independent accounting firm for an audit or review of financial statements as specified. This would *not* apply to payments made using usual and customary rates as contained in Title 17

Third, it requires Regional Centers to review the audit results and take any necessary action to resolve issues.

D. Regional Center Conflicts of Interest. This language requires DDS to adopt emergency regulations to establish standard conflict-of-interest reporting requirements regarding Regional Centers (board members, directors, and identified employees). Each Regional Center must submit a conflict-of-interest policy to DDS by July 1, 2011 and post this information on-line by August 2011.

By requiring that the statement be signed under penalty of perjury, this legislation imposes a State-Mandates local program by changing the definition of an existing crime.

E. Regional Center Accountability and Transparency. *First*, this language requires Regional Centers to annually submit to DDS documentation regarding the composition of their Board and that the Board is in compliance with specified statutory provisions. *Second*, it requires the Board to adopt written policy that requires contracts of $350,000 or more be discussed and approved by the Board. This information would be placed on its Internet Web site, along with many other provisions regarding public information policies and requirements.

Third, it would make certain persons or entities ineligible to be Regional Center vendors if convicted of prescribed crimes or have been found liable for fraud or abuse of civil proceedings within the previous 10 years. DDS states that this provision is in response

to a *draft* federal CMS report on California's Medi-Cal Program ("Medicaid Integrity Program, California Comprehensive Program Integrity Review). Specifically, DDS must develop and promulgate significant changes to its existing Title 17 regulations governing Regional Center vendorization of Service Providers. DDS contends that changes are needed or there is a potential loss of about $1.6 billion in federal funds (Home and Community-Based Waiver). (The current Home and Community-Based Waiver expires as of September 30, 2011 and needs to be renewed.)

Fourth, the language provides for emergency regulation authority to amend provider and vendor eligibility and disclosure criteria to meet federal requirements.

Fifth, it requires the Department of Social Services and Department of Public Health to notify the DDS any administrative action initiated against a licensee serving consumers with developmental disabilities.

Background: Bureau of State Audit (BSA's) Concerns. In a Joint Hearing of the Senate Committee on Human Services and the Assembly Committee on Human Services in November 2010, a comprehensive discussion was had regarding the BSA's Report entitled *"Department of Developmental Services: A more uniform and transparent procurement and rate-setting process would improve the cost-effectiveness of Regional Centers" (August 2010).*

The BSA Report includes numerous recommendations, including that DDS should provide more oversight and issue more guidance to Regional Centers for preparing and adhering to written procedures regarding rate-setting, vendor selection, and procurement processes to ensure consumers receive high-quality, cost-effective services that meet the goals of the consumers and the Lanterman Act. It was also recommended that DDS monitor Regional Center's adherence to laws, regulations and new processes by enhancing the level of its reviews. The need for transparency in several areas was also of critical concern.

As discussed at the Joint Hearing, DDS has taken some steps to address issues identified in the Report, including issuing various directives and conducting some reviews and audits of their own. One outcome from this process was placing Inland Regional Center on probation in January 2011 and requiring special contract language. DDS contends trailer bill language is necessary to address remaining audit concerns and recommendations.

Subcommittee Staff Comment. This language was just recently provided and more discussion with constituency groups is warranted. DDS also needs to provide fiscal information regarding potential savings from these proposals.

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

1. DDS, Please provide a complete description of each of the proposal trailer bill pieces, including why it is necessary, what it would do, and key outcomes that are anticipated from proceeding with the language.

3. New Federal Funds through DDS 1915 (i) State Plan Amendment

Budget Issue. The budget assumes an increase of $60 million in federal funds to offset General Fund support by adding additional consumers and their related expenditures into the State's 1915 (i) State Plan Amendment as permitted under the federal Patient and Affordable Care Act of 2010. This savings is being applied towards the Administration's $750 million (General Fund) system wide reduction.

The 1915 (i) State Plan Amendment funds a broad array of Purchase of Service costs for eligible individuals. It includes all categories *except* for Medical Facilities, Transportation, Supported Employment and Self-Directed Services.

DDS states that total 1915 (i) expenditures for 2011-12 are estimated to be $321.6 million ($160.8 million General Fund).

The 1915 (i) State Plan Amendment is a newer method offered by the federal CMS for covering Home and Community-Based services for Medi-Cal enrollees who are *not* at risk for institutionalization as presently required under the State's federal Home and Community-Based Waiver administered by the DDS. Therefore, this provides California an additional opportunity to utilize federal fund support, in lieu of General Fund.

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

1. DDS, Please provide a *brief* description of the 1915 (i) and how it is different from the State's federal Home and Community-Based Waiver.
2. DDS, Could additional General Fund savings be identified here by identifying more eligible expenditures? Please explain.

4. New Federal Funds through "Money Follows the Person" Project.

Budget Issue. The budget proposes an increase of $5 million (federal funds) to offset General Fund support by using the "Money Follows the Person" (also known as California Community Transitions) federal grant. This savings is being applied towards the Administration's $750 million (General Fund) system wide reduction.

This federal grant provides 100 percent funding for specified administrative positions and certain Purchase of Services for the *first* 12-months of the eligible consumer who is relocating into the community from an institution (such as a Developmental Center).

In order to receive these funds, the community living arrangement must be in a 4-bed residential home or lower. DDS notes that Specialized Residential Homes are 4-beds or less and these homes provide specialized behavioral services.

Subcommittee Staff Comment—More Savings. DDS is only accessing a total of $8.5 million (federal funds) from this federal grant. Subcommittee staff believes that more General Fund savings can be identified by more fully utilizing these federal grant funds. Information from the DDS is to be forthcoming on this topic.

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

1. DDS, Please briefly describe the use of these federal funds and who is eligible.
2. DDS, Are additional General Fund savings possible here please?

5. Continuation of the 4.25 Percent Reduction to Operations and POS

Budget Issue. The budget proposes to extend for one more year the 4.25 percent reduction to *both* Regional Center Operations and Provider Payments made for services. The trailer bill language extends the date to June 30, 2012.

A total reduction of $165.5 million ($91.5 million General Fund) is achieved from this action. This reduction is being applied towards the Administration's $750 million (General Fund) system wide reduction.

Of the total amount, $22.7 million ($15.5 million General Fund) is obtained from Operations, and $142.8 million ($76 million General Fund) is obtained from Provider Payments.

The existing exemptions for Supported Employment, the SSP supplement for independent living, and services with "usual and customary" rates as established in regulation are not proposed to change.

In addition, other services may be exempt for this reduction if a Regional Center demonstrates that a non-reduced payment is necessary to protect the health and safety of a consumer and the DDS has granted approval.

It should be noted that a 3 percent reduction was enacted beginning in February 2009 (SB X3 6, Statutes of 2009). This reduction level was increased to 4.25 percent by the previous Administration beginning in 2010. This proposal extends this action for another year.

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

1. DDS, Please provide a brief description of the proposal.
2. DDS, Has the DDS been monitoring the effect of this reduction and if so, what have been some of the consequences?

6. Budget Bill Language for Prevention Program

Budget Issue. The budget proposes Budget Bill Language to allow the DDS to transfer funds from the Prevention Program to the Purchase of Services. The proposed language is as follows:

> "Notwithstanding Section 26.00, the Department of Finance may authorize transfer of expenditure authority from Schedule (4) 10.10.080—Prevention Program to Schedule (2) 10.10.020—Purchase of Services to more accurately reflect expenditures in the Prevention and Early Start Programs.

DDS states this language is needed to effectively administer the Prevention and Early Start Programs and ensure the funds are correctly budgeted based on actual caseload during the fiscal year.

Since the Prevention Program was established in 2009 as part of the cost containment actions, it has been difficult for the DDS to know whether infants and toddlers would be coming into this program or would be receiving services through the Early Start Program.

For 2011-12, it is assumed that 10,860 infants and toddlers will obtain services in the Prevention Program for expenditures of $20 million (General Fund). The proposed Budget Bill Language would provide DDS with flexibility to move funds from the Prevention Program to the Purchase of Services line for expenditure under the Early Start Program contingent upon the flow of caseload.

Background—Early Start and Prevention Program. Through the $334 million (General Fund) cost containment measures enacted in 2009, several changes were done to the Early Start Program, including a narrowing of program eligibility. Specifically, toddlers aged 24 months need to have a delay of 50 percent or greater in one domain or 33 percent or greater in two domains to enter into the Early Start Program. Previously, it was a delay of 33 percent or greater in one of the five domains.

Also as part of this framework, a Prevention Program was established for infants and toddlers who are "at risk" and are no longer eligible for the Early Start Program but can participate in a new non-Lanterman Act program.

The Prevention Program provides safety net services (intake, assessment, case management, and referral to generic agencies) for eligible children from birth through 35 months. These are children who are at substantially greater risk for a developmental disability than the general population but who would otherwise be ineligible for services in Early Start.

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

1. DDS, Please provide a brief explanation as to why this language is necessary.

7. Legislative Analyst's Office—Options (Hand Out)

LAO Options. The LAO has prepared two options to achieve savings in the community services program.

Option 1 is to expand the Family Cost Participation Program to include more services. By including more services the LAO believes a reduction of $10 million (General Fund) could be achieved. The additional services for families to have a share of cost in would include transportation services and Day Program expenditures.

The DDS notes that they too would be likely proposing changes to the Family Cost Participation Program as part of their Purchase of Services Standards process.

Option 2 is to implement a "means testing" for families 400 percent of poverty and above and only to families with children under 18 who are living at home. The LAO believes that 9,700 families would be impacted and that a reduction of $57 million (General Fund) could be achieved.

DDS notes that means testing is not a preferred approach for many reasons, including program administration, as well as the need to maintain families at home. One does not want families to not be supported at home and instead, choose to place their children in an out-of-home environment. Further, DDS notes that parental responsibilities and family income levels will be a consideration in their development of their Purchase of Services Standards process.

Background—Family Cost Participation Program. Under the Family Cost Participation Program established in 2005, families that meet the following conditions are identified for FCPP participation and pay a share of cost for Respite and Day Care services:

- Child has a developmental disability or is eligible for services under the Early Start Program;
- Children are ages 0 through 17 years old;
- Children live at home;
- Children are not Medi-Cal eligible; and
- Family income is at or above 400 percent of poverty.

Questions. The Subcommittee has requested the LAO to respond to the following question:

1. LAO, Please provide a brief summary of the LAO Options.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 25th, 2011

9:30 AM

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

AGENDA I

Item	Department
4440	Department of Mental Health—State Hospitals

PLEASE NOTE:
Only those items in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings. Issues will be discussed in order as shown in the Agenda unless otherwise directed by the Chair. Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible. Thank you.

A. Vote Only for Department of Mental Health: State Hospitals

1. Request for Coleman Bed Expansion Restoration (DOF Issue 551).

Legislative Actions Contained in SB 69 Budget Bill. The Legislature appropriated a total of $5.7 million (General Fund) to support a phase-in of 80 positions to increase the capacity of the Vacaville Psychiatric Program (at Vacaville). The purpose of these positions is to accelerate the activation schedule for 64 beds in the Intermediate Treatment Program as desired by the *Coleman* Court.

The Legislature's appropriation is $1.8 million (General Fund) *less* than requested in the Governor's January budget. This is because the Legislature adopted an LAO recommendation to reduce by the $1.8 million (General Fund) to account for a phase-in of the positions.

The DMH had assumed that all 80 positions would be hired by July 1, 2011. The LAO recommendation assumed positions would be hired by September 2011, which results in a reduction of $1.8 million (General Fund)

Governor's May Revision. The May Revision requests a restoration of the $1.8 million (General Fund) which was reduced by the Legislature.

Background—Coleman Court Requires More Mental Health Beds. Pursuant to *Coleman v. Schwarzenegger* an order was issued in October 2004 pertaining to the unidentified needs of CDCR Mental Health Program Inpatient Services. The Coleman Special Master directed the Administration to submit short-term and long-term plans to address the mental health bed capacity need. One aspect of the CDCR plan is to have additional mental health beds at Vacaville.

According to the DMH, Vacaville has a total of 218 Inpatient Beds in the Acute Psychiatric Program and 114 beds in an Intermediate Treatment Program. *However,* an additional 64 beds for high custody Intermediate Treatment Program are to be constructed and activated by no later than September 2011.

The additional 64-beds are to be constructed on VDVR property adjacent to the CA Medical Facility in Vacaville. *The construction of these beds is to be completed by September 2011.* By adding these beds, CDCR will partially achieve the Court's directed increased in bed capacity and avoid a possible order by the federal Court.

Subcommittee Staff Recommendation—Deny the May Revision Request. It is recommended to deny the May Revision request to restore the $1.8 million (General Fund) since the LAO's recommendation reflects a reasonable phase-in of personnel based upon State hiring practices.

Further, it should be noted that DMH received all of their requested positions (30 staff) to begin Phase I activation at Vacaville, and have received approval to proceed with hiring 80 staff in 2011-12, just at a more realistic rate.

Finally, there is presently a strict State hiring freeze, including for 24-hour facilities and the DMH presently has hundreds of vacancies.

2. Funding for Training Program (DOF Issue 556)

Governor's May Revision. The May Revision requests an increase of $250,000 (General Fund) for the DMH to sponsor and train employees in accordance with the Collective Bargaining Agreement for Unit 18 related to Psychiatric Technicians

The following Budget Bill Language is also proposed for this appropriation:

> "Of the amount appropriated in this Item, $250,000 is to be used for candidates participating in the Psychiatric Technician Assistant 20./20 training program subject to the terms and conditions agreed upon in the Memorandum of Understanding with Bargaining Unit 18 on June 16, 2010."

DMH will be ramping up its training effort with the Stockton Health Care Facility activation in 2013and the increased need for Psychiatric Technicians at the State Hospital.

Subcommittee Staff Recommendation—Approve May Revision. The $250,000 is needed for sponsorships and training of Psychiatric Technicians at the State Hospitals as noted. It is recommended to approve the May Revision request, including the proposed Budget Bill Language.

3. Technical Scoring Issue—Unencumbered Balance to Revert

Budget Issue and Subcommittee Staff Recommendation. As noted above, the May Revision proposes an increase for the sponsorship and training of Psychiatric Technicians.

Funding in the amount of $3 million (General Fund) was originally provided for this program in Chapter 322, Statutes of 2007. According to the DOF, about $2.7 million (General Fund) was still available for this program in 2010-11. The unencumbered balance is scheduled to revert as of June 30, 2011 according to the enabling legislation, and as confirmed by the DOF.

Based on information obtained from the DOF, the expenditures to-date for this appropriation have been as follows:

2007-08	= $0
2008-09	= $156,699
2009-10	=$137,563
2010-11	=not yet available

Since expenditures have been modest, and the May Revision is providing a new appropriation of $250,000 (item 2, above), it is recommended to recognize $2 million (GF) in savings for the anticipated reversion as of June 30, 2011.

Recognizing a $2 million (GF) reversion still provides a more than adequate margin for expenditures in 2010-11 ($i.e. $700,000), and recognizes the State's difficult fiscal situation.

B. Discussion of Department of Mental Health—State Hospitals

1. Safety and Security at the State Hospitals (DOF Issue 670)

Prior Subcommittee Hearing—February 1st. The Subcommittee discussed safety and security issues regarding the State Hospitals in its February 1st hearing due to a number of assaults on State Hospital staff and patients, including a tragic fatality.

The DMH provided an update regarding recent changes to improve safety and security and noted that further analysis and recommendations would be forthcoming at the Governor's May Revision.

Governor's May Revision. The May Revision proposes an increase of $9.5 million (General Fund) and 78 positions to implement safety and security measures at three of the State Hospitals—Napa, Metropolitan and Patton. Each of these State Hospitals has an "open campus" and was originally designed for treating civilly committed patients (not Pena Code-related patients). As such, additional safety and security measures are needed as the patient population has considerably changed.

This proposal contains *four key components*, as displayed in the Table below:

Summary of Safety and Security Components

Component	Description	Positions	General Fund Expenditures
Grounds Presence Teams	A team will consist of 7 staff—six Psychiatric Technicians and one Senior Psychiatric Technician. Two teams will be deployed at Napa, and two teams at Metropolitan. These teams would cover the Secured Treatment Areas during the hours the patients have access to the grounds.	14	$2.152 million
Grounds Safety Team	Grounds Safety Teams will consist of Hospital Peace Officer staff. Napa and Metropolitan will receive 13 staff each (10 Hospital Peace Officers, two Sergeants, and one Lieutenant). Patton will receive 24 staff (20 Hospital Peace Officers, three Sergeants, and one Lieutenant).	50	$3.215 million
Personal Alarms	Napa will have an improved "personal alarm system" to provide coverage throughout the entire facility, including campus grounds. This is to be implemented as a pilot project and is to include a study/reporting component.	0	$4.0 million
Patient Transfer (Section 7301, W&I Code)	DMH intends to transfer up to 100 individuals from the State Hospitals to the Department of Corrections and Rehabilitation (CDCR). DMH states this will be at no cost to the DMH and will increase the safety and security of patients and staff.	0	0
TOTAL		**78 positions**	**$9.5 million**

Key duties of the “Grounds Presence Teams” are:

- Direct supervision of all patients as they move with and without staff throughout the Secure Treatment Area;
- Detect safety and security issues;
- Redirect inappropriate activities or behavior of patients;
- Provide crisis intervention as needed;
- Serve as supplement to the Hospital Police Officer during emergencies;
- Perform periodic searches throughout the grounds and individuals; and
- Implement and oversee all policies and procedures concerning health, safety and the protection of individuals and staff from physical or environmental hazards.

Psychiatric Technicians are used for these Teams since it is essential that these duties be conducted by staff that are licensed and trained to interact with the State Hospital patient populations.

The “Grounds Safety Teams” would augment the existing compliment of Hospital Peace Officers at the State Hospitals. The DMH notes that the State Hospitals have not had an increase in their Hospital Peace Officer allotment since the late 1990’s. In that same time, there has been a dramatic shift in the patient demographic to a predominately Penal Code-related population which requires more security.

Key duties of the “Grounds Safety Teams” are:

- Serve as a greater security presence and actively look for contra band;
- Patrol the grounds, including the perimeter;
- Provide police interventions in an effective and efficient manner.

The May Revision request of $4 million for a Personal Alarm System at Napa is vital. The existing alarm system does not allow for enhancement or modifications and the manufacturer no longer makes the alarm pens used for the system. Further, the existing alarm system is building specific and does not provide any coverage outside of the buildings. These system deficiencies have resulted in health and safety issues.

The proposed Personal Alarm System would be wireless and include all buildings and grounds within the designated perimeter at Napa. It would provide for personal safety of staff moving to and from buildings and grounds, and identify exactly where staff is located within the facility in case of an emergency. Each employee will be equipped with a personal alarm device attached to a lanyard that can be easily activated in an emergency. Activation of the device will cause audible and visual indicators to locate the problem. The wireless monitoring will enable the Hospital Police and medical staff to know exactly who and where the staff person is requiring assistance.

DMH is pursuing a third-party assessment and all business requirements will then be published for a “Request for Bid” (RFB) process. DMH has obtained demonstrations of available systems and refinement of business and technical requirements needed to solicit bids on the project.

Due to health and safety issues, *the DMH is seeking to expedite this project* and will be requesting the California Technology Agency (CTA) to exempt the project from having to submit a "Feasibility Study Report" which is normally required for these information technology projects. DMH will also be working with the Department of General Services (DGS) to employ an existing State contract in order to expedite and facilitate procurement of the proposed system. Both CALNET 2 and Western States Contracting Alliance (WSCA) contracts provide the vehicle for an RFB and Statement of Work to be processed for final contract approval.

If DMH is successful in expediting the project, they estimate that the installation and activation of the new Personal Alarm System *can be completed within four months of enactment of the 2011-12 Budget*.

Existing statute—Section 7301 of Welfare and Institutions Code—authorizes the transfer of patients from DMH to the CA Department of Corrections and Rehabilitation when specified individuals committed to DMH need care and treatment under conditions of "custodial security" that can be better provided by CDCR. DMH states their current Memorandum of Understanding (MOU) with the CDCR outlines the responsibilities of the respective departments when such transfers are authorized. The DMH states they are meeting with the CDCR to revise "entry" and "exit" criterion to address a more expedited and efficient transfer process (from DMH to CDCR) when "custodial security" is appropriate. DMH anticipates transitioning up to 100 patients within 2011-12 for safety and security reasons related to conditions of "custodial security". This is an administrative function and no budgetary action is needed within the DMH item.

Legislative Analyst's Office Recommendation—Adjust for Salary Savings. The LAO notes the DMH assumes that *all* 78 positions to implement safety and security measures at Napa, Metropolitan and Patton would be filled by July 1, 2011, the start of the budget year. *However, the LAO analysis indicates that it would take the DMH several months to fill all of the new positions.*

Therefore, the LAO recommends a reduction of $1.1 million (General Fund), or a 25 percent salary savings level, to more accurately reflect the rate at which the positions are likely to be filled by the State Hospitals over the course of the budget year. This reduction assumes that all of the positions are filled by no later than September 2011.

Subcommittee Staff Comment and Recommendation—Adopt the May Revision with Technical LAO Adjustment. Safety and security are an integral aspect of patient care and active treatment, and employees must have a safe work environment. Health and safety issues at the State Hospitals need to be significantly mitigated and the May Revision proposes positive steps in that direction.

The LAO's adjustment represents a standard practice for reflecting a phase-in for salary savings purposes is reasonable given the number of new positions and the existing State hiring freeze. Therefore it is recommended to adopt the May Revision with the LAO adjustment.

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

1. DMH, Please provide a summary of the May Revision request and briefly describe each component noted in the Table.
2. DMH, What is presently being done to expedite the personal alarm system at Napa?
3. DMH, Please provide a brief update regarding safety and security efforts at Napa.
4. DMH, Are there any other aspects of the security and safety measures at the State Hospitals which should be noted please?

2. Stockton Health Care Facility: Pre-Activation Functions (DOF Issue 550)

Governor's May Revision. The May Revision proposes an increase of $1.364 million (General Fund) and 8 positions to support the acute and intermediate in-patient mental health treatment services to CDCR inmate-patients and operate 480 inpatient beds in a *Plata* Receiver constructed hospital facility (to be constructed under a separate court ordered plan).

This facility will have an organizational structure that is similar to current State Hospitals and DMH operated Psychiatric programs.

These positions will assist the CDCR in establishing policies and procedures needed to activate this facility in 2013 and to accept patients by December 2013. The positions include the following:

- Executive Director
- Hospital Administrator
- Chief Psychiatrist
- Chief Psychologist
- Clinical Administrator
- Supervising Registered Nurse III
- Senior Information Systems Analyst
- Executive Assistant

Among other things, the *Plata* Receiver is authorized to address the need to construct heath related facilities and housing for inmates with medical and/or mental health needs. In a court order filed in the Coleman v. Schwarzenegger (*Coleman*) class action lawsuit in January 2010, the court ordered that a Health Care Facility be activated and have patient admissions completed to full occupancy by December 2013. This is a compressed time frame, much shorter than a normal activation of a licensed hospital facility.

The schedule necessitates that resources and recruitment begin, and policies and procedures be developed immediately. The requested positions need to be brought on line to support the pre-activation workload that must be in place prior to activation, hiring and training of the Health Care Facility level-of-care staff.

DMH further states that the success of this Health Care Facility is highly dependent upon the DMH's ability to provide clear direction and oversight from its headquarters to ensure adequate planning and the timely delivery of quality of care required by the *Coleman* Court.

The Coleman Court will be tracking bed utilization, staffing and inmate-patient waitlists. Court orders require the Coleman Court and Special Master to continue to oversee the provision of mental health care services, assess the effective utilization of those services, and determine if the resulting outcomes effectively address the court's orders.

Subcommittee Staff Comment and Recommendation. The requested positions and funding are necessary to commence with pre-activation activities, particularly with the imminent activation timeline of December 2013. DMH has justified the positions and the funding request.

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

1. DMH, Please provide a brief overview of the May Revision request.

3. Proposed Restructure of the Department of Mental Health—State Hospitals

Governor's May Revision--Informational. As part of the Governor's realignment and restructuring, the May Revision proposes to create a Department of State Hospitals over the course of 2011-12.

At this time it appears that the Department of State Hospitals would not take effect until July 2012 and will therefore be addressed in the 2012-13 budget process.

The Administration states that a separate department is necessary in order to more comprehensively focus on mitigating significant health and safety issues, to centralize administrative functions, and address core patient population management and fiscal administration.

Background and Description of State Hospital Patient Population. 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.

A total patient caseload of 6,342 patients is assumed for 2011-2012. This includes 5,558 patients at the State Hospitals and 766 patients at the two acute psychiatric programs. Of the total patient caseload, only 471 patients are civil commitments.

Patients admitted to State Hospitals are generally either **(1)** civil commitments; or **(2)** judicial commitments. These referrals come from County Mental Health departments, the courts, and the CA Department of Corrections and Rehabilitation (CDCR).

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 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.

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.

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 $1.220 billion ($1.140 billion General Fund) for 2010-11. *This represents an increase of about $516 million in General Fund support, or an 83 percent General Fund increase in only six-years.*

The DMH contends these increased expenditures are attributable to: **(1)** compliance with 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.

Subcommittee Staff Comment. The patient population at the State Hospitals has evolved from primarily being a civilly committed population to now consisting of over 94 percent Penal-Code population. Significant issues need to be address and having a Department of State Hospitals would assist in focusing timely resolution to issues.

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

1. Administration, Please provide a framework as to the intent of this proposal.
2. Administration, Please provide a perspective on next steps please.
3. Administration, How may the Legislature be kept informed during 2011-12 as discussions on this topic occur?

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 25, 2011

9:30 AM

Room 4203
(John L. Burton Hearing Room)

Staff: Jennifer Troia

AGENDA II

Item	Department
0530	Health & Human Services Agency (HHS), including Office of Systems Integration (OSI)
4140	Office of Statewide Health Planning & Development (OSHPD)
4170	Department of Aging (CDA)
4200	Department of Alcohol & Drug Programs (ADP)
5160	Department of Rehabilitation (DOR)
5170	State Independent Living Council (SILC)
5175	Department of Child Support Services (DCSS)
5180	Department of Social Services (DSS)

PLEASE NOTE:

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

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

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

VOTE-ONLY AGENDA

Item Department Page

Continued on next page

VOTE-ONLY AGENDA, CONTINUED

5180 **Department of Social Services (DSS)** **Page**

* *Note:* These agenda items include cross-over between OSI and DSS proposals.

DISCUSSION AGENDA

Vote-Only Agenda

0530 Health & Human Services Agency (HHS), including Office of Systems Information (OSI)

HHS Issue 1: Tech4Impact Grant Award

Budget Issue (#302): HHS requests, in an April 1 finance letter, to increase Reimbursement authority for 0530-001-0001 by $65,000 in order to utilize Tech4Impact grant funding awarded to the agency by the Public Health Institute Center for Technology and Aging (a private nonprofit research and education organization). The grant does not require a state match, and there is no General Fund (GF) impact.

Background: The total Tech4Impact grant award is $100,000. A 2010-11 budget revision was processed for $35,000 of this total, and this request reflects the remainder of the grant funding. The grant is intended to support local incorporation of web-based technology into existing Aging & Disability Resource Connection programs. As a result, individuals with chronic conditions may be able to manage their health through electronic personal health records.

Subcommittee Staff Comment and Recommendation: Staff recommends approval of the requested $65,000 increase in Reimbursement authority for 0530-001-0001.

HHS Issue 2: Aging & Disability Resource Connection (ADRC) Services

Budget Issue (#s 501 & 503): HHS requests, as part of the May Revision, to increase Schedule 1 of Item 0530-001-001 and Item 0530-001-0890 by $246,000. This additional federal funding authority will allow expenditure of available federal grants intended to strengthen ADRC services. This action would incorporate recently awarded second year funding of the ADRC Evidence Based Care Transitions grant ($206,000) and roll-over $40,000 in unexpended 2010-11 grant funds previously approved by the Legislature in SB 69.

HHS also requests, as part of the May Revision, to extend an existing limited-term Staff Services Manager (SSM) I position by 15 months through the end of the ADRC Options Counseling grant period, which is September 30, 2012. The current position was administratively established in January 2010, and is set to expire on June 30, 2011. No increase in expenditure authority is being requested as the grant funding was already approved as part of SB 69 as passed by the Legislature. This position is federally funded with no state match requirement.

Subcommittee Staff Comment and Recommendation: Staff recommends approval of the requested increases in expenditure authority and establishment of authority for the limited-term SSM I position.

HHS Issue 3: Child Welfare Services/Case Management System (CWS/CMS)

Budget Issue (#515): OSI requests, as part of the May Revision, to decrease expenditure authority for Item 0530-001-9732 by $3.2 million. This reduction reflects lower negotiated rates with the system's prime vendor. On December 17, 2010, CWS/CMS received approval from the federal Administration for Children and Families to amend the prime vendor contract. The current contract has been in place for 18 years with a term end-date of July 31, 2013. The agreement has been negotiated to obtain savings, extend the base contract term through 2016, and allow for three additional optional years to ensure uninterrupted maintenance support. OSI will submit additional decreases for the out-years of the contract through the annual budget process. There are corresponding $3.2 million ($1.5 million GF) decreases in the DSS local assistance budget for 2011-12.

Subcommittee Staff Comment and Recommendation: Staff recommends approval of the requested decreases in 2011-12 expenditure authority.

HSS Issue 4: Case Management Information and Payrolling System (CMIPS II) Project

Budget Issue (Issue #s 081, 514): According to the Administration, changes to the schedule and funding for CMIPS II are necessary because of significant programmatic changes in the In-Home Supportive Services (IHSS) program resulting from the 2009-10 and 2010-11 budget agreements, including implementation of Chapter 725, Statutes of 2010 (AB 1612). Given the magnitude of these program changes, the Administration estimates a schedule extension of another 18 months for the CMIPS II project. As a result, and as part of the May Revision, DSS requests to decrease its local assistance budget for CMIPS II in 2010-11 by $31.3 million ($11.6 million GF) and to increase its local assistance budget for the project in 2011-12 by $15.3 million ($5.6 million GF). Similarly HHS requests, related to these changes and as part of the May Revision, to decrease its 2010-11 expenditure authority by $11.5 million and to increase 2011-12 expenditure authority for Item 0530-001-9732 by $12.5 million.

In addition, DSS proposes, as part of the May Revision, an increase of $456,000 ($228,000 GF) and the one-year extension of 4.0 limited-term positions that support implementation of CMIPS II. According to the department, these positions provide the IHSS programmatic expertise necessary to ensure successful project implementation.

Background on CMIPS II: The existing CMIPS is a more than 20-year-old system that offers mainly payroll functions for providers in the In-Home Supportive Services (IHSS) program. CMIPS II is intended to be a web-based solution that integrates off-the-shelf products to perform IHSS case management, payroll, and timesheet processing, as well as reporting and data exchange functions. OSI has indicated that this new system will offer a number of benefits as compared with the existing system, including more timely updates of information; more easily accessible reports; increased work automation; and a greater ability to interface with other data systems.

Timing of CMIPS II Development: Procurement planning activities for CMIPS II originally began in fiscal year 1999-00. Procurement was then delayed and final proposals from bidders were received in August 2006. The incumbent contractor was the sole bidder. The contract award was supposed to be made on July 1, 2007, but negotiations took longer than anticipated. As a result, the contract was awarded in March 2008. Federal approval of the Implementation Advanced Planning document was also received in March 2008. Project initiation and planning began on July 1, 2008. Most recently, the CMIPS II project was expected to finish system testing and move into pilot operations in the spring of 2011. With these new delays, those activities are instead expected to begin in October 2011, with full implementation of the new system scheduled for January 2013.

Subcommittee Staff Comment and Recommendation: Staff recommends approving the proposed changes in HHS and DSS expenditure authority, as well as the requested one-year extension of the four limited-term positions at DSS.

HSS Issue 5: Health Information Exchange Support

Budget Issue: The Office of Health Information Integrity within the Health and Human Services Agency proposes to establish a two-year limited term Staff Service Analyst/Associate Governmental Program Analyst position ($99,000 federal funds) to support the Deputy Secretary in coordinating and leading the California electronic health information technology and exchange program. There is no General Fund impact.

Background: The Deputy Secretary for Health Information Technology (HIT) is California's designated HIT leader. The Deputy Secretary also serves as the chief advisor to the Governor and Secretary on issues pertaining to health information exchange. As the state's HIT leader, the Deputy Secretary is operationally responsible for the overall coordination with a large number of federal and state initiatives impacting HIE such as California Cooperative Agreement for Health Information Exchange, Regional Extension Center grants, Medi-Cal HIT Incentive Program, Cal ERX, California Telehealth Network and HIT Workforce Development grant programs. Additionally, the Deputy Secretary coordinates strategic planning efforts with state departments that will be affected and impacted by the health information programs.

According to the Administration, support for the Deputy Secretary's work was previously achieved through a redirection of resources from the California Office of Health Information Integrity (CalOHII). However, due to its own program demands, CalOHII cannot continue to provide the support needed for the activities and efforts of the Deputy Secretary as the state's HIT leader. Therefore, the administration is requesting this position to serve as an Executive Assistant and Analyst for the Deputy Secretary of HIT. The position will be funded by ARRA grant funds already included in CalOHII's budget authority.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee approve this request.

HSS Issue 6: Proposed Elimination of the CA Health Care Quality Improvement & Cost Containment Commission

Budget Issue: HSS proposes, as part of the May Revision, trailer bill language to eliminate this Commission, which has never convened.

Background: The California Health Care Quality Improvement and Cost Containment Commission was created by AB 1528 (Chapter 672, Statutes 2003) to research and recommend strategies for promoting quality health care. The 27 member commission was to include members knowledgeable about health care with appointment authority shared between the Office of the Governor (17 appointments), and the Senate and Assembly, each having four appointments. The commission was to issue a report to the Legislature and the Governor, on or before January 1, 2005, making recommendations for health care cost containment. According to the Administration, the passage of federal health care reform means that this advisory board is no longer needed. Federal health care reform implementation includes quality and cost assessments related to health care and in California some of these evaluations will be provided by the newly created Health Benefit Exchange.

Subcommittee Staff Comment and Recommendation: Staff recommends that the Subcommittee approve the proposed trailer bill language to eliminate this Commission.

4140 Office of Statewide Health Planning & Development (OSHPD)

OSHPD Issue 1: Implementation of Senate Bill (SB) 90

Budget Issue: OSHPD requests, as part of the May Revision, 5.0 two-year limited-term positions (two senior architects, two structural engineers, and one office technician) and a corresponding increase in Hospital Building Fund expenditure authority of $746,000 in 2011-12 and $706,000 in 2012-13 to implement the mandates of this recently enacted legislation (Chapter 19, Statutes of 2011). There is no GF impact.

Background: Following the 1971 San Fernando Valley earthquake, California enacted the Alfred E. Alquist Hospital Facility Seismic Safety Act of 1973, which mandated that all new hospital construction meet stringent seismic safety standards. In 1994, after the Northridge earthquake, the Legislature passed and the Governor signed SB 1953 (Alquist), which required OSHPD to establish earthquake performance categories for hospitals, and established a January 1, 2008 deadline by which general acute care hospitals must be retrofitted or replaced so they do not pose a risk of collapse in the event of an earthquake, and a January 1, 2030 deadline by which they must be capable of remaining operational following an earthquake. SB 1953 also allowed most hospitals to qualify for an extension of the January 1, 2008 deadline to January 1, 2013.

SB 90: This recently enacted legislation is the latest policy bill that has amended the seismic safety requirements for hospitals since 1994. Under SB 90, the 2013 deadline by

which hospitals must meet existing seismic safety requirements may be extended by seven years when specified milestones and conditions are met. When determining whether to grant a requested extension, OSHPD must consider: 1) the structural integrity of the building based on its HAZUS evaluation score [using technology developed by the Federal Emergency Management Agency (FEMA)], 2) access to essential services within the community, and 3) specific factors related to the hospital owner's financial capacity.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the requested position and expenditure authority for the implementation of SB 90.

4170 Department of Aging (CDA)

CDA Issue 1: Carry-Over of Federal Funds

Budget Issue (Issue #503): CDA requests, as part of the May Revision, to carry over, from 2010-11 to 2011-12, $696,000 in federal Medicare Improvements for Patients and Providers Act (MIPPA) grant funding. This carry-over would be accomplished technically through amendments to Items 4170-001-0890, 4170-001-0001, 4170-101-0890, and 4170-101-0001 of the Budget Bill.

Background: MIPPA grant funds are intended to expand Medicare Beneficiary enrollment in the Prescription Drug Benefit Low Income Subsidy Program and the Medicare Savings Program, and to provide outreach. In total, the federal Administration on Aging awarded a two-year, $2.2 million grant to the California Department of Aging. Of this amount, $1.1 million was to be spent in the current year and the remainder in the budget year. However, as a result of the late enactment of the 2010 Budget Act, only $400,000 will be expended in 2010-11. According to the Administration, if the proposed funds are carried over into 2011-12, all of the $2.2 million in grant funds can still be expended by the end of the grant period.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the requested technical changes to carry-over the federal MIPPA funding.

5160 Department of Rehabilitation (DOR)

DOR Issue 1: Increased Federal Funding for Vocational Rehabilitation Services

Budget Issue: The Administration proposes, as part of the May Revision, changes to the Budget Bill to enable DOR to spend $2 million in additional federal funds that are available to support cooperative agreements for vocational rehabilitation (VR) services in colleges, high schools, and mental health programs. These funds require a state match, but that match will be met through certified time provided by the local partner agencies. The resulting total funds proposed for the VR program include $180.9 million ($28.4 million GF). There is no GF impact of the proposed May Revision change.

Background: The VR program is administered through DOR's staff of rehabilitation professionals, who assist individuals with disabilities in preparing for, entering into, and retaining competitive employment in integrated work settings and living independently in their communities. Nearly 80 percent of the VR Program funding is provided by a federal grant, with the remainder provided by state or "certified time" matching funds. The VR Program is not an entitlement program. Consumers are provided services within the amount of funds available and are limited by the federal grant and state or matching resources that are available.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the requested changes to Budget Bill Items for DOR, including Items 5160-001-0001, 5160-001-0890, and Reimbursements.

5170 State Independent Living Council (SILC)

SILC Issue 1: ADRC Federal Grant

Budget Issue: SILC requests, in a spring finance letter, an increase of $255,000 in federal fund authority for a third year of federal grant resources to manage a newly operational Aging and Disability Resource Connection site and perform other specified activities. The Council is not requesting any GF resources, as in-kind services will be used for the state match.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the requested resources.

5175 Department of Child Support Services (DCSS)

DCSS Issue 1: Estimate Changes

Budget Issue: DCSS requests, as part of the May Revision, technical adjustments that result from: 1) a $175,000 GF decrease and offsetting $175,000 Federal Trust fund increase, related to a projected increase in Federal Performance Basic Incentive Funds and 2) a $15.4 million decrease ($5.2 million GF and $10.2 million Federal Trust Fund) to reflect newly negotiated California Child Support Automation System (CCSAS) contract costs. The resulting total administrative costs for local assistance are estimated to be $906.3 million ($277.7 million GF) for 2010-11 and $866.6 million ($270.8 million GF) for 2011-12. The total distributed child support collections and revenues are projected to be $2.3 billion ($217.7 million GF) for 2010-11 and $2.3 ($256.3 million GF) for 2011-12. This reflects an increase of $77.4 million ($5.5 million GF) for 2010-11 and an increase of $117.7 million ($9.6 million GF) for 2011-12.

Background: Since Federal Fiscal Year 2000, states are evaluated for federal incentive funds based on five performance measures: 1) paternity establishment, 2) percent of cases with a child support order, 3) collections of child support currently owed, 4) collections of child support due in arrears, and 5) cost effectiveness as measured by total expenditures and total child support collections distributed. In addition, states can be penalized if they fail to perform at acceptable levels or to submit required data.

Federal law also mandates that each state create a single statewide child support automation system that meets federal certification. There are two components of California's statewide CCSAS system. The first is the Child Support Enforcement (CSE) system and the second is the State Disbursement Unit (SDU). The CSE contains tools to manage the accounts of child support recipients and to locate and intercept assets from non-custodial parents who are delinquent in their child support payments. The SDU provides services to collect child support payments from non-custodial parents and to disburse these payments to custodial parents. DCSS achieved full implementation of the CCSAS in November 2008, but the system, in the Maintenance & Operations phase now, undergoes continuing changes with contract updates.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the requested adjustments.

DCSS Issue 2: Transfer of Postage Funds

Budget Issue: DCSS requests, as part of the May Revision, to permanently transfer $9 million ($3.1 million GF) from Items 5175-002-0001 and 5175-002-0890 to Items 5175-001-0001 and 5175-001-0890 to provide sufficient funding in the correct budget items to pay for postage associated with child support forms and notices. The request is budget-neutral, and the Department indicates that it is necessitated by a change in practice at the Department of General Services (DGS) Office of State Publishing (OSP).

Background: The Child Support Program distributes numerous forms, notices, and statements to custodial and non-custodial parents, employers, other governmental entities and fiscal institutions. These documents are necessary to comply with federal and state child support requirements, inform parents of their child support rights and obligations, and provide support to parents participating in the child support program. DCSS currently has a five-year contract with DGS OSP to provide for printing and mailing services. The contract amounts to $18.5 million ($6.3 million GF) per year through June 30, 2011. Of this amount, $9 million ($3.1 million GF) is allotted for postage associated with child support forms and notices. The funds are currently budgeted in an item through which postage is not directly paid, as current practice is to reimburse after the expenses are incurred. DGS has advised departments that effective in the 2011-12 budget year, absent a timely state budget, DGS OSP no longer has the authority or funding to pay for postage for clients' mass mailing projects, including the DCSS postage. Therefore, the movement of funds between budget items is necessary to allow OSP to effectuate the mailing under the new conditions.

Subcommittee Staff Comment & Recommendation: Staff recommends approving the proposed technical adjustments needed to implement the new method of paying postage costs.

5180 Department of Social Services (DSS)

DSS Issue 1: Estimate Changes and Technical Adjustments

Budget Issue: DSS proposes, as is customary during the May Revision, to update caseload and workload estimates based on more recent data than was available at the time of the Governor's January budget release. This year, the Department proposes these updates relative to SB 69 (the budget bill) as it was passed by the Legislature in March of this year.

Caseload Estimates: March and May estimates of the average monthly caseloads associated with a number of major programs in 2011-12 include:

Program	March 2011 Conference Budget	May Revision
CalFresh (food stamp) Program	1,564,501 households	1,211,429 households
Supplemental Security Income/State Supplementary Payment (SSI/SSP)	1,284,825 cases	1,286,113 cases
CalWORKs	575,928 cases	593,828 cases
Child Welfare Services (Emergency Response, Family Maintenance & Reunification, Permanent Placement)	131,425 cases	136,433 cases
AFDC Foster Care	45,732 cases	45,857 cases
Kinship Guardianship Assistance Program (Kin-GAP)	13,102 cases	12,697 cases
Seriously Emotionally Disturbed Residential Placements	1,896 cases	1,768 cases
Adoption Assistance Program	88,431 cases	86,393 cases
In-Home Supportive Services (IHSS)	442,638 cases	437,997 cases

To reflect corresponding changes in the programs' caseload and workload budgets, DSS requests the following technical changes to budget bill items, totaling a net increase of $41.5 million (increases in Federal Trust Fund and other funds, offset by decreases in GF and Reimbursements):

Program	Item	Change from SB 69
CalWORKs / Kin-GAP	5180-101-0001 5180-101-0890 5180-601-0995	-$26,678,000 $59,042,000 -$202,000
Foster Care	5180-101-0001 5180-101-0890 5180-101-8004 5180-141-0001 5180-141-0890	-$9,194,000 -$7,107,000 $796,000 -$1,890,000 -$2,001,000
Adoption Assistance Program	5180-101-0001 5180-101-0890	-$5,345,000 $399,000
Supplemental Security Income/State Supplementary Payment (SSI/SSP)	5180-111-0001	$18,563,000
In-Home Supportive Services (IHSS)	5180-111-0001 5180-611-0995	-$1,025,000 -$39,261,000
Child Welfare Services (CWS)	5180-151-0001 5180-151-0890 5180-651-0995	-$3,445,000 -$8,948,000 $681,000
Other Assistance Payments	5180-101-0001 5180-101-0122 5180-101-0890	$1,360,000 $256,000 -$1,298,000
County Administration and Automation Projects	5180-141-0001 5180-141-0890 5180-641-0995	$17,188,000 $52,382,000 -$5,610,000
Title IV-E Waiver	5180-153-0001	$134,000
Remaining DSS Programs	5180-151-0001 5180-151-0890 5180-651-0995	-$704,000 $31,000 $3,413,000

Estimates Related to March Budget Package: The May Revision also reflects the Administration's revised estimates of savings related to the following policies adopted as part of the March, 2011 budget package:

Program	Policy Change[1]	2011-12 Change from SB 69 Estimates
IHSS	Medical Certification Requirement (Issue 102)	Erosion of $132.4 million ($53 million GF) in savings due to one-month delay and revised implementation plans
CalWORKs	8 Percent Grant Reduction	Increased savings of $18.3 million based on implementation changes
CalWORKs	Lowering of Time Limit for Adults to Receive Assistance	Erosion of $40.9 million in savings due to more accurate data regarding the numbers of affected individuals
CalWORKs	Time Limit Change, Incremental Grant Reduction for Child-Only Cases & Earned Income Disregard Changes	Erosion of $44.7 million in savings due to two-month delay in implementation

The impacts of the CalWORKs estimates adjustments listed above (combined with CalWORKs caseload estimate changes) are reflected in a reduced amount of federal Temporary Assistance to Needy Families (TANF) funds available to offset GF costs within the California Student Aid Commission's budget for Cal Grants.

Title IV-E Waiver Carryover: In addition, the May Revision reflects a technical adjustment to carry-over $53 million ($23.7 million GF) in unexpended waiver county funds from prior fiscal years. The IV-E Waiver is a five-year federal demonstration project that allows counties to test a "capped allocation" or block grant funding structure for child welfare services. Alameda and Los Angeles counties are participants in the waiver project.

Subcommittee Staff Comment & Recommendation: Staff recommends adopting the above described caseload and other estimate adjustments, with any changes to conform as appropriate to other actions that have been or will be taken.

DSS Issue 2: Staffing Requests Previously Denied Without Prejudice

Budget Issue: The Legislature previously denied without prejudice DSS's requests, in budget change proposals included as part of the Governor's January budget, for $7.9 million ($4.0 million GF) and 54.5 new or continuing limited-term positions. The Administration has since notified the Subcommittee that it has rescinded its requests for 16 of these positions.

Background on DSS Staffing: As of March, 2011, DSS reports that it has 4,246 authorized positions overall. Of that total, 3,677 positions are filled. The breakdown of these positions by Division is as follows:

[1] For further information on these and other policies adopted in the May, 2011 package, please see prior Committee agendas and publications posted on this website: http://sbud.senate.ca.gov/committeehome and the analysis of the Human Services budget trailer bill, SB 72, published online at: http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_0051-0100/sb_72_cfa_20110317_103809_sen_floor.html.

Division	Authorized Positions	Filled Positions
Administration	414	333
Adult Programs (including IHSS)	78	62
Children and Family Services	342	290
Community Care Licensing	1,062	865
Disability Determination Services	1,678	1,569
Executive Division	22	15
Human Rights & Community Services	35	32
Information Systems	147	124
Legal	165	140
State Hearings	127	104
Welfare to Work	176	142
Total	**4,246**	**3,677**

In general, around two-thirds of these positions are authorized for staff members who work directly with clients and the public (140 of the Children and Family Services positions under the Adoptions program and all or nearly all of the Disability Determination Services and State Hearings positions). The remaining roughly one-third of the positions are authorized to provide state oversight and administration of county-run social services programs, such as the CalWORKs welfare-to-work program, In-Home Supportive Services, and child welfare services.

Resources and Positions Denied without Prejudice that the Administration Continues to Propose include:

1) $2.5 million ($1.3 million GF) for 19 administration-related positions in the Children and Family Services Division, including:

    a) $1.6 million ($867,000 GF) to authorize 11 (seven permanent and four two-year, limited-term) positions and temporary help funding for the implementation of Assembly Bill 12, the California Fostering Connections to Success Act (AB 12);

    b) $837,000 ($279,000 GF) to authorize seven positions to perform field monitoring of county child welfare and CalWORKs programs;

    c) $101,000 ($64,000 GF) to establish one two-year, limited-term position to analyze an increased number of Financial Audit Reports that will be submitted to the Department by group homes in the wake of a recent lawsuit.

2) Approximately $1.7 million ($755,000 GF) for 15.5 new positions (3 permanent and the rest limited-term) and contract funding to implement recent budget-related changes to the IHSS program.

3) $467,000 ($233,000 GF) for an additional one-year extension of four limited-term positions to support the development of the Case Management Information Payrolling System (CMIPS II) system that will support the IHSS program.

Resources and Positions Denied Without Prejudice that the Administration is No Longer Pursuing include:

1) $2.4 million ($1.1 million GF) for four staff and contract funding at OSI, and the extension for two years of three limited-term staff at DSS, to support the development of the Child Welfare Services/Web project (which is proposed to be suspended as part of the May Revision);

2) $295,000 ($203,000 GF) to authorize three positions to conduct file reviews, prepare summaries and reports, provide technical assistance, and manage public information related to child fatalities and near fatalities resulting from abuse and/or neglect;

3) $199,000 ($147,000 GF) to make one previously approved limited-term manager position permanent and add a second limited-term position for implementation of the federal Fostering Connections to Success and Increasing Adoptions Act (FCSA);

4) $69,000 GF and 1.5 licensing analysts related to the enactment of AB 2084 (Chapter 593, Statutes of 2010), which required licensed child day care facilities to meet requirements related to nutrition and beverages served. DSS is required to inspect the facilities for compliance during regularly scheduled inspections; and

5) $50,000 GF and 0.5 limited-term accounting officer position related to the enactment of AB 1048/1983 (Chapter 587, Statutes of 2010 and Chapter 567, Statutes of 2010), which created the Safely Surrendered Baby Fund check-off on the personal income tax form, extended the period during which a person may safely surrender a baby at designated sites, and required new annual reports to the Legislature.

For further information on all of these proposals, please refer to Subcommittee agendas for February 3 and February 8, 2011.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the requested authority for the following positions and deny the requested authority for the remainder of the positions:

- Four two-year limited-term positions to support DSS's workload related to provider exclusions and the establishment of the provider sales tax at DSS (with two positions for each of these efforts).

- The one-year extension of four limited-term positions at DSS to support the final stages of CMIPS II development;

As a result, the Subcommittee would approve approximately $993,000 ($496,000 GF) in resources to support these positions (with final amounts to be determined by the Department of Finance and Subcommittee staff). *Continued on next page.*

Staff notes that these recommendations are made in the context of a higher level of resources in the Children and Family Services' Division than in other Divisions of the department. The department has not offered sufficient information to lead to the conclusion that existing Children and Family Services' Division staff would be unable to absorb the critical workload described above.

DSS Issue 3: Solano County Licensing Workload Transfer

Budget Issue: DSS proposes, as part of the May Revision, an increase of $43,000 ($27,000 GF) and 0.5 of a position to address additional workload associated with Solano County returning responsibility for the licensing of its foster family homes to the department. These increased state costs are more than offset by a reduction of $94,000 ($61,000 GF) in local assistance costs.

Background: DSS contracts with some counties to license and monitor foster family homes and family child care homes on the state's behalf. Solano County will be terminating its contract with the state effective July 1, 2011.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the requested resources and 0.5 of a position.

DSS Issue 4: Updates to Proposed Realignment of Child Welfare Services (CWS) Programs

Budget Issue: The Conference Committee previously approved the Governor's budget proposal to realign to the counties $1.6 billion in funding and primary program responsibility for the Child Welfare Services (CWS) system. The proposal included child abuse prevention and adoptions programs, as well as emergency response to allegations of abuse and neglect, supports for family maintenance and reunification, and out-of-home foster care services. The proposal did not, however, include changes related to the automation system for child welfare services case management and data collection or the licensing of residential placements for children.

The May Revision continues this realignment proposal, with the following modifications:

1) $68 million in funding for AB 3632 residential services provided to special education students are no longer included. As discussed below, the costs of these services are instead proposed to be transferred from DSS to the Department of Education;

2) $8.2 million is no longer included in order to retain funding for DSS to contract on a statewide basis for child welfare training activities;

3) $1.7 million and the responsibility for conducting activities associated with independent adoptions in the 55 counties that do not currently handle the work themselves are no longer included.

4) $6 million in state operations costs for Agency Adoptions are newly included in the proposal. The 30 counties that currently have DSS perform this workload for them would have the option to contract with DSS for the Department to continue its work or to choose another way to restructure their workload. The remaining 28 counties currently perform this work already.

5) $911,000 is no longer included in order to retain that funding at the state level to perform foster care and CWS work for tribal-state agreements.

Background: The total CWS budget includes $4.2 billion ($1.6 billion GF). Non-federal costs in each program are shared by the state and counties, with the highest county share of 60 percent in the foster care program and the lowest of 25 percent in the Adoptions Assistance Program (AAP). Under the Governor's revised proposal, nearly all of the state's CWS costs (currently GF) would be replaced by $1.6 billion in tax revenues to the counties.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the revisions to the previously approved realignment proposal outlined above.

DSS Issue 5: Proposed Transfer of Funding for Residential Costs of Special Education-Related Out-of-Home Placements (AB 3632)

Budget Issue: The Administration proposes, as part of the May Revision, to return responsibility from counties to schools for mental health care that is determined to be necessary in order for students who are deemed to be seriously emotionally disturbed (SED) to access a free, appropriate public education. Related to this larger proposal regarding the funding and responsibility for these services, the Administration proposes to transfer $166.5 million ($66.6 million GF) in funding for the board and care of these students who are in out-of-home residential placements from the DSS budget to the budget for the California Department of Education (CDE). The average cost for that board and care is just under $6,000 per student, per month. The Administration also proposes approximately $2.0 million ($1.4 million GF) in savings from not transferring funding that was budgeted for administrative costs incurred by county welfare departments (at a rate of close to $95 per case).

Background on DSS and County Welfare Departments' Roles in the AB 3632 Program: Approximately 20,000 special education students receive mental health services (assessments, case management, individual and group therapy, rehabilitative counseling, and medication support) under the AB 3632 program. Around 1,800 children per month receive mental health and other services in an out-of-home residential placement, generally a group home. The placement of these students into out-of-home care is determined by a team operating within the special education system. The youth who are placed in out-of-home residential care under the AB 3632 program are not in foster care. The parental rights of their parents or guardians are generally intact during the time that they are out of the home. Although DSS and county welfare departments have no custody, placement, or

case management responsibilities related to the care of these youth, they are involved as fiscal agents in the resulting payments of group home or residential care providers and do have a share of costs for this care. Specifically, county welfare departments receive state GF through DSS's budget and use local funds (mostly from the 1991 realignment) to pay the room and board costs for students whose Individualized Education Programs (IEPs) require residential placements. DSS is also responsible for licensing the California group homes and other community care facilities where these youth are often placed. In addition, the rates paid for the care and supervision of these youth are currently specified by law to equal the rates established for the care and supervision of youth who are in foster care.

Subcommittee Staff Comment & Recommendation: The proposed shift of funding for residential placement costs for students who are considered seriously emotionally disturbed is tied to a larger proposal regarding reforms to the funding and responsibility for overall AB 3632 programs. Those larger issues will also be heard in Subcommittee #1 on Education. Staff recommends that the outcome of this agenda item conform to the Committee's action on the larger shift of responsibilities for the program from counties to schools. If such a transfer of program responsibilities is adopted by the Committee, the proposed shift of residential funding from DSS to CDE should also be approved. To the extent that trailer bill language may be necessary to effectuate that outcome, it should be approved as placeholder language subject to review and consideration in the trailer bill drafting process.

DSS Issue 6: Adoptions Assistance Program – Overpayments

Budget Issue: DSS proposes, as part of the May Revision, technical trailer bill language to correct an inaccurate reference in existing law to sharing ratios to be used when collecting funds related to overpayments made through the Adoptions Assistance Program (AAP).

Background: The 2007-08 budget (in SB 84, Chapter 177, Statutes of 2007) required CDSS to implement processes and procedures to comply with federal reporting requirements for federal Title IV-E and adoption assistance overpayments. SB 84 also required CDSS to develop regulations to provide guidance and authority to counties to identify, track, and collect AFDC-FC overpayments to foster care providers. The regulation development and implementation was a result of federal notification that California was out of compliance with the Improper Payments Information Act of 2002. However, SB 84 incorrectly identified the Adoption Assistance Program sharing ratios in Welfare and Institutions Code Section 11466.23. According to the Administration, the proposed technical fix would ensure that counties will not be required to remit an incorrect non-federal share of AAP and Kinship Guardianship Assistance Program (Kin-GAP) overpayments.

Subcommittee Staff Comment & Recommendation: Staff recommends approving the technical trailer bill language to fix the inaccuracies in current law regarding sharing ratios to be used when collecting overpayments.

DSS Issue 7: Proposed Elimination of the Continuing Care Advisory Committee

Budget Issue: DSS proposes, as part of the May Revision, trailer bill language to eliminate the Continuing Care Advisory Committee (CCAC).

Background: The CCAC consists of 11 members appointed by the Governor, the Senate Rules Committee, the Speaker of the Assembly, and other CCAC members for two-year terms. The CCAC is responsible for advising the Continuing Care Contracts Branch of the Community Care Licensing Division within DSS regarding the continuing care industry. The CCAC meets three or four times per year. Members are paid a $25 stipend for each meeting attended and are reimbursed for their actual travel expenditures. The costs of the CCAC are paid from an account that is funded by annual provider fees and new project application fees. The CCAC was identified in the process created by AB 1659 (Huber, Chapter 666, Statues of 201) and AB 2130 (Huber, Chapter 670, Statutes of 2011) as a state agency that should sunset, and is otherwise scheduled to do so on January 1, 2013.

Subcommittee Staff Comment & Recommendation: Staff recommends approving the proposed trailer bill language to sunset the CCAC a year earlier than would otherwise occur.

DSS Issue 8: Proposed Suspension of Nutritional Requirements for Child Care Facilities (AB 2084)

Budget Issue: DSS proposes, as part of the May Revision, to suspend the requirements of AB 2084 in 2011-12. This proposal replaces the request in the Governor's budget for $69,000 GF and 1.5 Licensing Program Analyst positions to check during annual on-site inspections that the new standards are met. As outlined above, this is one of the budget change proposals that was included in the Governor's January budget, but that the Administration is no longer pursuing.

Background: AB 2084 (Chapter 593, Statutes of 2011) requires licensed child day care facilities to: a) serve only low fat or nonfat milk to children ages two or older; b) limit juice to not more than one serving per day of 100% juice; c) serve no beverages with added sweeteners, either natural or artificial; and d) make clean and safe drinking water readily available and accessible for consumption throughout the day. The provisions of this bill will become operative on January 1, 2012, and the bill specifies that DSS shall only determine compliance with these provisions during a regularly scheduled, authorized inspection, and shall not be required to conduct separate visits.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee reject the proposed suspension of AB 2084 and the related trailer bill language, directing the Department to instead absorb this minimal workload during its regularly scheduled inspections.

DSS Issue 9: Technical Adjustment to CalWORKs Stage One Child Care Funding

Budget Issue (#503): DSS proposes, as part of the May Revision, a technical adjustment to increase the base level of funding for CalWORKs Stage One Child Care by $32.2 million. This technical adjustment does not impact the amount of GF savings assumed as a result of CalWORKs policies contained in the March budget package.

Background: The March 2011 budget package included a significantly reduced funding level for the CalWORKs "single allocation," which funds employment services and child care for participants. Corresponding to the $427 million GF reduction in the 2011-12 fiscal year, language was approved to extend and expand upon exemptions from welfare-to-work requirements for parents of very young children (known as "short-term reforms") for the duration of the budget year. The proposed Governor's Budget had assumed that these short-term reforms would instead expire on June 30, 2011 and reflected resulting costs for Stage One in 2011-12, partially offset by savings based on a three-month phase-in of cases reengaging in work activities and needing child care. When SB 69 was passed by the Legislature, Stage One costs were reversed to be consistent with the Legislature's action. However, the phase-in savings were erroneously retained. Therefore, a technical adjustment is necessary to reflect the appropriate level of base funding for Stage One child care.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of this technical adjustment to the funding for Stage One Child Care.

DSS Issue 10: Proposed Extension of Moratorium on Group Home Rate Applications

Budget Issue: DSS proposes, as part of the May Revision, a one-year extension of the moratorium on the acceptance and processing of group home rate applications for new programs, new providers, program changes, and program reinstatements that was established in last year's Human Services budget trailer bill, AB 1612 (Chapter 725, Statutes of 2010).

Background on Group Home Placements and Rates: According to data from the Child Welfare Services/Case Management System (CWS/CMS), the overall number of children in child-welfare supervised foster care has been steadily declining (from 116,900 children in July 1999 to approximately 55,000 in July 2010). The number of children placed in group homes also declined during that time, from approximately 10,600 to around 4,000. After the outcome of a recent lawsuit over the state's non-compliance with federal requirements related to rate-setting for group homes, the rates paid to those care providers increased by approximately 32 percent – to a range of $2,085 to $8,835 per child, per month in 2010-11.

Background on the Moratorium: The Rates Moratorium was established to allow DSS to redirect staff to other activities, including the development of policies and rates for programs

like Multidimensional Treatment Foster Care (MTFC)/Intensive Treatment Foster Care (ITFC) programs which serve as family-based alternatives to group care. The department indicates that its ability to continue work on these issues given a one-year extension of the moratorium would benefit counties and foster children as a means to recruit and retain higher needs foster home placement options.

In proposing the moratorium last year, DSS indicated that it did not expect the policy to affect the state's ability to find placements for foster children, as there was at the time an over-capacity of available group home beds. The Department stated that as of February 2010, there were approximately 8,700 licensed group home beds available in California and approximately 6,000 children in group home placements.

The department is authorized to grant exceptions to the moratorium on a case-by-case basis, upon submission of a written request and supporting documentation provided to the department by a county welfare or probation director. To date DSS has received nine exception requests: four for capacity increases; one rate increase; three new provider applications; and one for a new program. All of these exceptions have been granted.

DSS has also surveyed counties regarding the impact of the moratorium on placements. Ten counties responded to the survey. Six respondents indicated that no problems were caused by the moratorium. Four counties indicated that they continued to have problems placing high needs children (although in most instances those problems likely pre-dated the moratorium). Four indicated that they had benefited from the moratorium. And four counties saw neither a benefit nor detriment from the moratorium.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the trailer bill language and proposed one-year extension of the moratorium on group home rate applications.

DSS Issue 11: Proposed Suspension of Foster Youth Identity Theft Prevention Efforts (AB 2985)

Budget Issue: DSS proposes, as part of the May Revision, savings of $0.3 million GF and trailer bill language to make the requirements of AB 2985 (Chapter 385, Statutes of 2006) subject to an appropriation.

Background: AB 2985 requires county welfare departments to conduct a credit check for all foster youth who reach the age of 16 years old in order to help determine whether the youth has been the victim of identity theft. When a credit report contains negative information or evidence of identity theft, the county must refer the child to an approved credit counseling organization from a list developed by DSS, in consultation with the County Welfare Directors Association and other stakeholders. DSS reports that to date, the department has led a workgroup to develop a process for social workers and probation officers to request the credit reports. After coordinating with the three national credit reporting agencies, DSS learned that those agencies automatically reject requests for credit reports for children under age 18. Therefore, additional intervention is required by social

workers to identify the child as a child in foster care and secure the credit report through a separate approval process. To the department's knowledge, counties have not implemented AB 2985 pending the issuance of guidance that the department has not yet completed or issued.

After AB 2985 was signed, implementation was delayed for one year due to budget constraints in 2007-08. Funds were appropriated and allocated to counties in 2008-09. Funds were appropriated but not allocated in 2009-10. There was no appropriation in 2010-11. DSS now indicates that given the ongoing budget situation and significant workload demands, the department cannot implement AB 2985 at this time. The department points out that social workers, probation officers, youth and caregivers would still be able to conduct credit checks in the absence of this mandate. For example, a related goal can be included in the youth's Transitional Independent Living Plan. Those checks would not, however, be required until an appropriation for the program is provided.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the proposed 2011-12 savings and adoption of trailer bill language to delay implementation of the requirements of AB 2985 until July 1, 2013 (rather than make them subject to appropriation).

DSS Issue 12: Proposed Suspension of Resource Family Approval Pilot Efforts (AB 340)

Budget Issue: DSS proposes, as part of the May Revision, to suspend the implementation of AB 340 (Chapter 464, Statutes of 2007) until January 1, 2012 and to make its implementation subject to appropriation thereafter. AB 340 created a Resource Family Approval pilot program to streamline existing multiple processes for licensing foster family homes and assessing/approving relative caregivers, non-relative extended family members (NREFM), adoptive applicants, and prospective guardians. Resources for implementation in 2011-12 include $238,000 ($150,000 GF) and two positions for state operations, as well as $771,000 ($330,000 GF) for six months of local assistance costs.

Background: In 2002, the state's child welfare system was reviewed by the federal government and found deficient in several areas, including the safety and stability of children in foster care and length of time it takes for these children to reach a permanent home when they cannot return to their parents. Failing to meet the federal requirements resulted in fiscal penalties to the state unless the state completed a Program Improvement Plan (PIP). As part of the PIP, DSS agreed to develop an improved caregiver assessment process that would combine foster care licensing, relative approvals, and adoption home studies. To this end, DSS and the County Welfare Directors Association (CWDA) worked for over three years to develop a proposal to revamp the process and standards by which individuals who were interested in caring for children in foster care are determined suitable. This work resulted in AB 340.

State-Level Resources: The Assembly and Senate Appropriations Committees' analyses

of AB 340 estimated approximately $150,000 GF in the first year for state personnel costs to oversee development and implementation of this pilot (and in one analysis, additional funds for its final evaluation). These analyses also recognized that the pilot should lead to some offsetting savings. The Department requested more resources than this in a 2008-09 budget change proposal, but was denied all resources for implementation in that budget year. The state operations resources mentioned above were later approved for 2010-11. Nonetheless, to date DSS has initiated only preliminary implementation activities of this pilot. The Department indicates that it has been unable to accomplish more due to resource limitations and the need to temporarily redirect existing staff to other mandated activities.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the proposed funding for 2011-12. Staff also recommends approval of the trailer bill language that suspends implementation until January 1, 2012, but with an amendment to delete the provision that would make implementation beyond that date subject to appropriation.

Discussion Agenda

4140 Office of Statewide Health Planning & Development (OSHPD)

OSHPD Issue 1: Proposed Eliminations of Three Healthcare-Related Policy Commissions

Budget Issue: OSHPD proposes, as part of the May Revision, trailer bill language to eliminate: 1) the California Health Planning and Data Advisory Commission (CHPDAC), 2) the California Healthcare Workforce Policy Commission, and 3) the California Healthcare Rural Health Policy Council. Proposed 2011-12 savings for the elimination of CHPDAC include $85,000 in California Health Data and Planning Fund resources and 0.5 of a position ($170,000 and 0.9 of a position when annualized). There are no GF impacts.

Background on the CHPDAC Proposal: The 13-member California Health Policy and Data Advisory Commission (CHPDAC) was established in 1986 to advise the Director of OSHPD regarding the collection and reporting of healthcare data, such as publishing data summaries, selecting data elements for the production of healthcare outcome reports, and regarding proposed regulations prior to Office of Administrative Law review. CHPDAC is also charged with hearing appeals brought by healthcare facilities that have not met healthcare data reporting requirements. CHPDAC members include representatives of health plans, hospitals, physicians, long-term care, ambulatory surgery clinics, a business coalition, healthcare consumers, labor, and nurses. The CHPDAC meets every two months. Commission members are paid a $100 per diem for attending meetings. In addition, they are reimbursed for travel expenses.

The Administration indicates that its review of CHPDAC meetings from 2006 shows a pattern of sporadic productivity. The CHPDAC's advisory role is related to the collection and reporting of health data and was created in the mid-1980s when the health data collection field was relatively new. Since then, health data collection and related health reporting has matured and become more routine for the Office. The Administration also indicates that without CHPDAC, OSHPD would still have the ability to convene ad hoc and stakeholder advisory groups to solicit input and respond to federal initiatives.

The Healthcare Workforce Policy Commission: This 15-member Commission, appointed by the Governor, the Assembly Speaker, and the Senate Rules Committee, was established in 1974 to provide the OSHPD Director with policy and program recommendations for Song-Brown Programs administered through the Song-Brown Health Care Workforce Training Act. The Song-Brown Programs support clinical training opportunities for a variety of health professionals in medically underserved areas and communities. The Commission meets four times per year and makes recommendations for Song-Brown awards totaling over $6.7 million. Commission members are paid a $100 per diem for attending meetings. In addition, they are reimbursed for travel expenses. Commission functions and responsibilities including reviewing Song-Brown applications and recommending awards, as well as identifying California's areas of unmet need for physicians, dentists, nurses, and

mental health providers. According to the Administration, these functions can instead be performed by existing OSHPD staff within the Healthcare Workforce Development Division.

The Rural Health Policy Council (RHPC): The RHPC was created in 1996 to coordinate rural health policy development and to disburse grants for rural health projects. The RHPC is comprised of representatives from several state departments, including the California Department of Mental Health, Emergency Medical Services Authority, and the Department of Health Care Services (DHCS), among others, and is housed within OSHPD. The RHPC holds public meetings to elicit testimony from rural constituents on a variety of rural health issues and to report to the public on state department rural health related activities. The RHPC last met in the fall of 2010. DHCS also has an Office of Rural Health, which was created to promote a working relationship between health-related state departments and rural health providers, consumers and others through education, communication, and outreach.

According to the Administration, no grant funding has been available for the RHPC to distribute for several years now, and future grants could be disbursed through OSHPD. In addition, the Administration indicates that the Governor and department leaders can convene for policy coordinating purposes without this statutorily created entity.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of trailer bill language to eliminate these three healthcare-related Commissions.

Questions for OSHPD:

1) Please briefly describe each commission proposed for elimination and the functions that OSHPD would take over if those eliminations were to be approved.

2) How will OSHPD work to ensure that the diversity of voices and experiences available via the Commissions' efforts will continue to be included in relevant policy decisions?

4200 Department of Alcohol & Drug Programs (ADP)

ADP Issue 1: Revision to Drug Medi-Cal (DMC) Estimates and Proposed Transfer of DMC to Department of Health Care Services (DHCS)

Budget Issue: ADP requests, as part of the May Revision, to revise its estimates of the caseload, utilization, and provider rates for services in the Perinatal DMC and Regular DMC programs. In comparison with the March budget package, the changes include a total increase of $490,000 ($351,000 GF). The May Revise rates reflect a cumulative increase of 4.6 percent due to changes in the Implicit Price Deflator used in calculating proposed DMC rates. The total budget for the DMC program is approximately $253.2 million ($134.3 million GF). Of this total, approximately $6.4 million ($3.2 million GF) is for support and the remainder is for local assistance. There are currently a total of 64 DMC-funded positions at ADP.

The Administration also proposes, as part of the May Revision, trailer bill language to transfer responsibility for management of the state's DMC program from ADP to DHCS by July 1, 2012. Technically, the move is proposed to be accomplished via proposed budget bill language amending Items under the Department of Health Care Services' budget to authorize the transfer of staff and expenditure authority between the Departments. The Subcommittee will consider the specifics of this budget bill language under other health agenda items.

Background: Since 1980, the DMC program has provided medically necessary drug and alcohol-related treatment services to Medi-Cal beneficiaries who meet income eligibility requirements (up to 250 percent of the Federal Poverty Level (FPL)). Services include Outpatient Drug-Free, Naltrexone (medication used to treat alcohol or opiod dependence), Narcotic Treatment, and Day Care Rehabilitative and Residential Treatment for eligible pregnant and postpartum women. DMC provider rates are currently based on the lower of factors listed in statute or adjustments for cumulative growth from prior year rates by a specified price deflator that measures the costs of goods and services to governmental agencies.

Rationale for the Proposed Transfer of DMC to DHCS: The Administration has indicated that the proposed move of DMC to DHCS will improve upon the state's ability to coordinate substance abuse (as well as mental health, which will be discussed in a separate agenda item) treatment as a part of the overall delivery of health care. The Administration also indicates that these goals are consistent with the goals of recent federal health care reforms, including the Affordable Care Act of 2010 and the 2008 passage of the Mental Health Parity and Addiction Equity Act, under which the Medicaid program will play an increasing role in the financing and delivery of mental health and substance use services. This integration of care is identified as particularly important given the prevalence of co-occurring illnesses.

Other Related Proposals to Reorganize the Delivery of Substance Abuse Programs: The Governor's January budget proposal and the May Revision both also propose to realign funding for DMC and other substance abuse treatment services (a total of $184 million) from

the state to the counties. The Budget Conference Committee adopted this aspect of the proposed realignment package in March. Related to realignment, the Governor is proposing a 25 percent reduction of state operations costs for the realigned programs. While the proposed transfer of DMC administration from ADP to DHCS has been put forth in the context of the realignment of substance abuse treatment services, the Administration also indicates that the proposed transfer of responsibilities among state departments is not contingent on realignment.

In addition to current proposals for realignment and the transfer of DMC administration, the Administration has indicated that it intends to propose elimination of ADP and the transfer of its remaining, non-DMC specific functions to another state department or departments beginning with the 2012-13 budget year. The non-DMC functions ADP currently provides include acting as the single state agency for the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant (which includes approximately $250 million), licensing and certifying alcohol and drug counselors and programs, collecting and managing data, and developing standards, statewide needs assessment and planning, training, technical assistance, and prevention programming.

Subcommittee Staff Comment and Recommendation: Staff recommends approval of the technical, estimate-related changes to the budget for the DMC program. Staff also recommends approval of a transfer of responsibility for administering the DMC program from ADP to DHCS. Correspondingly, staff recommends the adoption of placeholder trailer bill language to effectuate this transfer. Amendments to the Administration's proposed trailer bill language will be made as necessary, including any amendments needed to preserve Legislative oversight. The Subcommittee will have the opportunity to address the related budget bill language under future health-related agenda items.

Questions for ADP and DHCS:

1) Please describe the functions related to Drug Medi-Cal that are proposed to be transferred from ADP to DHCS and any that would remain at ADP, as well as the timeline during which this transfer would take place.

2) What are the arguments in favor of this proposed transfer? What, if any, concerns have been raised?

3) What are the departments' plans for effectuating the proposed transfer smoothly and without any interruptions in services to clients?

5160 Department of Rehabilitation (DOR)

DOR Issue 1: Proposed Change to Appeals Process

Budget Issue: DOR proposes, as part of the May Revision, to achieve savings and efficiencies from eliminating the Rehabilitation Appeals Board (RAB) and transferring the workload associated with reviewing appeals filed by applicants for or consumers of DOR services to impartial hearing officers through an interagency contract with another state entity (e.g., DSS or the Office of Administrative Hearings). The Administration estimates that contracting with IHOs will cost approximately $80,000 and DOR would continue to incur staffing costs of another $95,000 for one staff position to coordinate referrals of cases to the IHO. Thus, the total cost for this proposal would be $175,000 per year (no GF). By contrast, in 2010-11 the budget for RAB was $205,000, but actual expenditures over the last five years averaged $308,000.

Background: By law, the RAB consists of seven members appointed by the Governor, although at present one seat is vacant. Members serve a term of four years and are subject to Senate confirmation. A majority of board members must be individuals with disabilities who are independently self-supporting in businesses and professions within the community. Board members receive reimbursement for travel expenses and a per diem of $100 for each day spent on their duties. The RAB hears appeals by applicants for DOR services who wish to contest a denial of eligibility and by existing DOR consumers who are not satisfied with the services being provided to them. The DOR provides vocational rehabilitation services to approximately 115,000 Californians with disabilities annually. In federal fiscal year 2010, over 10,700 consumers achieved employment outcomes. During that same period of time, 39 requests for appeal were resolved.

Rationale for Proposed Change: According to the Administration, the present RAB appeals process complies with federal law but has several significant drawbacks, including that hearings cannot always be scheduled within the statutory time frames due to quorum requirements and that the RAB has consistently exceeded its budgeted operating costs. The Administration also indicates that impartial hearing officers with more legal and evidentiary expertise will have greater ease in sorting through complex legal questions and documenting related conclusions.

Subcommittee Staff Comment & Recommendation: The staff recommendation on this issue is pending.

Questions for DOR:

1) Please describe the appeal and decision-making processes as they exist today and how they would differ under this proposal.

2) What are the Administration's plans to ensure accessibility of the appeals process to consumers of the department's services?

5180 Department of Social Services (DSS)

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

AUTOMATION ISSUES

DSS Issue 1: Child Welfare Services (CWS)/Web Project

Budget Issue (#603): DSS and HHS request, as part of the May Revision, to suspend the development of the CWS/Web automation system. The resulting 2011-12 GF savings would be $3.1 million.

Prior to proposing the project's suspension, OSI estimated a total cost of $351.2 million ($165.5 million GF) for the project over the decade between 2006-07 and 2016-17. Of this amount, the one-time costs to implement the project are estimated to be $215.3 million ($97.5 million GF), with maintenance and operations costs of $135.9 million ($68 million GF). To date, $21.5 million ($10 million GF) in planning funds have been invested in the project.

Background: 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. The Child Welfare Services/Case Management System (CWS/CMS) is the existing 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 CWS/CMS system was implemented statewide in 1997, and OSI has previously stated that CWS/Web is necessary because the CWS/CMS technology is outdated and the new system would rely on a more modern, web-based technical architecture. In addition, OSI and DSS have reported that the CWS/Web system will increase efficiency and better comply with federal system requirements (which are tied to federal funding). The CWS/Web project is still in its planning phase. Full implementation was previously anticipated to occur after development ended in 2014.

Administration's Rationale for Suspending the Project: According to the Administration, the federal Administration for Children and Families has recently indicated that it intends to revise its requirements for statewide automated child welfare information systems. In light of this potential change in federal direction and to address the remaining budget shortfall since the Legislature passed SB 69, the Administration has proposed this project suspension.

Subcommittee Staff Comment and Recommendation: Staff recommends approval of the proposed suspension of CWS/Web given the evolving federal requirements under which any new system would be designed. *Continued on next page.*

In tandem with this halting of the current procurement, and in recognition of the continuing needs under the CWS/CMS M&O, staff additionally recommends adoption of trailer bill language directing DSS, in partnership with OSI and stakeholders, including Legislative staff and counties, to complete the following and provide an update to the Legislature by January 1, 2012:

1. Determine and describe the degree to which the CWS/CMS system:

    a. Is in compliance with current law, regulation, and policy.

    b. Supports current Child Welfare Services practice, including but not limited to key Child Welfare Service functions, ease of access to case and service information, multidisciplinary case management, and ease of use.

    c. Links to information that enhances investigation, case management, or efficiency.

    d. Provides ready access to data for reporting, planning, management, and program outcome monitoring.

2. Determine the best approach to address any missing functionalities that are critical to CWS operations. Options shall include building functionality into the current CWS/CMS system, restarting the CWS/Web procurement, or developing a new procurement.

3. Assess and report on communication from the federal government regarding requirements of the system, both by the January 1, 2012 deadline and thereafter when there is additional direction on federal expectations.

4. Recommend next steps, including a timeline, for implementing the recommended approach or approaches.

Questions for DSS & OSI:

1) CWS/Web was previously authorized in order to update outdated technology, improve efficiency, and better comply with federal requirements. If the project is no longer going to be pursued, would the existing CWS/CMS system be able to meet the department and counties' critical program and technology needs? What analysis has the department conducted to date to determine whether changes to that system or another project plan would be required?

2) What has the department heard from the federal government regarding any potential changes to applicable federal requirements?

DSS Issue 2: Los Angeles (LA) Eligibility, Automated Determination, Evaluation and Reporting (LEADER) Replacement System (LRS)

Budget Issue (#603): The Administration requests, as part of the May Revision, to indefinitely suspend the LRS automation project. The resulting GF savings in 2011-12 would be $26.7 million. This means that $783,000 ($202,000 GF) would remain in the budget for planning and close-out activities. The Administration indicates that the suspension of LRS is being proposed to address the remaining GF budget shortfall since the Legislature passed SB 69.

Last year, OSI estimated a total cost of $408.6 million over four years ($208.6 million GF/TANF, $173.3 million federal funds and $26.7 million county funds) for LRS development and implementation before the project would reach its maintenance and operations phase. The 2011-12 Governor's Budget includes updated costs based on the completion of Los Angeles County's negotiations with the selected vendor: $370.2 million over four years ($196.1 million GF/TANF, $147.3 million federal funds and $26.8 million county funds). To date, $5.8 million ($2.3 million GF) total of planning funding has been spent on the project. The most recent estimates of the 2010-11 budget also include $38.5 million ($14.3 million GF) for LRS planning and development costs. However, according to the Administration, only $723,000 ($283,000 GF) of those funds will be spent due to project delays.

Background: The Statewide Automated Welfare System (SAWS) 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. After a recently completed consolidation combining two out of the prior total of four SAWS consortia systems, there are currently three separate consortia systems that constitute SAWS. Each of the three contains information for roughly one-third of the statewide caseload. The total 2010-11 maintenance & operations (M&O) budget for SAWS is $181.8 million ($95.6 million GF/TANF).

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 the three consortia systems. LA County entered into an agreement for Unisys to develop LEADER in 1995 and completed countywide implementation of the system in 2001. The most recent contract for LEADER extends through April 2015.

According to OSI and LA County, LEADER technology is outdated and cumbersome (e.g., it uses outdated COBOL language with 9.5 million lines of code). In addition, LEADER relies on proprietary hardware and software components created by its vendor. The federal government has previously expressed concerns about the state and county's resulting non-competitive use of that same vendor; and OSI has indicated that no other qualified vendors have been willing to enter a bid to operate the LEADER system. The Administration previously indicated that LRS would streamline LA's business practices, eliminate duplicative data entry, and minimize errors. OSI also indicated that LRS would expand clients and service providers' ability to apply for benefits or report case changes online. LA

County also intends for LRS to replace its 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.

Given these concerns and goals, the Legislature first appropriated funding to support the planning process for a new system to replace LEADER in 2005-06. More recently, LA began negotiations for an LRS contract with a vendor in late 2009. Due to the state's fiscal condition, the project was delayed by six months each in the 2009-10 and 2010-11 budgets. The Administration also reports that more recently, the federal government has indicated that it will not approve funding for the project until it has received, reviewed and approved of the state's long-term plan for its overall eligibility system. Prior to recent delays and this May Revision proposal for project suspension, OSI had expected to conclude planning activities at the end of 2010 and to begin design, development, and implementation of the LRS project in January 2011, with an anticipated completion date of around December 2014.

Subcommittee Staff Comment and Recommendation: Staff recommends that the Subcommittee take action to sweep $14.1 million GF that was budgeted for LEADER in 2010-11, via the addition of the following Budget Bill Language:

> "5180-495 Reversion, Department of Social Services. As of June 30, 2011, the balances specified below, of the appropriations provided in the following citations shall revert to the balance in the fund from which the appropriations were made:
>
> 0001- General Fund
> (1) Item 5180-141-0001, Budget Act of 2010 (Ch. 712, Stats. 2010). Up to $14,062,000 appropriated in Program 16.75 – County Administration and Automation Projects."

Further, staff recommends that the Subcommittee approve a delay in the development of LRS in the budget year, with corresponding savings of approximately $13 million GF for 2011-12, and any attendant technical changes that are required to effectuate this reduction.

Questions for DSS & OSI:

1) LRS was previously authorized in order to update outdated technology, improve efficiency, and allow the state and LA County to cease using a sole-source contract. What analysis has the department conducted to date to determine how the state and county could address these concerns if LRS is not developed?

2) What has the department heard from the federal government regarding its pending approval of funding for LRS?

OTHER CALWORKS ISSUES

DSS Issue 3: Proposed Amendments to SB 72 (March Trailer Bill)

Budget Issue: DSS proposes, as part of the May Revision, trailer bill language to amend the provisions of SB 72 related to CalWORKs described below.

Background on SB 72: The March 2011 budget package made a significant number of changes to the CalWORKs program that were estimated to save approximately $1.0 billion GF in 2011-12. Among these changes were the following, for which statutory changes were made in SB 72:

1) Lowered the amount of time parents or caregiver relatives can receive aid -- from 60 to 48 months

2) Reduced the Maximum Aid Payment in effect on July 1, 2009 by 8 percent

3) Further reduced, by 5 percent increments (for a maximum total reduction of 15 percent), grants for children in cases without an aided adult who have received assistance for more than 60, 72, and 84 months, respectively

4) Lowered funding for child care, employment services, and administration in the counties' "single allocation" by $427 million GF in 2011-12. Correspondingly, extended and expanded upon exemptions from welfare-to-work requirements for parents of very young children (i.e., one child up to the age of 35 months or two children under the age of six years)

5) Suspended, for one year, the case management services and sanctions otherwise available under the CalLearn program for pregnant and parenting teenagers. The intent was that these teenagers would instead be eligible for regular welfare-to-work services that are available in their counties. They would also continue to be eligible for supplements or bonuses related to progress in school, as specified.

6) Amended the state's current policy of disregarding the first $225 of earned income and 50 percent of each dollar earned beyond $225 when calculating a family's monthly grant. Instead, disregard the first $112 of earned income and then 50 percent of all other relevant earnings

7) Made cost-neutral changes to expand the state's participation in an existing subsidized employment program and align the program more closely with operation of a related program that existed under the federal American Recovery and Reinvestment Act of 2009's (Public Law 111-5) Emergency Contingency Fund. As a result, the state will participate in half of the costs of the subsidized employment participant's wages, up to the amount that the state would instead have paid for the family's assistance grant.

Proposed Changes: In order to effectuate the intent of SB 72, DSS proposes the following technical changes:

1) An amendment to clarify that individuals who are participating in subsidized employment are not also required to participate in community service;

2) Amendments to clarify that teen parents who are not participating in CalLearn during that program's suspension do not have to stop going to school in order to receive welfare-to-work services;

3) Amendments to ensure the continued receipt of services by teens who are participating in the CalLearn program during their first or second trimester of pregnancy before July 1, 2011 (when the CalLearn program); and

4) Amendments to correct an inaccurate reference to the state's recovery of specified overpayments, as these activities are instead handled by counties.

In addition, the department proposes to change the provisions of SB 72 that would have created two separate "clocks" for time on aid—one for the 48-month time-limit created for CalWORKs and another for the 60-month time-limit that applies to federal Temporary Assistance to Needy Families (TANF) assistance received in any state. According to the department and counties, the implementation of these two separate clocks would otherwise delay implementation of the changes to CalWORKs time-limits enacted by SB 72 and erode the related savings assumptions. The counties have indicated that there are fewer than 200 CalWORKs families with out-of-state TANF months who may receive fewer months of CalWORKs aid because of the proposed change.

Subcommittee Staff Comments & Recommendation: Staff recommends that the Subcommittee approve the proposed trailer bill language, subject to technical changes that may arise in drafting but are consistent with the proposed policy changes and clarifications.

Questions for DSS:

1) Please briefly summarize the proposed amendments.

2) In particular, please describe the administrative complexities that would be avoided by the changes to language regarding time-limits described above and the resulting impacts on CalWORKs recipients who have received assistance in other states.

IN-HOME SUPPORTIVE SERVICES (IHSS) ISSUES

DSS Issue 4: Proposed Amendments to SB 72 (March Trailer Bill)

Budget Issue: DSS proposes, as part of the May Revision, amendments to SB 72 (Chapter 8, Statutes of 2011), which was the human services trailer bill enacted as a part of the March 2011 budget package.

Background on March Budget Package: The Legislature adopted changes to IHSS and Medi-Cal as a part of SB 72, including the following, which were anticipated to result in $486 million GF savings in 2011-12:

1) Created a requirement that an applicant for or recipient of IHSS obtain certification from a licensed health care professional declaring that the applicant or recipient is unable to perform one or more activities of daily living independently, and that without IHSS, the applicant or recipient is at risk of placement in out-of-home care.

2) Directed the Department of Health Care Services to determine whether it would be cost-efficient for the state to exercise the Community First Choice Option made available under section 1915(k) of the federal Social Security Act (42 U.S.C. Sec. 1396n(k)).

3) Established a pilot project that requires the Department of Health Care Services to identify individuals who receive Medi-Cal benefits on a fee-for-service basis and who are at high risk of not taking their prescribed medications. The Department will then procure automated medication dispensing machines to be installed in participants' homes and monitored as indicated.

4) Precluded the ability of recipients of Waiver Personal Care Services from backfilling IHSS hours lost due to IHSS reductions, including an existing 3.6 percent, across-the-board reduction to hours of authorized services.

5) Created a trigger mechanism for alternative reductions if the Department of Finance determines that data reported regarding the pilot project described above does not demonstrate the ability to achieve annualized net savings of $140 million GF. If the pilot and any subsequent legislation are not anticipated to result in $140 million annualized GF savings, DSS is required to implement an across-the-board reduction in IHSS services beginning October 1, 2012, with specified exceptions.

Proposed Amendments: The Administration proposes the following changes to provisions of SB 72:

1) With respect to the **across-the-board reduction** that may be triggered, DSS proposes to: 1) include intent language, 2) eliminate a pre-approval process to exempt certain especially at-risk recipients from the reduction, and 3) exempt recipients receiving services under specified waiver programs from the reduction. The Department has expressed concern that the pre-approval process would vary from county to county, thus creating inequities that may violate federal law.

2) DSS also proposes to delete an **exception to having a medical certification of need prior to receiving services**. The provision at issue creates an exception when "the deterioration of the recipient's health or mental health is likely to result in eviction from home, homelessness, or a hazardous living environment." The Department has expressed concern that this provision inappropriately expands social workers' roles and requires them to assess issues for which they do not have the requisite information or expertise.

3) DSS also proposes to repeal a provision that would otherwise prevent recipients of **Waiver Personal Care Services** from backfilling hours of IHSS that are lost due to across-the-board reductions in hours already in effect or that may take effect in the future. The original intention of this language was to protect against a loss of GF savings due to potential backfills. However, upon further analysis, it has become clear that under the waiver program some recipients would instead be able to backfill IHSS hours with more expensive services (e.g., nursing services) that would exceed the cost avoidance originally expected from the proposal.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee take the following actions with respect to the proposals described above:

1) Amend the proposed intent language as follows:

> 12301.03(a) Authorized hours under the IHSS program were reduced in fiscal year 1992/1993 and included a supplemental assessment process that ~~ensured~~ was intended to ensure that IHSS recipients remained safely in their homes.
>
> (b) The reduction in authorized hours as provided for in the Act that added this section includes a supplemental assessment process that ~~will~~ is similarly intended to ensure that IHSS recipients will remain safely in their homes.

2) Reject the proposed elimination of the pre-approval process to exempt certain especially at-risk recipients from the reduction and approve of the proposed exemptions for recipients receiving services under specified waiver programs. Although some of the waiver program recipients may be the same individuals who could otherwise be pre-approved for supplemental care, the pre-approval process could also capture narrow groups of other especially vulnerable populations as well.

3) Replace (rather than deleting as proposed) the language related to exceptions to having a certification of need prior to receiving services described in #2 of the background section on Proposed Amendments above. The new language would read: "Services may be authorized temporarily pending receipt of the certification when the county determines there is a risk of out of home placement."

4) Approve of the proposed repeal of the prohibition on backfilling lost IHSS hours with additional Waiver Personal Care Services hours. *Continued on next page.*

Questions for DSS:

1) Please briefly describe the pre-approval process codified in SB 72 and your concerns regarding the inclusion of that process. How are these concerns mitigated by the language in the statute that limits the process's applicability to "the extent permitted by federal law," which can be clarified in consultation with the federal government?

DSS Issue 5: IHSS- Proposed Trailer Bill Language Related to Provider Exclusions

Budget Issue: DSS proposes, as part of the May Revision, trailer bill language to amend the list of criminal offenses that serve as a bar to being an IHSS provider. The department also proposes to create a state and county-funded program for IHSS providers who have criminal histories that have resulted in a finding that they are ineligible to serve as providers whose work can be paid for with federal Medicaid funding. Under this proposal, those determinations would be made based on the individual's inclusions in a federal list maintained by the Office of the Inspector General and/or a state-level list of suspended and ineligible providers maintained by the Department of Health Care Services. The department estimates 2010-11 costs of $1.2 million GF associated with this new program.

Background: The 2009-10 and 2010-11 budget trailer bills for human services issues (Chapter 4, Statutes of the 2009-10, Fourth Extraordinary Session; Chapter 17, Statutes of 2009-10, Fourth Extraordinary Session; and Chapter 725, Statutes of 2010) created a series of new requirements for existing and new IHSS providers to be screened via criminal background checks. These statutes created a specified list of "Tier One" convictions that would serve as an absolute bar to being an IHSS provider. This list was intended to include all convictions that would serve as a bar to the use of federal Medicaid funding pursuant to federal law (i.e., specified abuse against a child, elder, or dependent adult, or fraud against a government health care or supportive services program). The statutes also created a list of "Tier Two" convictions (e.g., serious and violent felonies) which serve as a bar to being an IHSS provider. Tier Two convictions differ from Tier One in that providers with those convictions in their backgrounds can be authorized to provide IHSS services if a recipient signs a form indicating his or her informed consent or if the provider is granted a general exception by DSS.

DSS now asserts that the Tier One list of convictions may not adequately cover all convictions that are excluded under federal law. The department therefore proposes to expand statutory language describing Tier One to a more generalized reference subject to the department's interpretation, rather than a very specific list of offenses created by the Legislature. In addition, the department proposes to expand the language to exclude all individuals who are ineligible to provide more general Medi-Cal services as determined by the Department of Health Care Services. It is important to note that there are separate sections of state statute governing the exclusion of Medi-Cal providers generally from the exclusion of IHSS providers in particular. The IHSS-related sections of statute are narrower and more specific. This distinction was litigated in recent years and resulted in a court

decision that the more specific IHSS-related sections of state law control the exclusion of IHSS providers.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee reject the proposed trailer bill language to broaden and make more generic the list of criminal convictions that serve as a bar to being an IHSS provider. To the extent that there are any additional federally mandated convictions that the Administration or Legislature believe should be added to the list of Tier One exclusions, the full consideration of how to interpret federal law with respect to those offenses would be more appropriate for consideration by a policy Committee in consultation with Legislative Counsel.

Staff further recommends that the Subcommittee reject any portion of the proposed funding that is attributed to the use of the state-level Suspended & Ineligible list for Medi-Cal providers, which is not specific to the narrower sections of state statute that apply to the IHSS program.

Questions for DSS:

1) Please briefly describe the trailer bill language and the department's rationale for proposing it through the budget, rather than policy, process.

DSS Issue 6: IHSS- Public Authority Administration Funding

Budget Issue: The Administration proposes, as part of the May Revision, to reduce the funding for IHSS Public Authorities (PAs) by $7.7 million ($2.2 million GF). There are 52 PAs in the state that cover 56 counties. Including the impact of the proposed reductions, the total statewide PA funding would include $17.0 million ($6.6 million GF).

Background on PAs: Under state law, a county board of supervisors may elect to establish a PA to provide for specified functions related to the delivery of IHSS. The PAs are separate entities from the county in which they operate. PAs are the employers of IHSS providers for the purposes of collective bargaining over wages, hours, and other terms of employment. IHSS recipients, however, retain the right to hire, fire, and supervise the work of any IHSS worker providing services to them. PAs also provide at least the following functions: 1) assistance to recipients in finding IHSS providers through the establishment of a registry; 2) investigation of the qualifications and background of potential providers; and 3) training for providers and recipients.

Background on PA Funding: PA rates are county-specific and are computed by multiplying case-months by the average hours per case by the administrative hourly rates for each PA (established based on hourly wages, employer taxes, benefits, and administrative costs). Since 2009-10, the rates established by these formulas have, however, been reduced by 20 percent, as approved in the 2009-10 budget [in AB X4 1 (Chapter 1, Statutes of 2009, Fourth Extraordinary Session)]. In addition, the rates have been reduced by $8.7 million GF and corresponding other funds, as a result of Governor Schwarzenegger's 2009-10 veto of that amount of PA funding.

The total funding for PAs in recent years and as proposed for 2011-12 includes:

	2008-09	2009-10	2010-11	2011-12 March Budget	2011-12 May Revise
GF (000s)	21,800	10,000	9,700	8,900	6,600
Total Funds (000s)	60,700	27,100	27,200	24,700	17,000

According to the Administration, the proposed reductions from March to the May Revision are tied to the impacts of decreased caseload estimates since the Governor's January budget proposal.

Potential Impact of Reductions to PA Funding: According to the California Association of Public Authorities (CAPA), the proposed level of funding for PAs in the May Revision would mean that some PAs would have insufficient funds to pay rent, basic bills and personnel costs while complying with their mandated functions. CAPA proposes a restoration to the March level of PA funding, as well as the development of a replacement methodology for PA funding allocations.

Subcommittee Staff Comment & Recommendation: Staff recommends rejecting the proposed May Revision reduction to Public Authorities' Administration funding. Funding for PAs would thus remain at the level included in SB 69 as it was passed by the Legislature in March (approximately $24.7 million total funds, with $8.9 million GF). In addition, staff recommends the adoption of trailer bill language directing the Department, in consultation with stakeholders including at least the counties and public authorities, to develop a new rate-setting methodology for public authority administrative costs, beginning with the 2012-13 fiscal year.

Questions for DSS:

1) What are the potential consequences if the May Revision's proposed reduction in PA funding results in PA closures? How might IHSS consumers, providers, counties, and the overall program be impacted?

2) Has the Department previously explored alternative options for how to establish PA funding levels?

DSS Issue 7: IHSS- County Administration and District Attorney Funding

Budget Issue: The Administration proposes, as part of the May Revision, to reduce the funding for county administration of IHSS by $12.6 million ($5.2 million GF) from the level included in SB 69 in March. Including the impact of the proposed reductions, the total statewide funding for county administration of IHSS would include $390.3 million ($138.6 million GF). The Administration also proposes, as part of the Governor's January budget and May Revision, to continue $28.4 million ($10.0 million GF) for county district attorney activities related to the IHSS program.

Background on County Administration Funding for IHSS: County workers provide intake and case management for over 430,000 low-income individuals who are elderly, blind or who have disabilities and who receive IHSS services to remain safely in their homes. According to the County Welfare Directors Association, county staff have struggled over the past two years to keep pace with this ongoing workload and the many changes to the IHSS program, including new program-integrity measures described below and several other program reductions or changes.

Background on Funding for District Attorney/County Anti-Fraud Activities: With some minor exceptions when federal or state funds are available, local District Attorneys' offices are principally funded on a discretionary basis out of county General Funds. According to the California Department of Justice, approximately $1.2 billion total was spent on prosecution activities statewide (based on 2006-07 data).

The funding for these IHSS-related district attorney activities was first included in the 2009-10 budget, as part of a package of $54.2 million ($21.9 million GF) in new resources for additional IHSS program integrity efforts. The funds were tied to budget bill language that described them as one-time, but the funding was continued in the 2010-11 budget and is again proposed in 2011-12. A significant number of other permanent IHSS program and policy changes were made in 2009-10 that remain in place today. These include:

1) Criminal background checks and appeals processes for IHSS providers;
2) The requirement for providers to attend an orientation;
3) Authorization to send directed 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; and
7) Certifications on timesheets, after notice of possible criminal penalties for fraud.

In addition, between 2009-10 and 2010-11, the Administration received 42 new staff positions for IHSS program integrity at DHCS and DSS [at a cost of $3.0 million ($1.5 million GF)].

Subcommittee Staff Comment & Recommendation: Staff recommends holding the counties harmless from caseload changes in 2011-12 on a one-time basis by rejecting the portion of the proposed $12.6 million ($5.2 million GF) reduction from March to May in counties' administration funding that is attributable to those changes. In conjunction with this action, staff recommends rejecting the continuation of the $28.4 million ($10 million GF) for county district attorney activities.

Questions for DSS:

1) Please describe the funding methodology for county administration of the IHSS program and the attendant responsibilities of the counties, including program integrity-related responsibilities.

2) Please describe the uses of the county district attorney funding from 2009-10 to date and why this funding is proposed to be continued.

OTHER CHILDREN'S PROGRAM ISSUES

DSS Issue 8 (#836): Proposed Rate Increase for Foster Families and Other Specified Caregivers

Budget Issue: DSS proposes, as part of the May Revision, an increase of $41.3 million ($10.7 million GF) in 2011-12 to raise the monthly rates for care and supervision that are paid to foster families and to guardians or adoptive parents of former foster children. The changes to foster family home rates result from a recent court order. The Department also proposes budget trailer bill language to codify the new rate-setting methodology used to establish these increased rates. The rate changes by age range are as follows:

Age Range	Current basic rate	Proposed 2011-12 basic rate
0-4	$446/month	$609
5-8	485	660
9-11	519	695
12-14	573	727
15-19	627	761

Beginning in Fiscal Year (FY) 2012-13, the new rate structure would also be adjusted annually for the cost of living.

Background: According to the Department, the new foster family home (FFH) rate structure was developed as a result of a judgment issued by the court *in California State Foster Parent Association, et al. v. John A. Wagner, et al* (CSFPA). In the CSFPA lawsuit,

the court determined that DSS had never set a FFH rate based upon the federally required consideration of the costs of providing specified aspects of care. To remedy this violation of federal law, the Court ordered the Department to establish a new rate structure. CDSS commissioned a foster care rates study from The Center for Public Policy Research (CPPR) at the University of California, Davis to develop alternate rate methodology proposals and filed a report with the Court on April 8, 2011 outlining its proposal for which methodology to use.

Dispute Over Effective Date of the Rate Increase: DSS proposes to begin paying the new rates as of July 1, 2011, or upon enactment of the budget. On April 15, 2011, the plaintiffs filled a motion for further relief requesting that the Court instead enforce its December 2010 order and require the Department to immediately pay the new FFH rate. On May 5, 2011, the Department filed to oppose the plaintiff's motion. A court hearing on the issue is set for May 26, 2011.

Related Rate Increases for Adoption and Guardianship Placements: Historically, the basic foster care rate paid for care of children in out-of-home placements has also been used to either set the benefits, or as a factor in the setting of benefits, for children who have exited foster care to enter into permanent placement types, such as adoption and specified guardianships. Statutes tie these payments to the payment the child would have received if they had been in, or continued to be in, out-of-home (foster) care. In keeping with this existing law and practice, DSS proposes parallel rate increases for the rates used to support placements in guardian or adoptive homes. However, this proposed change applies only to prospective cases. So rates for the Adoption Assistance Program and specified guardianship cases created on or after July 1, 2011 will be set at the FFH rate level the child would have received on or after July 1, 2011, if the child had remained in foster care. The Department indicates that this continued link between rates in prospective cases is intended to avoid creating a disincentive to permanency for the child.

Under this proposal, guardianship and AAP rates for existing cases (established before July 1, 2011) would be de-linked from the new FFH rate levels, and instead tied to the rates for these cases in effect prior to July 1, 2011. The Department is distinguishing these cases because permanency has already been achieved at the previously existing rate (and thus the Department does not believe that questions related to incentives for permanency are as critical). The Department does, however, propose to increase these rates in existing cases based on cost of living adjustments beginning with FY 2012-13. Without this proposed creation of a separate benefit level for cases from before July 1, 2011, the GF impact of the newly proposed rates would be $91.2 million (rather than the $10.7 million being proposed).

Subcommittee Staff Comment & Recommendation: Staff recommends approving the requested resources and adopting the Administration's trailer bill language as placeholder language to effectuate the new rate-setting system. To the extent that a court decision necessitates a different starting date for the foster family home rate changes described above, additional changes related to those and the other rates described above may become necessary.

Staff also recommends that the Subcommittee direct the Administration to provide, prior to finalization of related trailer bill provisions that would identify a specific methodology,

additional information for the Subcommittee's consideration with respect to the options available for measuring proposed cost of living increases that would begin in 2012-13. This information shall include, but not be limited to how the options presented compare with other statutorily-based adjustments that may be comparable (e.g., for other foster care placements and other social services programs) and in terms of their potential fiscal impacts over time.

Questions for DSS:

1) Please describe the lawsuit and resulting rate study that led to this proposal. Please also explain the rationale for proposing related rate increases for prospective guardians and adoptive families for former foster children.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

Outcomes for Agenda II[1]
May 25, 2011

Staff: Jennifer Troia

Vote-Only Agenda

0530 Health & Human Services Agency (HHS), including Office of Systems Information (OSI)

HHS Issue 1: Tech4Impact Grant Award

Voted 3-0 to approve the requested $65,000 increase in Reimbursement authority for 0530-001-0001.

HHS Issue 2: Aging & Disability Resource Connection (ADRC) Services

Voted 3-0 to approve of the requested increases in expenditure authority and establishment of authority for the limited-term SSM I position.

HHS Issue 3: Child Welfare Services/Case Management System (CWS/CMS)

Voted 3-0 to approve the requested decreases in 2011-12 expenditure authority.

HSS Issue 4: Case Management Information and Payrolling System (CMIPS II) Project

Voted 3-0 to approve the proposed changes in HHS and DSS expenditure authority, as well as the requested one-year extension of the four limited-term positions at DSS.

[1] The agenda itself contains further details on the context for the actions described here. It is published online at http://sbud.senate.ca.gov/subcommittee3.

HSS Issue 5: Health Information Exchange Support

Voted 3-0 to approve this request.

HSS Issue 6: Proposed Elimination of the CA Health Care Quality Improvement & Cost Containment Commission

Voted 3-0 to approve the proposed trailer bill language to eliminate this Commission.

4140 Office of Statewide Health Planning & Development (OSHPD)

OSHPD Issue 1: Implementation of Senate Bill (SB) 90

Voted 3-0 to approve the requested position and expenditure authority for implementation of SB 90.

4170 Department of Aging (CDA)

CDA Issue 1: Carry-Over of Federal Funds

Voted 3-0 to approve of the requested technical changes to carry-over the federal MIPPA funding.

5160 Department of Rehabilitation (DOR)

DOR Issue 1: Increased Federal Funding for Vocational Rehabilitation Services

Voted 3-0 to approve the requested changes to Budget Bill Items for DOR, including Items 5160-001-0001, 5160-001-0890, and Reimbursements.

5170 State Independent Living Council (SILC)

SILC Issue 1: ADRC Federal Grant

Voted 3-0 to approve the requested resources.

5175 Department of Child Support Services (DCSS)

DCSS Issue 1: Estimate Changes

Voted 3-0 to approve of the requested adjustments.

DCSS Issue 2: Transfer of Postage Funds

Voted 3-0 to approve the proposed technical adjustments needed to implement the new method of paying postage costs.

5180 Department of Social Services (DSS)

DSS Issue 1: Estimate Changes and Technical Adjustments

Voted 3-0 to approve caseload and other estimate adjustments, with any changes to conform as appropriate to other actions that have been or will be taken.

DSS Issue 2: Staffing Requests Previously Denied Without Prejudice

Voted 3-0 to approve the requested authority for the following positions and deny the requested authority for the remainder of the positions described in this agenda item:

- Four two-year limited-term positions to support DSS's workload related to provider exclusions and the establishment of the provider sales tax at DSS (with two positions for each of these efforts).

- The one-year extension of four limited-term positions at DSS to support the final stages of CMIPS II development;

DSS Issue 3: Solano County Licensing Workload Transfer

Voted 3-0 to approve of the requested resources and 0.5 of a position.

DSS Issue 4: Updates to Proposed Realignment of Child Welfare Services (CWS) Programs

Voted 2-1 (Emmerson no) to approve the proposed revisions to the previously adopted realignment proposal [subject to any changes that may result from conforming actions, including for Issue 5 described below (AB 3632 funding)].

DSS Issue 5: Proposed Transfer of Funding for Residential Costs of Special Education-Related Out-of-Home Placements (AB 3632)

No action taken. The outcome of this agenda item will conform to the Committee's action on the larger shift of responsibilities for the program from counties to schools. If such a transfer of program responsibilities is adopted by the Committee, the proposed shift of residential funding from DSS to CDE should also be approved. To the extent that trailer bill language may be necessary to effectuate that outcome, it will be approved as placeholder language subject to review and consideration in the trailer bill drafting process.

DSS Issue 6: Adoptions Assistance Program – Overpayments

Voted 3-0 to approve technical trailer bill language to fix the inaccuracies in current law regarding sharing ratios to be used when collecting overpayments.

DSS Issue 7: Proposed Elimination of the Continuing Care Advisory Committee

Voted 3-0 to approve the proposed trailer bill language to sunset the CCAC a year earlier than would otherwise occur.

DSS Issue 8: Proposed Suspension of Nutritional Requirements for Child Care Facilities (AB 2084)

Voted 2-1 (Emmerson no) to reject the proposed suspension of AB 2084 and related trailer bill language, directing the Department to instead absorb this minimal workload during its regularly scheduled inspections.

DSS Issue 9: Technical Adjustment to CalWORKs Stage One Child Care Funding

Voted 2-1 (Emmerson no) to approve this technical adjustment to the funding for Stage One Child Care.

DSS Issue 10: Proposed Extension of Moratorium on Group Home Rate Applications

Voted 3-0 to approve the trailer bill language and proposed one-year extension of the moratorium on group home rate applications.

DSS Issue 11: Proposed Suspension of Foster Youth Identity Theft Prevention Efforts (AB 2985)

Voted 3-0 to approve the proposed 2011-12 savings and adopt trailer bill language to delay implementation of the requirements of AB 2985 until July 1, 2013 (rather than make them subject to appropriation).

DSS Issue 12: Proposed Suspension of Resource Family Approval Pilot Efforts (AB 340)

Voted 2-1 (Emmerson no) to approve the proposed funding for 2011-12 and the trailer bill language that suspends implementation until January 1, 2012-- but with an amendment to delete the provision that would make implementation beyond that date subject to appropriation.

Discussion Agenda

4140 Office of Statewide Health Planning & Development (OSHPD)

OSHPD Issue 1: Proposed Eliminations of Three Healthcare-Related Policy Commissions

Voted 3-0 to approve trailer bill language to eliminate these three healthcare-related Commissions.

4200 Department of Alcohol & Drug Programs (ADP)

ADP Issue 1: Revision to Drug Medi-Cal (DMC) Estimates and Proposed Transfer of DMC to Department of Health Care Services (DHCS)

Voted 3-0 to approve the technical, estimate-related changes to the budget for the DMC program and the transfer of responsibility for administering the DMC program from ADP to DHCS. Correspondingly, adopted placeholder trailer bill language to effectuate this transfer. Amendments to the Administration's proposed trailer bill language will be made as necessary, including any amendments needed to preserve Legislative oversight. The Subcommittee will have the opportunity to address the related budget bill language under future health-related agenda items.

5160 Department of Rehabilitation (DOR)

DOR Issue 1: Proposed Change to Appeals Process

Voted 3-0 to approve the proposed elimination of the Rehabilitation Appeals Board.

5180 Department of Social Services (DSS)

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

AUTOMATION ISSUES

DSS Issue 1: Child Welfare Services (CWS)/Web Project

Voted 3-0 to approve the proposed suspension of CWS/Web and adopt trailer bill language directing DSS, in partnership with OSI and stakeholders, including Legislative staff and counties, to complete the following and provide an update to the Legislature by January 10, 2012:

1. Determine and describe the degree to which the CWS/CMS system:

   a. Is in compliance with current law, regulation, and policy.

   b. Supports current Child Welfare Services practice, including but not limited to key Child Welfare Service functions, ease of access to case and service information, multidisciplinary case management, and ease of use.

   c. Links to information that enhances investigation, case management, or efficiency.

   d. Provides ready access to data for reporting, planning, management, and program outcome monitoring.

2. Determine the best approach to address any missing functionalities that are critical to CWS operations. Options shall include building functionality into the current CWS/CMS system, restarting the CWS/Web procurement, or developing a new procurement.

3. Assess and report on communication from the federal government regarding requirements of the system, both by the January 1, 2012 deadline and thereafter when there is additional direction on federal expectations.

4. Recommend next steps, including a timeline, for implementing the recommended approach or approaches.

DSS Issue 2: Los Angeles (LA) Eligibility, Automated Determination, Evaluation and Reporting (LEADER) Replacement System (LRS)

Voted 3-0 to sweep $14.1 million GF that was budgeted for LEADER in 2010-11, via the addition of the following Budget Bill Language:

"5180-495 Reversion, Department of Social Services. As of June 30, 2011, the balances specified below, of the appropriations provided in the following citations shall revert to the balance in the fund from which the appropriations were made:

0001- General Fund
(1) Item 5180-141-0001, Budget Act of 2010 (Ch. 712, Stats. 2010). Up to $14,062,000 appropriated in Program 16.75 – County Administration and Automation Projects."

Further, approved (also 3-0) a delay in the development of LRS in the budget year, with corresponding savings of approximately $13 million GF for 2011-12, and any attendant technical changes that are required to effectuate this reduction.

OTHER CALWORKS ISSUES

DSS Issue 3: Proposed Amendments to SB 72 (March Trailer Bill)

Voted 3-0 to approve the proposed trailer bill language, subject to technical changes that may arise in drafting but are consistent with the proposed policy changes and clarifications.

IN-HOME SUPPORTIVE SERVICES (IHSS) ISSUES

DSS Issue 4: Proposed Amendments to SB 72 (March Trailer Bill)

1) Voted 3-0 to amend the proposed intent language as follows:

   12301.03(a) Authorized hours under the IHSS program were reduced in fiscal year 1992/1993 and included a supplemental assessment process that ~~ensured~~ was intended to ensure that IHSS recipients remained safely in their homes.

   (b) The reduction in authorized hours as provided for in the Act that added this section includes a supplemental assessment process that ~~will~~ is similarly intended to ensure that IHSS recipients will remain safely in their homes.

2) Voted 2-1 (Emmerson no) to reject the proposed elimination of the pre-approval process to exempt certain especially at-risk recipients from the reduction and approve of the proposed exemptions for recipients receiving services under specified waiver programs.

3) Voted 2-1 (Emmerson no) to replace (rather than deleting) the language related to exceptions to having a certification of need prior to receiving services described in #2 of the background section on Proposed Amendments above. The new language would read: "Services may be authorized temporarily pending receipt of the certification when the county determines there is a risk of out of home placement."

4) Voted 3-0 to approve of the proposed repeal of the prohibition on backfilling lost IHSS hours with additional Waiver Personal Care Services hours.

DSS Issue 5: IHSS- Proposed Trailer Bill Language Related to Provider Exclusions

Voted 2-1 (Emmerson no) to reject the proposed trailer bill language to broaden and make more generic the list of criminal convictions that serve as a bar to being an IHSS provider and to reject any portion of the proposed funding that is attributed to the use of the state-level Suspended & Ineligible list for Medi-Cal providers.

DSS Issue 6: IHSS- Public Authority Administration Funding

Voted 2-1 (Emmerson no) to reject the proposed reduction to Public Authorities' Administration funding and adopt trailer bill language directing the Department, in consultation with stakeholders including at least the counties and public authorities, to develop a new rate-setting methodology for public authority administrative costs, beginning with the 2012-13 fiscal year.

DSS Issue 7: IHSS- County Administration and District Attorney Funding

Voted 2-1 (Emmerson no) to reject any part of the proposed reduction in counties' administration funding from March to May, as specified (approximately $4.5M GF and corresponding other funds). In conjunction with this action, rejected the continuation of the $28.4 million ($10 million GF) for county/district attorney activities.

OTHER CHILDREN'S PROGRAM ISSUES

DSS Issue 8 (#836): Proposed Rate Increase for Foster Families and Other Specified Caregivers

Voted 3-0 to approve the requested resources and adopt the Administration's trailer bill language as placeholder language to effectuate the new rate-setting system. To the extent that a court decision necessitates a different starting date for the foster family home rate changes described above, additional changes related to those and the other rates described in the agenda become necessary. Also, directed the Administration to provide, prior to finalization of related trailer bill provisions that would identify a specific methodology, additional information with respect to the options available for measuring proposed cost of living increases that would begin in 2012-13. This information shall include, but not be limited to how the options presented compare with other statutorily-based adjustments that may be comparable (e.g., for other foster care placements and other social services programs) and in terms of their potential fiscal impacts over time.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 26th, 2011

Upon Adjournment of Appropriations

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Vote Only Calendar: Listed by Department (Pages 2 to xx)

A. Department of Health Care Services (Items 1 through 12)

1. Medi-Cal Estimate: Adjustments Due to Erosion of Solutions (DOF issue 401)

Governor's May Revision. The May Revision reflects an increase of $313.2 million ($156.6 million General Fund) due to erosions in the solutions which were adopted in March.

The erosion is mainly caused by the one-month delay in implementation of budget solutions and the revised costing by the DHCS at the May Revision of enacted policies.

Subcommittee Staff Comment and Recommendation—Approve May Revision. It is recommended to adopt the May Revision to properly align the Medi-Cal Program with necessary adjustments due to the one-month delay in implementing solutions and other related May Revision costing adjustments. No issues have been raised.

2. Medi-Cal Estimate: Balance of the Estimate (DOF issue 420)

Governor's May Revision. The May Revision proposes two sets of technical adjustments related to caseload and cost changes, and non-budget act items which are continuously appropriated and are in statute.

Caseload and cost changes not highlight in other Medi-Cal issues:

- Item 4260-101-0001 be decreased by $81,609,000 and Reimbursements be decreased by $32,484,000
- Item 4260-102-0001 be decreased by $1,908,000
- Item 4260-105-0001 be decreased by $1,777,000
- Item 4260-113-0001 be decreased by $51,403,000
- Item 4260-117-0001 be increased by $1,145,000
- Item 4260-101-0890 be increased by $2,910,336,000
- Item 4260-102-0890 be decreased by $1,908,000
- Item 4260-106-0890 be increased by $15,323,000
- Item 4260-113-0890 be increased by $71,328,000
- Item 4260-117-0890 be increased by $6,199,000
- Item 4260-101-0080 be increased by $689,000

Additionally, the following items have been adjusted to fund Medi-Cal costs that are reflected in non-budget act items. No amendments to the Budget Bill are required for these changes because these items are continuously appropriated:

- Welfare and Institutions Code section 14166.12 is increased by $1,804,000
- Government Code section 13340 is increased by $79,647,000
- Welfare and Institutions Code section 14166.9 is decreased by $44,656,000
- Welfare and Institutions Code section 14166.21 is decreased by $165,801,000
- Welfare and Institutions Code section 14167.32 is increased by $320,000,000
- Revenue and Taxation Code section 12201 is increased by $105,788,000
- Welfare and Institutions Code section 14126.022 is decreased by $3,177,000
- Welfare and Institutions Code section 15910.1 is increased by $325,000,000

Subcommittee Staff Comment and Recommendation—Approve May Revision. These May Revision adjustments are technical and are necessary to properly align Medi-Cal Program expenditures. No issues have been raised.

3. Medi-Cal Program: Technical Trailer Bill for Correction to SB 90, Statutes of 2011

Governor's May Revision. The May Revision proposes technical trailer bill due to a drafting error in SB 90, Statutes of 2011, related to the implementation of hospital inpatient payment methodology for General Acute care services based upon diagnosis related groups (DRGs).

Specifically, SB 90 inadvertently repealed the requirement (established though the Budget Act of 2010) for the new DRG payment methodology be implemented by July 1, 2012 by means of a reconciliation process. The May Revision proposes technical trailer bill to clarify that July 1, 2012 is still assumed for the implementation date of the DRG payment methodology as noted.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. The proposed technical trailer bill is consistent with actions adopted in the Budget Act of 2010 and accompanying trailer bill legislation. The May Revision trailer bill language would correct the error contained in SB 90, Statutes of 2011. No issues have been raised.

4. Maddy Fund Shift (DOF Issue 424)

Background. Existing law authorizes collection of assessments on certain traffic and criminal violations, and revenue from traffic school fees. These funds are deposited in the Emergency Medical Services Fund (known as the "Maddy Fund"). These funds are used to compensate physicians and hospitals that provide emergency medical services to the uninsured and cannot pay for their medical care.

Legislative Actions Contained in SB 69 Budget Bill. The SB 69 Budget Bill reflects a reduction of $55 million (General Fund) by shifting a portion of the Maddy Funds to the State to offset General Fund support within the Medi-Cal Program.

This action was taken due to the fiscal crisis and implementation of the 1115 Medicaid Waiver which provides additional federal funds to local government for uncompensated care, including physicians and hospitals.

It should be noted that necessary statutory changes to affect this change *did not occur* in trailer bill.

Governor's May Revision. The May Revision increases by $55 million (General Fund) and decreases by $55 million special fund since it does *not* include the redirection of the Maddy Funds as contained in the SB 69 Budget Bill.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. It is recommended to adopt the May Revision to *no*t include the redirection of the Maddy Funds since necessary statutory changes were not enacted.

5. Medi-Cal Program: Technical Trailer Bill for 10 Percent Rate Reduction

Legislative Actions Contained in SB 69 Budget Bill—Conformed to Governor. The Legislature approved the Governor's January budget proposal to reduce Medi-Cal Provider reimbursement up to 10 percent as contained in AB 97, Statutes of 2011 (signed into law on March 24, 2011).

Except for those specialty exempted providers, the Provider payment reductions would apply to services rendered by any provider that is authorized to bill for Medi-Cal services. Federal approvals must be received before the 10 percent reductions can be implemented in order to comply with federal law.

The language also sunset the 1 percent and 5 percent Provider payment reductions, enacted previously, effective on or after June 1, 2011 with repeal date of July 1, 2014. This sunset language was included so previous payment reductions would not conflict with June 1, 2011 implementation date of the 10 percent reductions.

Governor's May Revision. The May Revision proposes clarifying adjustments to the 10 percent Medi-Cal Provider reimbursement reduction as contained in AB 97, Statutes of 2011, since the DHCS *will not be able* to obtain federal approvals by the implementation date of June 1, 2011.

Subsequently, this creates a transition period wherein neither a 1 percent and 5 percent Provider payment reduction nor a 10 percent provider payment reduction will be in effect, which was not the intent of AB 97, Statutes of 2011.

Therefore, the DHCS proposes clarifying trailer bill to maintain the 1 percent and 5 percent Provider payment reduction which had been in effect until the implementation of the 10 percent Provider payment reduction. The 1 percent and 5 percent Provider payment reductions have been in place since March 1, 2009; it is to remain operative.

Further, the trailer bill makes a correct to a minor citation error in the statute.

Subcommittee Staff Comment and Recommendation—Approve May Revision. It is recommended to approve "placeholder" trailer bill language as provided by the DHCS to ensure that the 1 percent and 5 percent Provider reimbursement reductions are maintained pending federal approval of the 10 percent Provider reimbursement reduction as noted above.

6. Medi-Cal Program: Adjustment for 10 Percent Rate Reduction (DOF 464)

Governor's May Revision. The May Revision requests that Item 4260-101-0001 be decreased by $30,122,000 to provide for the correction of a technical error associated with pharmacy rebates and the 10 percent provider payment solution proposed in the Governor's budget and contained in SB 69 Budget Bill.

The May Revision Medi-Cal baseline reduced pharmacy rebates associated with the 10 percent provider rate reduction. However, rebates are contracted with manufacturers and should not decrease because of a reduction in pharmacy reimbursements. This adjustment would correct the initial estimate provided in the May Revision.

Subcommittee Staff Comment and Recommendation—Approve May Revision. It is recommended to correct for this technical error and to adopt the May Revision. Previous calculations inadvertently included Pharmacy Rebates and these rebates are contract with the Manufacturers and should not have been included in the 10 percent calculation.

7. Adult Day Health Care (ADHC) Transition Program (DOF Issue 432)

Legislative Actions Contained in SB 69 Budget Bill. The Legislature appropriated $170 million ($85 million General Fund) to provide for a transition for existing ADHC enrollees to other Medi-Cal appropriate services, and to facilitate when applicable, transition to newly developed Waiver services.

The Budget Bill also contains language that states the Legislature's intent to proceed with legislation in the 2011-12 Session to develop a federal Waiver to provide a more narrow scope of services and to specify level of medical acuity for enrollment into this Waiver program.

AB 97, Statutes of 2011 (Health Trailer Bill), provides for a transition program as specified and provides the DHCS with broad discretion to implement the program through the use of grant funding. The purpose of the transition program is to assist individuals receiving ADHC services to transition to other Medi-Cal services, social services, and respite programs, or to provide social activities and respite assistance for individuals who were receiving ADHC services at the time the services were eliminated.

In addition, AB 97, Statutes of 2011, also specifies the Legislature's intent to proceed with legislation to establish a Waiver program for Keeping Adults Free from Institutionalization (KAFI). Presently there are *two policy bills*—SB 73 by Senator DeSaulnier, and AB 96 by Assembly Member Blumenfield—which are moving on this topic.

Governor's May Revision. The Governor's May Revision proposes to appropriate *only* $50 million ($25 million General Fund) for expenditures associated with the ADHC transition. No trailer bill language is proposed. DHCS states these funds may be used for assessment, placement, and the provision of services.

The May Revision reflects *a reduction of $120 million* ($60 million General Fund) as compared to the Legislature's action contained in the SB 69 Budget Bill.

Subcommittee Staff Comment and Recommendation--(1) *Reject* May Revision; (2) Adopt KAFI Trailer Bill, and (3) Retain SB 69 Budget Bill Action. It is recommended to *reject* the Governor's May Revision and to *retain* the full $170 million ($85 million General Fund) appropriation as contained in the SB 69 Budget Bill.

The SB 69 Budget Bill appropriation level will provide for a longer transition process and will assist in ensuring consumer health and safety. Therefore it is necessary to retain this level of funding.

In addition, in order to expedite implementation of a Waiver and KAFI, it is recommended to adopt placeholder trailer bill (language similar to the two policy bills).

8. Restoration of General Fund in Lieu of Proposition 10 Funds (DOF Issue 448)

Legislative Actions Contained in SB 69 Budget Bill. The SB 69 Budget Bill conformed to the Governor's January budget proposal and included his proposal to use $1 billion in Proposition 10 Funds—California Children and Families First Act— to backfill for General Fund support within the Medi-Cal Program. AB 100, Statutes of 2011, made necessary statutory changes for this action to occur.

Governor's May Revision. The May Revision proposes to increase by $1 billion (General Fund) and to reduce by $1 billion Proposition 10 Funds within the Medi-Cal Program. This proposal is intended to be a "prudent budgetary approach" given that the Proposition 10 Fund shift is currently being challenged in Court.

The Administration states they are continuing to pursue these Proposition 10 Fund savings by defending all legal challenges at this time. Therefore, they have *not* proposed any statutory changes in trailer bill.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. It is recommended to adopt the May Revision to increase by $1 billion (General Fund) to backfill for the Proposition 10 Fund expenditure which is being challenged in Court.

9. Extension of Hospital Fee to June 2012 (DOF issue 423)

Governor's May Revision. The May Revision reflects a savings of $320 million (General Fund) to Medi-Cal for Children through extension of the existing Hospital Quality Assurance Fee to June 30, 2012.

SB 90 (Steinberg), Statutes of 2011, allows for an acute care hospital building that is classified as a Structural Performance Category 1 building to be used for non-acute care hospital purposes after January 1, 2010, contingent upon the hospital Quality Assurance Fee being extended for one year, along with $320 million in fee revenue being used for children's health care services within Medi-Cal.

Policy legislation is proceeding on the continuation of the Quality Assurance Fee.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. The May Revision is consistent with SB 90 (Steinberg), Statutes of 2011, and policy legislation is proceeding on the continuation of the fee. No issues have been raised.

10. May Revision Updates for Family Health Programs (DOF issues 501, 502, 503 & 504)

Governor's May Revision. The May Revision proposes an overall *net* reduction of $132.9 million (General Fund) in the Family Health Programs which includes the Genetically Handicapped Persons Program (GHPP), the California Children's Services (CCS) Program, and the Child Health and Disability Prevention (CHDP) Program.

The $132.9 million General Fund reduction results from the following key factors:

- A reduction in estimated caseload for each of the programs;
- Reflection of federal Safety Net Care Pool Funds transferred into each of the programs which results in a reduction of $106 million General Fund (i.e., a fund shift). This fund shift occurs in the CCS Program and the GHPP. There is no policy change associated with this shift.
- Adjustment to reflect a 10 percent Provider reimbursement reduction as contained in AB 97, Statutes of 2011, which conformed to the Medi-Cal Program.

The budget proposes technical fiscal adjustments and caseload adjustments to three distinct programs within Family Health. These are as follows:

- *Genetically Handicapped Persons Program (GHPP).* Total expenditures of $75.6 million ($36.1 million General Fund, $ 35.2 million federal Safety Net Care Pool, $4 million Rebate Fund, and $367,000 Enrollment Fees) are proposed for 2011-12. This reflects technical fiscal adjustments and caseload only. Total caseload is 976 people.

- *California Children's Services Program (CCS).* Total expenditures of $230.4 million ($48.5 million General Fund and $181.9 million federal funds) are proposed for 2011-12. This reflects technical fiscal adjustments, including the 10 percent Provider reimbursement reduction and the Safety Net Care Pool federal fund shift, and caseload adjustments only. In addition, a total of $117.2 million (County Realignment Funds) are estimated for expenditure in 2011-12 but these funds do not flow through the State's budget. Total caseload is estimated to be 40,559 children.

- *Child Health & Disability Prevention (CHDP) Program.* Total expenditures of $2.3 million ($2.2 million General Fund, and $32,000 Children's Lead Poisoning Prevention Funds) are proposed for 2011-12. This reflects technical adjustments, including the 10 percent Provider reimbursement reduction, and caseload adjustments only. Total caseload is estimated to be 34,550 children.

In addition, the May Revision proposes a reduction of $79.4 million ($44.3 million General Fund) by shifting children in the Healthy Families carve-out portion of the CCS Program to Medi-Cal to coincide with the Administration's proposal on merging the Healthy Families Program into the Medi-Cal Program based on a phase-in transition beginning January 1, 2012. No net statewide savings will result from this shift. This is discussed more comprehensively within the Transition to Health Families document. *It should be noted that any Subcommittee #3 action taken with regards to the merger of the Healthy Families Program into the Medi-Cal*

Program will conform to the CCS Program where applicable to ensure continuity of services for children enrolled in the CCS Program.

Background—Genetically Handicapped Persons Program (GHPP). The Genetically Handicapped Persons Program (GHPP) provides comprehensive health care coverage for persons with specified genetic diseases including Cystic Fibrosis, Hemophilia, Sickle Cell Disease, Huntington's Disease, Joseph's Disease, metabolic diseases and others. GHPP also provides access to social support services that may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions.

Persons eligible for GHPP must reside in California, have a qualifying genetic disease, and be otherwise financially *ineligible* for the CCS Program. GHPP clients with adjusted gross income above 200 percent of poverty pay enrollment fees and treatment costs based on a sliding fee scale for family size and income.

Background: CA Children's Services Program (CCS). The CA Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children with specific medical conditions, including birth defects, chronic illness, genetic disease and injuries due to accidents or violence. The CCS services must be deemed to be *"medically necessary"* in order for them to be provided.

CCS focuses specifically on children with special health care needs. It depends on a network of specialty physicians, therapists and hospitals to provide this medical care. By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service). CCS was included in the State-Local Realignment of 1991 and 1992. As such, counties utilize a portion of their County Realignment Funds for this program.

CCS enrollment consists of children enrolled as: **(1)** CCS-only (not eligible for Medi-Cal or the Healthy Families Program); **(2)** CCS and Medi-Cal eligible; and **(3)** CCS and Healthy Families eligible. Where applicable, the state draws down a federal funding match and off-sets this match against state funds as well as County Realignment Funds.

Background: The Child Health & Disability Prevention Program (CHDP).
The CHDP provides pediatric prevention health care services to (1) infants, children and adolescents up to age 19 who have family incomes at or below 200 percent of poverty, and (2) children and adolescents who are eligible for Medi-Cal services up to age 21.

CHDP services play a key role in children's readiness for school. All children entering first grade must have a CHDP health exam certificate or equivalent.

This program serves as a principle provider of vaccinations and facilities enrollment into more comprehensive health care coverage, when applicable, via the CHDP gateway.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. No issues have been raised regarding this estimate package for these three programs. It is consistent with prior actions and appropriately reflects federal fund adjustments and Provider reimbursement reductions. *This action will be adjusted to conform where necessary to any action taken with regards to the merger of Healthy Families into the Medi-Cal Program.*

11. Department of Health Care Services: State Support Requests

The May Revision proposes the following State Support requests for the DHCS:

A. State Option to provide Health Homes to Enrollees with Chronic Conditions (DOF 440)

Governor's May Revision. The May Revision proposes an increase of $700,000 ($350,000 in Reimbursements and $350,000 federal funds) for assessment activities related to a federal State Option to Provide Health Homes for Enrollees with Chronic Conditions" Program. Specifically, these funds would provide for the planning and assessment activities and do not commit the State to implementing the Health Homes program. This assessment phase will allow the State to evaluate whether the activity is warranted, particularly when the two-year enhanced federal funds are no longer available.

Background. Under this federal option, an enhanced federal match to provide for care coordination services for a two-year period. Health Home services include coordination of physical health and behavioral health care and linkages to social services that are related to the beneficiary's health.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. This is an important federal option which California should study and plan for in the future. No issues have been raised and there is no effect to the General Fund.

B. Health Care Reform

Governor's May Revision. The May Revision requests an increase of $1.2 million ($495,000 General Fund) to fund a total of 9 limited-term positions (to June 30, 2013) to implement additional health care reform mandates. The positions include some clinical staff as well as administrative positions.

These positions would be responsible for:

- Conducting Enhanced Provider Screenings;
- Developing the infrastructure for integrating dual eligible beneficiaries into a new health care delivery system;
- Expanding the Program All-Inclusive Care for the Elderly (PACE) health plans; and
- Addressing workload related to various Wavier analyses and system changes.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. It is recommended to approve the May Revision to ensure California can make all necessary changes to implement federal mandates as they pertain to the Medi-Cal Program and federal health care reform. No issues have been raised.

C. Federally Mandated HIPAA Updates and System Compliance

Governor's May Revision. The May Revision proposes an increase of $2 million ($462,000 GF) to extend 11.5 positions for an additional three-years, and establish four new three-year limited term positions. Federal funding is available for some of these activities at a 90 percent federal match for a limited time.

These positions would be used to implement new federal HIPPA (Health Insurance Portability and Accountability Act) requirements that were created as part of federal health care reform. The new requirements include more frequent HIPAA updates, new operating rules, new standards, and new health pan certification requirements

Subcommittee Staff Comment and Recommendation—Adopt May Revision. It is recommended to approve the May Revision to ensure California can make all necessary changes to implement federal mandates as they pertain to the Medi-Cal Program and federal health care reform. No issues have been raised.

D. Proposed Compromise on Positions for Development of Hospital DRGs

Background. Among other things, SB 853, Statutes of 2010, (Omnibus Health Trailer bill for the Budget Act of 2010) requires the DHCS to development a new hospital inpatient payment methodology for general acute care services based upon diagnosis related groups (DRGs). Initially a reconciliation process is to commence as of July 1, 2012, with full implementation of the DGR payment method by July 1, 2014. The Medicare Program has utilized a DRG methodology for over 15 years.

Prior Action and Revised DHCS Proposal. In the SB 69 Budget Bill, the Legislature did not approve a January budget request by the DHCS for staff pertaining to the development and implementation of this new methodology. The Budget Bill reflects *a reduction* of $1.2 million ($480,000 General Fund) and 11 positions from this action.

The DHCS has subsequently identified a redirection of five audit positions to address some of their need for staff and are now requesting an increase of only $118,000 ($59,000 General Fund) to hire a Research Program Analyst I in order to conduct this work.

Subcommittee Staff Comment and Recommendation—Approve DHCS Compromise. It is recommended to approve the DHCS compromise to redirect five audit positions from within the DHCS to this function, and to approve an increase of $118,000 ($59,000 General Fund) for the Research Program Analyst I position.

12. Technical Adjustment to Managed Care Organization (MCO) Tax (DOF 463)

Background. AB 1422, Statutes of 2009, established an alternative funding mechanism for essential preventative and primary health care services provided through the Healthy Families Program by adding Medi-Cal Managed Care Plans to the list of insurers subject to California's gross premiums tax of 2.35 percent. It is required that the tax proceeds be used to offset, in the capitation rate development process, payments made to the State that result directly from the imposition of the tax.

Governor's May Revision. The May Revision proposes a technical adjustment to increase by $103.4 million (General Fund) to provide for a correction of a technical error in the Administration's MCO tax extension calculation. Capitated Rates to Medi-Cal Managed Care Plans are paid out of the General Fund. Revenues from the MCO tax are used to backfill those expenditures with no net effect in the DHCS Medi-Cal budget. Savings are realized in the Managed Risk Medical Insurance Board budget.

The General Fund expenditures associated with the MCO tax were inadvertently scored as special fund expenditures. This adjustment would correct the initial Medi-Cal estimate provided to the Legislature on May 16th.

Subcommittee Staff Comment and Recommendation—Approve Technical Correct. A technical adjustment is necessary. It is recommended to adopt this later change.

B. Department of Public Health (Items 1 through 9)

1. Every Woman Counts (EWC) Program (DOF Issues 220 and 221)

Legislative Actions Contained in SB 69 Budget Bill—Conformed to Governor. The Legislature adopted total expenditures of $64.9 million ($27.8 million General Fund) to serve 393,000 clients for 2011-12. This action conformed to the Governor's January budget.

Governor's May Revision. The May Revision proposes total expenditures of $71.5 million ($18.4 million General Fund, $10.7 million Breast Cancer Control Account, $22.1 million Cigarette and Tobacco Product Surtax Funds, and $4.4 million federal funds).

As shown in the *table below*, the May Revision reflects total expenditures of $57.8 million, or a total fund reduction of $7.1 million (reduction of $9.3 million General Fund), as compared to the SB 69 Budget Bill. Two adjustments are proposed as follows:

- **10 Percent Medi-Cal Rate Reduction**. Reduce by $7.1 million (General Fund) to reflect a conforming action in Medi-Cal Program to reduce provider reimbursement by 0 percent. The EWC Program reimburses providers using Medi-Cal Program rates.
- **Increased Revenues from Breast Cancer Control Account.** Increase by $2.2 million from the Breast Cancer Control Account, and reduce General Fund support, to reflect the availability of special funds available from interest revenues that had accrued in the Breast Cancer Fund and are proposed to be transferred to the Breast Cancer Control Account for expenditure.

Table: Fiscal Comparison (dollars rounded)

Fund Source	May Revision 2011-12	SB 69 Budget Bill	**Difference**
General Fund	$18.4 million	$27.8 million	-$9.3 million
Breast Cancer Control Account	$12.9 million	$10.6 million	+$2.2 million
Proposition 99 Funds	$22.1 million	$22.1 million	--
Federal Funds	$4.5 million	$4.5 million	--
Total Program	**$57.8 million**	**$64.9**	**-$7.1**

Background. The Every Woman Counts (EWC) Program provides breast and cervical cancer screening services to low-income individuals. Generally, to be eligible for services, a person must have no health care coverage, have a family income below 200 percent of the federal poverty level, and be 40 years of age or older. Under EWC, breast cancer screening includes clinical breast exams, mammograms, and diagnostic work ups. It also provides cervical cancer screening and diagnostic services to women aged 25 and over who meet similar eligibility criteria. Cancer treatment is not covered by this program. If a cancerous condition is found, treatment services are available through Medi-Cal, or other referrals are made.

Subcommittee Staff Recommendation—Approve May Revision. It is recommended to approve the May Revision to reflect two technical adjustments as noted. No issues have been raised.

2. State Operations: Adjustment for Breast Cancer Research (DOF Issue 220)

Governor's May Revision. The May Revision proposes a one-time reduction of $86,000 (Breast Cancer Research Fund) in State Operations expenses in order to maintain fiscal solvency in the Breast Cancer Research Account.

Subcommittee Staff Recommendation—Approve May Revision. This is a technical adjustment and no issues have been raised.

3. Proposition 99 Funds: Research Account & Health Education (DOF Issues 225 & 226)

Governor's May Revision. The May Revision proposes three adjustments in the Department of Public Health that pertain to the expenditures of Proposition 99 Funds (Cigarette and Tobacco Product Surtax Funds) in the Research Account and Health Education Account.

These adjustments are as follows:

- **Environmental Health Branch ($6,160 Research Account).** This increase will allow the Branch to expand its investigations into the analysis of dust samples collected at fire stations for the Firefighters Occupational Exposure study. The samples will be analyzed for the presence of carcinogenic chemicals in the firefighting environment.
- **Cancer Surveillance and Research Branch ($49,840 Research Account).** This increase will allow the Branch to design and conduct initial testing for the Integrating Medical Informatics Systems to Expand Cancer Surveillance and Research. The overall goal of this project is to ultimately implement a new approach to cancer data collection that will provide more detailed, high-quality data on persons diagnosed with cancer in a faster, more cost-effective manner.
- **CA Tobacco Control Program ($173,000 Health Education Account).** This increase will allow the California Tobacco Control Program to increase the purchase of media in rural and smaller markets.

Subcommittee Staff Recommendation—Approve May Revision. No issues have been raised regarding these adjustments.

4. Medical Marijuana Program Loan Repayment (DOF Issue 254)

Governor's May Revision. The May Revision proposes to extend the repayment date of the $1.5 million loan from the Health Statistics Fund to the Medical Marijuana Fund for two years--from June 2012 to June 2014. The extension is requested due to low fund balances in the Medical Marijuana Program Fund.

The Budget Act of 2004 provided a loan of $1.5 million from the Health Statistics Fund to begin implementation of the program. It was anticipated that the loan funds would be used for the first 18 months of program operation until fees collected from card program users began to flow into the State to offset program costs and repay the loan.

In 2010-11, $500,00 will be repaid to the Health Statistics Fund and the remaining $1 million is due to be repaid by June 30, 2012. However, due to less than anticipated fees, this loan repayment must be deferred until June 2014.

Background. Senate Bill 420 (Vasconcellos), Statutes of 2003, required the DPH to establish and maintain a voluntary medical marijuana identification card and registry program for qualified patients and their primary caregivers through County Health Departments or designee. It is supported by fee revenue and the loan from the Health Statistics Fund.

Subcommittee Staff Recommendation—Approve May Revision. No issues have been raised regarding these adjustments.

5. Reappropriation: Health Care Surge Capacity (DOF Issue 213)

Governor's May Revision. The May Revision proposes to reappropriate $1.272 million through June 30, 2013 from unspent funds originally appropriated in SB 162 (Ortiz), Statutes of 2006. The reappropriation is to support the storage, maintenance, and transportation costs associated with transitioning DPH's healthcare surge stockpile and the Emergency Medical Services Authority (EMSA) mobile field hospitals.

The Administration states that over the course of 2011-12, the DPH and EMSA will work together to secure alternatives to distribute the assets to public and private organizations. The following Budget Bill Language is proposed for the reappropriation:

"As of June 30, 2011, the appropriation provided in the following citation is reappropriated for the purposes of storing emergency preparedness assets, including pharmaceuticals, medical supplies, and state mobile field hospitals, to allow the DPH and EMSA to distribute the assets to alternate, permanent points of responsibility. These funds shall be available for encumbrance or expenditure until June 2013.

0001—General Fund
(1) $1,832,000 in Item 4260-111-0001, Budget Act of 2006 (Chs. 47 and 48, Stats. 2006).

Subcommittee Staff Recommendation—Approve May Revision. This conforms to the Governor's January comments to limit General Fund expenditures associated with the Health Surge Capacity Initiative implemented in 2006 in readiness for a potential influenza pandemic which did not occur. The May Revision will continue storage and maintenance for one-year while alternate, permanent points of responsibility can be ascertained. It is recommended to approve the May Revision.

6. Health Care Reform: National Background Check Program (DOF Issue 251)

Governor's May Revision. The May Revision proposes an increase of $1.721 million (federal grant funds) to enhance the State's criminal record clearance process for direct patient access employees of Long-Term Care Facilities. Federal funds were made available for this purpose under the federal Patient Protection and Affordable Care Act of 2010.

The DPH will be working with the Department of Social Services (DSS) to implement additional criminal record searches via the Federal Bureau of Investigation (FBI), the National Sex Offender Registry, the Health Care Integrity Protection Data Bank/National Practitioner Data Bank, the Federal Department of Health and Human Services, Office of Inspector General, Medi-Cal Ineligible and Suspended List, and other relevant State Registries based on residency.

Subcommittee Staff Recommendation—Approve May Revision. The May Revision is consistent with the purposes of the federal grant award. No issues have been raised.

7. General Fund Loan Repayment by Childhood Lead Prevention (DOF Issue 214)

Legislative Actions Contained in SB 69 Budget Bill. General Fund support was provided as a loan to the Childhood Lead Poisoning Prevention Fund for expenditure in the program in 1996-97 and was never repaid. The Legislature identified $6 million in reserve funds available in the Childhood Lead Poisoning Prevention Fund to transfer to the General Fund for a partial repayment of the original loan for 2011-12. This resulted in $6 million in General Fund savings.

Governor's May Revision. The May Revision has identified an additional $3.1 million available for repayment to the General Fund for this same purpose. This additional amount provides for a repayment of $9.1 million to the General Fund.

Subcommittee Staff Recommendation—Approve May Revision. The May Revision provides an additional $3.1 million in General Fund savings as noted. It is recommended to approve the May Revision.

8. Licensing and Certification: Technical Adjustment to Staffing Ratio (DOF Issue 255)

Governor's May Revision. The May Revision proposes a net increase of $252,000 ($234,000 Licensing and Certification Fees, and $18,000 in Reimbursements) and 12 positions due to a correction in applying the Health Facilities Evaluator Nurse staffing ratio.

Subcommittee Staff Recommendation—Approve May Revision. This is a technical adjustment to the baseline Licensing and Certification Program and has *no* General Fund or policy implications. In addition, this action has *no* Fee implications for the facilities. It is recommended to approve the May Revision.

9. Increase for Vaccine Purchases

Governor's May Revision. The May Revision proposes an increase of $7.3 million (General Fund) to provide influenza vaccine for distribution to Local Health Jurisdictions to immunize up to 700,000 "at-risk" populations, including the elderly and pregnant women.

The DPH notes that Section 104900 of Health and Safety Code directs that the State is to provide appropriate flu vaccine to local governmental or private, nonprofit agencies at no charge in order that agencies may provide the vaccine, at minimum cost, at accessible locations in the order of priority first, for all persons 60 years of age or older and then to other high-risk groups as identified.

Subcommittee Staff Recommendation—Approve May Revision. It is recommended to adopt the May Revision to provide increased funding for influenza vaccine.

10. State Operations: Women, Infants and Children (WIC) Nutrition Program

Governor's May Revision. The May Revision requests an increase of $7.642 million (federal funds) as compared to the SB 69 Budget Bill which for WIC conformed to the Governor's January budget.

This $7.642 million (federal fund) request consists of funds for **(1)** Interagency Agreements with various State agencies due to increases in vendor applications, increased WIC participation and changes in federal regulations; and **(2)** Consultant Contracts related to two automated management systems which generate reporting data to the USDA and WIC stakeholders. The table below provides a summary of this information.

WIC $7.6 million Federal Funds Augmentation

Entity	Description	Amount (Federal Funds)
A. Interagency Agreements		
UC Davis	Special Grant project for Toddler Behavior Research designed to assist WIC programs in evaluating innovative methods of service delivery.	$122,851
DPH—Maternal & Child Health Branch	Conducts epidemiology services to support caseload growth, identification of geographic areas of unmet need for WIC services, outreach and breastfeeding.	$1,855,750
State Treasurer's Office	Processes WIC checks and reimburses WIC vendors for purchases.	$600,000
State Controller's Office	Conducts vendor and local agency audits to ensure compliance.	$1,874,000
Department of Health Care Services	Conducts administrative hearings for appeals by WIC vendors.	$150,000
Office of State Publishing	Prints and distributes required nutrition education and breastfeeding materials to WIC families.	$1,900,000
B. Contracts For:		
Electronic Benefit Transfer	These are earmarked federal funds to conduct the planning process for transferring WIC food benefits from paper to an Electronic Benefits Transfer system.	$389,000
Automated Management System	This pertains to two contracts to maintain WIC's automated management system.	$750,000
TOTAL Federal Funds		**$7,642,000**

Subcommittee Staff Recommendation—Approve May Revision. The request is consistent with the federal grant funds and the purposes of the WIC Program. No issues have been raised.

C. Department of Mental Health (Items 1 and 2)

1. Technical Adjustment to Reimbursements for Local Assistance (DOF Issue 564)

Governor's May Revision. The May Revision proposes to reflect an increase of $914.2 million in Reimbursements in Item 4440-101-0001, and to eliminate two other Item numbers (i.e., 4440-103-3085 and 4440-105-3085.

The purpose of this action is to simplify the invoicing and payment processes of the Department of Mental Health and the Department of Health Care Services.

Subcommittee Staff Comment and Recommendation—Approve May Revision. The May Revision is a technical adjustment and is intended to streamline payment processes. It is simply consolidating budgetary items into one item. No issues have been raised.

2. State Staff: Legal Resources

Legislative Action as Contained in SB 69 Budget Bill. The Legislature *denied* a request from the Governor's January budget to increase by $2.1 million (General Fund) for legal services to be performed by the Attorney General's Office (AG's Office) for DMH regarding health education and welfare work and all new tors and condemnation work.

This budget proposal lacked fiscal detail and justification for the need of the $2.1 million (General Fund) request and was denied by the Legislature. This 2011-12 request simply reflected the amount which was denied by the Legislature last year regarding legal work at the DMH.

Governor's May Revision. The Department of Finance requested reconsideration of this proposal.

Background. Historically, the AG's Office has provided legal representation to the DMH for litigation and court appearances. In September 2009, the AG's Office informed the DMH of policy changes that would substantially reduce the amount of legal services provide by the AG's Office to the DMH as a result of reduced resources within the AG's Office.

In spring 2010, the DMH requested 6 new Legal positions for total expenditures of $3.1 million (General Fund). As recommended by the Legislative Analyst's Office (LAO), only $1.2 million (General Fund) was approved, along with Budget Bill Language requiring the AG's Office to provide certain legal representation for the DMH. DMH states that the funds are needed in 2011-12 since the AG's Office needs resources from the DMH to perform the work.

Legislative Analyst's Office Recommendation—Reject. Similarly to last year, the LAO has questions regarding this proposal and are still awaiting responses from the DMH. The LAO recommends denying this proposal.

Subcommittee Staff Recommendation—Deny. No new information has been provided by the DMH and it is recommended to continue the denial of this request for an augmentation.

D. Managed Risk Medical Insurance Board

1. Various Healthy Families Program Adjustments (DOF 401, 403, 404, and 407)

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.

Governor's May Revision. *First*, the Governor's May Revision proposes a series of estimate adjustments for the Healthy Families Program, including adjustments made due to the erosion of savings from delayed enactment of cost-containment actions, adjustments to caseload, adjustments which pertain to services provided by Federally Qualified Health Centers, and other related changes to the baseline Healthy Families estimate. These adjustments are listed below.

Second, the May Revision proposes to transition the Healthy Families Program into the Medi-Cal Program, as administered by the Department of Health Care Services. This issue will be discussed separately under the Department of Health Care Services.

- **Healthy Families Program Estimate—**It is requested that Schedule (2) of Item 4280-101-0001 be decreased by $9,885,000, Item 4280-101-0890 be decreased by $6,425,000, Item 4280-101-3156 be increased by $8,844,000, Schedule (1) of Item 4280-102-0001 be increased by $1,160,000, Item 4280-102-0890 be increased by $827,000, Item 4280-102-3156 be increased by $422,000, and Reimbursements be increased by $235,000.

  The net impact of these changes is an $12,628,000 decrease in the General Fund. These adjustments are primarily the result of a projected caseload decrease of 10,600 enrollees, as well as a $9,266,000 million increase in Managed Care Organization (MCO) tax revenue resulting from carryover of revenue from fiscal year 2010-11.

- **Healthy Families Program—Erosions of Savings to Vision Cost Containment, Emergency Room Co-Payment, and Hospitalization Copayment Budget Solutions--**It is requested that Schedule (2) of Item 4280-101-0001 be increased by $2,557,000, Item 4280-101-0890 be increased by $1,662,000, Item 4280-101-3156 be increased by $12,000, and Item 4280-102-3156 be decreased by $12,000.

The net impact of these changes is an $895,000 increase in the General Fund. These adjustments reflect a one month erosion of savings previously adopted by the Legislature for the vision benefit costs containment proposal and increased copayments for emergency room visits and inpatient hospital stays.

- **Healthy Families Program—Implementation of Children's Health Insurance Program Reauthorization Act** (**CHIPRA) Requirements—Local Assistance** It is requested that Schedule (1) of Item 4280-102-0001 be increased by $89,226,000 and Item4280-102-0890 be increased by $57,997,000. The net impact of these changes is a $31,229,000 increase in the General Fund.

  These adjustments primarily reflect the costs of prospective payments for services provided through Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs) as required by the federal CHIPRA. These costs include federally required retroactive payments to FQHCs/RHCs for the period of October 2009 through June 30, 2011. Compliance with this requirement is necessary to maintain California's allocation of federal funds.

- **Healthy Families Program—Erosions of Savings to Vision Cost Containment, Emergency Room Co-Payment, and Hospitalization Copayment Budget Solutions—**It is requested that Schedule (2) of Item 4280-101-0001 be increased by $2,557,000, Item 4280-101-0890 be increased by $1,662,000, Item 4280-101-3156 be increased by $12,000, and Item 4280-102-3156 be decreased by $12,000. The net impact of these changes is an $895,000 increase in the General Fund. These adjustments reflect a one month erosion of savings previously adopted by the Legislature for the vision benefit costs containment proposal and increased copayments for emergency room visits and inpatient hospital stays.

- **Healthy Families Program—Increase in Managed Care Organization (MCO) Tax Revenue—**It is requested that Item 4280-101-0001 be decreased by $5,823,000, Item 4280-101-3156 be increased by $5,823,000, Item 4280-102-0001 be decreased by $241,000, and Item 4280-102-3156 be increased by $241,000.

  These adjustments reflect a $6,064,000 increase in the projected $97,226,000 budget year MCO tax revenue anticipated from the extension of the statutory authority through December 31, 2013. The resulting reduction of $6,064,000 in General Fund costs is necessary to address the remaining budget shortfall.

2. Access for Infants and Mothers (AIM) (DOF issue 501)

Background. The Access for Infants and Mothers (AIM) provides low cost insurance coverage to uninsured, low-income pregnant women with family incomes up to 300 percent of the federal poverty level, as well as to women who must pay an insurance deductible over $500. The subscriber cost is 1.5 percent of their adjusted annual household income. AIM is supported with Cigarette and Tobacco Product Surtax Funds deposited into a special account, as well as federal funds to supplement the participant's contribution to cover the cost.

Governor's May Revision. The May Revision proposes total expenditures of $120.3 million ($53.9 million Perinatal Insurance Fund and $66.4 million federal funds) and trailer bill language.

These adjustments and proposed trailer bill language reflect the proposal to use the Medi-Cal Fee for Service system on a reimbursement funding basis to deliver AIM benefits beginning October 1, 2011. Use of Medi-Cal Fee-For-Service will assists to control program costs as well as ensure adequate statewide program coverage. The funding increase includes costs for AIM administrative vendor operational changes.

It is requested that the following technical adjustments be made to reflect this proposal: Schedule (1) of Item 4280-101-0001 be increased by $2,993,000, Item 4280-101-0890 be increased by $2,993,000, and Item 4280-602-0309 be increased by $3,908,000.

It also is requested that transfer authority in Item 4280-111-0232 be increased by $718,000, transfer authority in Item 4280-111-0233 be increased by $1,985,000, and transfer authority in Item 4280-111-0236 be decreased by $325,000.

Subcommittee Staff Recommendation—Adopt May Revision and Placeholder Trailer Bill. The Administration states that the use of Medi-Cal Fee-For-Service is necessary in order to provide adequate access to AIM Services. It is recommended to adopt the May Revision and placeholder trailer bill.

3. The Major Risk Medical Insurance Program (MRMIP) (DOF issues 701 and 702)

Background. MRMIP provides health insurance for Californians unable to obtain coverage in the individual health insurance market because of pre-existing conditions. Californians qualifying for the program participate in the cost of their coverage by paying premiums. Cigarette and Tobacco Product Surtax Funds are deposited into a special fund and are used to supplement premiums paid by participants to cover the cost of care in MRMIP. The budget proposes no policy changes for MRMIP. The changes between the two fiscal years reflect technical adjustments from prior years and payments to health plans.

Governor's May Revision. It is requested that transfer authority in Item 4280-112-0233 be decreased by $1,780,000 from the Physicians' Services Account and transfer authority in Item 4280-112-3133 be decreased by $1,186,000 from the Managed Care Administrative Fines and Penalties Fund.

The first decrease reflects a transfer of Proposition 99 revenue to the Perinatal Insurance Fund to meet 2011-12 funding needs of the Access for Infants and Mothers Program (as noted under item 2, above). The second decrease reflects an adjustment to projected Managed Care Administrative Fines and Penalties Fund revenue as reported by the Department of Managed Health Care. This special funded program provides comprehensive health insurance benefits to individuals who are unable to purchase private coverage because they were denied individual coverage or were offered coverage at rates they could not afford. Caseload for this program varies as funding is available.

Subcommittee Staff Recommendation—Adopt May Revision. No issues have been raised regarding these technical changes.

4. County Health Initiative Matching Fund Program Estimate (DOF 601)

Background. Established by AB 495, Statutes of 2001, this program provides four counties the ability to obtain federal funds for their Healthy Children's Initiatives by providing local funds to match the federal dollars. The budget proposes no policy changes for CHIM.

Governor's May Revision. It is requested that Schedule (1) of Item 4280-103-3055 be increased by $43,000 and Item 4280-103-0890 be increased by $28,000.

These increases reflect a slight increase in program enrollment projected for the budget year. This county funded program allows the use of matching federal dollars to provide health coverage for children between 250 percent and 300 percent of the federal poverty level and who otherwise meet federal eligibility qualifications. Overall caseload has increased by 103 individuals among the three Phase I pilot counties of Santa Clara, San Mateo, and San Francisco.

Subcommittee Staff Recommendation—Adopt May Revision. No issues have been raised regarding these technical changes.

DISCUSSION ISSUES: Listed by Department

A. Department of Health Care Services & Managed Risk Medical Insurance Board:

Governor's May Revision: Overview and Perspective. The Governor proposes to shift *all* Healthy Families Program (HFP) children into Medi-Cal over a six-month period beginning in January 2012. Approximately 892,000 eligible beneficiaries would move to Medi-Cal in phases between January and June, 2012. A *net reduction* to the State, across the MRMIB and DHCS, of $91.7 million ($31.2 million General Fund) is reflected.

The Administration recognizes that many details need to be worked out once this proposal is enacted. They state that key benefits of this consolidation would be the following:

- Enrollment for children would be simplified with a unified program of coverage for all eligibles up to 250 percent of poverty;
- Families would be able to apply for coverage at a County, by mail, or on-line and will not have to have their application bounced between programs;
- Children at or below 150 percent of poverty would no longer pay premiums, as is presently done in the Healthy Families Program;
- Children would receive retroactive coverage for three-months *prior* to their application;
- Children would be eligible for the free federal Vaccines for Children (0 to 18 years);
- Makes available to low-income children comprehensive Medi-Cal services including Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) Program;
- Many children would be able to remain with their existing provider during the transition as Health Plans contract with providers for both Medi-Cal and Healthy Families. Updated information notes that 73 percent of Children in Healthy Families match to a Health Plan that currently participates in both Medi-Cal and Healthy Families;
- There has been a considerable decline in the Commercial Health Plans participating in Healthy Families in many counties. By consolidating Healthy Families and Medi-Cal, Children will have more stable plan choices;
- Consolidates health care entitlement programs under one department so that duplicative systems and processes can be eliminated to gain administrative efficiencies;
- Simplifies contracting requirements, rates and other core components of delivering services in the public sector for Health Plans and providers;
- Increases the ability of the State to monitor encounter data and payment data to better ensure the State is receiving its best value for the dollars it invests in Children's coverage;
- Serves as an early building block for successful implementation of federal health care reform. California must implement many changes before 2014, including new online enrollment processes, new eligibility rules, an expansion of coverage, and the development of the Health Benefit Exchange. Waiting to implement the transfer of Healthy Families to Medi-Cal until 2014 will impede the success of implementing these other major reforms.

Governor's May Revision: Transition and Budget Details. Currently enrolled HFP children would transition to Medi-Cal *over a six month period* and would receive coverage as targeted-low income Medicaid children as allowed under Medicaid. DHCS would obtain enhanced federal funds for this population at the 65 percent federal to 35 percent State sharing ratio.

To the extent possible, HFP children enrolled in Managed Health Care Plans or Dental Managed Care Plans that are *also contracted* plans under Medi-Cal would *remain* with the plan; *otherwise*, they will be provided the option of choosing from available Medi-Cal Managed Care Health Plans or Dental Plans in their respective county.

If a child resides in a county with a County Organized Health System (COHS), they would receive their care from the COHS. Children residing in counties *without* a Medi-Cal Managed Care Health Plan would receive their health care services under Medi-Cal Fee-For-Service delivery system.

For purpose of Medi-Cal Dental Managed Care, the county of residence and the dental delivery service model would determine if the child would receive services through *mandatory* enrollment in a plan, *voluntary* enrollment in a plan, or under a Medi-Cal Fee-For-Service arrangement.

The *two Tables* below display a phase-in approach that was used for "budgetary" purposes. *However,* the Administration has publically stated that if more time is needed to ensure a smooth transition, this phase-in would be pushed-back.

Table 1: Medi-Cal Program Budget Assumptions Used for Phase-In (begins January, 2012)

Children's Health Plan	**Eligibles**	**Percent of Eligibles**	**Phase-In Period**
Able to Enroll in Same Plan	387,366	43 percent	January to February
Enroll in Different Plan	454,734	51 percent	March to April
In Fee-For-Service County	49,600	6 percent	January to April
TOTAL Children	891,700	100 percent	January to June

Table 2: Medi-Cal Program Budget Assumptions: Detail of Member Months Assumed

Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	June 2012			
					15,849			
				15,100	15,100			
			12,400	12,400	12,400			
		12,400	12,400	12,400	12,400			
			230,058	230,058	230,058			
		230,050	230,050	230,050	230,050			
	196,358	196,358	196,358	196,358	196,358			
193,683	193,683	193,683	193,683	193,683	193,683			
193,683	**390,041**	**632,491**	**874,949**	**890,049**	**905,898**	Member Months		
					3,887,111	Total Member Months FY 2011-12		

The Table below provides more technical fiscal detail of the split between departments.

Table 3: State Budgetary Detail Across Departments (dollars in thousands)

Program Area and Category	**General Fund**	**Total Funds**
Medi-Cal Program		
Benefit Cost (non-CCS Program)	$101,191	$289,116
Premiums (150% to 250%)	-$26147	$74,704
Net Medi-Cal Benefit Cost	$75,044	$214,412
Benefit Cost of CA Children's Services Program	$9,314	$44,350
Bridge to Healthy Families Savings (not necessary)	-$363	-$1,036
Total Benefits Impact	$83,995	$258,762
County Administrative Cost (100% to 150%)	$2,967	$5,934
Total Medi-Cal Impact	$86,962	$263,660
Family Health Programs Impact	-$9,314	-$44,350
TOTAL DHCS Programs	$77,648	$219,310
Managed Risk Medical Insurance: Healthy Families		
Benefit Savings	-$104,903	-$298,969
Administrative Savings	-$3,945	-$12,022
TOTAL MRMIB	-$108,848$	-$310,991
State TOTAL	**-$31,200**	**-$91,681**

Governor's May Revision: New Applicants and Eligibility Processing. *New applicants* seeking services as of January 1, 2012 will *go straight* into Medi-Cal and continue to be able to apply for health care services through County Human Services Offices or through the existing "Single Point of Entry" (SPE) and "Public Access" (PA) website.

Counties would make eligibility determinations as they do today for Children applying at the local County office.

Children *with incomes up to 150 percent* of poverty would enroll into *no-cost* Medi-Cal, receive services through the Medi-Cal delivery system (i.e., Managed Care or Fee-For-Service) and receive ongoing case management through the County.

Children *with incomes above 150* percent of poverty and up to 250[1] percent of poverty would enroll in Medi-Cal and be *subject to premiums*. DHCS will use the same premium amounts as Healthy Families. The existing contractor that handles Healthy Families eligibility determinations *or* the Counties would handle the *ongoing management* of the cases for individuals with incomes above 150 percent of the poverty and up to 250 percent of poverty. To the extent the current eligibility processing vendor handles the ongoing case management for these children, DHCS *may* contract with select Counties (i.e., a "regional" approach rather than all Counties) to make the annual redetermination.

The "Single Point of Entry" vendor would continue to do the *initial screening* of applications it receives and would grant presumptive eligibility[2] for those who appear to meet established income guidelines. The SPE would forward the case to the County for a *final eligibility* determination. Once the County establishes eligibility, the income level of the Child would determine how the case would be managed as described above.

It should be noted that the DHCS is also proposing to proceed with a new "budgeting" methodology for County eligibility processing which is discussed later in this Agenda under the Medi-Cal Program.

Technical Finance Letter Schedules for Item 4280 (DOF Issue 402). It is requested that Schedule (2) of Item 4280-101-0001 be decreased by $298,969,000, Item 4280-101-0890 be decreased by $194,330,000, Item 4280-101-3156 be increased by $264,000, Schedule (1) of Item 4280-102-0001 be decreased by $12,022,000, Item 4280-102-0890 be decreased by $7,814,000, and Item 4280-102-3156 be decreased by $263,000.

The net impact of these changes is a $108,848,000 decrease in the General Fund. This reduction is necessary to address the remaining budget shortfall. These adjustments reflect the proposal to shift all Healthy Families children to the Medi-Cal program based on a phased in transition beginning January 1, 2012.

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[1] As noted in the accompanying TBL, income eligibility for targeted low-income children is technically 200 percent of the FPL pursuant to federal Medicaid law. Thus for individuals with incomes above 200 percent and up to 250 percent the FPL, an income deduction is provided in an amount that will result in an effective income of 200 percent of the FPL.

[2] DHCS is working out the details for how presumptive eligibility will be handled since elimination of this would be considered an ACA maintenance of effort violation.

This proposal would implement the Medicaid expansion for children to 133 percent of the federal poverty level required under health care reform early and take the additional step of transitioning all Healthy Families children to Medi-Cal. The net statewide impact of this proposal is a savings of $31.2 million General Fund in 2011-12.

Subcommittee Staff Comment and Recommendation—Adopt the May Revision in Concept. The Governor's restructuring has merit and is visionary. Federal Patient Protection and Affordable Care Act (ACA), coupled with the State's newly implemented 1115 Medicaid Waiver, and the Mental Health Parity Act of 2008, offer *very* constructive opportunities for a more inclusive and comprehensive delivery model.

Discussions need to be ongoing with various consumer advocacy groups, Health and Dental Plans, Vision Plans, various provider organizations and representatives, as well as the Policy and Fiscal Committees of the Legislature to ensure a constructive and seamless transition for all involved parties, particularly the child and families who receive vital health care services.

It is recommended to adopt the May Revision fiscal calculations and "placeholder" Budget Bill Language, as well as "placeholder" trailer bill language (an intent framework) to enable complex discussions to continue and for a comprehensive framework to be developed over the course of 2011-12.

A key component of the placeholder language needs to be identifying markers that demonstrate readiness to implement this proposal in an effective fashion. Before Children are transitioned to Medi-Cal, fulfillment of these identified "trigger" conditions must be demonstrated

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

1. Please provide an overview of the key concepts of the proposal.
2. How may all of the various constituency interests be actively engaged in these discussions?
3. What are the key short-term aspects that need to occur for this to be an effective transition?
4. What are the longer-term components that need to be addressed?
5. How may the State track progress during a phase-in to ensure that Children are being transitioned appropriately? How can access be assured?
6. What key issues have been express from Health Plan providers (provider networks, rates)?
7. What key issues have been express by County Mental Health Plans?
8. What key issues may there be regarding dental services?
9. May there be opportunities for improving the reimbursement paid to Medi-Cal providers by drawing increased revenues from the Managed Care Tax or by reinvesting savings from efficiencies in the out-years?

A. Department of Health Care Services: The Medi-Cal Program

BACKGROUND SUMMARY

Purpose. The federal Medicaid Program (Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance.

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).

Governor's May Revision—Substantially Lower than Current-Year. The May Revision proposes total expenditures of $46.3 billion ($14.7 billion General Fund) for 2011-12 which represents *a reduction* of $8.3 billion (total funds), or 15.3 percent less than the current-year.

At the same time, Medi-Cal caseload is hitting an all-time caseload high of 8 million eligibles. This reflects an increase of 6.5 percent, which does include the Administration's proposal to shift Healthy Families to Medi-Cal.

Medi-Cal Funding Summary *(Dollars in Thousands)*	**2010-11 May Revision**	**2011-12 May Revision**	**Difference**	**Percent**
Benefits	$51,745.8	$42,910.8	-$8,835.0	-17.1
County Administration (Eligibility)	$2,610.7	$3,022.2	-$373.5	15.8
Fiscal Intermediaries (Claims Processing)	$263.7	$3.53.1	$89.4	33.9
Total-Local Assistance	**$54,620.2**	**$46,286.1**	**-$8,334.1**	**-15.3**
General Fund	$12,437.1	$14,728.4	$2,291.3	18.4
Federal Funds	$36,553.0	$29,047.7	-$7,505.2	-20.5
Other Funds	$5,630.2	$2,510.0	-$3,120.2	-55.4

The May Revision continues all cost-containment enacted in the SB 69 Budget Bill, including the following key changes: (1) Placing limits on health care services; (2) Elimination of certain benefits; (3) Cost-sharing through Medi-Cal enrollee copayment requirements; (4) Provider payment reductions; and (5) Mandatory enrollment of seniors and persons with disabilities in Medi-Cal Managed Care.

Medi-Cal Program Discussion Issues

1. 1115 Medicaid Waiver: Trailer Bill Fund Shift for Federal Dollars

Background. California's 1115 Medicaid Waiver, approved in November 2010, is to provide $10 billion in federal funds over the course of the next five years and will serve as a bridge to federal health care reform. These federal funds will be obtained through the use of "Certified Public Expenditures" (CPE), both from the State and local public entities (i.e., Designated Public Hospitals and Counties).

No General Fund is expended for the Waiver. In fact the Waiver is to provide $400 million in annual General Fund savings by enabling the State to offset certain health care expenditures with federal funds available from the Waiver.

The Waiver has several key components including the following:

- Heath Care Expansion. Increases and expands health care coverage by phasing-in coverage for "newly eligible" adults (aged 19 to 64 years) with incomes up to 133 percent of poverty as offered under the federal Patient Protection and Affordable Care Act. This is to be accomplished through the new "Low Income Health Program".

  The Low Income Health Program consists of two components: **(1)** the existing "Health Care Coverage Initiative"; and **(2)** the new "Medicaid Coverage Expansion". Both are elective programs at the local government level (mainly Counties). Federal funds for the Health Care Coverage Initiative are capped at $180 million (federal funds) per federal year. The Medical Expansion Coverage initiative

  The new Medicaid Coverage Expansion within the Low Income Program will cover people with family incomes at or below 133 percent of poverty. The existing Health Care Initiative will cover people with family incomes above 133 percent through 200 percent of poverty.

- Safety Net Care Pool for Uncompensated Care. Provides for a federal "Safety Net Care Pool" to provide additional resources to support uncompensated care costs in both safety net care hospitals and critical State Programs;

- New Mandatory Enrollment in Medi-Cal Managed Care. Authorizes mandatory enrollment of Seniors and Persons with Disabilities into Medi-Cal Managed Care which implementation beginning June, 2011 ;

- Federal Funds for Delivery System Reforms. Establishes a Delivery System Reform Incentive Pool for Designated Public Hospitals to promote hospital delivery system transformation

Governor's May Revision. The May Revision proposes trailer bill to authorize the DHCS to obtain federal approval through an amendment to the 1115 Waiver to *annually transfer* federal funds from within the Health Care Coverage Initiative portion of the Waiver that will not be fully utilized in the federal demonstration-year, to the Safety Net Care Pool to be expended for uncompensated care provided by the State, and by the Designated Public Hospitals.

This would result in a shifting of federal funds to enable the State to *voluntarily* utilize "Certified Public Expenditures" (CPEs) from Designated Public Hospitals to draw federal funds from the Safety Net Care Pool to offset State General Fund expenditures up to $400 million.

Presently the DHCS contends the State does not have adequate State CPEs on its own to draw its share of the federal Waiver funds ($400 million annually), but believes the Designated Public Hospitals have "excess"/unused CPEs for which they will not be able to obtain federal matching funds unless the State obtains approval to transfer funds to the Safety Net Care Pool where the hospitals can also access federal funds.

Specifically, the Waiver annually provides up to $180 million in federal funds for "Health Care Coverage Initiative" counties, which are voluntary county programs that provide health care services for eligible individuals (incomes above 133 percent and up to 200 percent of poverty). The Health Care Coverage Initiative (HCCI) counties use "Certified Public Expenditures" (CPEs) to obtain federal matching funds for health care services provided to their eligible populations. According to the DHCS, it is estimated that a significant amount of the federal funds allocated for these HCCI counties *will not be* expended.

For the State to achieve its share of the federal funds and General Fund relief, it needs additional CPEs. The Designated Public Hospitals have CPEs but cannot draw the federal funds unless the State receives federal approval of the Waiver amendment to transfer more federal funds into the Safety Net Care Pool.

Based on recent estimates by the DHCS, the State estimates that from possibly as low as $40 million to as high as possibly $90 million or more in voluntary, excess CPEs are needed from the Designated Public Hospitals in order for the State to achieve its $400 million in annual General Fund savings from the Waiver.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder. It is recommended to adopt "placeholder" trailer bill language to craft a compromise that is workable for the State to achieve its General Fund savings target and to maintain the voluntary nature of the CPEs and Designated Public Hospital financing.

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

1. DHCS, Please provide a brief description of the May Revision request.

2. Managed Care: General Fund Reimbursement from Designated Public Hospitals

Background and Governor's May Revision. Effective June 1, 2011, Seniors and Persons with Disabilities enrolled in Medi-Cal Fee-for-Service are to be phased-in to mandatory enrollment in Medi-Cal Managed Care. Payments made to Designated Public Hospitals for health care services provided to people in Medi-Cal Fee-for-Service are comprised of "Certified Public Expenditures (CPE)" matched with federal funds. This payment mechanism was established under the original Hospital Financing Wavier.

However, payments made to these hospitals for Medi-Cal Managed Care inpatient days had historically been composed of General Fund and federal fund support, no use of these hospitals CPEs. Therefore, as Seniors and Persons with Disabilities are transitioned into mandatory Medi-Cal Managed Care, General Fund expenditures would increase for Inpatient days obtained at Designated Public Hospitals.

Under the 1115 Medicaid Waiver payment structures were modified. As a result, Designated Public Hospitals will reimburse the General Fund for the costs that are built into the Medi-Cal Managed Care capitation rates that would not have been incurred had the Seniors and Persons with Disabilities remained in Medi-Cal Fee-for-Service.

The May Revision assumes that annual reimbursement from the Designated Public Hospitals is $150.3 million (total funds). Because the mandatory Managed Care enrollment transition will be phased-in (starting June 1, 2011), the initial reimbursement from the Designated Public Hospitals to the State for *General Fund offset will be $94 million*.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. The proposal conforms to the 1115 Medicaid Waiver payment structure. No issues have been raised

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

1. DHCS, Please provide a brief description of the May Revision and fiscal calculation.

3. Managed Care: New Processing Fee for Inter-Governmental Transfers (DOF 425)

Governor's May Revision. The May Revision proposes trailer bill to institute a new 20 percent fee on *each* voluntary Inter-Governmental Transfer (IGT) that is used to match federal funds to provide Medi-Cal Managed Care rate increases, beginning July 1, 2011. Revenues generated from this 20 percent fee will be used to offset General Fund expenditures for medical services within the Medi-Cal Program. Federal approval is required for implementation.

The May Revision assumes savings of $34.2 million (General Fund) from the collection of this 20 percent fee. Presently about $173 million in voluntary IGTs is anticipated for 2011-12.

IGTs are used to provide additional funds for the "non-federal" portion of risk-based payments to Medi-Cal Managed Care Plans in order to provide increased compensation to certain Providers who provide health care services to Medi-Cal enrollees. The IGTs are matched with federal funds and serve as an additional funding source for Medi-Cal services. Funds for IGTs come from "transferring entities" which include any public entity, such as County, City, governmental unit or special district.

DHCS develops Medi-Cal Managed Care rates by establishing a rate range that consists of a lower to upper bound that has about a 7.5 percent range. DHCS reimburses at the lower end of this range.

Since the 2005-06 rate year Counties and Designated Pubic Hospitals have been voluntarily participating in this rate range IGT Program which they use to enhance health care services provided to Medi-Cal enrollees.

DHCS administers the IGT Program. They note that this is a voluntary program and could possibly be phased-out in the future.

The DHCS contends this new fee will benefit all involved. Medi-Cal Managed Care Plans are able to compensate Designated Public Hospitals and other providers for health care services provided to Medi-Cal enrollees, and the State can be reimbursed for the costs incurred for operating the IGT Program and the new fee benefits the Medi-Cal Program overall.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder. It is recommended to adopt "placeholder" trailer bill language and the May Revision savings of $34.2 million (General Fund).

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

1. DHCS, Please provide a brief explanation of the use of IGTs and the May Revision proposal.

4. Managed Care: Trailer Bill to Extend Managed Care Organization Tax

Governor's May Revision. The May Revision proposes to extend the exiting Managed Care Organization (MCO) Tax for almost three years, from July 1, 2011 to January 1, 2014.

Revenues from this tax are matched with federal funds and are 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).

Extending this statute will provide funding of about $334.1 million for the Healthy Families Program and $206.8 million to supplement Medi-Cal Managed Care Plan capitation rates, including the federal fund match.

Background. AB 1422, Statutes of 2009, established an alternative funding mechanism for essential preventative and primary health care services provided through the Healthy Families Program by adding Medi-Cal Managed Care Plans to the list of insurers subject to California's gross premiums tax of 2.35 percent. It is required that the tax proceeds be used to offset, in the capitation rate development process, payments made to the State that result directly from the imposition of the tax.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder. It is recommended to adopt placeholder trailer bill to extend the existing statute to January 1, 2014. Without this extension, the provision of health care services could be jeopardized and there would be added pressure on General Fund resources.

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

1. DHCS, Please provide a brief description of the May Revision.

5. Managed Care: Proposed Trailer Bill Language for a One-Year Lock In (DOF 427)

Background. Mandatory enrollment into Medi-Cal Managed Care for Seniors and Special Populations is to commence as of June 1, 2011. This will be an entirely new approach for hundreds of thousands of these individuals over the course of 2011-12. This is a vulnerable population, many of whom have unpredictable and changing needs which may require them to change plans more than once per year.

Currently, people in the Two-Plan Model and Geographic Managed Care forms of Medi-Cal Managed Care can change Health Plans when they choose. This is a critical option for Medi-Cal enrollees if they are not getting their needs met by a Health Plan, or if their doctor (such as specialty care) no longer contracts with the plan they are in.

Governor's May Revision. The May Revision proposes trailer bill to change this existing Managed Care enrollment policy to only allow Medi-Cal enrollees in Two-Plan and Geographic Managed Care counties to change plans *once a year*, effective as of October 1, 2011.

The effect of this proposal is that an open enrollment period would be set for September 1, 2011 of each year (after enactment). A notification would be mailed to each Health Plan member to allow the individual the opportunity to change Health Plans during a specified open enrollment period.

New Medi-Cal enrollees would only have a 60-day period from their initial enrollment date to switch plans after which they would be locked-in for the balance of the one-year period.

It should be noted that this DHCS proposal requires an amendment to California's 1115 Medicaid Waiver, and is a change in policy as it pertains to SB 203, Statutes of 2010, which provided the framework for the mandatory enrollment of Seniors and Special Populations into Medi-Cal Managed Care.

The May Revision reflects a *net* reduction of almost $3.3 million ($1.6 million General Fund) by implementing the proposed statutory change. This *ne*t reduction consists of the following two components:

- Reduction in Health Screens. Reduction of $5.3 million ($2.6 million General Fund) in health care services from a projected decrease in the need to perform initial health assessments that are done when a new Medi-Cal Managed Care enrollee starts with a health plan. This is because people would not be changing health plans due to the "lock-in".
- Increased Mailing Costs. Increase of $2 million ($1 million General Fund) to provide initial informing materials that must be mailed out to Medi-Cal enrollees explaining the "lock-in" proposal and process.

DHCS states that out-year expenditures related to this proposal would evolve and they expect additional savings on an annualized basis.

DHCS contends that a 12-month lock-in with an open enrollment period would provide the following beneficial outcomes:

- Greater opportunity for the continuity of health care to the enrollees;
- Greater opportunity for the continuity in maintenance drug therapies cine enrollees would have to go through medication step therapies when they join a new Health Plan;
- Greater opportunity for children to receive preventive visits since these are tracked by Health Plan providers;
- Provides Medi-Cal enrollees with a better opportunity to become familiar with their Health Plan and comfortable with using Health Plan; and
- Reduces costs associated with multiple plan changes such as: multiple initial health assessments, informing materials (printing and distribution).

The DHCS notes that several States, including Maryland, Michigan, Hawaii, Colorado, Minnesota, New Jersey and New York have one-year lock-in requirements in their Medicaid programs.

Subcommittee Staff Comment and Recommendation—Deny Proposal. It is recommended to deny the trailer bill and to adjust the Medi-Cal budget (benefits and health care options) accordingly.

First, according to advocates, the proposal violates federal regulations that require Medicaid enrollees to be given *90 days* from the date of initial enrollment or the date the State sends notice of enrollment, whichever is later.

Second, mandatory enrollment is just commencing June 1, 2011. It is imperative for this year to be a transition year with a focus on having Medi-Cal enrollees comfortable with their plans, this is particularly important for Seniors and Special Populations. Imposing a “lock-in” immediately after this new program starts is unworkable.

Third, the proposal is not in concert with the intent of the enabling legislation and 1115 Medicaid Waiver which were just approved late last year.

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

1. DHCS, Please provide a summary of the May Revision request.

6. Medi-Cal Eligibility: Trailer Bill for New Budgeting Methodology

Governor's May Revision. Federal Medicaid law requires a governmental entity to finalize *all* eligibility applications. In California, County Human Services Departments serve as surrogate for the State to perform this important function.

The May Revision proposes trailer bill to develop a new methodology for reimbursing Counties for Medi-Cal eligibility determinations for applicants and enrollees. This new methodology would be developed in consultation with County representatives and is to include the following components:

- Establishment of eligibility category groups;
- Establishment of case rates for distinct eligibility categories;
- Recognition of time and resource costs incurred when making eligibility determinations; and
- Recognition of time and resource costs for ongoing case maintenance activities, including annual redeterminations.

Based on discussion and analysis, the DHCS states that the new budget methodology for determining expenditures for Medi-Cal eligibility processing conducted by Counties would be presented in the Governor's May Revision of 2012 and utilized thereafter.

DHCS states that a new methodology needs to be developed for several reasons. *First*, the federal Patient Protection and Affordable Care Act (federal ACA) requires Medicaid (Medi-Cal) eligibility to transition to using "modified adjusted gross income" (MAGI) standard for making eligibility determinations for most of the population. The use of MAGI is designed to simplify eligibility determinations and to eliminate the use of asset tests for families, children, and newly eligibility populations.

Second, the federal ACA also requires implementation of streamlined eligibility processing procedures t help facilitate the enrollment of individuals into coverage.

Third, the existing process for determining county administrative baselines, adding in caseload increases and making other special and technical adjustments has not been an effective method for the State or for the Counties.

DHCS states that a new budgeting methodology would result in a simpler and more accurate budgeting of Medi-Cal eligibility processing and would provide flexibility in the future when the State adds new eligible groups pursuant to the ACA. Further it would help inform budget decisions, allow for ongoing monitoring, improve fiscal accountability and support better management and evaluation of program administration.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder. It is recommended to adopt "placeholder" language that, at a minimum, would require the DHCS to provide an overview of any recommended methodology change to the Legislature for its review *prior* to its inclusion as a budget calculation as of May 2012 as presently stated in the Administration's trailer bill.

It is expected that a compromise can be ascertained by working with the DHCS and interested stakeholders. Therefore it is recommended to adopt "placeholder" trailer bill.

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

1. DHCS, Please provide a brief summary of the trailer bill proposal.

7. Trailer Bill: Average Acquisition Price as New Pricing Benchmark

Legislative Actions Contained in SB 69 Budget Bill. The Legislature conformed to the Governor's budget by reducing Pharmacy reimbursement by up to 10 percent for a reduction of $271.9 million ($143 million General Fund). This reduction is contingent upon federal CMS approval.

In addition, AB 97, Statutes of 2011 (Omnibus Health Trailer Bill), contained Legislative intent language which states expresses the desire to have new legislation by August 1, 2011 that provides for a new Pharmacy reimbursement methodology based on the actual acquisition cost of drug ingredients.

Background on Pharmacy Reimbursement and Average Wholesale Price (AWP). The Medi-Cal Pharmacy reimbursement consists of two components—a professional dispensing fee *and* payment for drug ingredient costs.

For the drug ingredient cost of this equation, DHCS relies primarily on the Average Wholesale Price benchmark (AWP minus 17 percent). This is because Average Wholesale Price has been the only price readily available for all drugs but its calculated value is based on information supplied solely by drug manufacturers. Over time, the Average Wholesale Price has been subject to differing and variable interpretations, as evidenced by legal actions relating to its calculation and use.

The primary sources of Average Wholesale Price are private drug data compendia, with most Pharmacies and Third-Party payers using First Data Bank or Med-Span. The DHCS currently uses First Data Bank as its primary pricing reference.

However in 2009, First Data Bank and the McKesson Corporation (drug wholesaler)) were found to have wrongfully inflated the mark-up factor used to determine the Average Wholesale Price for certain prescription drugs. Subsequent to the settlement of that lawsuit, First Data Bank announced that it would cease the publication of Average Wholesale Price for drugs within two-years (as of September 2011).

In addition, DHCS notes that federal regulation requires that any new drug ingredient cost benchmark must be one that has a genuine relationship to what Pharmacies are actually paying for drug acquisition costs.

Governor's May Revision. The May Revision proposes trailer bill which provides for the DHCS to establish an Average Acquisition Price which is to represent the purchase price paid for a drug product by retail Pharmacies in California. The Average Acquisition Price shall not be considered confidential and shall be subject to disclosure under the California Public Records Act.

The trailer bill provides the DHCS with broad authority to establish the Average Acquisition Price for single source, innovator multiple source drugs and non-innovator multi-source drugs.

The language articulates that, *at the discretion of the DHCS*, the Average Acquisition Price may be established in one of the following ways:

- Based on volume weighted Average Acquisition Price (AAP) adjusted by the DHCS to ensure that it is representative of retail Pharmacies in California;
- Based on a national pricing benchmark, established by the federal CMS, or a on a similar benchmark listed in the DHCS's primary price reference (such as First Data Bank), and adjusted for California; or
- Pursuant to a contract with a Vendor for the purpose of data analysis and calculating a proposed Average Acquisition Price.

The trailer bill requires providers to submit drug pricing information and if this information is not provided, the DHCS may suspend the provider from the Medi-Cal Program.

In addition the language states that a *one-time* adjustment to the Pharmacy professional dispensing fee *may* occur if the new Average Acquisition Price results in lower drug ingredient costs on the aggregate to providers. Any one-time adjustment to the Pharmacy professional dispensing fee would not exceed the aggregate savings associated with the implementation of the Average Acquisition Price (i.e., cost neutral to the State).

DHCS contends trailer bill language is necessary in order to ensure that a process is in place *prior* to the elimination of the Average Wholesale Price which is to occur in October 2011.

DHCS states that while it's possible that Medi-Span or other companies *may* continue to publish the Average Wholesale Price past September 2011, it is widely accepted and validated through federal audits that the Average Wholesale Price based Pharmacy reimbursement is *not* a true reflection of the actual acquisition costs Pharmacy providers are paying for pharmaceuticals in the marketplace.

DHCS notes that current statute does not provide them with a viable mechanism to reimburse Pharmacy providers if the State does not have an alternative to replace the current Average Wholesale Price pricing methodology.

The DHCS states that no fiscal adjustment is reflected in the May Revision for this proposed trailer bill language since a method needs to be established and costs analyzed. This information would be updated in the Governor's January budget release for 2012.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder. It is recommended to adopt placeholder trailer bill to develop a transition methodology. Details need to be addressed and conversations are progressing.

This issue needs to be included as trailer bill in order to address the timing of the anticipated elimination of the Average Wholesale Price and to address how Medi-Cal is to appropriately reimbursement Pharmacy providers.

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

1. DHCS, Please provide a summary of the proposed trailer bill *and* why the Administration believes trailer bill is necessary.

8. Trailer Bill: Extension of Sunset Date for AB 1629 Quality Assurance Fees & Expansion of Fee to Pediatric Subacute Care Facilities

Legislative Actions Contained in SB 69 Budget Bill. Both the SB 69 Budget Bill and AB 97, Statutes of 2011 (Health Trailer Bill) conformed to the Governor's January budget to reduce payments by 10 percent to AB 1629 Nursing Facilities effective June 1, 2011.

In addition, this conforming action reduces Pediatric Subacute Care Facilities to 2008-09 levels then further reduces payments by 10 percent effective June 1, 2011.

Governor's May Revision. The May Revision proposes a series of changes to the Administration's January budget with was approved by the Legislature. Specifically, the May Revision makes the following changes.

First, it extends the sunset on the Quality Assurance Fee and makes adjustments to the rates paid to Nursing Homes. These adjustments are contained below:

- Extends Sunset on Fee. Extends the sunset date by one year to July 31, 2013 for the AB 1629 Quality Assurance fee (QAF) and the rate-setting methodology.
- Terminates Rate Reduction. Terminates the 10 percent payment reductions on August 1, 2012 for AB 1629 Nursing Homes as specified.
- One-Time Supplemental Payment. Provides a one-time supplemental payment in the 2012-13 rate year that is equivalent to the 10 percent reduction that was applied from June 1, 2011 to July 31, 2012 for Medi-Cal fee-for-service Nursing Homes.

  DHCS will provide the supplemental payment to Med-Cal fee-for-service Nursing Homes by December 31, 2012 (for claims adjudicated by October 31, 2012). Medi-Cal Managed Care Nursing Homes will receive an actuarially equivalent amount of the supplemental payment.
- Apportion the Reduction. Applies the 10 percent payment reduction effective June 1, 2011 equally to each Nursing Facilities' 2010-11 rates.

  For the 2011-12 rate year beginning August 1, 2011, DHCS will *offset* the 10 percent payment reduction by the weighted average rate increase applicable to the rate year and will apply the net percent decrease equally to each Nursing Home's 2010-11 rates.

  For Rate Year 2011-12, the *net percent decrease* will be approximately 7.6 percent.

Second, it expands the Quality Assurance Fee to Pediatric Subacute Care Facilities and makes changes to their reimbursement rates as follows:

- Expand the Fee. Applies the Quality Assurance Fee to Pediatric Subacute Care Facilities (both Distinct Part and Freestanding) beginning August 1, 2011. The proposal provides certain flexibilities to the DHCS in the collection of the new Quality Assurance Fee to assist the facilities with the financial transition.

- Adjustment to Payments. Reduces the payment reductions on the Pediatric Subacute Care Facilities 2008-09 rates based on the QAF revenue received and the increased federal matching funds.

  Beginning June 1, 2011, the payment reduction on the 2008-09 rates for Freestanding Subacute Facilities will be a 5.75 percent decrease.

  Beginning June 1, 2011, the payment adjustment on the 2008-09 rates for Distinct-Part Pediatric Subacute Care Facilities will be a 1.5 percent increase.

- Quality and Accountability Supplemental Payment System. Delays implementation of the Quality and Accountability Supplemental Payment System for one year; and

- Set-Aside for the Quality and Accountability Supplemental Payment System. Delays until Rate Year 2012-13 the set-aside to the Quality and Accountability Supplemental Payment System of one percent of the AB1629 facilities reimbursement rate.

DHCS states that in the absence of an extension of the Quality Assurance Fee, there would be a loss of about $500 million in revenue (in July 2012). They state they would need to either implement a future rate reduction or seek increased General Fund support. The one year extension of the QAF provides continued revenue and federal matching funds for AB 1629 Nursing Facility rates.

Further, DHCS notes the Long-Term Care Industry is unlikely to support an extension of the Quality Assurance Fee without assurance that the funds would benefit the industry. This proposal will roll back the June 1, 2011 reductions after 14 months, but it is balanced with an extension of the Quality Assurance Fee.

The Administration notes that by assessing a Quality Assurance Fee on Pediatric Subacute Care Facilities, the State will receive additional revenue and obtain additional federal funds which would enable DHCS to lower the reductions applied to these facilities.

Finally the DHCS contends that delaying the Quality and Accountability Supplemental Payment System for one year enables DHCS to delay the set-aside of 1 percent of the weighted average Medi-Cal reimbursement rate that it would have used for the supplemental rate pool. This limits further erosion of funding for the SNFs in addition to the payment reduction.

Background—Nursing Home Reimbursement (AB 1629, Statute of 2004). Certain Nursing Home rates are reimbursed under Medi-Cal using combinations of federal funds, General Fund and revenues collected from Quality Assurance Fees (QA Fee). Use of QA Fees has enabled California to provide reimbursement increases to certain Nursing Homes with *no* added General Fund support.

This existing reimbursement method established under AB 1629, Statues of 2004, requires the DHCS to implement a facility-specific rate system for certain Nursing Homes and it established the QA Fee. Revenue generated from the QA Fee is used to draw federal funds and provide additional reimbursement to Nursing Homes for quality improvement efforts.

The *current* QA Fee structure sunset as of July 31, 2012. If the QA Fee sunsets, over $500 million in General Fund support is at risk.

Background--Summary of Budget Act of 2010 Actions. Through the Budget Act of 2010 and corresponding trailer bill (SB 853, Statutes of 2010), a comprehensive Nursing Home Quality and Accountability package was adopted and contained the following *key* components:

- *Rate Adjustments*. Provides for a two-year rate adjustment of 3.93 percent increase in 2010-11 and up to 2.4 percent in 2011-12 by extending the sunset of the Quality Assurance Fee to July 31, 2012.
- *Quality & Accountability.* Begins to phase-in a Quality and Accountability system by establishing a special fund and a reward system for achieving certain measures. A comprehensive stakeholder process will be used by the Administration to proceed with implementation of this system and to publish specific information.

  A special fund was established for supplemental payments to be made under this system. Penalty collections will also be deposited into this special fund. Supplemental payments for 2011-12 are anticipated to be $50.9 million (total funds).
- *Compliance with 3.2 Nursing Ratio.* Required the State to audit nursing homes for complying with the existing 3.2 nursing hours to patient ratio. Nursing homes who are non-compliant from 5 percent to 49 percent of audited days would be assessed a penalty of $15,000. This increases to $30,000 for those who are non-compliant from 50 percent or more of audited days.
- *Legal Costs and Liability.* Limited legal costs incurred by nursing homes engaged in the defense of legal actions filed by governmental agencies or departments against the facilities. In addition, it limits Medi-Cal reimbursement for liability insurance to the 75th percentile computed on a geographic basis.
- *Expanded the Quality Assurance Fee.* Expanded the Quality Assurance Fee to include Multi-Level Retirement Communities as proposed by the Administration since Medi-Cal pays for over 50 percent of these facilities patients.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder. The May Revision completely revisits actions taken in the Budget Act of 2010 regarding the beginnings of implementing a quality assurance system, but also considerable changes what the Administration had proposed in its January budget.

Due to the sweeping nature of the May Revision, further discussions are warranted and it is recommended to adopt “placeholder” trailer to extend and expand the fee and work with all constituency groups on a resolution. Discussions need to continue.

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

1. DHCS, Please walk-through each component of the May Revision proposal.

9. Settlement in California v. Quest Laboratories—Recognize Settlement (DOF 460)

Background and May Revision. State Attorney General Kamala Harris just announced a $241 million settlement—the largest recovery in the history of California's False Claims Act—with Quest Diagnostics Incorporated, the largest provider of medical laboratory testing in California.

The settlement is the result of a 2005 whistleblower lawsuit alleging that Quest overcharged the Medi-Cal Program for more than 15 years and gave illegal kickbacks in the form of discounted or free testing to doctors, hospitals and clinics that referred Medi-Cal patients and other business to the labs.

The settlement provides for Quest to pay California $241 million in settlement claims that Quest overcharged Medi-Cal for testing services and gave kickbacks. Of this amount, $50.056 million will go to Medi-Cal.

Of the remaining amount, (1) $96.4 million is for the federal government for their portion of the Medicaid Program; (2) $69.9 million is for the whistleblower; and (3) $24.6 million is for the Department of Justice (AG's Office).

It should be noted that similar cases are still pending against four other defendants, including Laboratory Corporation of America (LabCorp), the second largest medical laboratory services provider in California. Trial is scheduled for early next year.

Subcommittee Staff Comment and Recommendation—Reflect Settlement. Since the settlement was just determined, the $50.056 million in recoupment for Medi-Cal is not reflected in the Governor's May Revision.

Therefore it is recommended to *reflect a General Fund savings of $50.056 million* in Medi-Cal by decreasing the General Fund appropriation and increasing Reimbursements by an equal amount.

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

1. Administration, Is there any comment regarding this settlement with Quest?

10. Gradual Transition of Community Mental Health to DHCS

Governor's May Revision. The May Revision proposes *a two-step process* for transitioning the State-Level responsibilities associated with Medi-Cal, including the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, and Mental Health Managed Care, to the DHCS. This transfer is intended to become effective as of July 1, 2012 (next budget-year).

First, the Administration is proposing trailer bill language which expresses the intent of the Legislature to transfer to the DHCS, by no later than July 1, 2012, Medi-Cal mental health functions currently administered through the State Department of Mental Health, without regard to whether or not that Medi-Cal mental health function has been formally created by statute.

Second, for 2011-12, the May Revision proposes cursory Budget Bill Language that would provide for broad authority for the Department of Finance to transfer both staff and funds from the Department of Mental Health to the DHCS after 10 days after giving the Legislature notification. The three pieces of proposed Budget Bill Language are as follows:

Add Provision 7 to Item 4260-001-0001

Provision 7. *Notwithstanding any other provision of law*, the Department of Finance may authorize the transfer of staff and related expenditure authority between the various appropriations itemized under departments 4200, 4280, 4440, 4260-001-0001, and 4260-001-0890 as a result of the shift of responsibilities from the Department of Alcohol and Drug Programs, the Managed Risk Medical Insurance Board, and the Department of Mental Health to the Department of Health Care Services' Medi-Cal Program. Department of Finance shall notify the Legislature within 10 days of authorizing such a transfer. The 10-day notification shall include the reasons for the transfer, the assumptions used in calculating the transfer amount, and any potential fiscal effects on the program from which resources are being transferred.

Add Provision 14 to Item 4260-101-0001

Provision 14. *Notwithstanding any other provision of law*, the Department of Finance may authorize the transfer of expenditure authority between the various appropriations itemized under departments 4200, 4280, 4440, 4260-101-0001, and 4260-101-0890 as a result of the shift of responsibilities from the Department of Alcohol and Drug Programs, the Managed Risk Medical Insurance Board, and the Department of Mental Health to the Department of Health Care Services' Medi-Cal Program. The Department of Finance shall notify the Legislature within 10 days of authorizing such a transfer unless prior notification of the transfer has been included in the Medi-Cal estimates submitted pursuant to Section 14100.5 of the Welfare and Institutions Code. The 10-day notification shall include the reasons for the transfer, the fiscal assumptions used in calculating the transfer amount, and any potential fiscal effects on the program from which funds are being transferred.

Add Provision 2 to Item 4260-113-0001

Provision 2. *Notwithstanding any other provision of law*, the Department of Finance may authorize the transfer of expenditure authority between the various appropriations itemized under department 4280 to 4260-113-0001 and 4260-113-0890 for activities necessary to transition and maintain programs and populations administered by the Managed Risk Medical Insurance Board to the Department of Health Care Services' Medi-Cal Program. The Department of Finance shall notify the Legislature within 10 days of authorizing such a transfer unless prior notification of the transfer has been included in the Medi-Cal estimates submitted pursuant to Section 14100.5 of the Welfare and Institutions Code. The 10-day notification shall include the reasons for the transfer, the fiscal assumptions used in calculating the transfer amount, and any potential fiscal effects on the program from which funds are being transferred.

No other structural programmatic or fiscal detail has as yet been provided by the Administration.

Legislative Analyst's Comment and Recommendation. The LAO states the Governor's proposal has merit because it has the potential to streamline administrative functions and improve service delivery. They note that it could result in the elimination of administrative redundancies and could facilitate better coordination and integration of the behavioral services provided through EPSDT, and Mental Health Managed Care, as well as Drug Medical (proposed for transfer from the Department of Drug and Alcohol).

However, the LAO notes few details have been provided on how the transition would be implemented.

The LAO expresses concerns with the Administration's sweeping Budget Bill Language, and its lack of Legislative oversight, and also recommends for the Legislature's Policy Committees to be engaged in decision making regarding these critical issues.

Subcommittee Staff Comment and Recommendation—Adopt in Concept with Placeholder Trailer Bill *and* Placeholder Budget Bill Language. This transition is an integral component of the Governor's Realignment and is consistent with the Legislature's approval to transition the Early and Periodic, Screening, Diagnosis and Treatment Program (EPSDT) and Mental Health Managed Care to the Counties, as discussed through the March budget deliberations. While the State will continue to have important oversight functions and federal responsibilities, it is no longer essential to have separate State departments with overlapping responsibilities and potentially unclear accountabilities.

This proposed consolidation not only offers administrative efficiencies, but it can also offer fuller integration of health and behavior health care services to consumers in need of these critical services. The State's newly implemented 1115 Medicaid Waiver, coupled with federal health care reform, and the Mental Health Parity Act of 2008, offer very constructive opportunities for a more inclusive and comprehensive delivery model.

Considerable discourse needs to occur with mental health advocates, mental health system providers, County Mental Health Plans, various interest groups and with the Legislature. It is anticipated that these discussions will be ongoing through the course of 2011-12.

With respect to the Administration's proposed Budget Bill Language, it is recommended to adopt placeholder Budget Bill Language to conceptually require a comprehensive description of funding and positions to be transferred from DMH to the DHCS, as well as other aspects of a transition plan. In addition, this information should be provided to the relevant fiscal and policy committees of the Legislature at least 45-days prior to any fiscal or position transfers.

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

1. Administration, Please provide a conceptual summary of the intent of this State administrative consolidation.

11. Transfer of Drug Medical Program to DHCS

Prior Subcommittee Hearing. In the Subcommittee's May 25th hearing, the Governor's May Revision proposal to transfer the Drug Medical Program to the DHCS was discussed and adopted in concept.

Governor's May Revision—Budget Bill Language. The May Revision for the DHCS proposes the following broad Budge Bill Language to provide for the fiscal

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Budget Bill Language. It is recommended to adopt placeholder Budget Bill Language to conceptually require a comprehensive description of funding and positions to be transferred from the Department of Alcohol and Drug (DADP) to the DHCS, as well as other aspects of a transition plan. In addition, this information should be provided to the relevant fiscal and policy committees of the Legislature at least 45-days prior to any fiscal or position transfers.

This language would be crafted in the same manner as that for the transfer of Community Mental Health programs as noted above.

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

1. Administration, Please provide a conceptual summary of the intent of this State administrative consolidation.

B. Managed Risk Medical Insurance Board-- Transition

Governor's May Revision. The May Revision proposes to eliminate the Managed Risk Medical Insurance Board (MRMIB and have MRMIB's Executive Director report to the Secretary of the California Health and Human Services (CCHHS) Agency by July 1, 2012.

During 2011-12, the Healthy Families Program and the Access for Infants and Mothers (AIM) Program would be transferred to the Department of Health Care Services (DHCS).

In 2012-13, the remaining MRMIB programs—the Pre-Existing Condition Insurance Plan (PCIP), Major Risk Medical Insurance Program (MRMIP) and the County Children's Health Initiative Program would be transferred to the DHCS.

Background. The Managed Risk Medical Insurance Board provides health coverage through commercial health plans, local initiatives and County Organized Health Systems to certain persons who do not have health insurance. The Board also develops policy and recommendations on providing health insurance to uninsured Californians. It administers programs, which provide health care coverage through private health plans to certain groups without health insurance. The MRMIB administers *five programs* as follows:

- Healthy Families Program;
- Pre-Existing Conditions Insurance Program (PCIP).
- Major Risk Medical Insurance Program (MRMIP);
- Access for Infants and Mothers (AIM) Program; and
- County Children's Health Initiative Matching Program (CHIM).

MRMIB has a total of 110 positions budgeted for 2011-12.

Background--the Major Risk Medical Insurance Program (MRMIP). MRMIP provides health insurance for Californians unable to obtain coverage in the individual health insurance market because of pre-existing conditions. Californians qualifying for the program participate in the cost of their coverage by paying premiums. Cigarette and Tobacco Product Surtax Funds are deposited into a special fund and are used to supplement premiums paid by participants to cover the cost of care in MRMIP. The budget proposes no policy changes for MRMIP. The changes between the two fiscal years reflect technical adjustments from prior years and payments to health plans.

Background--Access for Infants and Mothers (AIM). AIM provides low cost insurance coverage to uninsured, low-income pregnant women. The subscriber cost is 1.5 percent of their adjusted annual household income. AIM is supported with Cigarette and Tobacco Product Surtax Funds deposited into a special account, as well as federal funds to supplement the participant's contribution to cover the cost.

Background--County Children's Health Initiative Matching Fund Program (CHIM). Established by AB 495, Statutes of 2001, this program provides four counties the ability to

obtain federal funds for their Healthy Children's Initiatives by providing local funds to match the federal dollars. The budget proposes no policy changes for CHIM.

Subcommittee Staff Comment and Recommendation—Adopt the May Revision in Concept. It is recommended to adopt the May Revision in concept. With respect to the Administration's proposed Budget Bill Language, it is recommended to adopt placeholder Budget Bill Language in the same manner as proposed under the transfer of State-level functions as discussed under the Medi-Cal Program. (See items 10 and 11 above, in Medi-Cal). In addition, this information should be provided to the relevant fiscal and policy committees of the Legislature at least 45-days prior to any fiscal or position transfers.

Question. The Subcommittee has requested the Administration to respond to the following question:

1. Administration, Please provide a brief summary of the May Revision.

C. CA Medical Assistance Commission (CMAC)

1. Dissolve the California Medical Assistance Commission

Governor's May Revision. The May Revision proposes trailer bill language and a reduction of $129,000 (General Fund) and 3.5 personnel years by dissolving the CMAC.

Specifically, the Commission would be dissolved as of January 1, 2012, and all staff would then be transferred to the CA Health and Human Services Agency (CHHS Agency). All the duties and responsibilities of CMAC related to hospital contracting would still continue until the new hospital in patient payment methodology using Diagnosis Related Groupings (DGRs) is implemented.

With the implementation of a new hospital inpatient payment system for general acute care services based upon DRGs, the services CMAC provides will no longer be needed.

Background. Established in 1983, the California Medical Assistance Commission (CMAC) negotiates with hospitals through the Selective Provider Contracting Program on a per diem rate for the health care services they provide to Medi-Cal enrollees. The goal of the Commission is to promote efficient and cost-effective Medi-Cal programs through a system of negotiated contracts fostering competition and maintaining access to quality health care for Medi-Cal enrollees.

Among other things, SB 853, Statutes of 2010, requires the DHCS to development a new hospital inpatient payment methodology for general acute care services based upon diagnosis related groups (DRGs). Initially a reconciliation process is to commence as of July 1, 2012, with full implementation of the DGR payment method by July 1, 2014. The Medicare Program has utilized a DRG methodology for over 15 years.

Subcommittee Staff Comment and Recommendation—Adopt the May Revision. It is recommended to adopt the May Revision

Question. The Subcommittee has requested the Administration to respond to the following question:

2. Administration, Please provide a brief summary of the May Revision.

D. Department of Public Health

1. AIDS Drug Assistance Program (ADAP)

Legislative Actions Contained in SB 69 Budget Bill. In *prior action*, the Legislature modified the Governor's January proposal for the AIDS Drug Assistance Program by **(1)** shifting a total of $73 million in General Fund expenditures to Reimbursements and federal funds; and **(2)** identified savings of $4 million (General Fund) from revised transaction processing to be conducted under the new Pharmacy Benefit Manager contract. The specific actions were as follows:

- Reduced by $70 million (General Fund) and increased by $70 million (Reimbursements which are federal funds from Department of Health Care Services) to reflect ADAP's share of the Safety Net Care Pool Funds made available under California's 1115 Medicaid Waiver.
- Reduced by $3 million (General Fund) and increased by $3 million (federal funds) in anticipation of receipt of additional federal Ryan White CARE Act funds.
- Reduced by $4 million (General Fund) to reflect anticipated transaction processing savings from a new Pharmacy Benefit Manager contract to be effective as of July 1, 2011.
- Rejected the Governor's proposal to institute monthly premiums in ADAP estimated to generate $19.7 million in revenue from ADAP Clients which would have been offset by $2.9 million in administrative costs for a net reduction of $16.8 million (General Fund).
- Directed the Office of AIDS *to work immediately* with Stakeholders and other departments to **(1)** recast and expand the Health Insurance Premium Payment Program under the federal Ryan White Comprehensive AIDS Resources Emergency Act (CARE/HIPP); and **(2)** utilize the federal Pre-Existing Condition Insurance Program (PCIP) to provide health care coverage for eligible people with HIV/AIDS.

  Both the CARE/HIPP and PCIP can be utilized to reduce expenditures in ADAP while providing more comprehensive health care to people living with HIV/AIDS.

Governor's May Revision for 2011-12. The May Revision proposes total expenditures of $511.1 million for ADAP. The chart below displays the proposed fund sources.

AIDS Drug Assistance Program Fund Sources: Governor's May Revision

General Fund	$ 86.7 million
Drug Rebate Fund	$253.8 million
Reimbursement—1115 Medicaid Waiver	$ 70.0 million
Federal Funds	$100.6 million
Total Funds	$511.1 million

First, the Governor's May Revision reflects the Legislature's direction and actions in SB 69 by:

- Identifying General Fund savings by enrolling people with HIV and AIDS into the Pre-Existing Condition Insurance Plan (PCIP);
- Identifying General Fund savings by expanding the Comprehensive AIDS Resources Emergency/Health Insurance Premium Payment Program (CARE/HIPP);
- Rescinding the Governor's January proposal to institute monthly premiums in ADAP; and
- Reflecting increased in Reimbursements from the Department of Health Care Services (DHCS) from the receipt of federal funds from the 1115 Medicaid Waiver (Safety Net Care Pool).

Second, the Governor's May Revision makes a series of technical updates regarding **(1)** savings attributable to the Pharmacy Benefit Manager Contract; **(2)** updated revenues in the Drug Rebate Fund; and **(3)** caseload adjustments.

Background: ADAP Eligibility. Eligible individuals receive drug therapies through participating local pharmacies under subcontract with the Pharmacy Benefit Manager (PBM) (Ramsell Holding Company is the State's PBM for ADAP)

Individuals are eligible for ADAP if they:

- Reside in 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 to cover medications or do not qualify for no-cost Medi-Cal.

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 (2011-12)

Coverage Group	Clients	Percent
ADAP-Only	22,910	53.8
Medi-Cal Program	524	1.2
Private Insurance	9,509	22.4
Medicare coverage (Part D)	9,631	22.6
TOTAL	42,574	100.0

ADAP clients with incomes between $43,560 (401 percent of poverty as of April 1, 2011) and $50,000 are charged monthly co-pays for their drug coverage which is established annually at the time of enrollment or recertification.

The cost-sharing formula is based on twice the client's individual income tax liability, minus any health insurance premiums paid by the individual. The final amount due can vary greatly depending on the client's tax deductions, that are used to reach their final income tax liability (based on tax return). This amount is then split into 12 equal monthly payments which are collected at the Pharmacy at the time the client picks up their medication

The client's payment is then credited and the amount the Pharmacy bills the ADAP Pharmacy Benefits Manager is adjusted to account for this credit.

Background: 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).

Background—ADAP is Cost-Beneficial to the State. 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.

Background--Availability of Other Programs. The availability of the following two programs, as discussed in the Subcommittee's hearing of February 1, 2011, will enable the Office of AIDS to reduce expenditures in the ADAP:

CARE/HIPP. Federal law authorizes this Health Insurance Premium Payment (HIPP) program under the Ryan White Comprehensive AIDS Resources Emergency Act. This program provides premium payment assistance for eligible people for various insurance policies including: private insurance; COBRA; Cal-COBRA; and others. Eligible individuals are low-income California residents unable to work full time due to HIV-AIDS related health problems that are either receiving or in the process of applying for disability benefits. The income and asset limits are 400 percent of poverty and assets of $6,000. The monthly health insurance premium must be less than $700 per month. The private insurance plan must have prescription coverage as well. Current caseload is about 174 cases.

Pre-Existing Condition Insurance Program (PCIP). As discussed in Subcommittee on January 26th, California received federal approval and an allocation of $761 million (federal funds) to operate a high risk health insurance pool. PCIP offers health coverage to *medically uninsurable* individuals 18 years or older who live in California. It is available for people who did not have health coverage in the 6-months prior to applying. PCIP uses a preferred provider network that has contracted health providers in all 58 counties statewide. Monthly premium costs are based on the applicant's age and the region where the applicant lives. PCIP is to provide health care coverage for eligible individuals through December 31, 2013,

Subcommittee Staff Comment and Recommendation—Adopt the May Revision. It is recommended to adopt the May Revision

Question. The Subcommittee has requested the Administration to respond to the following question:

1. Administration, Please provide a brief summary of the May Revision.

E. Department of Mental Health: Community-Based Programs & State Support

Background Summary

Summary of Legislative Actions Contained in SB 69 Budget Bill. *First,* the Legislature adopted the Governor's proposal to realign certain community-based mental health programs, including the Early Periodic Screening, Diagnosis, & Treatment (EPSDT) Program, Medi-Cal Specialty Mental, and mental health services provided to special education pupils. *Second*, the Legislature modified the Governor's Finance Letter regarding adjustments to the State Administrative component of the Mental Health Services Act (Proposition 63 Funds).

Specifically, these actions by the Legislature are detailed below:

- o One-Time Redirection of $861.2 million (Mental Health Services Act Funds). Redirected a total of $861.2 million (MHSA) from Counties to backfill for General Fund support, as contained in AB 100, Statutes of 2011, for three programs as follows: **(1)** EPSDT = $579 million; **(2)** Medi-Cal Specialty Mental Health Managed Care = $183.6 million; and **(3)** Mental Health Services to Special Education Pupils = $98.6 million.

  This *one-time* redirection is necessary to adequately fund essential mental health services that would otherwise be significantly reduced absent this temporary funding support. This funding serves as a bridge to the 2011 Realignment.

- o 2011 Realignment. Beginning in 2011-12, upon passage of the Constitutional Amendment and a vote of the people, these three programs will be managed by the Counties, with oversight and direction by the State as necessary due to federal requirements. The Legislature's intent is to more equitably align program responsibilities and to provide a stable funding source.

- o State Administration Changes. Modified the 5 percent of total annual revenues for State administrative expenditures to support the DMH, the MHSA Oversight and Accountability Commission and other State entities to be a total of 3.5 percent. Appropriated a total of $21.975 million (MHSA Funds) for State administration.

  Of this amount, $1.9 million (MHSA Funds) is for State staff at the DMH. This provides for a total of 19 positions, including seven positions for housing, three positions for suicide prevention, four positions for stigma mitigation, and five positions for focused data analysis. The DMH will no longer be reviewing and approving County MHSA Plans. A total of five positions were also provided to the Mental Health Planning Council to continue their involvement with the MHSA.

Governor's May Revision. The May Revision *continues* the Governor's Realignment proposal for community mental health and State support as adopted in AB 100, Statutes of 2011 and as contained in SB 69 Budget Bill, ***except*** *for the following proposed modifications:*

- Mental Health Services to Special Education Students (AB 3632). The May Revision continues to provide $98.6 million (MHSA Funds) on a one-time basis for mental health services to special education students; however, ongoing responsibility for these services is proposed for realignment to school districts instead of County Mental Health beginning in 2012-13. The 2011-12 MHSA Funding is *not* affected by this proposal. *(Senate Budget Subcommittee #1 on Education will discuss this proposal. There is no action required of Senate Budget Subcommittee #3.)*

- Mental Health Managed Care Technical Adjustment. The May Revision proposes an increase of $294,000 ($148,000 General Fund and $146,000 federal funds) to reflect an increase in programs costs related principally to the number of Medi-Cal eligibles. This issue is discussed below.

- Increase in Proposition 63 Mental Health Services Fund Revenue. The May Revision reports a *decrease* of $20 million (MHSA Funds) for 2010-11, an *increase* of $123 million (MHSA Funds) for 2011-12 is assumed, as compared to the Governor's January budget revenue projections. Therefore a net increase of $103 million is projected across the two-years, as compared to the Governor's January budget. *(No additional budgetary changes are necessary for these revenues to be recognized.)*

- State Support for Mental Health Services Act (Proposition 63). The May Revision proposes to augment by $2.277 million (MHSA Funds) and 51 positions (25.5 personnel years) for transition planning purposes. This issue is discussed below.

Discussion Issues

1. Mental Health Managed Care—Technical Adjustments (DOF issue 520)

Governor's May Revision. The May Revision proposes an increase of $294,000 ($148,000 General Fund and $146,000 Reimbursements which are federal funds) for 2011-12 to reflect an increase in program costs related principally to the number of Medi-Cal eligibles.

This technical adjustment is in augmentation of the appropriation contained in the SB 69 Budget Bill.

SB 69 Budget Bill conformed to the Governor's January Budget for 2011-12 and appropriates $367.1 million ($183.6 million one-time MHSA/Proposition 63 Funds and $183.5 million federal funds) for this program. County Realignment Funds, which do not flow through the State's budget, are also used by Counties for these services.

Background: Mental Health Managed Care (Adults) and Existing Waiver. California provides "specialty" mental health services under a comprehensive federal Waiver that includes outpatient specialty mental health services, such as clinic outpatient services, 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. County Mental Health Plans contract with local providers to provide services.

California's Waiver for this program and for EPSDT (one Waiver) is set to expire as of June 30, 2011. This Waiver provides about $2 billion in funding. The DHCS is presently working for a renewal of this Waiver.

This program is funded using a combination of predominately County Realignment Funds, some General Fund support, and federal matching funds (50 percent and is drawn from the Counties and the State's contribution). State General Fund support for Mental Health Managed Care has been reduced considerably over the past years from about $226 million (General Fund) in 2008 to only $131 million in 2010.

Subcommittee Staff Recommendation—Approve May Revision. It is recommended to approve the May Revision as noted. No issues have been raised.

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

1. DMH, Please provide a brief summary of the May Revision technical adjustment.

2. State Support for Mental Health Services Act (Proposition 63) (DOF issue 509)

Governor's January Budget & March Finance Letter. Through a Finance Letter in March, the Governor proposed to provide a total appropriation of *only* $19.1 million (Mental Health Services Act Funds) and 62 positions for State Administrative expenditures to support the Department of Mental Health, as well as all other State entities engaged in various Proposition 63 activities.

The Governor's Finance Letter reflected a *reduction* of $30.5 million (MHSA Funds) and 143 positions in State Administrative expenditures as compared to his January budget. This reduction eliminated the Mental Health Planning Council, cut by 50 percent the Mental Health Services Act Oversight and Accountability Commission, and eliminated all positions within education related to the Mental Health Services Act.

The Finance Letter reduced the Department of Mental Health's positions from a total of 146.5 positions to 34.3 positions, for a reduction of 112.2 positions.

In addition, trailer bill language was proposed to reduce the role of the Department of Mental Health's administrative functions relating to Proposition 63, and to make other related changes, including capping at 3.5 percent the amount of MHSA Funds that could be expended for State Administrative functions.

These State Administrative reductions were proposed in an effort to recognize the need to streamline State Government, to improve program efficiency and to direct more MHSA funding to county mental health programs.

Legislative Actions Contained in SB 69 Budget Bill. The Legislature modified the March Finance Letter by appropriating a total of $26.7 million (MHSA Funds) for State Administrative expenditures, or $7.6 million (MHSA Funds) more than the Finance Letter. A total of total of 67 positions were provided to various departments.

The Legislature *restored* funding and positions to the Mental Health Services Act Oversight and Accountability Commission (OAC), the Mental Health Planning Council, key contracts such as those that fund consumer advocacy and trainings, as well as key positions for education.

A total of 24 positions were provided to the DMH for their remaining functions, including 5 for the Mental Health Planning Council.

Governor's May Revision. The May Revision proposes to augment State Administration within the Department of Mental Health on a *one-time only basis* by $2.277 million (MHSA Funds) and 51 positions (25.5 personnel years) for transition planning purposes and to effectuate a State Staff reduction plan as a result of the MHSA realignment.

The 51 positions (25.5 personnel years) are positions that pertain to business functions, such as Accounting, Business Management, Data Processing, Personnel, and Legal. The DMH arrived at this request by already taking into account 27 vacant positions (as of April 15, 2011). This temporary funding and position authority is intended to provide the DMH with appropriate planning time to develop and implement a State Staff reduction plan that must conform to Department of Personnel Administration (DPA) and bargaining unit contract obligations. For this to occur, the DMH must identify the number of positions and classifications affected, confirm all affected staff's accurate State service credits and provide timely and complete notice to State Staff of their rights and obligations under the reduction plan.

The DMH projects that a State Staff reduction plan of this magnitude will take six to nine months to develop *and* implement.

Further, these requested positions and funding are intended to provide assistance in monitoring financial aspects of the funding, conducting certain accounting and data reporting, and facilitating a transition to the counties.

Subcommittee Staff Recommendation—Approve May Revision. It is recommended to approve the May Revision as requested. The DMH needs to develop and implement a State Staff reduction plan as noted, and the requested positions will be used to complete certain data and fiscal requirements.

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

1. DMH, Please provide a brief summary of the May Revision request.

F. Emergency Medical Services Authority (EMSA)

1. Eliminate the Commission on Emergency Medical Services

Governor's May Revision. The May Revision proposes trailer bill language to eliminate the Commission on Emergency Medical Services as established by Chapter 8 of Division 2.5 of the Health and Safety Code (Section 1799, et al). This results in a decrease of $38,000 ($9,000 General Fund) in 2011-12.

The statutory duties of the Commission on Emergency Medical Services are as follows:

- Shall advise the Emergency Medical Services Authority (EMSA) on the development of an emergency medical data collection system;
- Shall advise the Director of the EMSA concerning the assessment of emergency facilities and services;
- Shall advise the Director of the EMSA with regard to communications, medical equipment, training personnel, facilities, and other components of an emergency medical services system;
- Shall review and comment upon the emergency medical services portion of the State Health Facilities and Service Plan developed by the EMSA; and
- Make recommendations for further development and future directions of the emergency medical services in the State.

The Administration states that the EMSA can obtain input from various other groups without the Commission on Emergency Medical Services structure in place.

Constituency Group Concerns. The Subcommittee is in receipt of several letters expressing concerns regarding the Administration's proposed elimination of this Commission. They state that the duties include the approval of regulations and guidelines developed by the EMSA to provide advice on a number of components of the emergency system, including appeals by local emergency medical service agencies which are critical to maintaining the system.

Subcommittee Staff Recommendation—Approve May Revision. It is recommended to approve the May Revision by adopting placeholder trailer bill language as proposed to eliminate the Commission on Emergency Medical Services.

The EMSA is well established and does seek consultation and information from various professional groups and interested parties as necessary.

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

1. Administration, Please provide a brief description of the current functions of the Commission on Emergency Medical Services and the May Revision proposal.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 27th, 2011

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. *Please* see the Senate File for dates and times of subsequent hearings.

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

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

VOTE ONLY ITEMS

A. Department of Public Health: Various Federal Grants

1. Strengthening Epidemiology, Laboratory and Health Systems Capacity (DOF 100)

Governor's Finance Letter. Department of Public Health (DPH) proposes an increase of $1.2 million (federal funds) for epidemiology and laboratory enhancement to improve detection, investigation and response to foodborne and emerging infectious diseases in the Central Valley and the San Francisco Bay Area.

This federal funding was made available through the federal the Patient Protection and Affordable Care Act of 2010. This federal grant included $755,000 for the current year, which was approved through a Section 28 letter to the Legislature.

Background. According to the DPH, the estimated annual health cost of foodborne illnesses is $152 billion nationally. The DPH further explains that many of the contaminated foods are major agricultural exports produced in California, including lettuce, spinach, eggs, cheese, and others. California's geography, cultural diversity, and international borders increase opportunities for foodborne illnesses to occur and to spread. This federal funding is intended to address the following:

- Laboratory capacity. These funds will be used to increase laboratory capacity to rapidly transport and analyze specimens, including Salmonella isolates sent to the lab.

- Public health information and surveillance systems. The effectiveness of data collection is diminished by the sheer size of California as well as by the decentralized nature of the state's public health system. These funds will be used to train additional local staff, develop standardized methods and questionnaires, and coordinate information sharing by streamlining databases and reporting systems.

Subcommittee Staff Comment and Recommendation. It is recommended to approve the Finance Letter. No issues have been raised.

2. Expanded HIV Testing for Disproportionately Affected Populations

Governor's Finance Letter. DPH requests an increase of $3.75 million (federal funds) to support expanded HIV testing services for disproportionately affected populations. This federal grant includes $2.6 million (federal funds) for the current year, which was approved through a Section 28 letter to the Legislature. States that received funds under a prior grant were eligible to compete for this grant, which was awarded based on demonstrated need.

Background. This federal grant is for the purpose of funding high-volume HIV screening in healthcare settings, linkages to care, and partner services. According to the DPH, the HIV epidemic continues to disproportionately affect racial and ethnic minority populations, particularly African Americans and Hispanics, men who have sex with men and injection drug users. The DPH also explains that insufficient HIV testing continues to enhance the epidemic as HIV positive individuals who are unaware of their HIV status are four times more likely to transmit HIV to another person, according to national research. Early treatment also helps reduce transmission of the disease.

In 2007, the federal Centers for Disease Control and Management (CDC) implemented an HIV testing program and California was awarded $716,000 annually which funded three emergency departments in Alameda and San Francisco. 24,137 people were tested and 188 of those tested HIV positive. This new grant is intended to sustain progress made under the prior program and expand routine testing to new clinical venues to reach more at-risk populations. This new funding will cover eight new testing sites, including Local Health Jurisdictions, large hospitals, or health care clinics.

Subcommittee Staff Comment and Recommendation. It is recommended to approve the Finance Letter. No issues have been raised.

3. Ryan White HIV/AIDS Program in Sonoma County

Governor's Finance Letter. The DPH requests an increase of $555,000 to support HIV care services in Sonoma County whose direct funding from the Health Services Resources Administration (HRSA) is being redirected to the State grant award for the Office of AIDS.

Background. The Ryan White HIV/AIDS Program, Part A, provides direct funding to cities and counties, including areas known as Transitional Grant Areas, which are areas most severely affected by the HIV/AIDS epidemic based on a minimum number of living AIDS cases.

Sonoma County *no longer qualifies* for Transitional Grant Areas status because it failed for the third consecutive year to meet the mandated eligibility criteria of total cumulative AIDS cases and number living with AIDS. Therefore, as of April 2011, Sonoma County will no longer receive Transitional Grant Areas funding directly from HRSA.

The Ryan White HIV/AIDS Treatment Extension Act of 2009 stipulates that states affected by a loss of TGA funding will receive TGA-transition step-down funds for a three year period to ensure continuation of HIV care services to clients living in the former TGA jurisdiction.

This request will implement this step-down period.

Subcommittee Staff Comment and Recommendation. It is recommended to approve the Finance Letter. No issues have been raised.

B. Department of Developmental Services

1. Technical May Revision Changes (DOF issues 304, 305, 306, 310, 312, and 313)

Governor's May Revision. The May Revision estimate for the Regional Center contains a series of technical adjustments to prior changes previously adopted by the Legislature, as well as technical adjustments to the base-line estimate which pertain to caseload and utilization of services, as well as federal monitoring requirements.

These changes are contained within the summary dollars discussed above under the Background section of this document. The list below reflects all of the technical changes (fund sources, caseload, utilization of services, and federal requirements) to existing budget schedules.

These technical adjustments include changes to the following budget schedules:

- **4.25 Percent Operations and Provider Payment Reductions.** It is requested that Schedule (1) of Item 4300-101-0001 be increased by $303,000 and Reimbursements be decreased by $143,000 and Schedule (2) of Item 4300-101-001 be decreased by $14,369,000 and Reimbursements be increased by $11,526,000 to reflect the revised estimate of the 4.25 percent reduction to operations and provider payments.

- **Enrollment, Caseload, Population Adjustment**. It is requested that Schedule (1) of Item 4300-101-0001 be decreased by $132,000 and Reimbursements be increased by $419,000. It is requested that Schedule (2) of Item 4300-101-0001 be increased by $28,849,000 and Reimbursements be increased by $1,836,000. It is requested that Schedule (4) of Item 4300-101-0001 be decreased by $16,297,000. It is requested that Schedule (7) of Item 4300-101-0001 be amended to reflect a reduction in Item 4300-101-0172 of $693,000. It is requested that Schedule (8) of Item 4300-101-0001 be amended to reflect an increase in Items 4300-101-0890 of $17,000 to reflect the adjustments due to revised estimates of caseload and utilization.

- **Quality Assurance Fees.** It is requested that Item 4300-101-0001 be amended to reflect an increase of $555,000 in Reimbursements to reflect a revised estimate of Quality Assurance Fees paid by Intermediate Care Facilities for Developmentally Disabled (ICF-DD).

- **Community Placement Plan Savings from Closure of Agnews Developmental Center.** It is requested that Item 4300-101-0001 be decreased by $347,000 and Reimbursements be decreased by $479,000 to reflect a revised estimate of *community placement plan* costs associated with individuals who have moved from Agnews Developmental Center.

- **Adjustment to Correct Funding for Regional Center Operations and Purchase of Services.** It is requested that Schedule (1) of Item 4300-101-0001 be decreased by $11,713,000 and Schedule (2) of Item 4300-101-0001 be increased by $11,713,000 to correct a program scheduling error in the Governor's Budget.

- **Conflict of Interest Savings Technical Adjustment.** It is requested that Item 4300-101-0001 be amended by increasing Reimbursements by $900,000 to correct the estimated savings resulting from the cost containment measure to deter conflicts of interest.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. The May Revision contains a series of technical adjustments as referenced above. There are no proposed policy changes in these items. No issues have been raised.

It is recommended to approve these May Revision technical adjustments as noted.

2. Intermediate Care Facility Developmentally Disabled State Plan (DOF 307)

Governor's May Revision. The May Revision is requesting *two changes* related to the receipt of federal funds by reconfiguring the billing mechanism for ICF—DD facilities as it pertains to transportation. This change, enacted in the Budget Act of 2008, enables the DDS to claim increased federal funding.

The first change pertains to retroactive billing and a need for reappropriation to capture federal funds. The federal CMS approved California's State Plan Amendment as of April 15, 2011. Retroactive claiming for services starting on July 1, 2007 is in progress but cannot be completed prior to June 30, 2011 when the 2007-08 and 2008-09 State appropriation revert. Therefore, DDS is requesting the following uncodified trailer bill language in order to provide for a reappropriation in order to claim federal funds. The request language is as follows:

> Due to a change in the availability of federal funding that addresses the ability of California to capture additional federal financial participation for day treatment and transportation services provide to a Medi-Cal beneficiary residing in a licensed ICF as specified in Welfare and Institutions Code, Section 4646.55 and Section 14132.925, funds appropriated in the following items shall be available for liquidation until December 30, 2011:
>
> Item 4300-101-0001, Budget Act of 2007, Chapters 171 and 172, Statutes of 2007, previously reappropriated by Chapter 268, Statutes of 2008, and Item 4300-101-0001, Budget Act of 2008, Chapter 268, Statutes of 2008.

The second change pertains to a technical to reflect base-line estimate adjustments. It is requested that Schedule (1) of Item 4300-101-0001 be decreased by $58,000 and Reimbursements be decreased by $57,000 to reflect the revised estimate of ICF-DD State Plan Administration fees.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. No issues have been raised regarding these *two changes* related to the ICF-DD State Plan Amendment. The ICF-DD State Plan Amendment, provided the Developmental Services system with additional federal funds through an approved federal CMS billing mechanism and enables the State to offset a portion of General Fund expenditures.

3. Regional Center Operations: Meeting Federal Medicaid Requirements (DOF 309)

Governor's May Revision. An increase of $1 million ($500,000 General Fund) is proposed for Regional Center Operations to comply with statutory changes contained in SB 74, Statutes of 2011 (Omnibus Developmental Services trailer bill) regarding accountability and transparency. This adjustment provides for 16 Regional Center positions.

Specifically, Regional Centers will need to gather and review business ownership, control and relationship information pursuant to federal law, from prospective and current vendors.

In addition, Regional Centers will be required to determine that all prospective and current vendors are eligible to participate as Medicaid service providers by verifying that they have not been convicted of a crime related to Medicare, Medicaid or federal Title XX programs. This pertains to concerns expressed by the federal CMS in a draft audit report—"Medicaid Integrity Program, California Comprehensive Program Integrity Review."

Subcommittee Staff Comment and Recommendation—Adopt May Revision. The proposal is consistent with statutory changes adopted in SB 74, Statutes of 2011, and changes as noted in the federal CMS draft audit need to occur or hundreds of millions in federal funds are at risk.

4. Offset to Regional Center Cost Containment (DOF Issue 315)

Governor's May Revision. The May Revision adjusts the 2011-12 budget to reflect an offset of $28.5 million (GF) from savings from 2010-11. This assists with phase-in of the Cost Containment proposals.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. Increasing 2011-12 by $28.5 million (GF) to reflect savings achieved in 2010-11 will assist with phasing-in the identified Cost Containment proposals since some of these proposals will require a period of time for implementation to take place. No issues have been raised.

5. Capital Outlay: Fairview Developmental Center Fire Alarm System

Budget Issue. DDS requests an increase of $8.6 million (General Fund) through a "re-appropriation" for the construction phase of the Fairview Fire Alarm System Upgrade.

The fire alarm system upgrade was approved in the Budget Act of 2008 with $9 million (General Fund) for Preliminary Plans ($597,000), Working Drawings ($565,000) and Construction ($8.5 million). The system was approved to meet the current fire codes in consumer-utilized buildings at Fairview.

DDS states the outdated fire alarm system at Fairview DC affects the safety and quality of life of individuals living and working in the DC. For example, routinely fire and policy personnel are dispatched to living units to silence loud audible fire alarms. A complete upgrade of the system is necessary since replacement parts are no longer available for this 1970's system.

DDS states that there were several delays in completing the upgrade and this is why the re-appropriation is needed.

Subcommittee Staff Comment and Recommendation--Approve. The SB 69 Budget Bill did not include this DDS request due to fiscal constraints and the need to reduce expenditures overall.

However the Administration has requested reconsideration due to considerable health and safety issues if the Fire Alarm System is not upgraded. The Assembly Budget Subcommittee #1 on Health and Human Services did reconsider this request and has approved it.

It is recommended to *conform to the Assembly's action* and approve the request.

Department of Developmental Services

A. BACKGROUND

1. Comparison and Summary of Legislative Actions in SB 69 Budget Bill

Legislative Actions as contained in SB 69 Budget Bill. As shown in the Table below, the Legislature modified the Governor's January budget proposal in several key areas.

First, the Legislature *did not adopt* the Governor's full reduction amount of $750 million (General Fund). Instead a lessor amount, though still very significant, of $577 million (General Fund) was adopted.

Every effort was made to identify savings as far away from direct consumer services as possible in this extremely difficult fiscal environment by: **(1)** increasing the receipt of federal funds and other alternative sources; **(2)** spreading the overall reduction across the developmental services system to include a reduction at the Developmental Centers; **(3)** approving trailer bill to improve system accountabilities and recognize efficiencies; **(4)** reducing Regional Center Operations expenditures where feasible; and **(5)** continuing the 4.25 percent reduction from the current-year into 2011-12.

Table: Comparison & Summary of Proposed Reductions to General Fund Expenditures

Summary of Key Proposals *(Dollars are Rounded)*	Governor's January Budget (January)	Legislature's SB 69 Budget Bill (March)	Difference
1. Less of a General Fund Reduction Overall	-$750 million	-$577 million	**+$173 million *Restored by Legislature***
2. Reductions in Developmental Centers	--	-$39.5 million	-$39.5 million
3. Identified Additional Alternative Funds	-$125 million	-$137.7 million	+$12.7 million
4. Trailer Bill Language Package	-$109.7 million	-$109.7 million	--
5. Less Impact from other Departments (Medi-Cal related)	--	-$15 million	-$15 million
6. Identified Additional RC Operations Cuts	--	-$9.5 million	-$9.5 million
7. 4.25 percent RC Operations Cut *&* 4.25 percent Provider Reduction	-$91.5 million	-$91.5 million	--
8. Establish Process to Identify $174 million (GF) Through Best Practices	-$423.8 million	-$174 million	$249.8 million ***Away from Consumer***

A. BACKGROUND *(continued)*

2. Summary Overview of Governor's May Revision Changes

The May Revision continues the $174 million (General Fund) reduction amount identified in the SB 69 Budget Bill.

The May Revision consists of *two core components*. The *first component, "**A" below**,* consists of savings offsets and reduction to administrative functions. The *second component, **"B" below**,* reflects reductions associated with the Purchase of Services.

A. Savings Offsets & Reductions to Administrative Functions= -$121 million (GF)

- Use Current-Year Savings as Offset. Recognizes $28.5 million (GF) savings from 2010-11 to be applied as an offset against 2011-12. This assists with phase-in of proposals.
- Lower Base-Line Costs for 2011-12. Reflects $55.6 million (GF) savings due to updated expenditures, caseload and utilization changes. This reflects updated cost information.
- Additional Federal Funds for Purchase of Services. Reduce by $20.9 million (GF) due to the receipt of federal funds from various actions. This results in a fund shift only.
- Reduce DDS Headquarter Contracts. Cut a total of $1.8 million (GF) in various contracts, including information technology, quality assessment, and client's rights advocacy.
- Reduce Regional Center Operations. Reduce by $14.1 million (GF) Operations expenditures at Regional Centers, including $3 million in office relocations, $1.9 million in community placement plan staff, and $5.4 million as an unallocated reduction.

B. Reductions Associated with Changes to Purchase of Services= -$53.1 million (GF)

Reductions Associate with Purchase of Services Proposals	2011-12 May Revision (GF Reduction)	Annualized (GF Reduction)
• Community Placement Plan	$6.9 million	$7.0 million
• Rate Equity and Negotiated Rate Control	$3.4 million	$9.6 million
• Annual Family Program Fee	$3.6 million	$7.2 million
• Maintaining Consumer's Home of Choice: Mixed Payment Rates	$1.4 million	$2.5 million
• Maximize Utilization of Generic Resources-- Education	$10.2 million	$13.6 million
• Supported Living Services: Maximize Resources	$5.5 million	$10.9 million
• Individual Choice Day Service	$9.6 million	$12.3 million
• Maximizing Resources for Behavioral Services	$3.8 million	$3.8 million
• Transfer Prevention Program to Family Resource Centers	$7.5 million	$10.0 million
• Development of Transportation Access Plans	$1.1 million	$2.2 million
Subtotal of Purchase of Services	**-$53 million**	**-$79.1 million**
TOTAL General Fund Reductions "A" + "B"	**-$145.5 million**	**-$174 million**

Discussion Items

A. Community-Based Services

1. Proposed Purchase of Services Reductions (-$53.1 million GF) (Pages 12 to 19)

Background. The Legislature adopted a lower reduction amount-- $174 million (GF) – than proposed in the Governor's January budget and directed the DDS to work collaboratively with stakeholder groups to develop draft proposals to achieve the $174 million (GF) reduction level.

DDS established eight subject area workgroups, including: (1) Behavioral Services; (2) Day Program, (3) Supported Employment, and Work Activity Program Services; (4) Early Start Services; (5) Health Care and Therapeutic Services; (6) Independent Living and Supported Living Services; (7) Residential Services; Respite and Other Family Supports; and (8) Transportation Services. Sixteen workgroup meetings were held throughout March and April 2011, totaling over 70 hours of discussion with stakeholders. In addition, DDS held three public forums –Los Angeles, Oakland and Sacramento –to receive comments on the proposals.

As noted on page two of this Agenda, the May Revision proposes base-line savings offsets and reductions to administrative functions which result in a total reduction of $121 million (GF), which leaves about $53 million (GF) to be obtained from Purchases of Services.

Governor's May Revision Proposals in Purchase of Services

Proposals in Purchase of Services	2011-12 May Revision (GF Reduction)	Annualized (GF Reduction)
Community Placement Plan	-$7.0 million	-$7.0 million
Rate Equity and Negotiated Rate Control	-$3.4 million	-$9.6 million
Annual Family Program Fee	-$3.6 million	-$7.2 million
Maintaining Consumer's Home of Choice: Mixed Payment Rates	-$1.4 million	-$2.5 million
Maximize Utilization of Generic Resources-- Education	-$10.2 million	-$13.6 million
Supported Living Services: Maximize Resources	-$5.5 million	-$10.9 million
Individual Choice Day Service—Three Components	-$9.6 million	-$12.4 million
Maximizing Resources for Behavioral Services	-$3.8 million	-$3.8 million
Transfer Prevention Program to Family Resource Centers	-$7.5 million	-$10.0 million
Development of Transportation Access Plans	--$1.1 million	-$2.1 million
TOTAL General Fund Reductions	**-$53.1 million**	**-$174 million**

Each of the May Revision Purchase of Services proposals is discussed below:

- *Community Placement Plan (CPP).* Under the Community Placement Plan (CPP) process, each Regional Center provides an annual Plan to DDS based on necessary resources, services, and supports for consumers moving from a Developmental Center, as well as the resources needed to prevent Developmental Center admission ("deflection"). As part of this process, Regional Centers must forecast the dates consumers will move into the community as well as when community resources will become available.

  DDS conducted an analysis of the funds budgeted, allocated, and expended on CPP and has determined that a total of $10 million ($7.3 million GF) can be reduced to more closely align identified needs and expenditures. Of this amount, $315,000 is reflected as a reduction to Regional Center Operations. Most of the proposed reduction is from "start-up", placement and deflection expenditures. No direct effect on consumer services is anticipated. No statutory changes are required.

- *Rate Equity and Negotiated Rate Control.* The May Revision reduces by $4.6 million ($3.4 million General Fund) for 2011-12 under this proposal. Annual savings are $13 million ($9.6 million General Fund).

  The rate setting methodologies for services funded by Regional Centers are specified in law. These methodologies include: **(1)** negotiations resulting in a rate that does not exceed the Regional Center's median rate for that service, *or* the statewide median, whichever is lower; and **(2)** the provider's "Usual and Customary" rate, which means the rate they charge the members of the general public to whom they are providing services.

  The 4.25 percent payment reduction for the Purchase of Services went into effect July 1, 2010 *but did not apply* to service providers with a "Usual and Customary" rate. The intent of the "Usual and Customary" exemption was for businesses that serve the general public without specialty in services for persons with developmental disabilities.

  This proposal clarifies that the exemption to the 4.25 percent payment reductions does not apply to providers specializing in services to persons with developmental disabilities. This proposal also calls for DDS to update the calculation of the Regional Center and statewide median rates, established as part of the 2008-09 budget reductions, applicable to new vendors providing services for which rates are set through negotiation. The proposal impacts providers who were not previously impacted by the 4.25 percent payment reduction and new providers of negotiated rate services.

  Trailer bill clarifies the 4.25 percent reduction that exempted usual and customary payments by listing services that are not exempted from this reduction.

- *Annual Family Program Fee.* The May Revision reduces by $3.6 million ($3.6 million GF) by requiring certain families of consumers to pay an annual family program Fee in the amount of $150 *or* $200 depending on family income.

  This proposal requires trailer bill and assumes implementation as of July 1, 2011. The Fee would be phased-in at the time of in-take, or at the time of development, scheduled review, or modification of a consumer's Individual Program Plan (IPP), but no later than June 30, 2012.

  It should be noted that the language does provide for an *exemption* from paying the Fee if the parents can demonstrate that: (1) exemption from the Fee is necessary to maintain the child in the family home; (2) the existence of an extraordinary event as specified; (3) the existence of a catastrophic loss that temporarily limits the ability of the parents to pay as specified.

  This annual fee would be assessed for families of consumers receiving services from the Regional Centers who *meet* the following criteria:

  - Family's income is at or above 400 percent of poverty based upon family size;
  - Child lives at home, is under 18 years of age, and is *not* eligible for Medi-Cal; and
  - Child or family receives services beyond eligibility determination, needs assessment, and case management.
  - Families of consumers who *only* receive respite, day care, and/or camping services are also *excluded* under the Annual Fee Program if assessed separately in the Family Cost Participation Program (no double payment).

  It is estimated that there will be a total of 46,900 families responsible for paying this Fee. It is assumed that 5 percent of these families will be exempt from paying for various reasons.

  Of the remaining 42,400 families remaining, about 18,800 families will have incomes between 400 percent and 800 percent of poverty and would be assessed an annual Fee of $150, generating $2.8 million in savings.

  The remaining 23,600 families will have incomes in excess of 800 percent of poverty and would be assessed a family fee of $200, generating $4.8 million in savings.

  Annual savings would be $7.2 million (GF) and 2011-12 savings would be the $3.6 million (GF) due to the phasing-in.

- Maintaining Consumer's Home of Choice: Mixed Payment Rates. The May Revision reduces by $2.3 million ($1.4 million General Fund) in 2011-12. Annual savings are $4.2 million ($2.5 million General Fund).

  Under this proposal, rather than a consumer having to leave their preferred residential living arrangement because their service and support needs have changed, it allows for Regional Center payment of a lower rate that meets the needs of the individual while leaving intact the higher level of services and support for the other individuals residing in that home and the facility's ARM service level designation.

  Current regulations for ARM facilities (Title 17, Section 56902) allow regional centers to negotiate a level of payment for its consumers that is lower than the vendored rate established by the Department (ARM rate). However, the vendor must still provide the same level of service (i.e. staffing ratios and hours, and consultant services) for which they are vendored. This proposal would allow, pursuant to the consumer's IPP, and a contract between the regional center and residential provider, a lower payment rate for a consumer whose needs have changed but wants to maintain their residency in the home, without impacting the facility's ARM service level designation.

  This estimate assumes approximately 450 consumers residing in service level 4 ARM facilities that are determined through their IPP to no longer need the level of service provided by that facility through its assessed rate, but want to remain in their home. To resolve this, a lower level of payment (within the existing ARM rate structure) would be negotiated and established in contract. A change in the level of residential services would be done through the IPP process, and subsequently through a contract between the regional center and residential service provider.

  Trailer bill is added to allow regional centers to enter in contracts with residential service providers for a consumer's needed services at a lower level of payment and staffing without adjusting the facility's approved service level.

- Maximizing Utilization of Generic Resources—Education. The Lanterman Act requires the use of generic services to meet the needs of consumers, as applicable, and public school services are a generic resource to be utilized.

  Publicly funded school services are available to regional center consumers until age 22. The Education Code lists services provided by the school system, including orientation and mobility services, school transition services, specialized driver training instruction, specifically designed vocational education and career development, and transportation.

  As such, this proposal requires Regional Centers to access public schools services in lieu of purchasing Day Program, work/employment, independent living, and associated transportation services, as feasible for consumers who remain eligible for services through the public school system.

This proposal requires trailer bill and would take effect immediately. A reduction of $13.7 million ($10.2 million GF) is assumed for 2011-12, with annual savings projected to be $18.2 million ($13.6 million GF). This would affect consumers between the ages of 18 to 22 years.

It should be noted that the Budget Act of 2009 required Regional Centers to use generic education resources for minor school aged children.

- Supported Living Services: Maximize Resources. Supported Living Services (SLS) is a community living option that supports adult consumers who live in homes they control through ownership, lease, or rental agreement. In supported living, a consumer pays for living expenses (e.g. rent, utilities, food, and entertainment) out of Social Security Income, work earnings or other personal resources. Regional Centers pay the vendor to provide the SLS. This proposal reduces expenditures by $9.9 million ($5.5 million GF) in 2011-12 *based on two changes*.

  First, a savings of $3.8 million ($2.1 million GF) is assuming by requiring Regional Centers to assess, during IPP meetings, whether there are tasks that can be shared by consumers who live with roommates. DDS states that 40 percent of consumer receiving SLS share living arrangements with another adult. It is assumed that 10 percent of these households will choose to share equally in tasks. The annual savings for this component are estimated to be $7.7 million ($4.2 million GF).

  Second, an independent needs assessment will be required for all consumers who have Supported Living Services costs that *exceed 125 percent* of their annual statewide average cost of providing supported living service.

  A reduction of $6.1 million ($3.4 million GF) is assumed for this component. This calculation assumes a reduction of 5 percent due to the independent assessments of those individuals above, or expected to be above the 125 percent of the annual statewide average (mean), or $15.2 million (total funds). This reduction is offset by the cost of the independent assessment, at about $1,000 per assessment, or $3 million (total funds). Annual savings from this component are anticipated to be $12.2 million ($6.7 million GF).

  This proposal requires trailer bill.

- Individual Choice Day Service—Three Components. This proposal reduces by $12.8 million ($9.6 million GF) by offering alternative choices to traditional Day Programs, including: **(1)** Tailored Day Program Service Option; **(2)** Vouchered Community-Based Training Service Option; and **(3)** Modified Full and Half-Day Program Attendance Billing.

  The first two proposals address the community's desire for greater consumer choice in day services.

  The Tailored Day Program Service Option would result in savings of $7 million ($5.3 million GF) in 2011-12 and annualized savings of $9.4 million ($7 million GF). In this option, through the IPP process, the consumer, vendor and Regional Center can create a program

tailored to the consumer's needs. Once the type and amount of service desired by the consumer is determined, the regional Center and vendor can negotiate the appropriate hourly or daily rate. Staffing may be adjusted but must meet all health and safety requirements for the consumer and meet the consumer's tailored needs.

The Vouchered Community-Based Training Service Option would result in savings of $3.9 million ($2.9 million GF) in 20112 and annualized savings of $5.2 million ($3.9 million GF). In this option, consumers and/or parents who choose to directly hire a support worker to develop functional skills to achieve community integration, pursue post-secondary education, employment, or participation in volunteer activities. A Financial Management Services entity would be available to assist the consumer in payroll activities and up to 150 hours of services are available each quarter.

The third proposal modifies the current billing for Day Programs that bill a *daily* rate. A full day of service is defined as at least 75 percent of the declared and approved programed day, and a half-day of service is any attendance less than a full-day of service. Presently, regulations governing the provision of Day Programs are silent on what constitutes a full or half-day for billing purposes. This proposal would ensure the consumer is receiving the level of services purchased. This component would result in savings of $1.9 million ($1.4 million GF) in 2011-12 and annualized.

Total annualized savings are $16.5 million ($12.3 million General Fund) for implementation of these three changes.

This proposal requires trailer bill for enactment.

- Maximizing Resources for Behavioral Services. Behavioral Services are services that provide instruction and environmental modifications to promote positive behaviors and reduce behaviors that interfere with learning and social interaction. These include designing, implementing and evaluating teaching methods, consultation with specialists, and behavioral interventions; and training for consumers and/or parents on the use of behavioral intervention techniques and home-based behavioral intervention programs. DDS regulations establish the qualifications for the various professionals delivering these services.

  There are *two components* to this proposal. *First*, it requires parents to verify receipt of Behavioral Services provided to their child to reduce the unintended occurrence of incorrect billings. A reduction of $2.7 million ($2 million GF) in 2011-12 is assumed from this component, as well as annually. This reflects a one percent savings level based upon projected expenditures of $265.7 million (total funds) for behavioral services (ages 0 to 17 years).

  Second, it authorizes the DDS to promulgate emergency regulations to establish a new service to enable Regional Centers to contract with paraprofessionals with certain educational or experiential qualifications and acting under professional supervision (i.e.,. group practice), to provide behavioral intervention services. A reduction of $2.5 million ($1.9 million GF) for 2011-12 is assumed from this component, as well as annually. This savings level assumes that 25 percent of Behavioral Management Assistant services are

provided by a paraprofessional and that the rate paid to the paraprofessional is 75 percent of the current rate.

This proposal requires trailer bill for enactment.

- Transfer Prevention Program to Family Resource Centers. The May Revision reduces by $7.5 million (General Fund) for this proposal. Annualized savings are $10 million (General Fund) as detailed below.

  The Prevention Program was established in October 2009 after changes in eligibility to achieve savings in the Early Start Program. The Prevention Program provides services in the form of intake, assessment, case management, and referral to generic agencies for those infants and toddlers, 0 to 2 years of age, who are *not eligible* for Early Start services but who *are at risk* for developmental delay. The Prevention Program is currently budgeted at $12 million for 2011-12 (as contained in SB 69 Budget Bill).

  This proposal would *decrease the required functions* of the Prevention Program to information, resource, outreach, and referral; transfer responsibility for these functions to Family Resource Centers, and reduce funding to $4.5 million for 2011-12 and to only $2 million in 2012-13.

  Since approximately 3,200 children presently remain in the Prevention Program, this proposal assumes $2.5 million for Regional Centers to complete services to the existing caseload and $2 million for Family Resource Centers to serve *new* referrals.

  Beginning July 1, 2012, the program would be completely transferred to the Family Resource Centers through a contract between the DDS and the Family Resource Center Network of California, or a similar entity.

  Regional Centers will continue to provide all infants and toddlers with intake, assessment, and evaluation for the Early Start Program. Infants and toddlers ineligible for the Early Start Program would be referred to the Family Resource Centers.

  The proposed trailer bill amends statute to specify that babies identified as being "at-risk" who are in the prevention program as of June 30, 2011, shall continue in the prevention program until the child reaches the age of 36 months, the Regional Center has determined the child is eligible for services under the California Early Intervention Program pursuant to Title 14, or June 30, 2012, whichever date is earlier.

  Language also phases out the Prevention Program by July 1, 2012. Lastly, language is added to allow DDS to contract with an organization representing one or more family resource centers which receive federal funds from Part C of the Individuals with Disabilities Education Act to provide outreach, information and referral services to generic agencies for children under 36 months of age who are otherwise not eligible for the California Early Intervention Program pursuant to Title.

- Development of Transportation Access Plans. The May Revision reduces by $1.5 million ($1.1 million General Fund) for this proposal. Annual savings would be $2.9 million ($2.1 million General Fund).

  Current law provides that Regional Centers will *not* fund private, specialized transportation services for an *adult consumer* who can safely access and utilize public transportation when that transportation modality is available and will purchase the least expensive transportation modality that meets a consumer's needs as set forth in the Individualized Program Plan (IPP) or Individualized Family Services Plan (IPP/IFSP).

  To maximize consumer community integration and to address barriers to the most integrated transportation services, a Transportation Access Plan would be developed at the time of the IPP, for consumers for whom the Regional Center is purchasing specialized transportation services or vendored transportation services. The Transportation Plan would address services needed to assist the consumer in developing skills to access the most inclusive transportation option that can meet the consumer's needs.

  Trailer bill is proposed to implement the review of transportation needs of a consumer through a Transportation Access Plan. Changes to the consumer's transportation needs will be completed through the IPP and will address a consumer's community integration and participation through the use of public transportation services. The planning team will consider safety, availability, accessibility, and future services and supports which include mobility training services and transportation aides.

Subcommittee Staff Comment and Recommendation. The workgroups, public forums, and commitment from *all* interest groups has significantly influenced the outcomes for the best practices for Purchase of Services language as contained in SB 74, Statutes of 2011 (Omnibus Developmental Services Trailer Bill).

The Administration has done commendable work by identified *both* savings from the current-year (i.e., $28.5 million GF savings) and budget year (i.e., $55.6 million GF savings), as well as identifying more federal funding opportunities, and administrative savings (discussed later in this Agenda.)

It is recommended to **(1)** Adopt the $53.1 million (General Fund) reduction to the Purchase of Services, as referenced above; **(2)** Adopt "placeholder" trailer bill language to continue the fine-tuning of language on *all issues as long as the savings level is achieve*; **(3)** Adopt a two-year sunset on the Annual Family Program Fee; and **(4)** Adopt Supplemental Reporting Language regarding the Prevention Program component. This recommendation would conform to the Assembly.

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

1. DDS, Please provide a *brief overview* of the *key components* of the Governor's May Revision.
2. DDS, Please describe *each* of the proposed changes to the Purchase of Services as referenced above in this issue (all ten proposed changes).

2. Governor's May Revision Proposals: Federal Funds, Contracts & Regional Center Operations

Governor's May Revision. As noted earlier in this Agenda, the May Revision recognizes reduced General Fund expenditures from *three other components* as follows:

First, as listed in the chart below, additional federal funds of $20.9 million have been identified for 2011-12. Receipt of federal funds is an integral component of the Regional Center services system and comprises about $1.7 billion of the funding.

DDS will expand receipt of federal funding through the **(1)** renewal of the Home and Community-Based Waiver; **(2)** the 1915(i) State Plan Amendment; and **(3)** Money Follows the Person Grant.

In addition, trailer bill is proposed to require consumers or family members to provide a copy of the consumer's Medi-Cal, Medicare, and insurance cards at the time of the IPP to ensure federal funds and other resources are maximized.

Further, DDS will pursue accessing funds through the federal 1915 (k) Community Living Options, which becomes available to states in October 2011.

A. Increased Federal Funds for the Purchase of Services

Category of Federal Funds	2011-12 GF Offset	2012-12 GF Offset
Add Voucher of Nursing to Home & Community Based Waiver	-$528,000	-$528,000
Money Follows the Person for Residents of Institutional Settings	-$1.9 million	-$3.5 million
Enhanced Funding from 1915 (k) Medicaid Plan	-$1.2 million	-$1.2 million
Obtain Federal Funding for Infant Development	-$13.2 million	-$13.2 million
1915 (i) New Expenditures	-$4.1 million	-$4.1 million
Total	**-$20.9 million**	**-$22.5 million**

Second, DDS proposes to reduce certain contracts as shown in the Table below. No issues have been raised regarding these reductions.

B. Reductions to Specified Contracts

Contract	2011-12 GF Reduction	2012-12 GF Reduction
Information Technology	-$545,000	-$545,000
Clients Rights Advocacy	-$200,000	-$200,000
Quality Assessment	-$424,000	-$424,000
Direct Support Professional Training	-$85,000	-$85,000
Office of Administrative Hearings	-$200,000	-$200,000
Risk Management	-$100,000	-$100,000
Self-Directed Service Training	-$200,000	-$200,000
Total	**-$1.7 million**	**-$1.7 million**

Third, DDS proposes reductions to the Regional Center Operations budget as shown in the Table below.

C. Reduction & Efficiency in Regional Center Operations

Regional Center Operations Area	2011-12 GF Reduction	2012-12 GF Reduction
Self-Directed Services Waiver—reduce staff	-$861,000	-$861,000
Community Placement Plan—reduce staff	-$315,000	-$315,000
Roll Back Prior Year Staffing Increase	-$1.9 million	-$1.9 million
Reduce Accelerated Waiver Enrollment	-$1.7 million	-$1.7 million
Administrative Efficiency—Electronic Billing	-$883,00	-$1.7 million
Eliminate one-time Office Relocation Funds	-$3 million	-$3 million
Unallocated Reduction	-$5.4 million	-$5.4 million
Total	**-$14.1 million**	**-$15 million**

Subcommittee Staff Comment and Recommendation-- Adopt. It is recommended to approve as contained in the May Revision the **(1)** reduction of $20.9 million (General Fund) due to increased federal funds; **(2)** reduction of $1.7 million (General Fund) from contracts as specified; and **(3)** reduction of $14.1 million (General Fund) from efficiencies and reductions to the Regional Center Operations.

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

1. DDS, Please provide a *brief descript* of the *key components* related to the receipt of federal funds, reduction to contracts and adjustments to the Regional Center Operations.

B. State Developmental Centers (DOF issues 100, 101,102,103,105, and 106)

1. Adjustments to Achieve $15 million (GF) Reduction Allocated by Legislature

Legislative Actions Contained in SB 69 Budget Bill. As referenced in the Table above on page 2, the Legislature reduced the Developmental Centers by a total of $39.5 million (General Fund).

This $39.5 million (General Fund) reduction consists of the following actions:

- o $30 million ($15 million General Fund) unallocated reduction;
- o $13.3 million ($6.8 million General Fund) and 140 Non-Level of Care positions associated with resident and program consolidations;
- o $6.6 million ($5.2 million General fund) through limiting equipment replacement, special repairs and other operations;
- o $2.1 million ($1.2 million General Fund) by reducing 28 positions from Lanterman Developmental Center to adjust for population reductions.
- o $2.7 million (General Fund) by deleting the Sonoma Developmental Center capital outlay project for medical gases; and
- o $8.6 million (General Fund) by deleting the Fairview Developmental Center fire alarm system.

Governor's May Revision. The May Revision recognizes the approach of the Legislature in the SB 69 Budget Bill and is proposing to conform to the above listed actions, *except for the $30 million ($15 million General Fund) reduction.*

Specifically, DDS has identified reductions in the May Revision to achieve the $30 million ($15 million General Fund) unallocated reduction. The proposed reductions are shown below.

May Revision: DDS Proposals for $15 million (General Fund)	2011-12 May Revision (General Fund)	2012-13 Projection (General Fund)
1. One-time staff savings in 2010-11, apply to 2011-12	-$1.4 million	--
2. One-time operations reduction in 2010-11 apply to 2011-12	-$2.2 million	--
3. Cap Secure Treatment at Porterville DC	-$5.1 million	-$10 million
4. Population Adjustment for 2011-12	-$3.2 million	-$3.2 million
5. Reduce Major Equipment	-$1.6 million	-$1.5 million
6. Reduce Janitorial Services	-$0.3 million	-$0.3 million
7. One-time staff adjustment at Lanterman DC	-$0.1 million	
8. One-time General Expense Reduction	-$1.1 million	
TOTAL Reduction	**-$15 million**	**-$15 million**

- Current-Year Reduction (-$3.6 million GF). A total reduction of $3.6 million (GF) one-time only is reflected due to May Revision adjustments to Developmental Center staffing and operations.

- Cap Secure Treatment at Porterville DC (-$5.1 million GF). Through trailer bill, DDS proposes to suspend admissions at Porterville Developmental Center for the "Secured Treatment Program" for a reduction of $5.1 million (General Fund) and 71 positions. The current cap at the Secured Treatment Program is 297 residents. The May Revision proposal would cap it at a total of 230 residents which includes those residents receiving services in the Porterville transition treatment program.

- May Revision Population Adjustment (-$3.2 million GF). The May Revision reflects an average in-center reduction of 31 residents (from 1,783 to 1,752) as compared to the January budget projection. This results in a reduction of $3.2 million (GF).

- One-Time Operating and Equipment Expenses (-$3.2 million GF). As noted in the Table above, the May Revision reflects several adjustments to reduce operating expenses.

- Technical Adjustment for Excess Reimbursement Authority. The May Revision also requests a technical adjustment to realign the reimbursement authority within the Developmental Centers Item by decreasing by $3.5 million (Reimbursements) to reflect the closure of the Primary Care Clinic and warm shut-down staffing.

Subcommittee Staff Comment and Recommendation. The DDS has responded to the Legislature's actions in SB 69 and the May Revision is consistent with its intent.

First, it is recommended to adopt the May Revision as proposed for the Developmental Centers, including *placeholder* language regarding the cap on Secure Treatment at Porterville Developmental Center.

In addition, it is recommended to *adopt uncodified placeholder trailer bill language* as follows:

> The Department of Developmental Services (DDS) shall reimburse the Office of Statewide Audits and Evaluations (OSAE) within the Department of Finance to conduct a review and analysis of the budget methodology, including relevant data, formulas and cost assumptions, used in determining the annual State budget for the Developmental Centers. The DDS shall provide information to the OSAE as necessary for them to complete their analysis and provide recommendations. It is the Legislature's intent for the DDS to notify the OSAE and to proceed with this analysis during the fall of 2011.

The uncodified placeholder trailer bill language is recommended in order to access the expertise of OSAE which has a myriad of fiscal, evaluation and audit expertise. OSAE has completed similar analyses previously, including a similar analysis regarding the State Hospitals administered by the Department of Finance.

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

1. DDS, Please provide a brief update on the continuing closure of Lanterman Developmental Center.

2. DDS, Please provide a summary of the proposed cost-containment for the Developmental Centers.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

September 2, 2011

1:00 PM *or* Upon Adjournment of Session

Room 4203

Discussion and Oversight of
Administration's Transition Plan for Adult Day Health Care Services

(Panel Discussion and Public Comment)

I. Presentation of Administration's Transition Plan for Services

- Secretary Diana Dooley, California Health and Human Services Agency
- Toby Douglas, Director, Department of Health Care Services
- Eileen Carroll, Deputy Director of the Adult Programs Division, Department of Social Services
- Ed Long, Deputy Director of Long-Term Care and Aging Services Division, Department of Aging
- David Maxwell-Jolly, Under Secretary, CA Health and Human Services Agency

2. Discussion and Comment on Administration's Transition Plan

- John F. Grgurina Jr. , Chief Executive Officer, San Francisco Health Plan
- Lydia Missaelides, Executive Director, California Association for Adult Day Services
- Cathy Davis, Executive Director, Bayview Hunters Point Multipurpose Senior Services

- David Friedman, Vice President State Health Programs, Health Net
- Debbie Toth, Chief Program Officer, Rehabilitation Services of North California
- Robert E. Edmonson, Chief Executive Officer, On Lok

3. Public Comment

Public Testimony is welcomed but may need to be limited by the Chair to accommodate all parties. Written comments are also encouraged.

PLEASE NOTE:

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

A complete package of materials for this hearing is available in the hearing room (Room 4203 of the State Capitol) as well as in the Senate Budget and Fiscal Review (SBFR) Committee office (Room 5019 of the State Capitol).

The Senate Budget and Fiscal Review Committee has posted its background materials on its website and the participating State Departments are encouraged to post their materials on their respective websites.

Senate Budget & Fiscal Review,

Subcommittee #3
On Health and Human Services

Senator Mark DeSaulnier, Chair

Discussion and Oversight of Administration's Transition Plan for Adult Day Health Care Services

Subcommittee Background Materials

(Diane Van Maren)

I. Summary of Actions Leading to the Need for a Transition Plan

A. Budget Actions: Funding, Vetoes, and State Statutory Changes.

Through extremely difficult budget deliberations from January through June, due to California's continuing fiscal crisis, Adult Day Health Care Services, considered an Optional Medicaid Benefit under federal law, is designated to be phased-out as of December 1, 2011.

In lieu of the Governor's original January proposal to eliminate services by June 1, 2011, the Legislature negotiated an appropriation of $170 million ($85 million General Fund) for the transition of Medi-Cal enrollees from receiving Adult Day Health Care services to other related supportive services. The Governor sustained this appropriation in the Budget Act and made a commitment to continue the $170 million ($85 million General Fund) as an on-going baseline appropriation within the Medi-Cal Program.

The Legislature sent three ADHC-related trailer bills to the Governor for signature—AB 97 (Omnibus Health Trailer), SB 91 (ADHC Licensure), and AB 96 (Keeping Adults Free from Institutionalization).

AB 97, Statues of 2011 was enacted as of March 24, 2011. With respect to ADHC services, this legislation (1) provides for the cessation of the Optional Medicaid Benefit upon approval of the federal Centers for Medicare and Medicaid (CMS); and (2) authorizes the DHCS to contract with public or private entities to assist individuals receiving ADHC services to transition to other Medi-Cal services, social services, and respite programs, or to provide social activities and respite assistance for individuals who were receiving ADHC services at the time the services were eliminated. This broad contracting authority was provided to the DHCS by the Legislature to assist in ensuring a smooth transition of individuals to other appropriate services. (See Member's Binder.)

SB 91 (ADHC Licensure), Statutes of 2011, delinks the requirement for Adult Day Health Care Centers to have Medi-Cal certification as a condition of their license. Thus, some centers could continue to operate if they are able to identify third-party payment sources (other than Medi-Cal).

Other trailer bill legislation—AB 96, as amended on June 8, 2011—was *vetoed* by the Governor. This legislation would have provided for the creation of the Keeping Adults Free from Institutions (KAFI) Program under a federal Waiver to utilize licensed Adult Day Health Centers to provide a well-defined scope of specified services for Medi-Cal enrollees who have been assessed to be at significant risk of institutionalization. Both the legislation and the Governor's veto message are contained in the Member's Binder.

B. Status of California Offering ADHC Optional Benefit in Medi-Cal Program

Cessation of ADHC Services as a Medi-Cal Benefit. As authorized in AB 97, Statutes of 2011, signed by the Governor in March, the DHCS submitted a State Plan Amendment to the federal CMS in May 2011 to eliminate the Optional Medicaid Benefit of ADHC services. A State must obtain federal CMS approval when it modifies its Medicaid (Medi-Cal) program. The federal CMS approved California's State Plan Amendment for cessation of ADHC services in July 2011 with an effective date of September 1, 2011.

However, the DHCS has administratively extended continuation of the Medi-Cal ADHC services benefit through November with a *revised elimination date of December 1, 2011* to facilitate the transition of Medi-Cal enrollees using ADHC services to other appropriate, publically provided services as referenced in the Administration's *Transition Plan* (Member's Binder) and as discussed further below.

ADHC Services for Individuals Accessing Regional Center Services. The Budget Act provides about $32 million ($16 million General Fund) to continue to provide ADHC services for individuals with developmental disabilities enrolled in the Regional Center system and administered by the State Department of Developmental Services. Individuals receiving services through the Regional Centers have an entitlement to services contingent upon appropriation. This budget estimate assumes there are about 4,000 individuals who will continue to receive services through the developmental services system.

Litigation. Class action litigation has been filed against the State which contends the State cannot legally eliminate the Medi-Cal Optional benefit of Adult Day Health Care Services *without first ensuring that an adequate transition plan is in place*, including that ADHC consumers will receive adequate, appropriate and uninterrupted replacement services necessary to prevent their institutionalization.

The original July 26th hearing date has been moved to November 1, 2011 as requested by the State (defendants) since elimination of the Medi-Cal Optional benefit of Adult Day Health Care Services is now scheduled for December 1, 2011. This revised elimination date is the result of administration action taken by the Director of the DHCS.

II. Key Issues to Consider with Administration's Transition Plan

A. Administration Intends Transition Plan to be Responsive and Dynamic

The Administration has convened two stakeholder meetings in Sacramento (May and August), along with other scheduled regional meetings, and has released a *Transition Plan*. (See Member's Binder and DHCS website.)

The Department of Health Care Services (DHCS) states that dialog on the *Transition Plan* and process is *ongoing* and will evolve to determine the best methods for delivery of care to individuals transitioning from ADHC services to other services. Further, the Administration notes the *Transition Plan* and process will be based on consumer's needs and is to take into account regional service delivery considerations and costs.

DHCS contends that considerable groundwork and planning has occurred and is continuing. Among other things, the Administration specifically notes the following:

- A *Transition Outreach Plan* has been developed which articulates the different aspects of ADHC consumer notifications (letters) and other related items. (See Member's Binder and DHCS website.)
- A *Transition Monitoring Plan* framework has been developed, with further details to follow, to monitor the transition of ADHC consumers over a two-year period. (See Member's Binder and DHCS website.)
- DHCS and the California Department of Aging (CDA) have reviewed over 8,000 Individual Plans of Care (IPC) for existing ADHC consumers who receive four to five days of ADHC services per week (i.e., high acuity consumers). This review has assisted the Administration in identifying the most prevalent diagnoses and range of services and is to be used by them to help identify the resources that may provide alternative services.
- Various Home and Community-Based Services are available for transitioning ADHC consumers, along with enrollment for case management and care coordination services (available in Medi-Cal Managed Care and through APS Health).
- DHCS to provide assistance to facilitate coordination between ADHC Providers and Medi-Cal Managed Care Health Plans.
- A smooth transition for ADHC consumers to other services is of key importance to the Brown Administration and multiple departments are engaged in its efforts.

Subcommittee Staff Comment—Provide Implementation Updates. Subcommittee staff would encourage the Administration to provide the Legislature and interested parties with an implementation update in September complete with key milestones and key activities which are pending completion and have been completed. Any geographic or regional service delivery adjustments should also be articulated in the suggested update. This information could be *updated periodically* as needed through-out the transition and posted on the DHCS website for easy access.

B. Key components and Processes to the Administration's Plan

The Administration's *Transition Plan* contains many components. Key aspects are briefly highlighted and discussed below. (See Member's Binder for *DHCS Schematic*, Administration's *Transition Plan*, and *DHCS Hearing Hand Out* for more detail).

- ***1. ADHC Consumer Discharge Planning.*** Discharge planning is a required component of the existing ADHC program. As part of the Transition Plan, the DHCS is to facilitate consumer discharge planning and will be working closely with ADHC Providers.

  Key aspects of the discharge planning process are to (1) assess the consumer's needs; (2) identify appropriate services to meet the transitioning consumer's needs; (3) identify appropriate providers in the geographic service area; and (4) link consumers to services based on need, availability and consumer choice.

  ADHC Providers are to receive *additional* reimbursement for each discharge plan completed as part of the transition.

  Questions. Details of this process are being developed by the Administration and further refinement is forthcoming. Questions include the following:

  - What specific proactive steps is the Administration taking to ensure successful discharge planning?
  - What will the additional reimbursement amount be for ADHC Providers?
  - How will the Discharge Planning process be linked to assessments or reassessments required for other services, such as In-Home Supportive Services (IHSS)?
  - How is the Administration going to monitor the Discharge Planning process?

- ***2. Enrollment in Medi-Cal Managed Care and Use of Care Management Company***. A key aspect of the Administration's *Transition Plan* is a focus on case management and care coordination through the enrollment of transitioning ADHC consumers into Medi-Cal Managed Care where applicable, *or* enrollment with APS Healthcare (a DHCS contractor).

  DHCS states that each ADHC consumer will be enrolled into Medi-Cal Managed Care as applicable, contingent upon their county of residence (i.e., Two-Plan Medi-Cal Managed Care counties, County Organized Health System (COHS) counties, Geographic Managed Care counties, or rural county), and whether *the ADHC consumer chooses to actively "opt-out"* of being enrolled into Medi-Cal Managed Care.

Under this “opt-out” enrollment process, if the ADHC consumer does not respond regarding enrollment into a Medi-Cal Managed Care health plan, then the DHCS will automatically enroll the ADHC consumer.

If an ADHC consumer chooses to *“opt-out”* of enrollment into a Medi-Cal Managed Care health plan, *or* later decides at any time to dis-enroll in the Medi-Cal Managed Care health plan, *or* lives in a rural area where Medi-Cal Managed Care is not available (about 675 consumers), *then* case management and care coordination would be conducted by APS Healthcare.

DHCS will be providing reimbursement to Medi-Cal Managed Care plans and APS Healthcare for their services. DHCS has stated that *initial* reimbursement to Medi-Cal Managed Care Plans is to be a *supplement of $60 per ADHC consumer enrollee* but that this reimbursement amount is to be further analyzed by the Administration and needs to be calculated by its actuaries and approved by the federal CMS. As such, this initial supplemental $60 reimbursement amount most likely will be adjusted.

DHCS notes that this supplemental reimbursement is in addition to the “per member per month” Medi-Cal Managed Care reimbursement that is paid to Health Plans for people who are enrolled into Managed Care. DHCS states that all Medi-Cal reimbursement rates are to be actuarially based.

<u>*Questions*</u>. Questions regarding this aspect of the Administration’s Transition Plan include the following:

- How will ADHC consumers be informed of their choices for Medi-Cal Managed Care enrollment or APS Healthcare enrollment?
- How may the DHCS utilize its existing Health Care Options contractor (Maximus) *or* the Health Insurance Counseling and Advocacy Program (HICAP) administered under the Department of Aging to facilitate ADHC consumer choice of plans and enrollment?
- Since 82 percent of ADHC consumers are “dual eligibles” (enrolled in Medicare as their primary plan and Medi-Cal as their secondary plan) and the DHCS is also embarking on a “Dual Eligible Pilot Project in Medi-Cal Managed Care” under the State’s 1115 Medicaid Waiver, how may the Administration’s Transition Plan for ADHC consumers interface with this pilot project?
- When may the reimbursement level be further clarified?
- How is the DHCS to monitor this aspect of the *Transition Plan*?

- ***3. Comprehensive Health Care Assessment Process.*** Under the Administration's Transition Plan, once an ADHC consumer is enrolled in *either* a Medi-Cal Managed Care health plan *or* with APS Healthcare, a comprehensive health care assessment is to be completed *within* 45-days of enrollment.

  Questions. Questions regarding this aspect of the Administration's *Transition Plan* include the following:

  - Can the involved Health Plans ensure this timely access to a comprehensive health care assessment? Are there any health network capacity concerns?
  - Is the intent of this comprehensive health care assessment to also address the need for other services, such as IHSS, or will additional assessments be necessary as well?
  - How may the DHCS monitor this aspect of the *Transition Plan*?

- ***4. Consumer Access to Services.*** The Administration states about 82 percent of ADHC consumers are eligible for Medicare *and* Medi-Cal. DHCS states that services provided to individuals receiving federal Medicare services will not be affected by the transition.

  DHCS states in the *Transition Plan* that Medi-Cal services will include, but not be limited to, the following:

  - All existing applicable Medi-Cal services such as physicians, clinic, non-emergency medical transportation, pharmacy, hospital outpatient, home health, mental health services, and acute inpatient services;
  - Additional transition services provided through Medi-Cal Managed Care or APS Healthcare including the following:
    - Health Assessment;
    - Case Management;
    - Care Coordination;
    - Registered Nurse Advice;
    - Referrals for services
  - Other Home and Community-Based Services including the following:
    - Medication Management
    - Program of All-Inclusive Care for the Elderly (PACE) where geographically available;
    - Senior Care Action Network (SCAN) Health Plan where geographically available;
    - Multipurpose Senior Service Program (MSSP) Waiver;

- In-Home Support Services (IHSS);
- In-Home Operations (IHO) Waiver;
- Nursing Facility Acute Hospital Waiver;
- Adult Day Program Services through the Department of Aging;
- Assistance through the Department of Developmental Services, which received increased total funds of $32.1 million for this purpose.

Questions. Questions regarding this aspect of the Administration's *Transition Plan* include the following:

- Is there appropriate access and availability of these various services for transitioning individuals? Will this vary geographically?
- Are any changes to existing Waivers or additional program slots necessary for ADHC consumers to access services? (Please be specific)
- How will consumers be linked to these various different services? Will Medi-Cal Managed Care Health Plans or APS Healthcare be providing assistance?
- How is the Administration (DHCS, Department of Social Services and Department of Aging) working with local providers and counties to coordinate access to services for transitioning consumers?
- How will the DHCS monitor access to services?

- ***5. Consumer Education and Outreach.*** The DHCS has developed an *Outreach Plan* which consists of (1) Beneficiary Outreach; (2) Provider and Community Outreach; (3) Health Plan Outreach; and (4) Public Meeting and Hearings. (See Member's Binder and DHCS website.)

  Questions. Questions regarding this aspect of the Administration's *Transition Plan* include the following:

  - What are the consumer education goals to ensure choice and continuity of needed health care?
  - What are the short-term and ongoing goals of this outreach?
  - How will the Administration measure its usefulness or know how to target/focus its outreach accordingly as the transition progresses?