Senate Budget and Fiscal Review

Subcommittee No. 3 2012 Agendas

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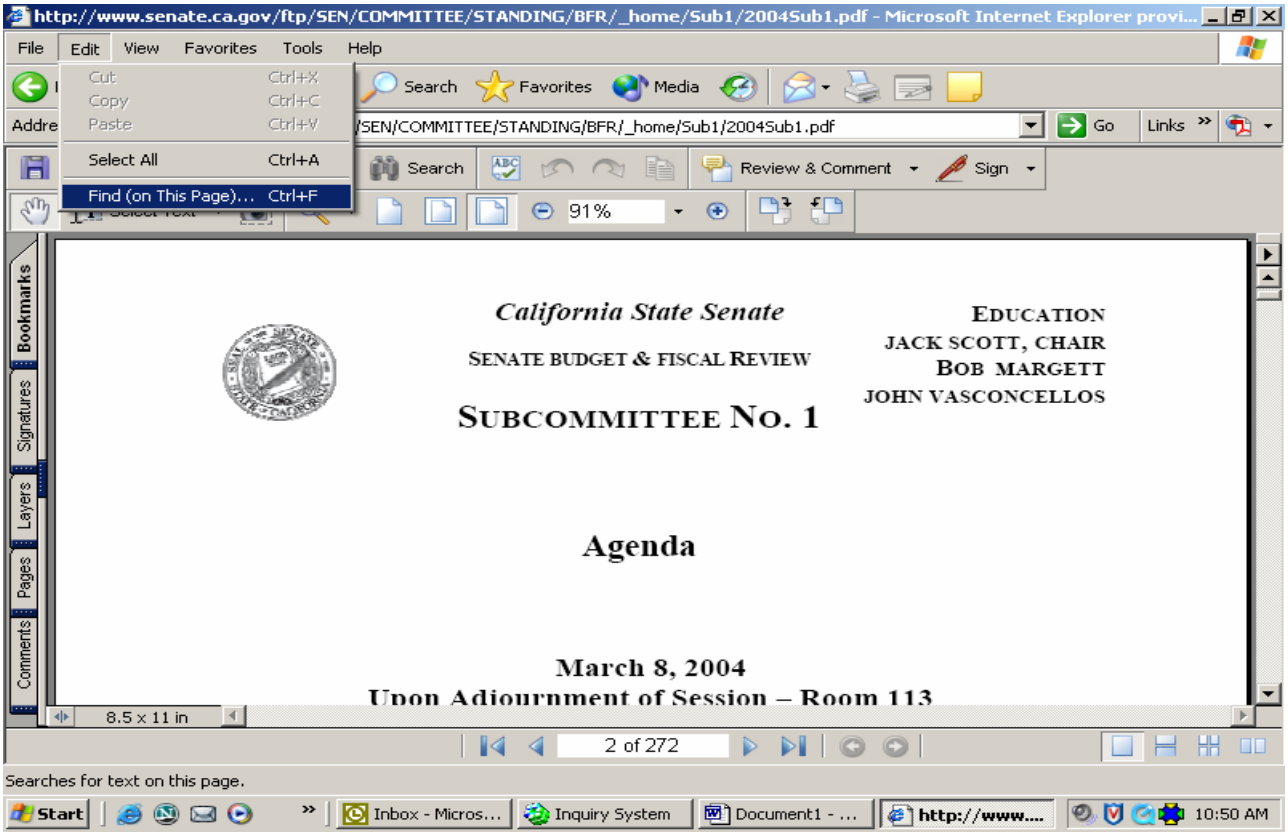

Joint Oversight Hearing

Assembly and Senate Health Committees
Assembly Budget Subcommittee No. 1 on Health and Human Services and Senate Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services

Tuesday, February 21, 2012, Upon Call of the Chairs – Room 4202

Restructuring the Behavioral Health System in California

This joint hearing of the Assembly Health Committee, the Senate Health Committee, the Assembly Budget Subcommittee No. 1 and the Senate Budget Subcommittee No. 3 will examine the implementation of budget and statutory changes related to community-based mental health and drug and alcohol services enacted through budget and health and human services budget trailer bill legislation in 2011, and the Administration's proposed mental health and substance use disorder budget changes for the 2012-13 budget.

Background on Mental Health and Substance Use Prevalence in California
As part of federal approval of California's 2010 "Bridge to Reform" Medicaid waiver, the Centers for Medicare and Medicaid Services (CMS) required California to submit a mental health and substance use needs assessment. This assessment is due to CMS on March 1, 2012, and a draft report was released for public review and comment on January 31, 2012. While the primary purpose of the needs assessment was to review the needs and service utilization of current Medi-Cal recipients and identify opportunities to prepare Medi-Cal for the expansion of enrollees and the increased demand for services resulting from health reform, but the draft report provides estimated prevalence for the entire state population. Findings of the statewide estimated prevalence from the draft report are as follows:

Youth (0-17) with serious emotional disturbance	7.56%
Adults with serious emotional disturbance	4.28%
Adults: broad definition of mental health need	15.85%
Youth (0-17) with substance use needs	2.7%
Adults (18+) with substance use needs	8.76%

In addition to the needs assessment, CMS required California to submit for CMS approval a detailed behavioral health services plan, including how the state will coordinate with the Department of Mental Health (DMH) and Department of Alcohol and Drug Programs (DADP) outlining the steps and infrastructure necessary to meet requirements of a benchmark plan no later than 2014. This plan is due to CMS by October 1, 2012. It is important to note that although substance use disorder (SUD) services were included in the assessment, SUD services were not made part of the 1115 waiver, and so are not being addressed in the "Bridge to Reform" in any direct way.

Background on California's Public Mental Health System
California has a decentralized public mental health system with most direct services provided through the county mental health system. The system of community-based mental health services was initiated through the Short-Doyle Act of 1957, which created a funding structure for the development of community-based mental health services. The purpose of the Short-Doyle Act was to develop a community-based system of services to improve care and encourage deinstitutionalization by providing state matching fund reimbursement for local mental health services. In 1968, the Lanterman-Petris-Short Act established standards for the involuntary treatment of individuals and increased the state funding participation rate for community mental health programs. Beginning with a pilot program in the early 1970s, Short-Doyle mental health program were allowed to draw down federal Medicaid matching funds to match their own funding to provide certain mental health services to Medi-Cal eligible individuals.

In response to state fiscal problems in the 1980s, the state began to reduce its General Fund commitment to mental health services. In 1990-91, the state faced an estimated $14 billion General Fund shortfall, and numerous programs, including mental health, faced reductions. In 1991, the Legislature passed and Governor Wilson signed into law AB 1288 (Bronzan and McCorquodale), Chapter 89, Statutes of 1991, which realigned the fiscal and administrative responsibility for county mental health care. The intent of mental health realignment was generally to provide a more stable funding source for community-based services, to shift program accountability to the local level, establish local advisory boards in each county to provide advice to local mental health directors, make services more client-centered and family-focused, develop performance measures and outcome data, and redefine the role of the state in providing services through the state hospital system and its responsibilities in program oversight and evaluation.

In 1992, realignment funding replaced about $700 million in state General Fund support for community mental health services. Realignment revenues, funded by an increase in the sales tax and in vehicle license fees, are collected by the state and allocated to various accounts and subaccounts in the Local Revenue Fund. The Mental Health Subaccount was the principal fund that contains revenues for the provision of local mental health services. These funds are distributed to the counties on a formula basis as contained in statute.

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA). Proposition 63 enacted a surcharge on incomes over $1 million annually, and dedicated the resulting revenue to expanding community mental health programs. The MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system, with the purpose of promoting recovery for individuals with serious mental illness.

Background on California's Substance Use Disorder Services
California's system for the provision of substance use disorder (SUD) services is primarily run at the county level, overseen by the Department of Alcohol and Drug

Programs (DADP). DADP administers the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, nearly $260 million in 2011-12 with a Maintenance of Effort requirement, and other discretionary grants from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the Parolee Services Network Program, Narcotic Treatment Program, Driving Under the Influence Program, Office of Problem Gambling, and Drug Court Programs. DADP also certifies and licenses SUD providers in the community and, until the transfer approved for 2011-12, administered the Drug Medi-Cal Treatment Program (DMC), which accounted for about a quarter of the functions at the Department.

DADP contracts with counties and direct service providers for the provision of DMC. County participation in DMC is optional, and counties may elect to provide services directly or subcontract with providers for these services. All but approximately 15 California counties currently maintain a program. If a county chooses to not participate in DMC and a certified provider within that county indicates a desire to provide these services, DADP currently executes a service contract directly with the provider.

The five covered services for the DMC program listed in Section 4.19B of California's Medicaid State Plan include:

- Day Care Rehabilitation Treatment - Minimum of three hours per day, three days per week, for EPSDT-eligible beneficiaries and pregnant and postpartum women only.
- Outpatient Drug Free Services – Individual counseling for 50-minute minimum or group counseling for 90-minute session.
- Perinatal Residential Substance Abuse Treatment – 24-hour structured environment, excluding room and board, for pregnant women and mothers.
- Naltrexone Treatment Services – Face-to-face contact per calendar day for counseling and/or medication services.
- Narcotic Treatment Services – Core services (intake assessment, treatment planning, physical evaluation, drug screening, and physician supervision), laboratory work (tuberculin and syphilis tests, monthly drug screening, and pregnancy tests for certain patients), dosing (ingredients and dosing for methadone and other patients).

Medi-Cal Managed Care plans exclude from their contracts all services available under the DMC Program as well as outpatient drug therapies that are listed in the Medi-Cal Provider Manual as alcohol and substance abuse treatment drugs, and reimbursed through the Medi-Cal fee-for-service program.

In 2000, California voters approved the Substance Abuse and Crime Prevention Act, or Proposition 36, which changed state law so that certain adult offenders who use or possess illegal drugs are sentenced to participate in drug treatment and supervision in the community rather than being sentenced to prison or jail, supervised on probation, or going without treatment. From 2001-02 until 2005-06, Prop. 36 provided annual appropriations of $120 million General Fund for related substance abuse treatment

programs. The Offender Treatment Program was an adjacent program, and the two programs were funded fully, then partially over the course of the next several years. The 2009-10 Budget included minimal federal funding and no General Fund for the programs. The two programs have remained with no funding since that time.

Drug court programs combine judicial monitoring with intensive treatment services over a period of about 18 months typically for nonviolent drug offenders. In general, these are county-administered programs through which the state provides funding and oversight. There are two main programs – the Drug Court Partnership Act program created in 1998 that supports adult drug courts in 32 counties and the Comprehensive Drug Court Implementation Act program created in 1999 that supports adult, juvenile, family, and some Dependency Drug Courts in 53 counties.

Overview of 2011 Realignment

In his first proposed budget for the 2011-12 fiscal year, Governor Brown called for a vast and historic realignment of government services in California. In his January 2011-12 budget summary, Governor Brown stated that realignment of government in California will allow governments at all levels to focus on becoming more efficient and effective. The Governor sought to more clearly define the role of the state and local government in service delivery. In his summary, the Governor stated the goal of realignment is to find the level of government where a service can best and most cost-effectively be delivered, and then provide a permanent funding source.

Through a series of budget bills and trailer bills, many provisions of the Governor's proposal to realign public safety and health and human services to counties were enacted into law. One of the primary vehicles for the 2011 Realignment is AB 118 (Committee on Budget), Chapter 40, Statutes of 2011, which transfers the equivalent of $5.569 billion of annual state fiscal responsibilities for "public safety programs" to counties. AB 118 also creates the account structure and allocations for some of this funding, and dedicates 1.0625 percent of existing state sales tax revenue to fund these local costs in 2011-12.

2011 Realignment and Mental Health Services

For the 2011-12 fiscal year only, AB 100 (Committee on Budget), Chapter 5, Statutes of 2011, amended the MHSA to allocate, on a one-time basis, $861 million in MHSA funds to counties to support the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, Medi-Cal specialty mental health managed care, and mental health services provided to special education students. In separate legislation, the mandate on county mental health departments to provide mental health services to special education students was repealed, thereby transferring the federal mandate to back to school districts.

EPSDT is a federally mandated program that requires the state to provide Medi–Cal beneficiaries under age 21 with any physical and mental health services that are deemed medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, including services not otherwise included in the state's Medicaid plan. Prior to the 2011 Realignment, the EPSDT program was funded by the General Fund and federal funds with the counties paying a 10-percent share of cost above a specified baseline.

County Medi-Cal specialty mental health managed care plans administer mental health managed care and are responsible for ensuring that Medi–Cal beneficiaries receive specialty mental health services. Under a federal waiver, specialty mental health services are "carved out" of the Medi–Cal Program administered by the Department of Health Care Services (DHCS), which provides physical health care. Prior to the 2011 Realignment, county specialty mental health plans were funded with 1991 realignment funds, state General Fund funds, and federal funds.

In addition to the one-time funding shift of MHSA funding, AB 100 also made changes to MHSA administration, including reducing the percentage amount available from MHSA revenues for state administration from 5 percent to 3.5 percent, requiring monthly distributions from the MHSA Fund, having the "state" (instead of DMH) administer the MHSA Fund, and having the Mental Health Services Oversight and Accountability Committee provide technical assistance to counties.

Administrative Transfer from DMH to Department of Health Care Services
In addition to the one-time fund shifts made by AB 100, AB 102 (Committee on Budget), Chapter 29, Statutes of 2011, transfers from DMH to DHCS, effective July 1, 2012, the state administrative functions for the operation of Medi-Cal Specialty Mental Health Managed Care, the EPSDT Program, and applicable functions related to federal Medicaid requirements. AB 102 states legislative intent that the transfer occur in an efficient and effective manner, with no unintended interruptions in service delivery to clients and families, and that the transfer accomplish improved access to culturally appropriate community-based mental health services; effectively integrate the financing of services to more effectively provide services; improve state accountabilities and outcomes; and provide focused, high-level leadership for behavioral health services within the state administrative structure.

AB 102 required DHCS, in collaboration with DMH and the California Health and Human Services Agency (Agency), to create a state administrative and programmatic transition plan, in consultation with stakeholders, that included specified components to guide the transfer of Medi-Cal specialty mental health managed care and the EPSDT Program to DHCS. DHCS was required to provide the transition plan to all fiscal committees and applicable policy committees of the Legislature by October 1, 2011. AB 102 required the state administrative transfer to conform to the state administrative transition plan provided to the Legislature. Finally, AB 102 also authorized the transition plan to also be updated by the Governor and provided to the Legislature upon its completion, but no later than May 15, 2012.

DHCS submitted the required transition plan, and two updates to that plan. Issues raised by stakeholders in the October 1, 2011 transition plan included the following:

- That DHCS improve business practices (examples include maximizing the claiming of federal funds; improving the claims reimbursement system, streamlining the cost reporting and settlement processes; eliminating redundancies in the provider certification process; facilitating same day billing for mental and

physical health care services; integrating audits; integrating information technology systems; and, reducing processing times);

- That DHCS assure access and improve services (examples include adopting community-based best practices, such as peer support and maximizing the use of social rehabilitation services; increasing the use of telepsychiatry; focusing on prevention and early intervention; ensuring state staff are knowledgeable about mental health services; assuring children's mental health policy expertise; assuring providers can continue to serve clients during and after the transfer; continuing progress in assuring cultural competence of services; addressing racial, ethnic, and cultural disparities in access to care and outcomes; reducing discrimination and stigma experienced by clients; eliminating disparity in access to services; integrating services; facilitating coordination with non-Medi-Cal mental health services; incentivizing the use of community settings; and assuring accountability in the mental health system and, of its providers and administrators);
- That DHCS ensure stakeholder participation (examples include providing regularly scheduled venues for regular stakeholder engagement; consulting with stakeholders on program changes, efficiencies, regulations, State Plan Amendments, and waiver amendments; engaging stakeholders in ongoing quality improvement, including county representation in assessment of legal issues and court decisions that require county implementation; facilitating stakeholder participation by funding travel to meetings; and, clearly identifying individuals that serve as state contacts for programs and services).

2011 Realignment and Substance Abuse Treatment

DADP was created in 1979 and is responsible for administering prevention, treatment, and recovery services for alcohol and drug abuse. California's statewide treatment, recovery and prevention network consists of public and private community-based providers serving approximately 230,000 people annually. The 2011 budget plan realigns several substance abuse treatment programs that were previously funded through the General Fund. The following are the major substance abuse treatment programs realigned:

- Regular and Perinatal Drug Medi–Cal. The Drug Medi–Cal program provides drug and alcohol–related treatment services to Medi–Cal beneficiaries. These services include outpatient drug free services, narcotic replacement therapy, day care rehabilitative services, and residential services for pregnant and parenting women.
- Regular and Perinatal Non Drug Medi–Cal. The Non Drug Medi–Cal program provides drug and alcohol–related treatment services generally to individuals, including women's and children's residential treatment services, who do not qualify for Medi–Cal.
- Drug courts. Drug courts link supervision and treatment of drug users with ongoing judicial monitoring and oversight. There are several different types of drug courts including: (1) dependency drug courts, which focus on cases involving parental rights; (2) adult drug courts, which focus on convicted felons

or misdemeanants; and (3) juvenile drug courts, which focus on delinquency matters that involve substance–using juveniles.

As part of the 2011-12 budget plan, funding for specific alcohol and other drug programs was shifted from the state to local governments through AB 118 and AB X1 16 (Committee on Budget), Chapter 13, Statutes of 2011. A total of about $184 million of DADP programs (Regular and Perinatal Drug Medi–Cal, Regular and Perinatal Non Drug–Medi–Cal, and Drug Courts) were shifted to the counties. Under the 2011 Realignment, funding for these programs is deposited into four separate subaccounts within the newly created Health and Human Services Account of the Local Revenue Fund 2011. Under Realignment 2011, state sales tax will comprise the dedicated revenue to support these programs, instead of the state General Fund.

Administrative Transfer from DADP to DHCS

In addition to the fund shifts in Realignment 2011, AB 106 (Committee on Budget), Chapter 32, Statutes of 2011 transferred the administrative functions for DMC Program that were previously performed by DADP to DHCS. DHCS, in collaboration with DADP, is required to develop an administrative and programmatic transition plan that includes specified components to guide the transfer of the DMC Program to DHCS. To inform the creation of the administrative and programmatic transition plan, DHCS and DADP are required to convene stakeholders to receive input from consumers, family members, providers, counties, and representatives of the Legislature concerning the transfer of the administration of DMC functions performed by DADP to DHCS.

AB 106 required DHCS to provide the transition plan to all fiscal committees and appropriate policy committees of the Legislature by October 1, 2011, and to provide additional updates to the Legislature during budget subcommittee hearings after that date, as necessary.

DADP submitted the required transition plan, and two updates to that plan. Issues raised by stakeholders that were incorporated in the October 1, 2011, transition plan, included the following:

- That the DMC Program transfer involve a program transformation by DHCS, and that the program transfer and stakeholder engagement present an opportunity to consider how the state can identify changes or efficiencies in services, policies and procedures;
- That DHCS ensure there would be no interruption or delay in claims processing during and after the transfer of the DMC Program;
- That DHCS review the treatment authorization request TAR process for fee-for-service medication services that interact with DMC Program to avoid TAR delays that result in the loss of treatment opportunities for beneficiaries and frustration for providers;
- That the DMC Program provider certification process affects access, and that DHCS evaluate the process and involve providers in the development and review of proposed changes;

- That benefits provided under the current DMC Program are outdated, and that services be augmented beyond the five services currently covered and include additional federally approved therapies (buprenorphine, Vivitrol and other new drugs);
- That benefits provided under the DMC Program include drug testing coverage and more, individual counseling; and allow for home counseling and intensive outpatient program service);
- That current regulations interfere with the delivery of appropriate health care, and that DHCS instead only follow federal requirements;
- That the provider application and certification process is duplicative and unnecessary and DHCS should instead rely on national accreditation;
- That DHCS evaluate and streamline the billing process, and allow same day billing if more than one service is provided in a single visit;
- That DHCS address problems with claiming denials; recoupment of funds; lengthy claims processing and reimbursement; and improve communication between the state and providers;
- That rate setting for the DMC Program remains a state function and that it not be delegated to counties;
- That DHCS review reporting requirements and eliminate cost reports; and,
- That DHCS retain experienced and expert staff in the field of substance abuse disorders, that DHCS have leadership that reports directly to the director, and that the program retain its dedicated focus and separate identity and not be engulfed by DHCS' current Medi-Cal program administration.

Governor's Budget Proposal for Community Mental Health

The Governor's budget proposes to eliminate the Department of Mental Health (DMH), establish the Department of State Hospitals to provide long-term care and services to individuals with mental illness at state hospitals, and redirect funding and positions for all remaining mental health services to other departments.

Specifically, in regards to community mental health, the budget proposes to:

1. Provide a permanent funding structure for 2011 Realignment (Medi-Cal specialty mental health managed care plan services and the EPSDT program).
2. Adopt trailer bill language to proceed with statutory changes necessary to transfer the administrative functions for Medi-Cal specialty mental health managed care plan services and the EPSDT program from DMH to DHCS.
3. Transfer the remaining non-Medi-Cal community health programs, including 58 positions and budget authority of $104.7 million ($16.3 million state operations, $88.3 million local assistance) ($15.6 million General Fund) from DMH to six other departments as described in the chart below. A description of some of these programs follows the chart.

As discussed previously, the reorganization of behavioral health began in 2011-12. The Administration intends that this proposal completes these efforts by transferring the remaining mental health programs to various state departments that perform related or

similar functions. The Administration believes the consolidation of mental health, substance use disorder, and physical health at DHCS will provide for a continuum of care for consumers in preparation for health care reform in 2014.

Behavioral Health Reorganization: Department of Mental Health Functions

FUNCTION OR PROGRAM	RECIPIENT DEPARTMENT POSITIONS/TOTAL FUNDING
Financial Oversight, Certification Compliance/Quality Improvement, MHSA State Level Issue Resolution, County Data Collection and Reporting, MHSA Statewide Projects (Suicide Prevention, Student Mental Health Initiative, Stigma and Discrimination Reduction Project), Co-Occurring Disorders, Veterans Mental Health, Substance Abuse and Mental Health Services Administration Block Grant, Projects for Assistance in Transition from Homelessness (PATH), Training Contracts – California Institute for Mental Health (CIMH), California Health Interview Survey (CHIS), Policy Management, MHSA Housing Program, Administrative Staff-Accounting, IT, California Mental Health Planning Council	**Department of Health Care Services** ($72.3 million ($256,000 General Fund) 41.0 Positions
Office of Multicultural Services Disaster Services and Response	**Department of Public Health** ($2.3 million Mental Health Services Fund) 4.0 Positions
Licensing/Quality Improvement (Mental Health Rehabilitation Centers, Psychiatric Health Facilities)	**Department of Social Services** ($1.1 million ($337,000 General Fund) 12.0 Positions
Early Mental Health Initiative	**Department of Education** ($15 million General Fund) 0.0 Positions
MHSA Workforce Education and Training (WET)	**Office of Statewide Health Planning and Development** ($12.3 million Mental Health Services Fund) 1.0 Positions
Training Contracts – Consumer Groups, MHSA Technical Assistance, MHSA Program Evaluation	**Mental Health Services Oversight and Accountability Commission** ($1.7 million Mental Health Services Fund) 0.0 Positions

Programs to be transferred to the Department of Health Care Services

The majority of existing community mental health programs and functions are proposed to be transferred to a new Division of Mental Health and Substance Use Disorders Services within DHCS, concurrent with the proposed transfer of most state-level programs within DADP, which is also proposed to be eliminated. In addition to the transfer of these programs, the Administration proposes to create a new Deputy Director, Mental Health and Substance Use Disorder Services, who would lead this new division. The new Deputy Director would be a Governor's Appointee and would require Senate confirmation.

Oversight of Certain MHSA Components. DHCS would be responsible for the financial oversight of MHSA funds (although the exact responsibilities have not yet been determined) and the collection of data relating to certain MHSA programs (Full Service Partnerships). In addition, DHCS would be responsible for MHSA state-level issue resolution which is a process by which consumers and stakeholders have a mechanism to resolve issues related to MHSA. And finally, DHCS would be responsible for MHSA Statewide Prevention and Early Intervention Projects (Suicide Prevention, Student Mental Health Initiative, and Stigma and Discrimination Reduction Programs).

Oversight of Federal Grants. In addition, DHCS would be responsible for the oversight and administration of federal mental health funds including the SAMHSA Block Grant and the Projects for Assistance in Transition from Homelessness (PATH). The SAMHSA block grant can be used to establish or expand an organized community-based system of care for providing non-Medi-Cal mental health services to children with serious emotional disturbances and adults with serious mental illness. The state administers this block grant and allocates the funds each year to 58 local county mental health agencies. The county mental health departments and contracted providers deliver a broad array of treatment and support services that include over 150 individual programs supported by the block grant. PATH funds community-based outreach, mental health and substance abuse services, case management, and limited housing services for people experiencing serious mental illness who are experiencing homelessness or are at risk of becoming homeless.

Oversight of Contracts, Certification Compliance, and Other Mental Health Programs. Finally, DHCS would be responsible for the oversight of certain administrative and training contracts related to the above-mentioned programs, the certification of mental health treatment programs, and the coordination of efforts related to veteran's mental health and co-occurring disorders.

Programs to be transferred to the Department of Public Health

Office of Multicultural Services. The Office of Multicultural Services (OMS) was established in 1998 and provides direction to DMH for promoting and establishing culturally and linguistically competent mental health services within the public mental health system through actions targeted both within and external to DMH. The OMS works with community partners to eliminate racial, ethnic, cultural, and language disparities within mental health programs and services.

The Administration proposes to consolidate the OMS at DMH into the proposed Office of Health Equity at the Department of Public Health. The budget proposes to create the new Office of Health Equity by consolidating OMS, the Department of Health Care Services' Office of Women's Health, and the Department of Public Health's Office of Multicultural Health, Health in All Policies Task Force, and Healthy Places Team. The Administration's intention is to create a more

comprehensive and integrative approach to better address issues of health disparity and promotion of healthy communities.

Disaster Services and Response. The Disaster Services Unit is responsible for the statewide coordination of disaster mental health responses to major disasters in support of local mental health agencies. This includes the development and maintenance of the mental health section of the State Emergency Plan and training and technical assistance to local mental health agencies on planning, preparedness, and mitigation for a disaster.

Program to be transferred to the Department of Social Services

Licensing and Quality Improvement. The DMH licenses mental health rehabilitation centers (MHRCs) and psychiatric health facilities (PHFs). MHRCs provide community-based intensive support and rehabilitation services designed to assist persons, 18 years or older, with mental disorders who would have been placed in a state hospital or another mental health facility to develop the skills to become self-sufficient and capable of increasing levels of independent functioning. There are currently 20 MHRCs with a total of 1,363 beds.

PHFs offer acute inpatient psychiatric treatment to individuals with major mental disorders in a nonhospital setting. PHFs mainly provide acute psychiatric treatment services to individuals subject to involuntary commitment under the Lanterman-Petris-Short Act. There are 25 PHFs in California with 432 beds.

Program to be transferred to the Department of Education

Early Mental Health Initiative. The EMHI is a school-based program funded with Proposition 98 funds; the Administration believes that being located within the Department of Education will provide the most opportunity for the program to leverage additional resources.

Program to be transferred to the Office of Statewide Health Planning & Development (OSHPD)

MHSA Workforce Education and Training. The MHSA workforce education and training component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. OSHPD currently operates the Loan Assumption Program and the Administration believes it has the existing infrastructure, experience and technical ability to effectively monitor grants and program activities. The Administration also states that this transfer will increase efficiency, reduce duplication and align the program with health care reform planning.

Program to be transferred to the Mental Health Services Oversight & Accountability Commission (MHSOAC)

Training Contracts for Consumer Groups, Technical Assistance, and Program Evaluation. The Administration states that these functions are consistent with the role of the MHSOAC, per the changes adopted in AB 100 and

that placing these functions within the MHSOAC will reduce duplication as the MHSOAC currently has similar contracts with stakeholder entities.

Issue to Consider

Placement of Community Mental Health Functions in Other Departments
Community mental health programs are proposed to be transferred to six different departments. Careful consideration must be made to ensure that the proposed placement of these programs makes sense and can be carried out effectively by the proposed department. For example, the Administration is proposing to transfer the licensing of mental health facilities to DSS. However, DSS is not currently involved in the licensing of health facilities. Rather, DPH is currently responsible for the licensing of health facilities in the state. It is not clear why the Administration has proposed to transfer this function to DSS rather than DPH, which already performs a similar function.

Incorporation of Stakeholder Input on Reorganization
The Administration facilitated a series of stakeholder meetings in various locations throughout the state during the summer of 2011 in order to seek input on the transfer of Medi-Cal programs from DMH to DHCS. According to the Administration, stakeholders also provided input on the proposed transfer of non-Medi-Cal mental health programs and functions. According to the DMH Community Mental Health Stakeholder Summary Report, stakeholders generally had concerns in the following five areas: (1) state-level executive leadership for community mental health is essential and that mental health expertise not be lost with the shifting of mental health functions away from DMH, (2) the benefits and challenges to local control, (3) the importance of cultural competence leadership and reducing disparities, (4) protecting the integrity of the Mental Health Services Act, and (5) the importance of the role of mental health consumers and their families. An alternative proposed by some stakeholders is the creation of a single state agency that oversees community mental health and substance use disorder programs mirroring the federal government structure. How the Administration's proposal addresses these key concerns needs to be evaluated during the budget subcommittee processes.

Key Pieces of Information Not Yet Available
Details on proposed changes to certain key state oversight functions are not yet available. For example, AB 100 eliminated state approval of county MHSA plans; however, as contained in AB 100, the Legislature expects the state to establish a more effective means of ensuring county performance compliance with the MHSA. Information on this new process is not yet available.

Similarly, as discussed earlier in this document, as part of the stakeholder meetings, participants highlighted the opportunity to consider how the state can identify changes or efficiencies in services, policies, and procedures for community-based mental health programs. How or if the Administration plans to address these concerns and potential opportunities for programmatic improvement is still unclear.

According to the Administration, this proposed consolidation not only offers the potential for administrative efficiencies, but also has the potential to offer fuller integration of health and behavioral health care services to consumers in need of these critical services. The state's 1115 Medicaid Waiver, federal health care reform, and the Mental Parity Act of 2008 also offer constructive opportunities for a more inclusive and comprehensive delivery model. However, careful deliberation between the Administration, mental health advocates and providers, Medi-Cal county specialty mental health plans, and the Legislature must occur to ensure a thoughtful and transparent reorganization.

Governor's Budget Proposal for Alcohol and Drug Programs

Outstanding Transition Efforts Affecting Alcohol and Drug Programs

Related to efforts discussed previously in this background paper, in regard to substance use disorder (SUD) services, the Governor's budget for 2012-13 proposes to:

1. Provide a permanent funding structure for the programs that were part of the 2011 Realignment, specifically Drug Medi-Cal Treatment Program (DMC Program), Non Drug Medi-Cal, and Drug Courts.

   Trailer bill language on a superstructure for realignment has yet to be received from the administration and issues with the realignment implementation for the current year are still coming forward from counties and stakeholders.

2. Propose trailer bill language to proceed with statutory changes necessary to transfer the administrative functions for the DMC Program from DADP to DHCS.

   The administration recently released its proposed trailer bill language. Stakeholders are reviewing it and reacting with issues and questions around governance, rates, contracts, and regulatory control. Further discussion and review of this trailer bill will follow, as will oversight over how the DMC Transition Plan aligns with the trailer bill, what issues stakeholders have in addition to what is captured in the Plan, and how monitoring, oversight, and corrective action for the DMC transfer, effective July 1, 2012, will occur.

Further Proposal to Eliminate DADP

The Governor's budget for 2012-13 additionally proposes to eliminate DADP entirely effective July 1, 2012 and redirect funding and positions for certain SUD services to other departments. This proposal would transfer the remaining non-Medi-Cal SUD programs, including 231.5 positions and budget authority of $322.103 million ($32.166 million state operations, $289.937 million local assistance) ($34.069 million General Fund) from the DADP to three departments as described in the chart below. A description of programs affected follows the chart.

The Administration states that the proposal follows the actions taken previously for DADP in the 2011-12 Budget and that the transfer of remaining departmental responsibilities to other state departments will integrate activities within those new placements.

Administration's Proposal: Department of Alcohol and Drug Program Functions

FUNCTION OR PROGRAM	RECIPIENT DEPARTMENT POSITIONS/TOTAL FUNDING
Administration of SAPT Block Grant and other SAMHSA Discretionary Grants, Data Collection Function, Reporting and Analysis, Statewide Needs Assessment and Planning, Program Certification, Technical Assistance and Training, Substance Abuse Prevention Activities, Resource Center, Parolee Services Network	**Department of Health Care Services** $305.572 million ($285.937 local assistance, $19.635 state operations) 161.5 Positions
Counselor Certification, Narcotic Treatment Programs, Driving Under the Influence Programs, Office of Problem Gambling	**Department of Public Health** $12.002 million ($4.0 local assistance, $8.002 state operations) 34.0 Positions
Program Licensing	**Department of Social Services** $4.529 million (all state operations) 36.0 Positions

Programs to be transferred to the Department of Health Care Services

The majority of SUD programs and functions, described below, are proposed to be transferred to a new Division of Mental Health and Substance Use Disorders Services within DHCS, concurrent with the proposed transfer of most state-level programs from DMH, which is also proposed to be eliminated. In addition to the transfer of these programs, the Administration proposes to create a new Deputy Director, Mental Health and Substance Use Disorder Services, that would lead this new division. The new Deputy Director would be a Governor's Appointee and would require Senate confirmation.

Administration of the SAPT Block Grant. DHCS would be responsible for the financial oversight of the Substance Abuse Prevention and Treatment (SAPT) Block Grant. DADP is the Single State Authority designee for receiving and administering the SAPT Block Grant. The SAPT Block Grant, ADP's largest source of federal funding, supports the state's prevention, treatment and recovery network. Ninety-two percent of the funding is allocated to local communities through county allocations and technical assistance and training contracts; a minimum of 20 percent of the Block Grant funds must be spent on primary prevention services. DADP is responsible for ensuring that SAPT Block Grant requirements are achieved and reported annually in each year's SAPT Block Grant application. Many of the requirements have significant fiscal consequences if they are not met and, therefore, require careful monitoring by various branches within DADP.

Administration of other SAMHSA Block Grants. Further information on these block grants was not provided by the Administration at the time of this writing.

Data Collection, Reporting and Analysis. Further information on the specific functions and tasks associated with this set of activities was not provided by the Administration at the time of this writing.

Statewide Needs Planning and Development. Pursuant to SAPT Block Grant requirements, DADP generates an annual Needs Assessment Report, which analyzes treatment and prevention data as well as prevalence, consumption and consequence trend data. The report identifies service needs and gaps in California's publicly funded system. This systematic needs assessment is instrumental in developing local and statewide plans and establishing data-informed policies for federal and state allocations.

Program Certification. Further information on this was not provided by the Administration at the time of this writing.

Technical Assistance and Training. Further information on this was not provided by the Administration at the time of this writing.

Substance Abuse Prevention Activities. The DADP Program Services Division (PSD) is responsible for policy development and monitoring of comprehensive statewide prevention, treatment and recovery systems to prevent, reduce, and treat SUD problems. PSD consists of Prevention, Treatment and Recovery Services. The PSD Prevention Services' stated mission is to develop and maintain a comprehensive statewide prevention system to prevent and reduce substance use problems, and to improve the health and safety of the citizens of California by:

- Modifying social and economic norms, conditions, and adverse consequences resulting from alcohol, tobacco and other drugs availability, manufacturing, distribution, promotion, sales, and use; and,
- Effectively addressing at-risk and underserved populations and their environments.

The SAPT Block Grant requires a minimum of 20 percent of the state's grant award to be expended on primary prevention services. The six primary prevention strategies include:

- Alternatives;
- Community-Based Process;
- Education;
- Environmental;
- Information Dissemination; and,
- Problem Identification and Referral.

Resource Center. The DADP Resource Center (RC) has four statewide lines of business: (1) the RC Call Center responds to requests for information and makes treatment/information referrals to counties, (2) the Clearinghouse distributes Alcohol and other Drug (AOD) informational materials across the state to individuals, schools, organizations, including faith-based organizations, and state

agencies as well as to conferences, (3) the RC operates the state AOD prevention and treatment website with downloadable materials and develops special sections for evolving issues such as alcoholic energy drinks, and (4) the Lending Service holds almost 6,000 unique AOD materials for statewide use.

Parolee Services Network (PSN). The PSN provides community-based alcohol and drug treatment and recovery services to parolees in 17 California counties. It is administered jointly by ADP and the California Department of Corrections and Rehabilitation (CDCR). The program design provides up to 180 days of treatment and recovery services. Funding is provided by CDCR. The PSN places parolees in appropriate AOD treatment and recovery programs, either from the community parole systems or immediately upon release from prison custody. The goals are to improve parolee outcomes as evidenced by fewer drug-related revocations and related criminal violations, to support parolee reintegration into society by encouraging a clean and sober lifestyle, and to reduce General Fund costs for incarceration and parole supervision.

Programs to be transferred to the Department of Public Health

Counselor Certification. DADP approves certifying organizations (COs) which register and certify individuals to provide AOD counseling. Each CO must meet regulatory requirements in order to remain an approved CO.

Narcotic Treatment Programs (NTP). DADP currently has the sole authority to license NTPs. NTPs provide replacement narcotic therapy in outpatient, medically supervised settings to people addicted to opioids. Services include, but are not limited to, replacement narcotic medication and counseling. DADP monitors these clinics and programs, and ensures federal Drug Enforcement Agency requirements are met.

Driving Under the Influence (DUI) Programs. DADP currently has sole authority to license DUI programs. DADP's role is to issue, deny, suspend or revoke licenses of DUI alcohol and drug education and counseling programs. The purpose of the DUI program is to reduce the number of repeat DUI offenses by providing a state-licensed DUI program for offenders, and to provide participants an opportunity to address problems related to the use of alcohol and/or other drugs. Annually, DUI programs serve an average of 150,000 clients. The county board of supervisors, in concert with the county alcohol and drug program administrators, determines the need for DUI program services and recommends applicants to the state for licensure. DADP licenses programs, establishes regulations, approves participant fees and fee schedules, and provides DUI information.

Office of Problem Gambling. The Office of Problem Gambling (OPG):

- Administers a statewide toll-free problem gambling helpline providing crisis management and referrals to treatment services.

- Develops a strategic plan for periods of five years in collaboration with the OPG Advisory Group.
- Provides technical assistance and training to health care professionals, educators, non-profit organizations, gambling industry personnel and law enforcement agencies related to the signs and symptoms of problem gambling behavior and available resources.
- Conducts outreach to multi-cultural and vulnerable populations (such as youth and seniors) to educate about problem gambling behavior and negative consequences.
- Coordinates annual Problem Gambling Awareness Week Campaign.
- Conducts research to determine efficacy of programs and ensure the delivery of evidence-based practices.
- Initiates innovative problem gambling programs including evaluation components to deliver ground breaking services.
- Administers the California Problem Gambling Treatment Services Program, delivering a continuum of services including telephone interventions, outpatient, intensive outpatient and residential care.
- Trains and authorizes licensed multi-lingual therapists throughout the state to ensure access to care.
- Develops program standards in policies and procedures and assures accountability through on-site provider compliance monitoring reviews.
- Collects, analyzes and disseminates treatment client demographics and outcomes data.

Program to be transferred to the Department of Social Services

Program Licensing. DADP currently has sole authority to license facilities located in California which provide 24-hour residential non-medical services to adults with problems related to AOD abuse which require AOD treatment services. DADP certifies programs for the DMC Program. DADP offers voluntary AOD certification to residential and non-residential programs which exceed minimum levels of quality and are in compliance with state standards.

Issues to Consider

History of Proposal. As summarized earlier, the 2011-12 Budget included the realignment of SUD services and the transfer of state administrative functions for the operations of the DMC Program to DHCS. At the same time that these proposals were being contemplated in May 2011, the Administration proposed to also eliminate DADP, as it is again proposing now. The Legislature chose at that time to reject the elimination proposal for several reasons, including timing of the proposal and lack of a full vetting with the Legislature and stakeholders. Little detail on the planning and process for the proposed elimination and transfer was provided at that time.

Current Proposal Lacks Detail. The current elimination proposal lacks detail on (1) the rationale for the elimination and what real program outcomes are goals for the reorganization, (2) the readiness and appropriateness of receiving departments to take on

the DADP positions, functions, and oversight, (3) accountability and transparency in the implementation of this elimination and transfer, and (4) assurances that the elimination and shifting will not disrupt services for consumers, patients, and providers dependent on current DADP functions. Stakeholder reaction to the proposal and the reflection of any feedback from stakeholders within the proposal is unknown at this time. Policy and oversight considerations require time and attention, and are further challenged without a detailed proposal.

Fiscal Assessment. The proposal from the Administration contains no cost savings as a result of the DADP elimination and attendant transfer of all functions to three departments. Without a thoughtful, thorough transition plan to understand how this transfer would occur over a phased-in period and under what principles and terms, it is difficult for the Legislature to evaluate the Administration's claim that the proposal is cost neutral, as it is possible that the transition may produce costs within government. Stakeholders, including counties, providers and consumers, may also face increasing costs as their services and programs are affected by new relationships with new departments, offices, and bureaus in place of their current relationships with DADP.

Questions for the Administration

Current Year

AB 102 Implementation

(1) AB 102 (Committee on Budget), Chapter 29, Statutes of 2011 states that the transfer of Medi-Cal mental health from the Department of Mental Health (DMH) to the Department of Health Care Services (DHCS) is intended to improve access to culturally-appropriate community-based mental health services, integrate the financing of services to more effectively provide services, improve state accountabilities and outcomes, and provide high-level leadership focused on behavioral health services within the Administration. How have the transition plans accounted for these goals?

(2) What are the key outstanding milestones related to the transition of Medi-Cal specialty mental health? What risks might the Administration face in meeting these milestones?

(3) What steps have been taken to address the concern, frequently expressed during stakeholder meetings, that reimbursements may be interrupted during the transition period and its aftermath?

AB 106 Implementation

(4) AB 106 (Committee on Budget), Chapter 32, Statutes of 2011 authorized the transfer of administration of the Drug Medi-Cal Treatment Program and applicable federal Medicaid functions from the Department of Alcohol and Drug Programs (DADP) to DHCS, effective July 1, 2012, and required DHCS to submit a transition plan to guide the transfer in a manner that results in no unintended interruptions in service delivery to clients and families, as well as improve access to the service and more effectively integrate financing, among other primary goals. How have the transition plan and its attendant updates accounted for these goals?

(5) What progress has been made toward a seamless transfer of the program by July 1, 2012, and what issues does the Administration foresee as key outstanding or delayed tasks and milestones that the Legislature needs to be made aware of at this time?

(6) What steps have been taken to address the issues in program administration, billing, and the benefit structure for the Drug Medi-Cal Treatment Program frequently raised by stakeholders?

AB 102 and AB 106

(7) For the programs realigned last year, what is the Administration's view on providing programmatic flexibility to counties to provider higher or lower level of services or different reimbursement structures than under current law, versus requiring counties to operate these programs consistent with past practices?

(8) For the mental health and substance use disorder programs that were realigned last year, how does the state envision it will change oversight of service delivery?

(9) One of the themes in the stakeholder comments referenced in the transition plans is that DHCS should use the transition to improve current processes. Please describe what program practices DHCS will change as part of assuming administrative responsibility over transferred programs.

Budget Year

Consolidation

(10) Why integrate DMH and DADP in the manner that has been proposed?

(11) How does the Administration plan to avoid interruptions of mental health and substance use disorder services during the proposed departmental restructuring?

(12) Many stakeholders view this transition as a time to identify changes or efficiencies in services, policies, and procedures; how does the Administration plan to address these potential changes or efficiencies?

Oversight

(13) How will DHCS evaluate the effectiveness of county mental health service delivery systems and substance use disorder programs and contracts?

(14) With the elimination of state approval of county Mental Health Services Act (MHSA) plans, how is the state going to establish an effective means to ensure county performance that complies with the MHSA?

(15) Given the movement of DADP functions to several departments under the proposal, what interdepartmental entity or bridges will be created to monitor substance use disorder services across state government and ensure that there is coordination where possible?

Licensing & Quality Improvement

(16) What is the Administration's rationale for transferring the DMH licensing and certification of Mental Health Rehabilitation Centers (MHRCs) and Psychiatric Health Facilities (PHFs) to the Department of Social Services (DSS) rather than the Department of Public Health (DPH)?

(17) What is the rationale for the splitting of licensing and certification functions for substance use disorder providers between DSS and DPH? How will coordination of these functions operate under this scenario?

(18) How will the Administration ensure that DSS licensing staff, who review facilities that are often more custodial in nature, have the requisite training and expertise to review MHRCs and PHFs, facilities that are uniquely designed for individuals with serious mental illness? In the same vein, what readiness exists at DSS to evaluate outpatient substance use programs and 24-hour residential services providers of substance use services?

Leadership

(19) What is being done to recruit candidates to fill the critical new high level leadership position(s)? Is the proposed pay structure adequate to attract competitive candidates?

(20) Are the new positions and organization chart designed for the transfer of both Medi-Cal and non-Medi-Cal programs in 2012-13?

Workforce

(21) A new statewide five-year plan on Workforce, Education, & Training is required by statute. As the Governor has proposed to transfer all Mental Health Service Act (MHSA) Workforce, Education, & Training functions to the Office of Statewide Health Planning & Development (OSHPD), how will OSHPD work with the Mental Health Planning Council in developing the next 5-year plan?

Federal Block Grant

(22) The Administration's proposal includes movement of Substance Abuse Prevention and Treatment (SAPT) Block Grant administration to DHCS. The grant requires an annual Needs Assessment and Planning Report which analyzes treatment and prevention data, as well as prevalence, consumption, and consequence trend data that identifies alcohol and other drug services needs and gaps in California's system. How will these duties fare under the elimination proposal and what exact steps are in place to assure that the requirements of the grant are met and that the grant is administered properly?

Health Equity

(23) The Governor proposes to transfer the DMH Office of Multicultural Services and related contracts to a new "Office of Health Equity" at the DPH, while both Medi-Cal Specialty Mental Health and MHSA – which are proposed to be transferred to DHCS – are similarly charged with ensuring cultural competency and reducing disparities. How will DPH work collaboratively with DHCS to prevent overlapping or redundant requirements related to the promotion of health equity?

(24) Does the Administration intend to make any changes to the state-level expenditures currently used to support DMH contractors? For example, the contracts for consumer and family member organizations, including those that represent ethnic and cultural communities?

(25) What goals does the Administration have for the improvement in quality of and access to substance use services? How will these be measured and on what timeline?

Questions for Counties, Providers and Consumers

Current and Budget Year

(26) What are your primary concerns with the Administration's proposals to reorganize mental health and substance use disorder programs?

(27) What, if any, information about the proposed reorganization have you been waiting for from the Administration in order to evaluate its effects on the group(s) that you represent?

(28) What have you learned from the ongoing efforts to transfer Medi-Cal related mental health and Drug Medi-Cal Treatment Program functions that can inform what the Administration is proposing to do to further change how mental health and substance use disorder services are administered?

(29) What are your main questions or concerns for the July 1, 2012 transfer that the Legislature and Administration should be made aware of at this time?

(30) Do you think the proposed reorganization will make it easier for you to work with the state?

(31) What program regulations, practices and policies would you like to see changed if DMH and DADP are merged with DHCS?

(32) What state-level organization of these programs and services would be best for consumers? If this involves a transfer, what transfer process and timeline would you recommend?

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

March 8, 2012

10:30 AM or
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

(Michelle Baass)

PLEASE NOTE:

Only those 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 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

8885 Commission on State Mandates

1. SIDS Autopsies

Budget Issue. The Administration proposes to repeal the SIDS Autopsies mandate that requires counties to conduct autopsies on infants who die suddenly and to use state protocols and forms related to Sudden Infant Death Syndrome. The Administration finds that this should be standard operating procedure. This mandate has been suspended since 2003.

Subcommittee Staff Recommendation—Make mandate permissive. Adopt trailer bill language to make this mandate permissive, so that counties may follow the state protocols if they choose to without any reimbursement from the state.

2. SIDS Contacts by Local Health Officers

Budget Issue. The Administration proposes to repeal the mandate that requires local health officers to provide information on counseling and support services to the guardian of an infant who has died from Sudden Infant Death Syndrome. The Administration finds that this should be standard operating procedure. This mandate has been suspended since 2003.

Subcommittee Staff Recommendation— Make mandate permissive. Adopt trailer bill language to make this mandate permissive, so that counties may provide SIDS support services without any reimbursement from the state.

3. Perinatal Services

Budget Issue. The Administration proposes to repeal the mandate that requires local health county practitioners to establish protocols between county health departments, county welfare departments, and all hospitals in the county regarding a substance-exposed infant, and to submit an assessment of needs. The Administration finds that this mandate should be repealed because counties have broad authority to establish protocols for the provision of services to substance-exposed infants. This mandate has been suspended since 2009.

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

4140 Office of Statewide Health Planning and Development

The Office of Statewide Health Planning and Development (OSHPD) collects and disseminates information about California's healthcare infrastructure, promotes an equitably distributed healthcare workforce, and publishes information about healthcare outcomes. OSHPD also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to facilitate the capital needs of California's not-for-profit healthcare facilities.

Budget Overview. The budget proposes expenditures of $116.5 million ($74,000 General Fund and $1.4 million federal funds) and 473.6 positions for OSHPD.

Workforce Cap Plan. Pursuant to Executive Order S-01-10, Control Section 3.90 of the Budget Act of 2010, Budget Letters 10-31 and 10-38, OSHPD was required to reduce its budget by 4 positions and $2.1 million ($17,000 General Fund). This executive order called for all departments to take immediate steps to cap the workforce by achieving an additional 5 percent salary savings by July 1, 2010 and maintain the additional salary savings. The WCP savings were measured by personal services dollars, not personnel years.

1. Song-Brown Health Care Workforce Training Program

Budget Issue. The Governor's Budget proposes a $5 million General Fund reduction to reflect permanent funding for the Song-Brown Primary Care Practitioner Training program from the California Health Data and Planning Fund (CHDPF).

Furthermore, due to CHDPF's significant balance, the Administration is also proposing a reduction in the assessment rate on hospitals and long-term care facilities that support the CHDPF. The annual assessment rate to hospitals and long-term care facilities would be reduced from 0.034 percent to 0.027 percent for hospitals and 0.025 percent for long-term care facilities.

Background. The Song-Brown Program plays a critical role in improving access to health care for California's low-income and uninsured population. There are approximately nine million Californians living in medically underserved areas, with few or no primary healthcare providers. The Song-Brown Program is responsible for increasing the number of family practice physicians, primary care physician's assistants (PA), family nurse practitioners (FNP), and registered nurses (RN) to address access to health care and the critical health workforce shortages.

The Song-Brown Program partners with accredited Family Practice Residency Training Programs and Physician Assistant, Family Nurse Practitioner, and Registered Nurse programs as well as hospitals and other health care delivery systems to increase the number of students and residents training in primary care. By providing financial support via a competitive grant

program to these training and education programs, the Song-Brown Program increases the supply of primary care providers practicing in California's underserved areas.

Prior to 2008-09, the Song-Brown Program was funded 30 percent from the CHDPF and 70 percent from the General Fund. Since 2008-09, the Song-Brown Program has been funded 100 percent from the CHDPF through annual legislative or administrative proposals and the fund is able to permanently support the costs of this program.

Subcommittee Staff Comment and Recommendation—Approve. Funding the Song-Brown Program at 100 percent from the CHDPF saves $5 million General Fund each fiscal year and sustains funding for valuable health workforce education and training programs that provide a critical source of health care services to California's rural and low-income communities.

DEPARTMENTS FOR DISCUSSION

2400 Department of Managed Health Care

I. BACKGROUND

The Department of Managed Health Care (DMHC) was established in 2000, when the licensure and regulation of the managed health care industry was removed from the Department of Corporations and placed in a new, standalone, department.

The mission of DMHC is to regulate, and provide quality-of-care and fiscal oversight for Health Maintenance Organizations (HMOs) and two Preferred Provider Organizations (PPOs). These 125 health care plans provide health insurance coverage to approximately 61 percent of all Californians. DMHC is also responsible for the oversight of 200 Risk Bearing Organizations (RBOs), who deliver or manage a large proportion of the health care services provided to consumers.

Within DMHC, the Office of the Patient Advocate helps educate consumers about their HMO rights and responsibilities.

Assembly Bill 922, Chapter 552, Statutes of 2011 transfers DMHC to the California Health and Human Services Agency (CHHSA) from the Business, Transportation, and Housing Agency effective July 1, 2012. Additionally, AB 922 transfers the Office of Patient Advocate (OPA) to CHHSA effective July 1, 2012 and adds additional duties and responsibilities to OPA effective January 1, 2013. These changes will be discussed at a future subcommittee hearing.

Budget Overview. The budget proposes expenditures of $53 million ($51.1 million from the Managed Care Fund, $755,000 federal funds, and $1.2 million in reimbursements from the Managed Risk Medical Insurance Board and the Department of Health Care Services) and 349.6 positions for DMHC.

Workforce Cap Plan. Pursuant to Executive Order S-01-10, Control Section 3.90 of the Budget Act of 2010, Budget Letters 10-31 and 10-38, DMHC was required to reduce its budget by 5 temporary help positions and $1.3 million (Managed Care Fund) by permanently downgrading 16 positions to lower level positions, eliminating temporary help spending, freezing overtime, and reducing Career Executive Assignment position salary. This executive order called for all departments to take immediate steps to cap the workforce by achieving an additional 5 percent salary savings by July 1, 2010 and maintain the additional salary savings. The WCP savings were measured by personal services dollars, not personnel years.

II. ISSUE FOR DISCUSSION

1. Premium Rate Review Cycle II Federal Grant

Budget Issue. The DMHC requests 2 two-year limited-term positions and an increase of federal expenditure authority of $755,000 for 2012-13, $691,000 for 2013-14, and $72,000 for 2014-15 to administer the Health Insurance Premium Rate Review Cycle II Federal Grant.

These positions and spending authority would be used to enhance DMHC's capabilities in collecting premium rate data, improving rate filing requirements, enhancing the rate review process, reporting data to the federal government, and disclosing rate information to consumers.

Background. The Affordable Care Act of 2010 (ACA) makes several fundamental changes to the private health insurance market including a wide variety of provisions designed to promote accountability, affordability, quality, and accessibility in the health care system. The ACA directs states to establish a formal process for the annual review of health insurance premiums to protect consumers from unreasonable rate increases. To support this, the federal government established grant opportunities that states may apply for to help develop or improve and enhance their current health insurance rate review process.

On September 30, 2010, California passed SB 1163 as conforming legislation to begin aligning California's laws with the ACA. With the passage of ACA and SB 1163, Knox-Keene licensed full-service health plans are now required to file premium rate data for their individual, small employer, and large employer products with DMHC and DMHC is required to review these premium rate filings for unreasonable premium rate increases and issue guidance regarding compliance.

In August 2010, DMHC applied for and received a federal grant (Cycle I) in the amount of $1 million to be shared with the California Department of Insurance. DMHC received $608,000 of this grant. These funds were used to (1) implement the National Association of Insurance Commissioner (NAIC) System for Electronic Rate and Form Filing, (2) enhance DMHC's information technology capacity to support rate review activities, (3) enhance DMCH's website, (4) provide transparency of rate filing information and allow public comments on rate filings, and (5) obtain actuarial services. The Cycle I grant ended December 31, 2011.

In September 2011, DMHC was awarded a Cycle II grant of $2.1 million for October 1, 2011 through September 30, 2014.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended for approval.

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

1. Please provide a brief summary of the proposal.

2. Oversight of Medi-Cal Managed Care Plans

Oversight Issue. A December 2011 report by the Bureau of State Audits (BSA) found that DMHC (1) has inconsistencies in the financial reviews it conducts of Medi-Cal managed care plans run by county entities under the two-plan model (local initiatives), (2) does not have an effective process to monitor local initiatives' response to corrective action plans that result from its financial examinations, and (3) fails to conduct medical audits (intended to review aspects of the provision of health care).

The DMHC concurred with most of the audit findings and recommendations. It is in the process of developing corrective actions, which are expected to be completed by October 31, 2012.

Additionally, recent press articles have outlined severe issues with Medi-Cal Dental Managed Care in Sacramento. The articles highlighted that children may be forced to wait months or even years before receiving needed dental treatment. Some of these concerns focus on DMHC's lack of enforcement to ensure timely access to dental care.

Background. The DMHC is responsible for ensuring that managed health care plans, including local initiatives, are financially viable and comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975. The Knox-Keene Act requires DMHC to conduct a routine medical survey of each licensed full service and specialty health plan at least once every three years. The survey is an evaluation of the plan's compliance with the law in the following areas: quality management, grievances and appeals (member complaints), access and availability, utilization management, and overall plan performance in meeting enrollees' health care needs.

Subcommittee Staff Comment. The DMHC and the Department of Health Care Services share oversight responsibility for Medi-Cal managed care plans. The issues raised by the audit and the recent press articles raise concern as to whether or not the state is prepared to proceed with further Medi-Cal managed care expansions, as proposed in the budget (and to be discussed at a later Subcommittee hearing).

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

1. Please discuss DMHC's role in monitoring Medi-Cal Managed Care plans and "specialty" plans such as dental and vision.

2. Please discuss how DMHC shares the information it receives regarding health plan complaints with the Department of Health Care Services and how DMHC follows-up regarding these complaints.

3. Please discuss how DMHC and DHCS coordinate their oversight of Medi-Cal managed care plans and where there are opportunities for improvement.

4260 Department of Health Care Services

1. BACKGROUND

DHCS finances and administers a number of individual health care service delivery programs, including the California Medical Assistance Program (Medi-Cal), California Children's Services program, Child Health and Disability Prevention program and Genetically Handicapped Persons Program. DHCS also helps maintain the financial viability of critical specialized care services, such as burn centers, trauma centers and children's specialty hospitals. In addition, DHCS funding helps hospitals and clinics located in underserved areas and those serving underserved populations.

DHCS programs are designed to (1) deliver health care services to low-income persons and families who meet defined eligibility requirements, (2) emphasize prevention-oriented health care measures that promote health and well-being, (3) ensure access to comprehensive health services through the use of public and private resources, and (4) eEnsure appropriate and effective expenditure of public resources to serve those with the greatest health care needs.

Summary of Funding for the Department of Health Care Services. The budget proposes expenditures of about $61 billion ($15.4 billion General Fund and $33.8 billion in federal funds) for the DHCS and 3,381 positions.

Workforce Cap Plan (WCP). Pursuant to Executive Order S-01-10, Control Section 3.90 of the Budget Act of 2010, Budget Letters 10-31 and 10-38, DHCS was required to reduce its budget by $13.4 million. This executive order called for all departments to take immediate steps to cap the workforce by achieving an additional 5 percent salary savings by July 1, 2010 and maintain the additional salary savings. The WCP savings were measured by personal services dollars, not personnel years.

2. ISSUE FOR DISCUSSION

1. Genetically Handicapped Persons Program (GHPP)

Budget Issue. The budget proposes total expenditures of $97.3 million ($63.3 million General Fund, $25.5 million federal funds, $8 million Rebate Fund, $436,000 Enrollment Fees). 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.

Subcommittee Staff Comment and Recommendation—Hold Open. This estimate assumes that the 10 percent provider payment reductions (as required by AB 97, Chapter 2, Statutes of 2011) would be implemented in February 2012 and would be retroactive to June 1, 2011. These reductions are under court injunction and have not been applied. DHCS indicates that it will update this estimate in the May Revise.

No other issues have been raised regarding this estimate.

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

1. Please provide a brief update on GHPP.

2. Child Health and Disability Prevention (CHDP) Program

Budget Issue. The budget proposes total expenditures of $2.4 million ($2.3 million General Fund, and $32,000 Children's Lead Poisoning Prevention Funds). This reflects technical fiscal adjustments and caseload only.

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 facilitates enrollment into more comprehensive health care coverage, when applicable, via the CHDP gateway.

Subcommittee Staff Comment and Recommendation—Hold Open. This estimate assumes that the 10 percent provider payment reductions (as required by AB 97, Chapter 2, Statutes of 2011) would be implemented in February 2012 and would be retroactive to June 1, 2011. These reductions are under court injunction and have not been applied. DHCS indicates that it will update this estimate in the May Revise.

No other issues have been raised regarding this estimate.

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

2. Please provide a brief update on CHDP.

3. California Children's Services (CCS) Program

Budget Issue. The DHCS proposes trailer bill language to apply financial eligibility requirements to qualify for the CCS Medical Therapy Program (MTP).

These financial eligibility requirements would be:

- A family income ceiling of $40,000 per year adjusted gross income (AGI) OR
- An estimated annual CCS related medical expenses in excess of 20 percent of family AGI

These financial requirements are the same as those used to qualify a child for CCS diagnosis and treatment services.

The proposal would result in annual savings of $21.9 million ($10.9 million General Fund and $11 million county funds) as 4,779 of 24,433 children receiving CCS MTP would not qualify under the proposed financial eligibility requirements.

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 and young adults, aged 21 years and under, 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.

State law establishes a family income ceiling of $40,000 per year adjusted gross income (AGI) or estimated annual CCS related medical expenses in excess of 20 percent of family AGI in order for a child to be financially eligible for CCS diagnosis and treatment services, but does not require an income standard for the CCS MTP.

The CCS is the oldest managed health care program in the state and the 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.

CCS MTP. The CCS MTP provides physical therapy, occupational therapy, and medical therapy conference services to children who meet specific medical criteria. These services are provided in an outpatient clinic setting known as the Medical Therapy Unit (MTU) that is

located on a public school site. Currently, 24,433 CCS children are served by 125 school based MTUs operated by county CCS programs. Therapists at these sites are employed by the county.

Of these children, 14,273 have an Individual Education Program (IEP) under the provisions of the federal Individuals with Disabilities Education Act (IDEA). Schools are responsible for *educationally* necessary therapy services covered by a child's IEP, and the CCS MTP is responsible for *medically* necessary therapy services covered by a child's IEP.

Summary of CCS Budget Appropriation. The budget proposes total expenditures of $237 million ($68.3 million State Funds, $112.9 million federal Healthy Families Program funds, $49.4 million federal funds from the Safety Net Care Pool, $6.4 million federal Title V Maternal and Child Health Funds) and reflects a decrease of $25.7 million (total funds) as compared to the revised current-year.

As a "county-realignment" program, the DHCS estimates that counties will provide about $111.7 million in County Funds for their share of the CCS Program.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further discussions regarding the interaction between the CCS MTP and school IDEA requirements.

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

1. Please provide a brief overview of CCS MTP.

2. Please provide an overview of this proposal.

4265 Department of Public Health

I. BACKGROUND

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

According to the DPH, their goals include the following:

- ✓ Achieve health equities and eliminate health disparities
- ✓ Eliminate preventable disease, disability, injury, and premature death
- ✓ Promote social and physical environments that support good health for all
- ✓ Prepare for, respond to, and recover from emerging public health threats and emergencies
- ✓ Improve the quality of the workforce and workplace

The department comprises five public health centers, as well as the Health Information and Strategic Planning section, and the Public Health Emergency Preparedness Program. The five public health centers are as follows:

(1) Center for Chronic Disease Prevention and Health Promotion
(2) Center for Environmental Health
(3) Center for Family Health
(4) Center for Health Care Quality
(5) Center for Infectious Disease

Summary of Funding for the Department of Public Health. The budget proposes expenditures of $3.4 billion ($124.8 million General Fund) for the DPH as noted in the Table below and 3,807 positions. Most of the funding for the programs administered by the DPH comes from a variety of federal funds, including grants and subventions for specified areas (such as drinking water, emergency preparedness, and Ryan White CARE Act funds). Many programs are also funded through the collection of fees for specified functions, such as for health facility licensing and certification activities. Several programs are funded through multiple sources, including General Fund support, federal funds, and fee collections.

Of the amount appropriated, about $668.7 million is for state operations and $2.758 billion is for local assistance. The budget for 2012-13 reflects a net decrease of $76.8 million as compared to the revised 2011-12 budget.

Workforce Cap Plan (WCP). Pursuant to Executive Order S-01-10, Control Section 3.90 of the Budget Act of 2010, Budget Letters 10-31 and 10-38, DPH was required to reduce its budget by 171.5 positions and $14.2 million ($2.7 million General Fund) in associated funding for salaries and wages and operating expense and equipment. This executive order called for

all departments to take immediate steps to cap the workforce by achieving an additional 5 percent salary savings by July 1, 2010 and maintain the additional salary savings. The WCP savings were measured by personal services dollars, not personnel years.

Summary of Expenditures for Department of Public Health (dollars in thousands)	**2012-13**
Public Health Emergency Preparedness	**$101,971**
Public and Environmental Health	**$3,125,211**
Chronic Disease Prevention and Health Promotion	283,682
Infectious Disease	579,611
Family Health	1,776,824
Health Information and Strategic Planning	27,279
County Health Services	16,362
Environmental Health	441,453
Licensing and Certification Program	**$200,487**
Licensing and Certification of Facilities	187,288
Laboratory Field Services	13,199
Total Program Expenditures	**$3,427,669**
Funding Sources	
General Fund	$124,805
Federal Funds	$1,998,122
Genetic Disease Testing Fund	$114,885
Licensing and Certification Fund	$87,415
WIC Manufacturer Rebate Fund	$227,000
AIDS Drug Assistance Program Rebate Fund	$246,432
Water Security, Clean Drinking Water, Beach Protection Fund	$102,864
Safe Drinking Water Account of 2006	$56,196
Childhood Lead Poisoning Prevention Fund	$22,428
Radiation Control Fund	$23,218
Food Safety Fund	$7,499
Reimbursements	$244,146
Other Special Funds (numerous)	$172,659
Total Funds	**$3,427,669**

II. VOTE ONLY

1. Childhood Lead Poisoning Prevention Branch – Conversion to State Staff

Budget Issue. The DPH requests to retain 22 positions from the Workforce Cap Plan in lieu of existing contracts of $2.8 million to support the childhood lead poisoning prevention program. The workload includes: the monitoring of 45 state-supported childhood lead prevention programs in local jurisdictions which ensure appropriate care of lead-exposed children; surveillance activities, including providing that at-risk children are screened (blood test) for lead; ensuring universal laboratory reporting of all blood tests to Childhood Lead Poisoning Prevention Branch, so that lead-exposed children are identified; seeing that sources of lead exposure that are found are corrected; and providing administrative support for these functions.

The proposal will save approximately $381,000 (Childhood Lead Poisoning Prevention Fund) annually.

It should be noted that DPH has been phasing-in State civil service positions over a period of time (commencing in 2008-09).

Subcommittee Staff Comment and Recommendation—Approve. This proposal is consistent with state law (Government Code 19130) that prohibits the use of contract staff to perform work that civil service staff can perform. It is recommended for approval. This proposal has no impact on the General Fund.

2. Early Case Capture of Pediatric Cancers

Budget Issue. The DPH seeks $342,000 in federal expenditure authority annually for three years to support grants received by the Centers for Disease Control and Prevention to enhance the California Cancer Registry infrastructure to facilitate more rapid reporting of pediatric cancer cases and to increase availability of these data for surveillance activities at the local, state, and national level.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended for approval.

3. Reduction of Domestic Violence Training and Education Fund

Budget Issue. The DPH requests a reduction in ongoing spending authority for the Domestic Violence Fund by $280,000 due to a decrease in anticipated revenues. Revenue generated from fines levied against convicted batterers and deposited into the Domestic Violence Fund has declined for a variety of reasons, including a reduction or waiver of fines by local courts, or inability of batterers to pay fines due to poor economic circumstances. No changes to staffing are being requested.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended for approval.

4. Radiation Safety Program

Budget Issue. The DPH requests to establish as permanent 5 limited-term Health Physicist positions that expire on June 30, 2012; these positions are funded from the Radiation Control Fund ($672,000). This proposal would provide resources for DPH to address the mandated inspected and enforcement activities within the radiation machine and radioactive materials programs and reduce the health risk to the people of California by limiting their exposure to unsafe radiation sources.

Radioactive Machine Inspection Program. Three positions would be located in the Radioactive Machine Inspection Program and would continue to meet existing workload needs. These positions perform X-ray inspections, perform compliance reviews, handle enforcement actions, and investigation of radiologic exposure. According to DPH, this proposal would allow DPH to continue to inspect 900 more X-ray machines annually and investigate 10 additional allegations or medical events.

Radioactive Materials Inspection Program. Two positions would be located in the Radioactive Materials Inspection Program and would continue to meet existing workload. According to DPH, this proposal would allow DPH to continue to perform 80 radioactive materials licensee inspections and 50 investigations and enforcement activities currently being performed by the two limited-term positions.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended for approval.

5. Environmental Laboratory Accreditation Program

Budget Issue. The DPH requests a decrease in budget authority of $450,000 for the Environmental Laboratory Improvement Fund. The fees from the implementation of the Environmental Laboratory Accreditation Program are deposited into this fund. These accreditation fees have decreased in recent years and the department is requested to align its expenditure authority with revenues.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended for approval.

III. ISSUE FOR DISCUSSION

1. AIDS Drug Assistance Program (ADAP)

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 issues regarding AIDS Drug Assistance Program funding for 2012-13. These key issues are as follows:

a. Base-line Estimate for ADAP
b. Institution of New Client Cost-Sharing Policy for ADAP for a net reduction of $14.49 million
c. Transition of ADAP Clients to Low Income Health Program

a. Baseline Estimate for ADAP

Comparison of Current-Year & Budget Year. The Office of AIDS (OA) estimates that 39,146 people living with HIV/AIDS will receive drug assistance through ADAP in 2012-13, or a decrease of 2,741 clients over the current year. The budget estimates expenditures of $403.8 million which reflects a *net* decrease of $78 million as compared to the revised current year.

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

Fund Source	Revised Current Year	Proposed Budget Year	Difference
General Fund	$5.785 million	$6.445	$660,000
AIDS Drug Rebate Fund	$283.184 million	$245.520 million	-$37.664 million
Federal Funds – Ryan White	$118.797 million	$102.572 million	-$16.225 million
Reimbursements from Medicaid Waiver	$74.064 million	$49.300 million	-$24.393 million
Proposed New Premiums		-$16.486 million	
Total	**$481.830 million**	**$403.837 million**	**-$77.993 million**

Revised Current Year General Fund. OA attempts to minimize the need for General Fund support by maximizing the use of special funds, and federal funds. Consequently, the 2011 Budget Act General Fund expenditures of $82.6 million have been revised to $5.8 million. The *net* decrease of $76.8 million in General Fund is due to:

- A projected decrease based on updated actual expenditure information (as a result of the new Pharmacy Benefit Manager Contract including lower transaction fees, higher split fee savings and lower drug reimbursement rates and ADAP counting towards TrOOP)
- The transition of ADAP clients to the Low Income Health Program
- The receipt of additional federal funds
- An increase in special fund expenditure authority

Discussion of Funding Sources & General Fund Shifts. Historically, three funding sources have supported ADAP: General Fund, 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.

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. A total of $74 million (Reimbursements from DHCS—federal funds) was identified for current year and $49.3 million for budget year.

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 drug manufacturers through the ADAP Taskforce). *Generally,* for every dollar of ADAP drug expenditure, the program obtains 48 cents in rebates. This 48 percent level is based on an average of rebate collections (both "mandatory" and "supplemental" rebates).

Background: Federal HRSA Maintenance of Effort (MOE) 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 2011 HRSA grant award is $140 million; therefore, the state match requirement for 2011-12 is $69.3 million. Additionally, HRSA requires grantees to maintain HIV-related expenditures at a level that is not less than the prior fiscal year. California's MOE target, based on 2009-10 expenditures, is $502.5 million.

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—Hold Open. Several concerns have been raised regarding the ADAP estimate particularly in regards to the timeline for the transition of ADAP clients to the Low Income Health Program (LIHP) and the estimated savings resulting from this transition. The OA estimates that beginning January 1, 2012, ADAP clients in the first ten counties initiating their LIHPs would begin to transition from ADAP to LIHP. However, Alameda and Los Angeles counties have delayed the implementation of their LIHPs until July 1, 2012. These counties serve potentially two-thirds of the eligible population, and consequently should not be reflected in the current year transition.

The Administration indicates that the ADAP estimate does not account for the updated schedule of LIHP implementation. It will update this estimate in the May Revision.

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

1. Please provide a *brief* description of the *baseline* ADAP budget.

b. Institution of New Client Cost-Sharing Policy for ADAP

Budget Issue. The budget proposes changes to ADAP's cost-sharing by instituting a monthly premium estimated to generate $16.47 million in revenue from ADAP clients. These revenues are offset by $2 million in expenditures for administrative costs associated with the monthly premium.

Therefore, a net reduction of $14.49 million in program expenditures is assumed from this effort. Trailer bill language is required for this action and a July 1, 2012, 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, ADAP-Medi-Cal clients, and Medicare Part D clients would have the *highest* premium payment. For Medicare Part D clients, the cost-sharing obligation excludes clients reaching catastrophic coverage, those dually enrolled in Medicare and Medi-Cal with no Medi-Cal share-of-cost, and all others who qualify for full-subsidy Medicare.

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

Table: Administration's Cost-Sharing Methodology for ADAP Only, ADAP-Medi-Cal, and Medicare Part D Clients

Percent of Federal Poverty Level	Income Range	Share of Cost	Number of Clients Impacted
0-100%	Up to $10,890	None	11,314
101-200%	$10,891 - $21,780	5 percent of gross income	9,736
201-300%	$21,781 - $32,670	7 percent of gross income	7,048
301% to ADAP Maximum	$32,671 - $50,000	10 percent of gross income	4,008

These share-of-costs percentage are the maximum allowable under federal law.

Private Insurance clients would have a *smaller* premium payment of two percent of gross income. 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.

Table: Summary of 2012-13 Fiscal Projections

	ADAP	Medi-Cal	Medicare Part D	Private Insurance	Total
Share of Cost Rate	5 / 7 / 10 %	5 / 7 / 10 %	5 / 7 / 10 %	2%	-
Percent of ADAP Clients	54.2% (21,230)	1.3% (505)	24.9% (9,744)	19.6% (7,667)	100% (39,146)
Revenue	$11,667,464	$202,486	$2,151,901	$2,453,113	$16,474,964
Expenditure Savings	$50,209	$23,030	$244,863	$472,668	$790,770
Rebate Loss	-$7,782	$0	-$186,096	-$586,108	-$779,987
Administration	-$1,389,180	-$18,638	-$175,361	-$416,992	-$2,000,171
Total	$10,320,710	$206,878	$2,035,307	$1,922,681	$14,485,577

The OA estimates about $780,000 in Expenditure Savings. This is a result of the estimated 2,692 ADAP clients that will leave the program because the ADAP SOC will exceed their monthly drug costs.

Background: ADAP Eligibility and Current Cost-Sharing. Eligible individuals receive drug therapies through participating local pharmacies under subcontract with the Pharmacy Benefit Manager (PBM). 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.

ADAP clients with incomes between $43,561 (401 percent of poverty) 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.

LAO Recommendation. The Legislative Analyst's Office (LAO) recommends approval of the Administration's proposal to increase the share of cost borne by ADAP clients due to the state's fiscal situation, not on a policy basis. The LAO also suggests that the Legislature could impose a lower level of cost sharing than the level proposed under the Governor's plan.

Subcommittee Staff Comment. The Administration submitted a similar proposal last year and it was rejected by the Legislature. Under this proposal, the level of cost-sharing is substantially beyond the level of income for individuals enrolled in the program. This could cause some ADAP clients to drop out of the program because they cannot afford to pay the increased costs; and consequently, they would stop taking their medications. Research indicates that increases in drug copayments reduces medication compliance.

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.

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

1. Please provide a brief description of the proposal and how it would operate.

2. What may the consequences of this approach be?

c. Transition of ADAP Clients to the Low Income Health Program (LIHP)

Oversight Issue. Concerns have been raised that OA's oversight and engagement in the transition of ADAP clients to LIHP has been inadequate. Counties that are implementing LIHPs are struggling with little or no guidance from OA on the LIHP transition. (Currently eight counties have implemented LIHP.) Consequently, clinics and providers serving persons with HIV do not have information to ensure treatment is not interrupted.

For example, LIHP drug formularies may not include anti-retrovirals that were covered under the ADAP formulary. Not all clinics are aware that all medically necessary drugs are required to be provided under LIHP (per federal regulations) even if they are not covered under the LIHP formulary. A lack of guidance and clarity such as this may cause interruptions in drug treatments.

Furthermore, on March 1, the system that is used to enroll individuals into ADAP was updated to include the ability to track ADAP client enrollment in LIHP. Counties were given less than a day's notice regarding these changes and not provided any training or guidance on how to operationalize these changes.

OA has indicated that it will routinely work with the eight counties to identify ADAP clients that have been enrolled in LIHP and required as an interim process for ADAP enrollment workers to notify the ADAP statewide pharmacy benefit manager (Ramsell Public Health Rx) that a client has been enrolled in LIHP, yet it is unable to provide an estimate for the number of ADAP clients that have transitioned to LIHP.

Background. People with HIV living in California have received coordinated medical outpatient care through Ryan White Parts A, B, C, and D, with pharmaceuticals provided largely from ADAP, funded by Ryan White Part B, General Fund, and rebate funds.

LIHP. As part of California's Bridge to Reform section 1115 Medicaid Demonstration, counties are implementing LIHP. The LIHP consists of two programs: Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). MCE will provide coverage for very-low income adults with incomes under 133 percent of the FPL and its federal funding through the waiver is capped. HCCI is coverage for low-to-moderate income adults with incomes between 133 and 200 percent of FPL and federal funding for HCCI is capped.

The state projects that 512,000 adults would be eligible for LIHP, with 385,000 eligible for MCE and 127,000 eligible for HCCI. Both programs are at county option and each county determines its own eligibility rules and sets its own income eligibility standards. For example, Los Angeles county set its MCE eligibility level at 133 percent of FPL, whereas San Francisco county set its MCE eligibility level at 25 percent of FPL.

The first ten counties (legacy counties) to implement LIHP are Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. Los Angeles and Alameda plan to begin enrollment on July 1, 2012.

The OA projects that, under current law, 9,089 ADAP clients are eligible for LIHP in the ten legacy counties. See table below for the estimate by county.

Table: Estimated Number of ADAP Clients Eligible for LIHP in 10 Legacy Counties

Legacy County	Number of ADAP Clients Eligible for LIHP
Alameda	678
Contra Costa	146
Kern	93
Los Angeles	5,152
Orange	700
San Diego	1,321
San Francisco	535
San Mateo	96
Santa Clara	267
Ventura	101
Total	**9,089**

Ryan White – Payer of Last Resort. In the summer of 2011, the federal government provided guidance to California regarding the Ryan White statutory "payer of last resort" requirement in relationship to LIHP. Specifically, that Ryan White funded services, including ADAP, can no longer be available to individuals once they become eligible for and enrolled in a LIHP. Additionally, such low-income persons with HIV who otherwise meet LIHP eligibility standards may not be excluded by the LIHP. This means that low-income persons with HIV previously covered by a Ryan White system of care will, upon enrollment of LIHP, be required to receive their medical care and pharmaceuticals under LIHP.

LIHP Screening Plan. Local health jurisdictions receiving Ryan White Part B funds were required to submit to OA a plan for screening of Ryan White clients for LIHP eligibility by November 15, 2011. According to the plan submission guidelines, these plans were "high-level" plans and not to be more than three to five pages. These plans did not address at the client level issues such as continuity of care, care coordination, and transition of care.

HIV Transition Incentive Program. In order to assure that persons with HIV make their transitions of coverage from Ryan White to LIHP with continuity of quality care, without loss of either core or other critical services, and with minimal disruption to critical patient/provider relationships, the Department of Health Care Services submitted a section 1115 Demonstration amendment to create the HIV Transition Incentive Program. Under the HIV Transition Incentive Program, $150 million would be available annually in 2011-12 and 2012-13 and $75 million in 2013-14 for the development of projects that support the LIHP systems' efforts to address the continuity of care, care coordination, and coverage transition issues for persons with HIV. DHCS expects a response from the federal government on the requested amendment on April 1, 2012.

Subcommittee Staff Comment and Recommendation. In order to ensure the continuity of care and minimal disruption to patient/provider relationships for persons with HIV that are eligible for LIHP, the following actions are recommended:

1. Adopt placeholder trailer bill language that would strengthen consumer protections for ADAP clients as they transition to LIHP and create a stakeholder advisory committee to give expert advice on transition policy decisions. The stakeholder advisory committee would include providers, both medical and non-medical, as well as beneficiaries.

2. Add a Health Program Specialist II position at the Department of Health Care Services to manage the HIV Transition Incentive Program and coordinate with DPH's Office of AIDS. This position would be funded using county funds (via certified public expenditures) and federal funds.

   Substantial work needs to be done in order to effectively manage this new program. It is critical that DHCS have the resources necessary to successfully support and oversee the projects developed under the HIV Transition Incentive Program to ensure that the $375 million is spent in a manner that addresses the continuity of care and care transition for persons with HIV moving into LIHP.

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

1. OA, please discuss OA's efforts and guidance to counties regarding the transition of ADAP clients to LIHP.

2. OA, what specific actions has OA taken to avoid interruptions to treatment and prevent barriers to accessing treatment for ADAP clients transitioning to LIHP?

3. DHCS, please provide a brief description and status of the HIV Transition Incentive Program.

2. Drinking Water Program: Three Issues

Background. The DPH has statutory authority to administer California's public Drinking Water Program. The program provides for ongoing surveillance and inspection of public water systems, issues operational permits to the systems, ensures water quality monitoring is conducted and takes enforcement actions when violations occur**.** They oversee the activities of about 8,000 public water systems (including both small and large water systems) that serve more than 36 million Californians.

The DPH is also designated by the federal Environmental Protection Agency (EPA) as the primacy agency responsible for the Administration of the federal Safe Drinking Water Act for California.

California's total need for water system infrastructure improvements is in excess of $39 billion, as reported in the EPA 2007 Drinking Water Infrastructure Needs Survey and Assessment. The majority of public water systems are not able to finance necessary improvements on their own and require state and federal assistance.

a. Safe Drinking Water State Revolving Fund (SDWSRF)

Budget Issue. The DPH requests permanent position and budget authority for the SDWSRF program for 23 limited-term positions that expire on June 30, 2012. Of these positions, 10 have been limited-term since 1999 and 13 were established July 1, 2010, to address increased workload and funding.

The SDWSRF project priority list currently has over 3,000 pre-applications for infrastructure projects from public water systems with a total value of over $8 billion. Since the 13 limited-term positions were established in 2010, the SDWSRF has issued 60 funding agreements annually. Prior to the addition of these staff, about 30 funding commitments were issued annually. By making these staff permanent, DPH proposes to continue issuing 60 funding agreements annually.

Background. Enacted in 1997, under the Safe Drinking Water State Revolving Fund (SDWSRF) program California receives federal funds to finance low-interest loans and grants for public water system infrastructure improvements. DPH has used the SDWSRF to provide loans and grants to 208 public water system projects, executed over $1 billion in funding agreements, and disbursed approximately $727 million. There are currently 44 permanent positions and 23 limited-term positions in the SDWSRF program.

In order to draw down these federal capitalization grants, the state must provide a 20 percent match. The Legislature authorized General Fund appropriations for the 1997 and 1998 capitalization grants, Proposition 13 bond funds for the 1999 through 2002 grants, Proposition 50 bond funds for the 2003 through 2008 grants, and Proposition 84 bond funds for the 2009 through 2011 grants. Assembly Bill 1292, Chapter 518, Statutes of 2011 provides DPH the authority to sell revenue bonds to provide a permanent source of funds for the state match.

The program is comprised of five set-aside funds, as well as a loan fund. The set-asides are as follows:

- Drinking water source protection (15 percent);
- Technical assistance to small water systems (up to 2 percent);
- Water system reliability/capacity development (2 percent);
- State water system program management activities (up to 10 percent);
- Administrative costs (up to 4 percent).

Table: DPH Summary of Safe Drinking Water State Revolving Fund Program

State Fiscal Year	20 Percent State Match	Federal Fund Amount	Total Amount
2011-2012	$13.134 million (Proposition 84) $4.205 million (Revenue Bonds)	$86.698 million	$104.037 million
2012-2013	$17.339 million (Revenue Bonds)	$86.698 million	$104.037 million
2013-2014	$17.339 million (Revenue Bonds)	$86.698 million	$104.037 million
2014-2015	$17.339 million (Revenue Bonds)	$86.698 million	$104.037 million

Subcommittee Staff Comment and Recommendation—Approve. SDWSRF is a mature, long-term program effectively managed by DPH for over 14 years. Congress has continued

funding for this program despite other budget reductions. No issues have been raised regarding this proposal. It is recommended to approve the request.

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

1. Please provide a brief summary of the Safe Drinking Water Program.

2. Please describe the request to make the limited-term positions permanent.

b. Renewal of Proposition 50 Limited-Term Positions

Budget Issue. The DPH requests the renewal of 12 limited-term positions due to expire on June 30, 2012. These positions support the $485 million in funding allocated to DPH from the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002 (Proposition 50). The DPH requests that these positions be renewed for two more years (through June 30, 2014) to the end of the projected spending plan for Proposition 50.

The positions are primarily engineering classifications, along with related environmental scientist classifications and administrative support. The DPH states these positions are necessary to meet workload needs for key activities as follows:

- Review "pre-applications" for Proposition 50 funding and rank proposals.
- Create a project priority list based on the priority ranking of the projects.
- Evaluate full project applications and prepare extensive technical report documents for each project.
- Review and evaluate the plans and specifications for each project and conduct construction inspections and a final inspection of each project.
- Review proposal for reduction or removal of drinking water contaminants and participate in demonstration projects such as ultraviolet treatment processes.
- Review and comment on draft environmental documents prepared for drinking water projects.
- Conduct final project inspection and certify completion.
- Conduct program fiscal management and administration.

In addition, DPH requests a $1.5 million in state support and $98.9 million in local assistance appropriations from Proposition 50 to align appropriation authority with actual expenditures.

Background. Proposition 50 of 2002 provides funds to a consortium of state agencies and departments to address a wide continuum of water quality issues. The DPH anticipates receiving up to $485 million over the course of this bond measure for water projects. As follows:

Chapter 3—Water Security ($50 million). Proposition 50 provides a total of $50 million for functions pertaining to water security, including the following: (1) monitoring and early warning systems, (2) fencing, (3) protective structures, (4) contamination treatment facilities, (5) emergency interconnections, (6) communications systems, (7) other projects designed to prevent damage to water treatment, distribution, and supply facilities**.**

Chapter 4—Safe Drinking Water ($435 million). Proposition 50 provides $435 million to the DPH for expenditure for grants and loans for infrastructure improvements and related actions to meet safe drinking water standards. A portion of these funds will be used as the state's match to access federal capitalization grants.

With respect to the other projects, the Proposition states that the funds can be used for the following types of projects: **(1)** grants to small community drinking water systems to upgrade monitoring, treatment, or distribution infrastructure; **(2)** grants to finance development and demonstration of new technologies and related facilities for water contaminant removal and treatment; **(3)** grants for community water quality; **(4)** grants for drinking water source protection; **(5)** grants for drinking water source protection; **(6)** grants for treatment facilities necessary to meet disinfectant by-product safe drinking water standards; and **(7)** loans pursuant to the Safe Drinking Water State Revolving Fund (i.e., whereby the state draws down an 80 percent federal match). In addition, it is required that not less than 60 percent of the Chapter 4 funds be available for grants to Southern California water agencies to assist in meeting the state's commitment to reduce Colorado River water use.

Of the $485 million outlined in the bond measure, $353.8 million was made available for commitment to new water projects after accounting for bond costs ($16.975 million), state administration costs ($24.250 million), and the state match for the State Revolving Fund ($90 million).

The department has committed $227.5 million to projects and $126.3 million remains available to be committed. Of the $126.3 million available to be committed, DPH has received project applications for $106.6 million.

Subcommittee Staff Comment and Recommendation--Approve. It is recommended to approve the renewal of the limited-term positions, the increased expenditure authority and related Budget Bill Language. No issues have been raised with this proposal.

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

1. Please provide an update regarding Proposition 50 bonds.

2. Please provide a brief summary of the budget request.

3. Please discuss what steps the drinking water program has taken to improve its ability to more quickly fund projects.

c. Small Water System Program

Budget Issue. The DPH requests 2 positions within the Drinking Water Program to carry out small water system regulatory programs in Marin, San Mateo, and Tuolumne counties in response to the decisions of these counties to return primacy to DPH. These positions would be funded from the Safe Drinking Water Account Fund ($183,000). The revenue generated from fees from small public water systems in these counties would support these positions.

These three public water systems have a total of 163 small public water systems that provide potable water to approximately 40,000 persons on a daily basis.

Although small public water systems serve only a small percentage of the state's residents, they represent a disproportionately high risk to public health because they have a greater number of violations and compliance problems than do systems that serve more than 1,000 service connections.

Background. Beginning in 1976, the California drinking water program has been conducted under an agreement with EPA that delegates primacy (i.e., responsibility) to the state. Consequently, DPH is responsible for regulating public water systems in the state. However, Assembly Bill 2995, Chapter 1248, Statutes of 1992, created a process that allowed the state to enter into delegation agreements with local health jurisdictions. These agreements allowed the counties to regulate small public water systems with less than 200 service connections.

Under current law, counties that have been delegated primacy for the regulation of small public water systems can return primacy to the state. The number of counties that were delegated primacy remained relatively stable at approximately 35 for over 15 years. However, since 2007, five counties have returned their small water system programs to the state (Fresno, Tehama, Marin, San Mateo, and Tuolumne).

Subcommittee Staff Comment and Recommendation—Approve. DPH is mandated to establish and maintain a regulatory program for small public water systems. If the state does not adequately fulfill its mandate to protect public health in this area, including those systems that were delegated to the counties, the federal government may withdraw funding. This proposal is consistent with state and federal law. It is recommended for approval.

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

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

2. California Home Visiting Program

Budget Issue. The DPH requests an increase of $20.43 million in federal expenditure authority ($650,000 in state operations and $19.78 million in local assistance) to continue and expand statewide operations of the California Home Visiting Program (CHVP). This program identifies and implements evidence-based home-visiting programs to improve outcomes for low income families who reside in at-risk communities.

This request consists of:

- An increase of $11 million in local assistance funding for the remainder of the Maternal, Infant and Early Childhood Home Visiting Program (MIECHVP) grant funding period through 2014-15. The department received an additional award. DPH finds that this would allow for the continuation of statewide operations of this program and the funding of 13 local health jurisdictions that were selected through a needs assessment process.
- An increase of $9.43 million ($650,000 in state operations and $8.78 million in local assistance) from the competitive Home Visiting Expansion Grant funds. California applied for and received $9.43 million from this competitive grant. DPH will use these funds to expand CHVP to eight additional communities where no home visiting services exist.

Background. The Affordable Care Act of 2010 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--Approve. No issues have been raised regarding this proposal. It is recommended to approve the request. There is no General Fund impact.

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

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

3. Maternal, Child and Adolescent Health - Reduction in Federal Funds

Budget Issue. The DPH requests to reduce federal expenditure authority by $6.8 million ($2.2 million in state operations and $4.6 million in local assistance) and eliminate 6 positions in the Maternal, Child and Adolescent Health (MCAH) division.

This proposed reduction is a result of several factors, including:

- The redirection of Title V Block Grant funds to programs that were previously funded with General Fund. Since 2007-08, a cumulative total of $13.4 million in Title V funds have been redirected.
- A net reduction in the federal Title V Block Grant funding. On July 15, 2011, DPH received notice from the federal government that the Title V Block Grant would be $800,000 less than the previous year.
- The increased rate of spending by local health jurisdictions (LHJs). In efforts to ensure that local health jurisdictions spent down the local assistance portion of the Title V Block Grant, the department has awarded LHJs contracts that, cumulatively, exceeded the actual federal block grant amount.

MCAH approved appropriations and expenditures have exceeded revenue since 2007-08.

Local Assistance Reductions. DPH convened local MCAH Directors and stakeholders to identify the most equitable and efficacious means to reduce local MCAH spending. This approach ensured that each jurisdiction would continue to fund a MCAH Director to maintain an adequate infrastructure to continue these programs. The reductions to local assistance are:

- $999,000 – Adolescent Family Life Program (AFLP). The AFLP is a statewide program providing case management services to pregnant and parenting teens in California. The number of clients served is approximately 4,200. This reduction will result in 700 fewer clients served. Of this reduction, $749,000 will come from two agencies that planned to discontinue their AFLP programs. The remaining $250,000 in reductions will be prorated among AFLP agencies with base funding above $84,000.

- $140,000 – Black Infant Health (BIH) Program. The BIH programs provides health education, health promotion, social support, and service coordination to pregnant and parenting African American adult women in the 15 LHJs where 75 percent of all African American births in California occur. The program serves nearly 1,700 clients. This reduction will result in a 3 percent reduction in client enrollment.

- $330,000 – Local MCAH Program. Local MCAH programs provide services and programs to improve the health of mothers, infants, children, adolescents, and their families. This reduction will eliminate the Local Assistance for Maternal Health (LAMH) Demonstration Projects. The goal of these projects was to facilitate the LHJ leadership to implement maternal quality care improvement projects. MCAH will continue to provide technical assistance to LHJs who initiate maternity care quality improvement projects through other funding.

- $324,000 – Maternal, Infant Health Information (MIHA) – DPH proposes to charge the cost of the MIHA local assistance survey contract to the Center for Family Health rather than directly to the MCAH program. The MIHA survey benefits all programs of the Center for Family Health and is used to meet multiple federal reporting mandates necessary to receive federal funding.

- $350,000 – California Birth Defects Monitoring Program (CBDMP) – The CBDMP collects and reviews data from birthing hospitals and maintains a database of birth defects occurring in California. This reduction will impact the ability to collect and monitor data for the Birth Defects Registry.

- $1.063 million – California Diabetes and Pregnancy Program (CDAPP) – The CDAPP allocates funding statewide to contractors (CDAPP Sweet Success affiliates) to improve the maternal and fetal birth outcomes through health education and promotion and disease prevention. There are currently over 100 affiliates serving approximately 17,240 clients. This reduction will eliminate affiliate funding.

- $191,000 – Advanced Practice Nurse Training (APN) Program – The APN program provides increased access to cost-effective, quality, reproductive health care services for medically indigent, childbearing women in underserved areas of California by recruiting and enrolling nursing students who reflect the linguistic, cultural, and geographic diversity of California into specialty area programs. Approximately 80 nurses are trained annually, and this 25 percent funding reduction will result in approximately 20 fewer trained nurses.

State Operations Reductions. The reductions to state operations are:

- $1.7 million – MCAH State Operations – Of this reduction, $1.6 million will be from contracts to conduct the Five-Year Needs Assessment and related collection of data at the local level for federal reporting; $65,000 from travel; $20,000 from general expenses; and $81,000 from operating expenses and equipment.

- $500,000 – MCAH Staff Reductions – The department proposes to eliminate 6 positions.

Subcommittee Staff Comment and Recommendation--Approve. A reduction in the federal block grant and the state's fiscal situation require an assessment of MCAH programs and a prioritization of funding for those programs that are the most effective. It is recommended to approve this proposal.

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

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

2. Please comment on DPH's prioritization of MCAH programs and the department's interaction with local MCAH Directors and stakeholders on this prioritization.

4. Women, Infant, Children's Supplemental Food

Budget Issue--Local Assistance Funding. The budget proposes total expenditures of $1.489 billion ($1.262 billion federal funds and $227 million Manufacturer Rebate Funds) for WIC local assistance which reflects an increase of $29.293 million (federal funds) for 2012-13.

DPH states that about 1,5214,110 WIC participants will access food vouchers in 2012-13. An estimated $63.14 is the monthly average participant cost for food.

Of the total federal grant amount, $961.3 million is for Base Food and $300.867 million is for Nutrition Services and Administration. The $227.7 million in Manufacturer Rebate Funds are continuously 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 as 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—Hold Open. DPH has negotiated a new rebate contract effective August 1, 2012. The terms of this contract were not considered as part of this estimate. DPH indicates that it will be revising the WIC estimate to reflect the new rebate contract in the May Revise. It is recommended to hold this item open. No other issues have been raised regarding this estimate.

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

1. Please provide a brief summary of this request.

5. Genetic Disease Testing Program (Prenatal Program and Newborn Program)

Budget Issue. The DPH proposes total expenditures of $87.8 million (Genetic Disease Testing Fund) for local assistance. This reflects a net decrease of $6.25 (Genetic Disease Testing Fund) as compared to the current-year. This program is fully fee supported.

The proposed expenditures for each of the programs are outlined below.

Program & Components	2012-13	Adjustment Over CY
Prenatal Screening:		
Contract Laboratories	$5,122,000	-$262,000
Technologic Support	13,300,000	-164,000
Systems Development, Equipment & Testing	4,803,000	-1,848,000
Follow-Up Costs	6,242,000	-481,000
Prenatal Diagnostic Services	17,411,000	-174,000
Result Reporting & Fee Collection	1,942,000	0
TOTAL for Prenatal	**$45,820,000**	**-$2,929,000**
Newborn Screening:		
Contract Laboratories	$7,177,000	$29,000
Technologic Support	23,165,000	-2,088,000
Systems Development, Equipment & Testing	3,773,000	-909,000
Case Management	4,575,000	-97,000
Reference Laboratories	2,491,000	-35,000
Diagnostic Services	2,500,000	-221,000
Result Reporting & Fee Collection	1,500,000	0
TOTAL for Newborn	**$45,181,000**	**-$3,321,000**
Total for Genetic Disease Testing Program	**$94,001,000**	**-$6,250,000**

Background—Genetic Disease Testing Program. The Genetic Disease Testing Program consists of two programs—the Prenatal Screening Program and the Newborn Screening Program. Both screening programs provide public education, and laboratory and diagnostic

clinical services through contracts with private vendors meeting state standards. Authorized follow-up services are also provided as part of the fee payment. The programs are self-supporting on fees collected from screening participants through the hospital of birth, third party payers, or private parties using a special fund—Genetic Disease Testing Fund.

The *Prenatal Screening Program* provides screening of pregnant women who *consent* to screening for serious birth defects. The fee paid for this screening is about $150. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees.

There are three types of screening tests to pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect. All three of these tests use blood specimens, and generally, the type of test used is contingent upon the trimester.

Women who are at high risk based on the screening test results are referred for follow-up services at state-approved "Prenatal Diagnosis Centers". Services offered at these Centers include genetic counseling, ultrasound, and amniocentesis. Participation is voluntary.

The *Newborn Screening Program* provides screening for all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is $113 (which includes the $9.95 fee increase implemented on January 1, 2013 for implementation of AB 395, as discussed below). Where applicable, this fee is paid by prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees.

The Newborn Screening Program screens for over 75 conditions, including certain metabolic disorders, PKU, sickle cell, congenital hypothyroidism, non-sickling hemoglobin disorders, Cystic Fibrosis and many others. Early detection of these conditions can provide for early treatment which mitigates more severe health problems. Informational material is provided to parents, hospitals and other health care entities regarding the program and the relevant conditions and referral information is provided where applicable.

a. Expand California's Newborn Screening Program

Budget Issues. The DPH requests 10 permanent positions and the associated $5.3 million in state operations expenditure authority (from the Genetic Disease Testing Fund) to implement Assembly Bill 395, Chapter 461, Statues of 2011, which requires DPH to add Severe Combined Immunodeficiency (SCID) to the panel of disorders screened for by the Genetic Disease Screening Program Newborn Screening Program. The screening for SCID began on January 1, 2012.

The positions requested are:

- Research Scientist Supervisor I (1) – This position will supervise the new staff and oversee the SCID laboratory.

- Research Scientist IV (1) – This position will review results submitted by the SCID laboratory and evaluates the quality controls.

- Senior Clinical Laboratory Technologist (5) – These positions will be responsible for the daily testing, review, and reporting of SCID laboratory results to ensure that all tests are performed appropriately.

- Senior Laboratory Assistants (3) – These positions will be responsible for the daily, non-technical duties such as laboratory set-up, laboratory equipment operation, process specimens, and assist in quality control efforts.

Background. The Newborn Screening Program screens for more than 75 disorders in over 500,000 newborns and diagnoses more than 700 babies each year. DPH was involved in a pilot study (which ended February 2012) to screen California newborns for SCID, SCID variants, and related T-cell lymphopenias. Over a 12 month period, 18 California newborns have been diagnosed with SCID. Literature and other state's experience reflect an incidence of SCID to be approximately 1 in 100,000 births. Medical treatment is available to eradicate SCID.

It is expected that 256,451 specimens will be processed annually for SCID.

Because the Newborn Screening Program is fully fee supported, a fee increase of $9.95 was implemented on January 1, 2012, to support the ongoing workload associated processing blood specimens and follow-up activities such as diagnostic work-up, confirmatory processing, and provider and family education.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is consistent with state law and is recommended for approval.

6. Federal Special Projects – Position Conversion

Budget Issue. The DPH proposes to convert 348 positions in the temporary help blanket to permanent positions. This proposal seeks to align the approved position authority for DPH with the approved federal and reimbursement expenditures.

Technically, the Administration proposes to redirect 100 existing authorized Workforce Cap Plan (WCP) positions and to request an additional 248 positions. The Administration finds that redirecting the WCP positions for this proposal and the other 2012-13 proposals is more administratively efficient.

This proposal will not impact the General Fund, special funds, or increase the total budget authority for DPH. The only impact will be to increase the number of authorized positions in order to accommodate the federally approved staffing levels.

Background. State personnel policy allows departments to use temporary help blankets. Temporary help blankets are to be used only for payment of employees for a limited duration of time.

DPH has utilized the temporary help blanket for:

- **Federal Special Projects with Personnel** – The department receives a significant number of grants from the federal government. As part of the grant application and award process, the federal government approves the use of state personnel to fulfill the requirements of the grant. Up to this point, the personnel hired to perform these activities have been appointed to the temporary help blanket. These federal projects include:
    - Immunizations – 16 positions - This grant supports efforts to plan, develop, and maintain a public health infrastructure which assures an effective immunization program.
    - Food Emergency Response Network – 5 positions – This grant enhances the state's laboratories to analyze for microbiological, chemical, and radiological threat agents and to improve laboratory capacities for food defense.

- **Reimbursement Activities** – The department has several agreements with other state agencies to provide services. Up to this point, the personnel hired to perform these activities have been appointed to the temporary help blanket. These include:
    - Supplemental Nutrition Assistance Program – Education Program (SNAP-Ed) – 82.5 positions are funded through a reimbursement contract with the Department of Social Services. The SNAP-Ed program provides a wide range of nutrition education services.
    - Safe and Active Communities Branch – 6.0 positions are funded by the Department of Alcohol and Drug Programs and the Office of Traffic Safety. These positions provide epidemiological surveillance, planning, census building,

interventions, policy development, and public information regarding the prevention of injuries.

According to the department, the rational for using the temporary help blanket was primarily due to the nature of the federal funding. Most of the federally funded programs were established as temporary federal projects awarded as grants available from three to five years in duration. Due to the short duration, these grants were treated as special projects and not deemed of sufficient permanence to request regular budgeted positions. Over the past several years, it has been evident that most of the federal special project grants received by DPH are consistent and stable from year-to-year.

Subcommittee Staff Comment and Recommendation—Approve. Moving these personnel into authorized positions will provide the Legislature and the public with accurate and transparent information as to the full staffing level for DPH. Many of these positions have been in existence for over 20 years and should be reflected in the department's permanent personnel count. Consequently, this proposal is recommended for approval.

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

1. Please provide a brief summary of this request.

7. Loan from Childhood Lead Poisoning Prevention Fund

Budget Issue. The Childhood Lead Poisoning Prevention Fund (CLPPF) has a reserve of $39.5 million, which reflects a 165 percent reserve margin. This reserve level is considerably higher than the 5 percent reserve margin which is normally considered prudent by the Department of Finance (DOF).

The Childhood Lead Poisoning Prevention Fund is funded from fees from companies involved in manufacturing or selling of lead based products or products containing lead. The funds support the Childhood Lead Poisoning Prevention Program.

Subcommittee Staff Comment. Given the substantial reserve of this fund and the state's fiscal situation, a $15 million loan from the CLPPF to the General Fund could be an option for General Fund savings. With a $15 million loan, the CLPPF would still have a reserve margin of 102 percent, well beyond DOF's recommended margin. This loan could be paid back to the CLPPF in 2014-15.

Questions. The Subcommittee has requested the DPH and DOF to respond to the following question:

1. Are there any technical issues with this proposal?

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, March 8 (Room 4203)

A. 8885 Commission on State Mandates

1. SIDS Autopsies

- Action – Reject Governor's proposal to repeal mandate.
- Vote – 3-0

2. SIDS Contacts by Local Health Officers

- Action – Reject Governor's proposal to repeal mandate.
- Vote – 3-0

3. Perinatal Services

- Action – Approve Governor's proposal to repeal mandate.
- Vote – 3-0

B. 4140 Office of Statewide Health Planning and Development

4. Song-Brown Health Care Workforce Training Program

- Action – Approve Governor's proposal.
- Vote – 2-1 (Senator Emmerson voting no.)

C. 2400 Department of Managed Health Care

1. Premium Rate Review Cycle II Federal Grant

- Action – Held Open

2. Oversight of Medi-Cal Managed Care Plans

- No action necessary.

D. 4260 Department of Health Care Services

1. Genetically Handicapped Persons Program (GHPP)

- Action – Help Open

2. Child Health and Disability Prevention (CHDP) Program

- Action – Held Open

3. California Children's Services (CCS) Program

- Action – Held Open

E. 4265 Department of Public Health

I. VOTE ONLY ITEMS

1. Childhood Lead Poisoning Prevention Branch – Conversion to State Staff

- Action – Approve Governor's proposal.
- Vote – 2-1 (Senator Emmerson voting no.)

2. Early Case Capture of Pediatric Cancers

- Action – Approve Governor's proposal.
- Vote – 3-0

3. Reduction of Domestic Violence Training and Education Fund

- Action – Approve Governor's proposal.
- Vote – 2-1 (Senator Emmerson voting no.)

4. Radiation Safety Program

- Action – Approve Governor's proposal.
- Vote – 3-0

5. Environmental Laboratory Accreditation Program

- Action – Approve Governor's proposal.
- Vote – 3-0

II. DISCUSSION ITEMS

A. AIDS Drug Assistance Program (ADAP) – Three Issues

1. Baseline Estimate for ADAP

- Action – Held Open

2. Institution of New Client Cost-Sharing Policy for ADAP

- Action – Rejected Governor's proposal.
- Vote - 2-1 (Senator Emmerson voting no.)

3. Transition of ADAP Clients to the Low Income Health Program (LIHP)

- Action – (1) Adopted placeholder trailer bill language that would strengthen consumer protections for ADAP clients as they transition to LIHP and create a stakeholder advisory committee to give expert advice on transition policy decisions. (2) Added a Health Program Specialist II position at the Department of Health Care Services to manage the HIV Transition Plan Waiver Program and coordinate with DPH's Office of AIDS.

- Vote - 2-1 (Senator Emmerson voting no.)

B. Drinking Water Program: Three Issues

- **Safe Drinking Water State Revolving Fund (SDWSRF)**
  - Action – Held Open.

2. Renewal of Proposition 50 Limited-Term Positions

- Action – Held Open.

3. Small Water System Program

- Action – Held Open.

C. California Home Visiting Program

- Action – Held Open.

D. Maternal, Child and Adolescent Health - Reduction in Federal Funds

- Action – Held Open.

E. Women, Infant, Children's Supplemental Food

- Action – Held Open.

F. Genetic Disease Testing Program (Prenatal Program and Newborn Program)

1. Expand California's Newborn Screening Program

- Action – Held Open.

G. Federal Special Projects – Position Conversion

- Action – Held Open.

H. Loan from Childhood Lead Poisoning Prevention Fund

- Action – Held Open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

March 15, 2012

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

Room 4203
(John L. Burton Hearing Room)

Staff: Jennifer Troia

Item	Department
4170	Department of Aging
4260	Department of Health Care Services
5160	Department of Rehabilitation
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 noted in the Agenda unless otherwise directed by the Chair.

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Agenda

(Vote-Only Items indicated by *)

Item Department Page

VOTE-ONLY AGENDA

Department of Social Services

IHSS- Trailer Bill Language to Define Criteria for Preapproval of Exceptions to 20 Percent Reduction

Budget Issue: The Administration proposes trailer bill language to provide additional detail to statutes that establish a 20 percent reduction in authorized hours of IHSS services for each IHSS recipient, subject to specified exemptions and exceptions. Specifically, existing law requires DSS to work with the counties to develop a process for counties to "preapprove" supplemental IHSS hours for individuals who clearly meet the criteria for an exception to the reduction policy. The Department indicates that it has worked with the counties to develop the required policy detail and now seeks to codify more specific criteria, which include preapproval for individuals who: a) receive Early and Periodic Screening, Diagnosis, and Treatment services, b) are authorized to receive the statutory maximum of 283 hours of services per month, c) are authorized to receive protective supervision, or d) have been assessed to have a particular level of need (a functional ranking of 5) for certain specified services.

The statutory provisions the Administration proposes to amend were established as part of the 2011-12 budget. More specifically, the 20 percent reduction with specified exceptions and exemptions was a part of the December 2011 budget "trigger" package that took effect when state revenues were lower than previously anticipated. However, this reduction was stopped from being implemented by a federal district court order in response to ongoing litigation.

Subcommittee Staff Comment & Recommendation: Staff recommends rejecting the proposed trailer bill language at this time. The statute the Administration proposes to amend is the subject of active litigation and the proposed amendments are intended to provide additional detail, not to make substantive changes in how the Department would implement the law.

IHSS- Trailer Bill Language to Amend Effective Date of Sales Tax on Supportive Services

Budget Issue: The 2010-11 budget established a sales tax on specified supportive services, which includes IHSS, and assumed $190 million General Fund (GF) savings due to enhanced federal funding from matching the use of revenues obtained pursuant to the tax. Related statutory provisions established supplementary payments for IHSS providers that would equal the portion of their gross receipts that is subject to state and federal taxation as a result of the tax on supportive services. These provisions are scheduled to take effect when the federal Centers for Medicare and Medicaid Services

(CMS) approves implementation of the state's related Medicaid plan amendment, but "no earlier than July 1, 2010." Because the state is still awaiting a response to its proposed plan amendment from the federal government, the Administration proposes to update the effective date of the statute to be "no earlier than January 1, 2012."

Subcommittee Staff Comment & Recommendation: Staff recommends approving the proposed technical change to the effective date of these statutory provisions.

DISCUSSION AGENDA

Department of Aging (CDA)

Multi-Purpose Senior Services Program (MSSP)

Budget Issue: The budget proposes $40.5 million ($20.2 million GF) for local assistance and $2.5 million ($1.2 million GF) for state operations related to the MSSP program. The budget also proposes to integrate MSSP, along with other long-term care supports and services, into Medi-Cal managed care over a period of three years.

Background on MSSP: MSSP provides care management services for frail, elderly clients who wish to remain in their own homes and communities. Clients must be age 65 or older, eligible for Medi-Cal, and certified (or certifiable) as eligible to enter into a nursing home. Teams of health and social service professionals assess each client to determine needed services and then work with the clients, their physicians, families, and others to develop an individualized care plan. Services that may be provided with MSSP funds include, but are not limited to: care management, adult social day care, housing assistance, in-home chore and personal care services, respite services, transportation services, protective services, meal services, and special communication assistance. CDA currently oversees operation 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.

Proposal to Integrate Long-Term Care Services and Supports (LTSS): As discussed during the full Budget Committee hearing on February 23, 2012, the Governor's budget includes a Coordinated Care Initiative for Medi-Cal enrollees. The Administration intends for the initiative to improve service delivery for 1.2 million people who are eligible for both Medi-Cal and Medicare (dual eligibles) and 330,000 Medi-Cal enrollees, many of whom rely on LTSS. To achieve these improvements, the Administration proposes to combine the full continuum of medical services and LTSS, including MSSP, into a single benefit package delivered through the Medi-Cal managed care delivery system starting on January 1, 2013. Additional information on the Coordinated Care Initiative is available in the background paper from the February 23rd

hearing (online at http://sbud.senate.ca.gov/fullcommitteehearings). The proposal will also be discussed further in Subcommittee #3 on April 26, 2012.

The core MSSP service is care coordination using a multidisciplinary team that identifies and responds to health and social service needs of seniors who are eligible to enter into a nursing home. In 2013, in counties not involved in the Dual Demonstration, the Administration proposes to maintain the MSSP program's current eligibility process and programmatic requirements. In Demonstration Counties, the Demonstration sites (through managed care plans) would be expected to contract with existing MSSP sites to provide care coordination to the plans' enrollees. In 2014, the managed care plans would be responsible for assessing the needs of all plan members and providing necessary health and long term support services (LTSS). Along with those responsibilities, they would have flexibility to determine how to provide care coordination to their members. They could contract with MSSP sites, hire and incorporate the current MSSP staff into the health plans' care management team, or choose other strategies. In 2015, eligibility for LTSS would be assessed by Demonstration sites using the proposed universal assessment tool. Between 2013 and 2015, as managed care plans and the Demonstration expand to all counties, MSSP program's care coordination functions would become part of the plans' care coordination systems. In other words, MSSP may not necessarily continue to exist as a discrete program.

Reduction to MSSP in 2011-12 Budget: The 2011 Budget Act included a reduction of up to $5 million ($2.5 million GF) to MSSP. Related budget bill language directed CDA and DHCS to consult with the federal government about how to achieve the savings operationally and to minimize any impacts on the number of clients served. The Department reports that minor administrative savings were achieved, but the bulk of the reduction was ultimately achieved reducing the number of clients served. There are 11,789 statewide slots for MSSP clients. After a reduction in 2008-09, the sites were operating at 87 percent of capacity. After this latest reduction, they are now operating at 77 percent of capacity.

Subcommittee Staff Comment & Recommendation: Staff recommends holding open the integration of MSSP into managed care pending further discussion and actions related to the larger Coordinated Care Initiative.

Questions for the Administration & LAO:

1) How was the 2011-12 reduction to MSSP implemented? What efforts did the Administration undertake to achieve the savings operationally?

2) Please describe the existing relationships between managed care plans and MSSP sites.

3) How would the transition to receiving LTSS through managed care work for current MSSP clients and those currently awaiting services?

4) How is the Administration engaging MSSP sites and staff as the Coordinated Care Initiative is being developed and refined?

5) Looking toward 2015 and beyond, would MSSP continue to be budgeted as a separate LTSS program? Would CDA maintain its programmatic oversight role? Who would authorize MSSP services? How would federal funding potentially change?

Department of Rehabilitation (DOR)

Rehabilitation Appeals Board

Budget Issue: The Governor proposes to achieve savings and efficiencies from eliminating the Rehabilitation Appeals Board (RAB), which currently reviews appeals filed by applicants for or consumers of DOR services. The associated responsibilities would be transferred to impartial hearing officers (IHOs) through an interagency contract with the Office of State Hearings or another state entity. 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 case referrals. Thus, the total cost for this proposal would be $175,000 per year ($37,000 GF). By contrast, in 2010-11 the budget for RAB was $205,000 ($43,000 GF); but actual expenditures over the last five years averaged $292,000. The Legislature rejected a similar proposal made by the Governor as part of the 2011-12 budget process.

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 2011, approximately 11,000 consumers achieved employment outcomes. During that same period of time, 32 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 timeframes due to quorum requirements and that the RAB has consistently exceeded its budgeted operating costs. The Administration also indicates that IHOs with more legal and

evidentiary expertise will have greater ease in sorting through complex legal questions and documenting related conclusions.

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

Questions for DOR:

1) Please describe the appeal and decision-making processes, including due process protections, as they exist today and how they would differ under this proposal.

2) How would the Administration ensure the accessibility of the appeals process to consumers of the department's services?

Department of Social Services (DSS)

1. CalFresh

CalFresh Program Overview & Administration

Budget Issue: CalFresh is California's name for the national Supplemental Nutrition Assistance Program (SNAP, formerly known as "food stamps"). As the largest food assistance program in the nation, SNAP aims to prevent hunger and to improve nutrition and health by helping low-income households buy the food they need for a nutritionally adequate diet. Californians are expected to receive a total of $7.2 billion (all federal funds) in CalFresh benefits in 2011-12, rising to $8.4 billion in 2012-13.

A Snapshot:

- Approximately 1.6 million households (including more than 3.6 million Californians) receive CalFresh benefits.
- This is estimated to represent only around half the population that is eligible.
- The average beneficiary household head is 37 years old and the average household size is 2.4 individuals.
- 54% of recipients are children.

The Governor's 2012-13 budget includes $1.6 billion ($540.0 million GF) for CalFresh administration costs, which are shared 50/50 federal/non-federal funds (with non-federal funds shared 35/15 by the state/counties). Since 1997, the state has also funded the California Food Assistance Program (CFAP), a corresponding program for around 40,000 legal immigrants who are not eligible for federal nutrition assistance. The proposed CFAP budget includes $68.5 million GF for food benefits in 2012-13.

Background on CalFresh Eligibility & Benefits: Most CalFresh recipients must have gross incomes at or below 130 percent of the federal poverty level (which translates to approximately $2,008 per month for a family of three) and net incomes of no more than 100 percent of the federal poverty level ($1,545 per month for a family of three) after specified adjustments. CalFresh benefits are provided on electronic benefit transfer cards and participants may use them to purchase food at most grocery stores and at convenience stores or farmers' markets that accept them. The average monthly benefit per household is around $335 ($150 per person).

Caseload Trends[1]: The CalFresh caseload grew every year from 1988-89 through 1994-95 and then declined each year until 1999-2000. The caseload has risen each year since that time, including recent growth of around 30 percent in 2009-10 and 20 percent in 2010-11. The Governor's budget assumes 16 percent growth in 2011-12 and 15 percent growth in 2012-13.

State Fiscal Year	# of Households
2007-08	625,511
2008-09	776,079
2009-10	1,009,292
2010-11	1,207,837
2011-12*	1,402,103
2012-13*	1,607,426

*Estimated

Performance Measures: The federal government assesses states' performances in the administration of SNAP programs via measures that include participation rates and administrative error rates. Participation rates rely on samples to estimate how many people who are eligible for SNAP or CalFresh benefits are receiving those benefits. They are measured for the population as a whole and specifically for the working poor. Nationally, 72 percent of eligible people received SNAP benefits in federal fiscal year 2009 (the last year for which data is available). In the western region of the country, the overall participation rate was lower at 63 percent. The participation rate for the working poor population was 60 percent nationally. California's overall participation rate was the lowest in the nation at an estimated 53 percent.[2] California's participation rate for the working poor population was also the lowest in the nation at an estimated 36 percent.

[1] Growth and caseload figures represent the "non-assistance" CalFresh caseload. Around another 330,000 households receive CalFresh benefits along with CalWORKs in 2011-12.

[2] DSS notes that the federal government does not count the state's "cash-out" policy for SSI/SSP recipients (whereby those individuals receive a small food assistance benefit through SSP and are not eligible for additional CalFresh benefits) in its participation rate. The Department estimates that the state's participation rate could be higher at 58 percent if 542,000 of those individuals who would otherwise be eligible for CalFresh were counted as participating because of the cash-out policy. The state would still have the lowest participation rate in the nation, but would then be closer to the next lowest ranked states (Wyoming and New Jersey, which have estimated participation rates of 59 percent).

While California's caseload has doubled in recent years, this does not necessarily alter the state's participation rate in a significant way because the number of eligible households and individuals has also risen steeply.

Accuracy or error rates are measured through state and federal review of a sample of cases to determine how frequently benefits were over- or under-issued. States are subject to federal sanctions when their error rates exceed six percent for two consecutive years. As of September 2011, California's error rate was 4.1 percent. The national average was 3.6 percent. California was sanctioned $11.8 million, $114.3 million, and $60.8 million in 2000, 2001, and 2002, respectively.

Proposed Changes in Program Administration: The Governor's budget includes the following proposals related to CalFresh administration in 2012-13:

1) A budgeting **adjustment** to take into account counties' expenditure patterns for the past few years.

   The January budget estimated that this adjustment would result in savings of $71.9 million GF in 2012-13. However, the Administration has since indicated that potential changes to this estimate are pending.

2) Various changes under a **"Refresh Modernization"** initiative to reduce administrative complexity, remove barriers to accessing the program, and modernize in advance of health care reform [with costs of policy changes assumed to be fully offset by administrative savings and economic benefits of increased federal CalFresh benefits, and $1.1 million ($385,000 GF) for automation].

   The proposed changes were developed in consultation with stakeholders, including advocates and the County Welfare Directors Association. They include: a) waiver of a face-to-face interview at recertification for households of people who are aged or who have a disability and do not have any earnings (estimated to reduce the time it takes to recertify these cases by half), b) implementing alternatives to face-to-face interviews at initial intake in 15 counties that have not yet done so, and c) automation solutions, including emailing certain notifications to recipients, permitting the use of telephonic signatures, and developing online case access for recipients.

3) Changes to state policies regarding **transitional recertifications** so that counties initiate aspects of the process rather than households (with costs of $370,000 GF in 2012-13 and automation changes assumed to be made without additional funding).

   This change is proposed in order to bring the state into compliance with federal rules about to avoid breaks in food benefits for households moving from transitional to ongoing benefits.

4) Increased funding as a result of **recently enacted legislation**, including:
   a. $32.1 million ($12.5 million GF) for AB 6 (Chapter 501, Statutes of 2011),

b. $3.8 million ($1.4 million GF) for AB 69 (Chapter 502, Statutes of 2011), and
c. $1.9 million ($960,000 GF) for AB 402 (Chapter 504, Statutes of 2011).

The changes in these statutes include elimination of a requirement to fingerprint CalFresh recipients, conversion from a quarterly to a semi-annual reporting system for eligibility determinations in CalFresh and CalWORKs, creation of a utility outreach service benefit, allowances for counties to rely on existing information regarding low-income seniors that is already collected by the federal government, and streamlining of the CalFresh application process through partnerships with local school districts. Of the total costs for implementing AB 6 in 2012-13, $13.8 million ($3.7 million GF) are associated with automation and training activities that are expected to end after 2013-14.

Efforts to Improve Participation: DSS indicates that California is making significant program changes to increase access to the CalFresh program. Several of these changes are included in the recently enacted legislation referenced above. The Administration also intends for the CalFresh Refresh Modernization referenced above to simplify the program's administration and remove barriers to access. Other efforts include a streamlined inter-county transfer process and state-level outreach planning, including a new partnership with the Department of Aging.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the above-described changes to the budget for CalFresh administration, except for the adjustment related to county expenditure patterns, which staff recommends that the Subcommittee hold open.

Questions for the Administration & LAO:

1) To what do you attribute California's low CalFresh participation rate?

2) How can the state better ensure that more eligible low-income Californians receive federally funded food benefits?

3) Are there additional efficiencies that the state could achieve in order to increase participation while utilizing existing administration funding?

2. In-Home Supportive Services (IHSS)

IHSS Overview

With a 2011-12 budget of $5.0 billion ($1.4 billion GF), the IHSS program provides personal care services to approximately 440,000 qualified low-income individuals who are blind, aged (over 65), or who have disabilities. IHSS services include tasks like feeding, bathing, bowel and bladder care, meal preparation and clean-up, laundry, and paramedical care. These services frequently help program recipients to avoid or delay more expensive and less desirable institutional care settings.

Funding and Oversight: IHSS is funded with federal, state, and county resources. Recently, the state opted to implement the program under a new federal Medicaid waiver option called the Community First Choice Option (CFCO), which offers an enhanced rate of 56 percent federal financial participation (six percent over the base rate of 50 percent). The state is also benefitting from an additional enhanced rate of 75 percent for a period of one year for IHSS recipients transitioning from nursing facilities to community-based settings. The state and counties split the non-federal share of IHSS funding at 65 and 35 percent, respectively. The average annual cost of services per IHSS client is estimated at $11,420 for 2012-13.

Program Structure and Employment Model: County social workers determine eligibility for IHSS after conducting a standardized in-home assessment, and periodic reassessments, of an individual's ability to perform specified activities of daily living. Once eligible, the recipient is responsible for hiring, firing, and directing an IHSS provider or providers. The counties or public authorities must conduct a criminal background check and provide an orientation before a provider can receive payment. At the end of 2011, there were just over 366,000 working IHSS providers. County public authorities are designated as "employers of record" for collective bargaining purposes, while the state administers payroll, workers' compensation, and benefits. Hourly wages for IHSS providers vary by county and range from the minimum wage of $8.00 per hour in nine counties to $12.20 in one county. The state participates in the costs of wages up to $12.10 ($11.50 plus $.60 for health benefits) per hour, with counties paying the difference if they negotiate a higher wage. In approximately 72 percent of cases, IHSS recipients choose a family member to provide care (including roughly 45 percent of providers who are a spouse, child, or parent of the recipient). In around half of cases,

A Few Facts About IHSS:

- There are 440,000 low-income IHSS recipients who are aged, blind, or who have disabilities.
- Services include personal care (bathing, grooming, etc.), as well as domestic and related activities of daily living.
- There are 366,125 IHSS providers whose wages vary from $8.00 to $12.20 hourly.
- In 2012-13, services are estimated to cost an average of $11,420 annually per client.

IHSS providers live with the recipients.

Recent Changes: The last three budgets included significant changes to IHSS. The following are in effect or pending implementation (savings are annual for 2012-13 unless otherwise noted):

Additional **program integrity measures**, including background checks and criminal records exclusions for providers, more training for social workers, changes to time sheets, and directed mailings or unannounced home visits when there is a concern.
Savings of $151.1 million General Fund from a requirement for recipients to obtain from a licensed health professional **a certification of their need** for services to prevent risk of out-of-home care.
Savings of $145.1 million General Fund from the federal **CFCO waiver** option.
Upon federal approval, savings of $95.5 million General Fund as a result of a **sales tax on supportive services** and matching funds for the use of the tax revenues.
Current year savings of $64.4 million General Fund from an **across-the-board reduction** of 3.6 percent in all recipients' authorized hours until July 1, 2012.
Increases in **out-of-pocket costs for consumers** (resulting from elimination of what was called a "share-of-cost buy-out").
Reductions in administrative funding for Public Authorities.

The following changes were also enacted, but federal courts have stopped them from taking effect as a result of ongoing litigation:

Savings of approximately $222.0 million General Fund (full year impact) from an across-the-board reduction, subject to specified exemptions and exceptions, of 20 percent of authorized hours. This reduction was triggered by lower than anticipated 2011-12 revenues.
Savings of $65.5 million General Fund from reducing to $10.10 ($9.50 plus $.60 per hour for health benefits) the maximum provider wages the state participates in.
Elimination of eligibility, subject to exemptions, for domestic and related services or all services, for individuals whose needs were assessed to be below a specified threshold.[3]

The 2011-12 budget also established a pilot that requires DHCS to identify Medi-Cal beneficiaries at high risk of not taking medications as prescribed and to procure

[3] This reduction has been statutorily delayed until July 1, 2012, subject to a final court order upholding the policy. No updated estimate of the savings associated with the policy is available at this time.

automated machines to assist them. If the pilot and any enacted alternatives for achieving savings would not together result in $140 million General Fund, an across-the-board reduction in IHSS services, with specified exceptions, would begin October 1, 2012.

Proposed Restrictions on Domestic & Related Services

Budget Issue: The budget proposes $206.2 million net GF savings in 2012−13 from the elimination of domestic and related IHSS services for approximately 245,000 IHSS recipients who reside in shared living arrangements and currently receive these services on a pro-rated basis and 80,000 who reside in shared living arrangements and currently receive these services without prorating (with some duplication between these groups). In roughly 0.2 percent or around 1,000 of these cases [accounting for $1.2 million ($0.4 million GF) of the proposed savings], the recipient is a child under the age of 18. The estimated savings account for administration costs of $9.4 million ($3.3 million GF) associated with the policy changes. There would also be corresponding losses of $317.0 million and $4.7 million in federal funds for services and administration, respectively. The budget assumes enactment of this policy by April 1, 2012, which would allow for a full-year of implementation to begin 90 days after enactment on July 1, 2012. The Administration made a similar proposal last year, which was rejected by the Legislature.

Background: Domestic and related services include housework, meal preparation, meal clean-up, laundry, shopping, and errands. The proposal also impacts heavy cleaning and yard hazard abatement services. 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. The Administration proposes to instead make all IHSS beneficiaries residing in shared living arrangements ineligible for domestic and related services based on the presumption that the underlying needs can be met in common. The proposal includes exceptions that rebut that presumption when: a) all other household members are IHSS recipients (estimated to be the case for one percent of domestic and related service recipients), or b) all other household members have physical or mental impairments that prevent them from performing domestic and related services (the prevalence of which the Department was unable to estimate). Under the proposed policy, the existence of an impairment would have to be verified by "reliable evidence," such as social worker observation or medical certification.

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: Recipients who reside in shared living arrangements and currently receive pro-rated domestic and related services would lose an average of 14 hours of services per month, effective 90 days after enactment of the proposed change. Recipients who live with others and have non-pro-rated hours today would lose an average of 9 hours of domestic and related services per month, effective after notice following their next reassessment.

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

Questions for the Administration & LAO:

1) Please briefly describe the proposal.

2) Under the proposed policy, would an IHSS recipient potentially be eligible for domestic and related services if his/her need was not being met in common for reasons other than a housemate's receipt of IHSS or physical or mental impairment (e.g., because the housemate is not available or not willing to assist)?

3) Does the presumption that domestic and related needs are met in common extend to areas of the house that are not shared (e.g., cleaning the recipient's bedroom and bathroom) or responsibilities that are not shared (e.g., laundering the recipient's sheets if s/he sleeps alone)?

4) What analysis has the Administration conducted to determine whether this reduction would comply with federal and state Medicaid and disability-related laws?

5) How does this proposal fit in with the Administration's Coordinated Care Initiative proposal, which relies on an increased investment in IHSS and other long-term care supports and services in order to reduce costs associated with hospitalizations and nursing home stays.

Medication Dispensing Machine (MDM) Pilot & Related IHSS Trailer Bill Language

Budget Issue: The 2011-12 budget established a medication dispensing machine pilot project that requires DHCS to identify Medi-Cal beneficiaries at high risk of not taking medications as prescribed and to procure automated machines to assist them. If the pilot and any enacted alternatives for achieving savings would not together result in $140 million GF, an across-the-board reduction in IHSS services, with specified exceptions, would begin October 1, 2012. The 2012-13 budget proposes to repeal these statutory requirements. The Department of Health Care Services indicates that further research led the Administration to conclude that the pilot may not result in savings and another 20 percent across-the-board reduction in IHSS services has since been enacted.

Medication Dispensing Machine (MDM) Pilot: DHCS and the California Medicaid Research Institute (CaMRI) contracted with the University of California, Davis Center for Healthcare Policy and Research (CHPR) to further assess the potential cost savings associated with the MDM pilot enacted last year. Their work was based on a review of the evidence-based literature related to the causes of non-adherence with medication prescriptions (e.g., characteristics of the patient, such as knowledge related to medication or personality factors, and factors related to the medication regimen, such as side effects and complexity). After this review, CHPR concluded that there is insufficient evidence to reliably assess the effectiveness of MDMs for overcoming many of these factors. The Center assumed that MDM would primarily assist patients who do not take medications as prescribed because of reasons like forgetfulness, confusion, or other cognitive impairments (and would not necessarily prevent adverse health consequences from other reasons for non-adherence). In addition, data available to DHCS does not allow the Department to clearly identify the group of patients who would be likely to suffer from these particular challenges and to use a high-cost health care service, such as in-patient hospitalization, as a result. For these reasons, CHPR recommended that before moving forward with statewide implementation of the pilot, the state would need to obtain the results of a research study lasting approximately three years and costing $3 million to $3.5 million.

DHCS estimates that moving ahead with full-scale implementation this year could result in net Medi-Cal costs from $5.2 up to $57.4 million GF. On the other end of the spectrum, in the most optimistic scenario, the state could instead save $59.9 million if allowed to share savings with the federal government. Ultimately, however, DHCS believes that the potential costs are more likely to be incurred than the savings are to be achieved. As a result, the Administration proposes to repeal the MDM pilot rather than invest significant additional time in researching or implementing the project.

Background on Other Across-the-Board Reductions in IHSS: The 2011-12 budget includes a reduction of $195.9 million ($64.4 million GF) from an across-the-board reduction of 3.6 percent in all recipients' authorized hours that is authorized until July 1,

2012. There are no exceptions to this existing reduction policy. The 2012-13 budget assumes that this 3.6 percent reduction will expire as currently scheduled.

The 2011-12 budget also included a 20 percent across-the-board reduction in authorized hours, with specified exemptions and exceptions, that was scheduled to take effect only if a related statutory "trigger" was pulled because of lower than anticipated revenue receipt. That trigger was pulled in December 2011. However, a federal court issued an injunction that prevented the reduction from taking effect. The 2012-13 budget assumes approximately $222.0 million GF from the full-year impact of the policy. At the same time, the Administration proposes a set-aside to fund the program in the event that the reduction continues to be enjoined.

Subcommittee Staff Comment & Recommendation: Staff recommends approving the proposed trailer bill language to repeal the medication dispensing machine pilot and the related trigger for an across-the-board reduction in IHSS hours.

Questions for the Administration:

1) What are the findings of available research regarding the causes of patients' non-adherence to medication prescriptions?

2) What research has been conducted on the effectiveness of medication dispensing machines in remedying the associated problems?

3) Please summarize your estimates of the likely costs or savings from implementing the pilot project as enacted.

3. Supplemental Security Income/State Supplementary Payment (SSI/SSP)

SSI/SSP Grants

Budget Issue: The Governor's budget recognizes the continuing impact of a 3.6 percent federal cost-of-living adjustment (COLA) that increased SSI/SSP payments as of January 1, 2012. The increase was $24 (from $830 to $854) for the typical individual recipient and $37 increase (from $1,407 to $1,444) for the typical couple. The budget also estimates that a federal COLA of 0.2 percent will increase grants further as of January 1, 2013. However, the final determination of this 2013 COLA will not be made by the federal government until later in the year.

The budget also includes parallel adjustments to grants provided under the Cash Assistance Program for Immigrants (CAPI). CAPI benefits are equivalent to SSI/SSP benefits, less $10 per individual and $20 per couple (so $844 and $1424, respectively), for legal immigrants who do not qualify for federal assistance. The total budget for CAPI is proposed to be $135.1 million GF.

Background on SSI/SSP: The SSI program is a federal cash assistance program that provides income support to low-income individuals and couples who are aged, blind, or who have disabilities. California supplements SSI grants through the state's SSP. There are approximately 1.3 million SSI/SSP beneficiaries in 2011-12. Around 70 percent qualify because of a disability, while 28 percent qualify because of advanced age and two percent because of blindness.

In prior years when there was a federal COLA that increased SSI benefits, the state was able to simultaneously lower its SSP payments (effectively "capturing" the federal COLA in order to save GF resources). However, state SSP payments are now at the minimum level required under federal Maintenance of Effort (MOE) requirements that look to the level of 1983 payment standards. If the state were to lower its SSP benefit levels below the federally required MOE, it would lose federal Medi-Cal funding.

Subcommittee Staff Comment & Recommendation: Staff recommends approving the budgeted changes in SSI/SSP grant levels, which include increases related to federal COLAs. This item was included for informational purposes as the Legislature receives frequent questions from the public about the level of SSI/SSP grants and impacts of federal COLAs.

Questions for the Administration & LAO:

1) Please briefly summarize the changes to SSI/SSP grant levels in recent years and as proposed for 2012-13.

4. CalWORKs

Maximum Aid Payments in Exempt Cases

Budget Issue: The Governor's budget proposes savings of $50.1 million TANF and GF from reducing grants for approximately 105,000 families with unaided, non-parent caretaker relatives or aided adults who receive specified disability-related benefits or assistance through the In-Home Supportive Services (IHSS) program as the head of household. Under existing law, these families (who make up approximately 18 percent of the CalWORKs caseload) are eligible for a higher maximum aid payment (referred to as the "exempt-MAP") than other families receiving CalWORKs. The difference between the average grant for these families and other families receiving CalWORKs benefits is $54. As an example, the MAP for most families of three receiving CalWORKs in a high-cost county is $638 as of July 1, 2011. By comparison, the maximum grant for a family of three that qualifies for an exempt-MAP is $714. As a result of the proposed reduction, 828 families would lose all assistance because their incomes would be too high for the resulting changes to eligibility criteria.

As discussed in the agenda for the full Committee's hearing on March 1, 2012 (available online at http://sbud.senate.ca.gov/fullcommitteehearings), the budget also proposes a reduction of 27 percent in the maximum child-only grants that would be available under the new Child-Maintenance program. Some families would be impacted by both the proposed child-only grant cut and the elimination of the exempt-MAP differential.

Background on CalWORKs Grant Levels: The overall average grant for CalWORKs recipient families is currently $471 per month (up to a maximum of $638 for a family of three in a high-cost county). This includes the impacts of a four percent reduction to the MAP enacted as part of the 2009-10 budget and an eight percent reduction to the MAP enacted as part of the 2011-12 budget. The maximum grant is also the same in actual dollars today as it was in 1987. After adjusting for inflation, the California Budget Project calculates that the purchasing power of today's grants is already less than half of what it was in 1989-90.

Higher exempt-MAPs have been in place since the mid-1990s in recognition that some recipients who are not able to work would not be able to make up for income lost due to grant reductions happening at the time. The state opted to continue providing this higher exempt-MAP after implementing federal welfare reform in 1997. While the exempt-MAP has declined in tandem with reductions to the regular MAP, a differential between the two has existed since that time.

Subcommittee Staff Comment & Recommendation: Staff recommends holding this issue open pending further discussion and actions related to CalWORKs.

Questions on next page

Questions for the Administration & LAO:

1) What is the policy rationale for eliminating the exempt-MAP, which has historically been higher in recognition that some families include adults who are unable to work and make up for lost income because of a disability?

2) How are families expected to fare in light of such historically large grant reductions that would come on top of other recent grant reductions?

3) What are the anticipated human consequences of an increased number of the state's children living farther below the federal poverty line? What pressures on other state and local systems, such as Child Welfare Services, might result?

Cal-Learn Program

Budget Issue: The Governor's budget proposes $35.4 million in savings from eliminating state funding for Cal-Learn, with the exception of funding for bonuses paid for satisfactory educational progress and high school graduation. The Administration indicates that counties could choose to provide intensive case management services to pregnant and parenting teens, but would have to do so without state resources.

Background on Cal-Learn: Cal-Learn provides intensive case management, supportive services, and fiscal incentives (bonuses) and disincentives (sanctions) to eligible teen recipients who are pregnant or parenting. The projected caseload for the program in 2012-13 includes 10,500 teens. The program's services are intended to encourage teen parents to stay in high school or an equivalent program and earn a diploma. Cal-Learn was evaluated by the University of California, Berkeley in 2000 and found to increase the number of teens who graduated (from 24 to 32 percent for 18-19 year olds and 33 to 47 percent by their 20th birthday).

Suspension in 2011-12: With the exception of the bonuses paid for satisfactory progress and graduation, state funding for the program was suspended as a part of the 2011-12 budget (in SB 72, Chapter 8, Statutes of 2011, a human services trailer bill). Some counties may have continued the program with other funding this year. The County Welfare Directors Association indicates, however, that few counties would likely be able to continue the program long-term if state funding is eliminated as proposed. Teens who would otherwise have participated in Cal-Learn during this year instead became eligible for regular welfare-to-work services and supports.

Subcommittee Staff Recommendation & Comments: Staff recommends holding this issue open pending further discussion and actions related to CalWORKs.

Questions on next page

Questions for the Administration & LAO:

1) What information is the Administration tracking in order to determine the impacts of suspending or eliminating funding for Cal-Learn?

2) Is the suspension or elimination of Cal-Learn funding likely to lead to fewer teen parents who are CalWORKs recipients graduating from high school or an equivalent program?

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

March 15, 2012

Human Services Hearing Outcomes

Department of Aging (CDA)

Multi-Purpose Senior Services Program (MSSP)

Held open the integration of MSSP into managed care pending further discussion and actions related to the larger Coordinated Care Initiative.

Department of Rehabilitation (DOR)

Rehabilitation Appeals Board

Held open.

Department of Social Services (DSS)

1. CalFresh

CalFresh Program Overview & Administration

Voted 2-1 (Emmerson no) to approve changes to the budget for CalFresh administration described in the agenda, except for the adjustment related to county expenditure patterns, which the Subcommittee held open.

2. In-Home Supportive Services (IHSS)

IHSS- Trailer Bill Language to Define Criteria for Preapproval of Exceptions to 20 Percent Reduction

Voted 3-0 to reject the trailer bill language at this time.

IHSS- Trailer Bill Language to Amend Effective Date of Sales Tax on Supportive Services

Voted 3-0 to approve the proposed technical change to the effective date of these statutory provisions.

Proposed Restrictions on Domestic & Related Services

Held open.

Medication Dispensing Machine (MDM) Pilot & Related IHSS Trailer Bill Language

Voted 3-0 to repeal the medication dispensing machine pilot and 2-1 (Emmerson no) to repeal the related trigger for an across-the-board reduction in IHSS hours.

3. Supplemental Security Income/State Supplementary Payment (SSI/SSP)

SSI/SSP Grants

Voted 3-0 to approve the budgeted changes in SSI/SSP grant levels, which include increases related to federal COLAs and 2-1 (Emmerson no) to approve the related changes in CAPI grants.

4. CalWORKs

Maximum Aid Payments in Exempt Cases

Held open.

Cal-Learn Program

Held open.

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, March 22 (Room 4203)

A. Department of Health Care Services

I. VOTE ONLY

1. Abolish Four Funds That Are No Longer Used

- Action – Adopt placeholder trailer bill language.
- Vote- 3-0

2. Medi-Cal Coverage of Juvenile Inmate Inpatient Costs

- Action – Approve Administration's proposal.
- Vote- 3-0

3. Medi-Cal Ground Emergency Medical Transportation

- Action – Approve Administration's proposal.
- Vote- 3-0

4. Maternal, Child and Adolescent Health Reductions

- Action – Approve Administration's proposal.
- Vote- 3-0

5. Breast and Cervical Cancer Treatment Program

- Action – Approve Administration's proposal.
- Vote- 2-0 (Senator Emmerson not voting.)

6. Extend Sunset Date for Rogers Amendment

- Action – Adopt placeholder trailer bill language.
- Vote- 3-0

7. Medi-Cal Targeted Case Management

- Action – Approve Administration's proposal.
- Vote- 3-0

8. **Local Educational Agency (LEA) Medi-Cal Billing Option Program – Staff**
   - Action – Approve Administration's proposal.
   - Vote- 3-0

II. ISSUE FOR DISCUSSION

1. **Sacramento Geographic Managed Care: Dental Services**
   - Action – Approve Senator Steinberg's placeholder trailer bill language in lieu of the administration's proposed trailer bill language regarding dental managed care performance measures.
   - Vote- 3-0
2. **Lock-In at Annual Open Enrollment for Medi-Cal Managed Care**
   - Action – Held Open
3. **Federally Qualified Health Center/Rural Health Clinic Payment Reform**
   - Action – Held Open
4. **Value-Based Purchasing**
   - Action – Held Open
5. **Eliminate Sunset for AB 1629 – Nursing Home Quality Assurance Fee**
   - Action – Held Open
6. **Eliminate Sunset for LEA Medi-Cal Billing Option Program**
   - Action – Approve staff recommendation.
   - Vote – 2-0 (Senator Alquist absent.)
7. **Redirecting Unpaid Stabilization Funding**
   - Action – Held Open
8. **Interest Rates on Medi-Cal Overpayments**
   - Action – Approve Administration's proposal.
   - Vote – 2-0 (Senator Alquist absent.)
9. **Hospital Quality Assurance Fee**
   - Action – Held Open
10. **Money Follows the Person**
    - Action – Approve Administration's proposal.
    - Vote – 2-0 (Senator Alquist absent.)

11. Access Monitoring Program

- Action – Held Open

B. 4280 Managed Risk Medical Insurance Board (MRMIB), on page 44 for issues.

1. Transition of Healthy Families Children to Medi-Cal – MRMIB and DHCS

- Action – Held Open

2. Healthy Families Program Rate Reduction

- Action – Held Open

3. Transfer of MRMIB Programs to the Department of Health Care Services

- Action – Held Open

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

March 22, 2012

9:30 AM or
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

(Michelle Baass)

PLEASE NOTE:

Only those 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 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.

4260 Department of Health Care Services

I. BACKGROUND – Medi-Cal Program

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: (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).

Medi-Cal Eligibility. 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.

Most Medi-Cal clients are from households with incomes at or below 100 percent of federal poverty level ($18,890 annually for a family of three).

Enrollment. Estimated Medi-Cal enrollment for the current year is 7.7 million people and for 2012-13 it is 8.3 million people. Medi-Cal provides health insurance coverage to over 20 percent of Californians.

Summary of Governor's Budget for 2012-13. As shown in the table below, the Governor proposes total expenditures of almost $57.7 billion ($14.8 billion General Fund, $34.3 billion federal Title XIX Medicaid funds, and $8.7 billion in other funds) for Medi-Cal in 2012-13.

This reflects a proposed *increase* of about $7.5 billion (total funds), or 15 percent, as compared to the revised 2011-12 budget.

Table: Medi-Cal Funding Summary (dollars in millions)

	2011-12	**2012-13**	**Difference**	**Percent**
	Revised	**Proposed**		
Benefits	$46,929.5	$54,416.2	$7,486.7	16.0%
County Administration (Eligibility)	2,913.7	3,015.5	101.8	3.5%
Fiscal Intermediaries (Claims Processing)	389.5	303.0	-86.5	-22.2%
Total-Local Assistance	**$50,232.7**	**$57,734.7**	**$7,502.0**	**14.9%**
General Fund	$15,297.1	$14,800.1	-$497.0	-3.2%
Federal Funds	$31,414.3	$34,271.7	$2,857.4	9.1%
Other Funds	$3,521.3	$8,662.9	$5,141.6	146.0%

II. VOTE ONLY

1. Abolish Four Funds That Are No Longer Used

Budget Issue. The budget proposes to add sunset dates for the following special funds:

1. Emergency Services and Supplemental Payments Fund (0693)
2. Medi-Cal Medical Education Supplemental Payment Fund (0550)
3. Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund (0549)
4. Small and Rural Hospital Supplemental Payments Fund (0688)

The Emergency Services and Supplemental Payments Fund has a balance of $10,000, DHCS is working with the State Controller's Office to transfer this balance to the Distressed Hospital Fund (as allowed by state law).

Background. The supplemental funds proposed to be discontinued were originally established to supply funds for the nonfederal share of supplemental payments to Disproportionate Share Hospitals.

The funding mechanism for the non-federal portion of these supplemental payments has changed since the establishment of the funds, most notably by SB 1100 (Chapter 560, Statutes of 2005). The intent of SB 1100 was to zero out the balances of the prior supplemental funds by transferring 20 percent of the money in the prior supplemental funds to the Distressed Hospital Fund each year over a five year demonstration period.

Existing statute does not specify a sunset date for these funds, nor does it provide any other mechanism by which the funds can be abolished. Amending current law to provide a sunset date for the statutory references to these prior supplemental funds will avoid inaccurate and outdated fiscal records, inconsistencies with current law, and DHCS staff time to track the funds and provide reports.

Subcommittee Comment and Recommendation—Approve. This proposal is consistent with state law. No issues have been raised with this proposal. It is recommended for approval.

2. Medi-Cal Coverage of Juvenile Inmate Inpatient Costs

Budget Issue. The DHCS is requesting one permanent position (an associate governmental program analyst) to assist in the development of a process to allow counties and the California Department of Corrections and Rehabilitation (CDCR) to receive available federal funds for inpatient hospital services and inpatient psychiatric services provided to Medi-Cal eligible juvenile inmates off the grounds of a correctional facility. The cost of this position is $99,000 ($49,500 reimbursement from counties and $49,500 federal funds).

Background. Current law provides Medi-Cal eligibility to adults incarcerated in a state correctional facility if the individual receives inpatient hospital services off the grounds of a correctional facility. AB 396 (Chapter 364, Statutes of 2011) allows counties and CDCR to receive any available federal financial participation for acute inpatient hospital services and inpatient psychiatric services provided to juvenile inmates who are admitted as patients to a medical institution off the grounds of the correctional facility, and who, but for their institutional status as inmates, are otherwise eligible for Medi-Cal benefits. DHCS is responsible for developing a process that would allow CDCR and counties that elect to voluntarily provide the nonfederal share of expenditures to be able to claim for federal funds.

Subcommittee Comment and Recommendation—Approve. This proposal is consistent with state law. No issues have been raised with this proposal. It is recommended for approval.

3. Medi-Cal Ground Emergency Medical Transportation

Budget Issue. The DHCS is requesting one and a half (1.5) positions and reimbursement authority for internal accounting and legal services efforts to initiate the Medi-Cal Ground Emergency Medical Transportation (GEMT) Services Program. The annual cost for this proposal is $238,000 ($119,000 reimbursements and $119,000 federal funds).

Background. Local fire departments in their first response capacity participate in transporting Medi-Cal patients at an increasing rate. For example, ambulance transports of Medi-Cal enrollees increased 19 percent from 2006 to 2009.

AB 678 (Chapter 397, Statutes of 2011) allows GEMT service providers owned or operated by public entities to receive supplemental Medi-Cal reimbursement, in addition to the rate of payment that these providers would otherwise receive, up to 100 percent of their actual allowable costs. The non-federal share of the supplemental reimbursement would be paid with funds from specified governmental entities through certified public expenditures (CPE). The intent of this legislation is to relieve the financial burden of these eligible public entities by providing supplemental reimbursement at no cost to the state. AB 678 also authorizes the reimbursement of DHCS administrative and staffing costs, so that the General Fund is not affected.

Subcommittee Comment and Recommendation—Approve. This proposal is consistent with state law. No issues have been raised with this proposal. It is recommended for approval.

4. Maternal, Child and Adolescent Health Reductions

Budget Issue. The DHCS requests to reduce federal expenditure authority by $1.2 million ($755,000 in state operations and $405,000 in local assistance) and eliminate 4 positions related to its work on maternal, child and adolescent issues.

(Reductions to the Department of Public Health's MCAH funding were discussed at the March 8, 2012 Senate Budget Subcommittee #3 Hearing.)

This proposed reduction is a result of several factors, including:

- The redirection of Title V Block Grant funds to programs that were previously funded with General Fund. Since 2007-08, a cumulative total of $13.4 million in Title V funds have been redirected.
- A net reduction in the federal Title V Block Grant funding. On July 15, 2011, the Department of Public Health received notice from the federal government that the Title V Block Grant would be $800,000 less than the previous year.
- The increased rate of spending by local health jurisdictions (LHJs). In efforts to ensure that local health jurisdictions spent down the local assistance portion of the Title V Block Grant, the department has awarded LHJs contracts that, cumulatively, exceeded the actual federal block grant amount.

The proposed DHCS reductions are:

- $605,000 – Children's Medical Services (CMS) – Of this reduction, $200,000 would come from the CMS program's operating expenses and equipment support budget. The remaining $405,000 would be from a reduction to the High-Risk Infant Follow-Up (HRIF) Program under the California Children's Services (CCS) program. The CCS HRIF program identifies infants who might develop CCS-eligible conditions after discharge from a CCS-approved Neonatal Intensive Care Unit (NICU).

  CMS will reduce the following: (1) support for one coordinator position at each of the CCS-approved NICUs, (2) the Quality Improvement Collaborative contract with reduction in activities to identify, measure, and improve the outcomes of graduates of CCS-approved NICUs, (3) the level of contractor assistance for the Neonatal Quality Improvement Collaborative, which helps reduce hospital acquired infections at participating CCS-approved NICUs, and (4) the interagency contract with California State University, Sacramento, which provides oversight and training of hospital staff in the usage of the Data Management System.

- $373,000 – Primary and Rural Health Division (PRHD) – The PRHD provides training, technical assistance, and limited funding to primary care providers in underserved areas throughout the state to sustain and improve the primary care infrastructure. This reduction includes the elimination of 4 state positions and will result in delays of

technical assistance, grant execution, and a decrease in support to community health centers and contract oversight.

- $182,000 – DHCS Audits and Investigations – A 50 percent reduction in the number of audits performed on MCAH local contractors.

Subcommittee Staff Comment and Recommendation—Approve. A reduction in the federal block grant and the state's fiscal situation require an assessment of MCAH programs and a prioritization of funding for those programs that are the most effective. It is recommended to approve this proposal.

5. Breast and Cervical Cancer Treatment Program

Budget Issue. The DHCS is requesting an increase of $537,000 ($269,000 General Fund) to continue six limited-term positions until December 31, 2013 to conduct eligibility processing for the Breast and Cervical Cancer Treatment Program (BCCTP).

Unlike other Medi-Cal programs where county eligibility workers make determinations, DHCS staff performs all the eligibility activities for BCCTP. This processing includes compliance with federal requirements such as citizenship verification, redetermination functions, and new applications.

The DHCS states continuation of these positions are necessary for completing redetermination reviews, obtaining retroactive coverage, and to ensure that people are able to access treatment services in a timely manner. Current workload is expected to continue and may increase due to more Medi-Cal enrollees pervasively.

The positions and a summary of key activities are as follows:

- Associate Governmental Program Analysts. A total of four positions are requested for extension. These positions are to (1) perform initial eligibility determination for new applicants; (2) perform determinations for annual review; (3) perform determinations for retroactive coverage; and (4) provide other assistance related to this work.
- Staff Service Manager I. This position is responsible for (1) supervising; (2) reviewing cases for accuracy in eligibility; (3) interpretation of changes to Medi-Cal as they pertain to this program; and (4) updating policies and procedures.
- Office Technician. This position is responsible for (1) organizing all new applications; (2) assigning cases; (3) sets up forms and redetermination packets; (4) files closed cases; and (5) various support activities related to this work.

Background. Established in 2002, this federal program provides cancer treatment services through Medi-Cal as appropriate, contingent upon eligibility. AB 430 (Statutes of 2011) also established a corresponding state-funded program for women and men who do not meet the eligibility criteria for the federal program.

Approximately 4,200 BCCTP applications are received annually. BCCTP staff must complete annual redeterminations each year on 12,136 of the 12,710 active, ongoing BCCTP cases. The remaining cases are state BCCTP cases that do not receive federal funding and are therefore not subject to the federal annual redetermination requirement. As of June 30, 2011, there are 6,864 federal cases overdue for an annual redetermination.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to extend these six positions for the Breast and Cervical Cancer Treatment Program to ensure people have access to treatment.

6. Extend Sunset Date for Rogers Amendment

Budget Issue. The budget proposes trailer bill language to extend the Rogers Amendment sunset date from January 1, 2013, to July 1, 2013, for capitation rates (known as Rogers Rates) paid to non-contract hospitals for emergency inpatient and post-stabilization services provided to Medi-Cal managed care plan (Plan) enrollees. The proposal would also allow DHCS to implement the Rogers rates methodology after June 30, 2012 via All Plan Letters (APL) or other similar instructions, rather than through the regulatory process.

Background. Medi-Cal provides health care services to 7.65 million beneficiaries through two distinct health care delivery systems: the traditional fee-for-service (FFS) system and the managed care system. Approximately 4.3 million Medi-Cal beneficiaries receive health services by enrolling in contracted Medi-Cal managed care Plans in 30 counties. These Plans emphasize primary and preventative care and offer established networks of organized systems of care. Most health care plans contracting with the Medi-Cal program are licensed under the Knox-Keene Health Care Service Plan Act of 1975.

Section 6085 of the Federal Deficit Reduction Act of 2005 established an upper limit to the amount Medicaid health plans may pay to hospitals that are outside the Plans' provider networks (out-of-network hospitals). The federal law, known as the "Rogers Amendment," was in response to demands by out-of-network hospitals for payments that were above the established Medicaid rates normally paid by health plans across the nation for inpatient emergency services.

AB 1183 (Chapter 758, Statutes of 2008) required DHCS to establish inpatient hospital rates as limits to the amounts that may be paid by Medi-Cal Plans to out-of-network hospitals. These rates are for both emergency inpatient bed days and for post-stabilization inpatient bed days.

DHCS is also required to develop and implement a payment methodology based on diagnosis-related groups (DRGs). Statute requires implementation by July 1, 2012, or on a date when the Director of DHCS executes a declaration certifying that all necessary federal approvals have been obtained and the methodology is sufficient for formal implementation, whichever is later. When implemented, these DRG rates will replace the existing Rogers Rates payment methodology.

Current statute provides for the Rogers Rates to sunset on January 1, 2013. Currently, the DRG methodology is expected to be implemented January 1, 2013. However, if there are delays past January 1, 2013, DHCS will not have statutory authority to continue payments under the Rogers Rates methodology to out-of-contract hospitals providing emergency and post-stabilization services to Plan enrollees. DHCS requests that statute be amended to extend the sunset date to July 1, 2013. Once the DRG methodology is implemented, the Rogers Rates will no longer be used.

Additionally, DHCS will need to establish a payment mechanism to cover the time period from the date of expiration of the California Medical Assistance Commission (CMAC) to the date the DRG methodology becomes effective. Existing law requires DHCS to carry out the Rogers Rates methodology through the regulatory process. This proposal would allow DHCS the ability to establish and implement the interim payment mechanism in a timely manner by granting DHCS the authority to extend the Rogers Rates methodology after June 30, 2012, when the CMAC methodology ends, via APLs or similar instruction.

Subcommittee Staff Comment and Recommendation–Approve. Extending the sunset date for an additional six months would allow payments to continue under the Rogers Rates methodology if the DRG rate methodology is not implemented on January 1, 2013. It would also provide plans with a greater degree of program stability by providing more predictability in reimbursement rates. No issues have been raised regarding this proposal.

7. Medi-Cal Targeted Case Management

Budget Issue. The DHCS is requesting to change 8 limited-term positions to permanent positions to support the federal oversight and corrective action for the Targeted Case Management Program. These positions are funded at a cost of $445,000 reimbursement from Counties and $445,000 in federal funds.

The eight positions include: (1) a Health Program Audit Manager I; (2) three Health Program Auditor IVs; (3) three Health Program Auditor IIIs; and (4) an Accountant Trainee.

Background. Targeted Case Management provides comprehensive case management services to Medi-Cal eligibles in six target populations—public health, adult probation, outpatient clinics, public guardian, community, and linkages. Local government agencies (LGAs) (mainly counties) use a "certified public expenditure" (CPE) approach to obtain federal reimbursement. Without this federal reimbursement, many of these services would cease.

In 2005-06, the federal CMS determined that DHCS was out of compliance with federal regulations that prohibit payments to exceed actual expenditures incurred by LGAs. In addition, CMS could not determine whether the CPE expenditures incurred were eligible and properly certified by the LGA. Consequently, CMS placed Targeted Case Management (TCM) local governmental agency claims on deferral in 2003-04 and has continued to defer claims through the 2006-07 budget year for a total of $39 million.

During this timeframe, the federal CMS sent notifications requesting the DHCS to respond to corrective actions to resolve the claims. These corrective actions included performing desk reviews and audits of cost reports and claims to examine the encounter rates, service costs and CPE. DHCS states that these functions need to continue and be expanded for all of the fiscal years in question and going forward.

CMS notified DHCS that it would disallow $18.9 million of the $39 million of deferred claims and the federal funds must be returned. DHCS has the responsibility to recover these funds from LGAs.

Subcommittee Staff Comment and Recommendation—Approve. Subcommittee staff concurs with the DHCS regarding their concern with fiscal integrity and the need for the state staff. This proposal is recommended for approval.

8. Local Educational Agency (LEA) Medi-Cal Billing Option Program - Staff

Budget Issue. The DHCS is requesting to change 14 limited-term positions to permanent positions to perform financial oversight requirements of the "Local Educational Agency" (LEA) billing option provided under the Medi-Cal Program. The positions are funded $820,000 from federal funds and $820,000 from LEAs; it does not require any General Fund.

Background. There are approximately 471 LEA providers participating in the LEA billing option program. The LEA billing option provides the federal share of reimbursement for health assessment and treatment for Medi-Cal eligible children and family members within the school environment.

The billing option program provides early and periodic screening, diagnosis, and treatment services such as physical therapy, occupational therapy, speech and audiology, physician and nursing services, and school health aid services.

As California's lead state agency for the Medicaid Program (Medi-Cal), the DHCS is required to perform financial oversight responsibilities for the LEA billing option to ensure that federal Medicaid funds are being appropriately expended.

These limited-term staff are in the process of completing the reconciliation and audits of the 2006-07 (392 reports), 2007-08 (403 reports), and 2008-09 (422 reports) cost reimbursement reports. DHCS estimates that these activities alone would take at least three years. Additionally, it anticipates 450 reports would need to be reviewed for 2009-10.

In the past the federal CMS has deferred payments to LEAs pending DHCS' completion of cost reimbursement report audits. DHCS notes that if it does not complete these audits, it is likely that CMS will resume deferring LEA claims and disallow $134 million in deferral claims in response to the department's failure to comply with oversight requirements.

Subcommittee Staff Comment and Recommendation–Approve. Permanent workload for this program has been established. It is recommended to approve this proposal to ensure federal payments to local educational agencies.

III. ISSUE FOR DISCUSSION

1. Sacramento Geographic Managed Care: Dental Services

Oversight Issue. It is clear the existing Sacramento Geographic Managed Care (GMC) Dental Services model is inadequate as articulated in correspondence between Senator Steinberg and the Department of Health Care Services (see hand out #1), and as documented through the extensive efforts of First 5 Sacramento, the Sacramento GMC Subcommittee, and the Board of Supervisors.

The March 15th hearing of the Select Committee on Healthcare Workforce and Access to Care, chaired by Assembly Member Pan, also illustrated the need for vast improvement with the model.

Senator Steinberg is submitting *placeholder* trailer bill legislation to change state statute, effective July 1, 2012, to improve dental services for children enrolled in Medi-Cal in Sacramento (see hand out #2). Key components of this language are as follows:

- Provide enrollment on a "voluntary" basis in lieu of existing "mandatory" enrollment.
- Require the department to establish performance measures and benchmarks for dental health plans, and to post each plan's performance on the department's website at least twice annually.
- Require the dental health plans to provide performance data to the department.
- Require the department to utilize dental health plan performance data for contracting purposes, including for the establishment of contract incentives and disincentives.
- Require the use of an independent External Quality Review Organization for dental health plans as is similarly done for Medi-Cal Managed Care health plans, and have this information posted on websites for public transparency.
- Require the department to review and approve dental health plan marketing plans.
- Require the department to review and approve member services procedures.
- Require the Department of Managed Health Care to report to the Legislature regarding its surveys of the five dental plans participating in the Sacramento Geographic Managed Care Program.

Discussions with stakeholder interests and the Administration are to continue over the next two months to further craft this proposed language which is intended to be included in the Omnibus Health Trailer Legislation for the enactment of the Budget for 2012-13. Statutory changes are necessary in order to effect changes by July 1, 2012, and fiscal assumptions will need updating.

It should be noted that many of the components in the proposed language were included in the Administration's trailer bill language submitted to the Legislature in January as part of the

Governor's proposed transition of the Healthy Families Program to improve dental health plan services. However, the proposed trailer bill language submitted today by Senator Steinberg does not address or include any aspects regarding the Healthy Families Program transition, only dental health plan improvements.

Background—Summary of Key Concerns and Recent Local Actions. First 5 of Sacramento, chaired by Board of Supervisor Phillip Serna, commissioned the "Sacramento Deserves Better" report which analyzed access, utilization and quality of dental care under the GMC Dental Services model. Key findings from this 2010 report included the following:

- Only 20 percent of children in GMC Dental Services used a dental service in 2008 as compared to over 40 percent of children in Medi-Cal statewide who are predominately in Fee-For-Service.
- Only 30 percent of children in GMC Dental Services received a dental service in 2010.
- Sacramento GMC Dental Services is consistently one of the lowest-ranking counties for Medi-Cal dental access in the entire state.
- Dental plans have not complied with "first tooth/first birthday" recommendation for the initial dental visit.
- Inadequate prevention services were provided.
- Minimal oversight by the state Department of Health Care Services of GMC Dental Services contracts.

The County formed a GMC Dental Subcommittee, consisting of numerous local stakeholders, to the County Public Health Advisory Board to develop recommendations for the State Department of Health Care Services (DHCS) to improve the GMC Dental Services model.

From this effort, correspondence to the DHCS offering recommendations was provided on several occasions, culminating with a comprehensive package of suggested contract changes provided in December 2011.

Key recommendations from the GMC Dental Subcommittee have included the following:

- Provide for "voluntary" enrollment in lieu of existing "mandatory" enrollment.
- Implement the Healthy Families Program utilization strategies and dental quality measures in Medi-Cal dental contracts.
- Allow families who choose a Federally Qualified Healthcare Center (FQHC) clinic as a dental home to maintain it.
- Develop comprehensive contracts with strong performance measures, including the ability to withhold payments it standards are not met, and the ability to provide incentives for outreach and performance.
- Improve state oversight, including data analysis, on-site visits and audit reviews of Dental Plan performance.

- Address the need for increased patient education and outreach strategies to support access to dental services and rights of Medi-Cal patients to services.
- Make improvements to the Medi-Cal Ombudsman process.

At the request of Supervisor Phillip Serna, the Sacramento Board of Supervisors will be receiving regular updates on GMC Dental Services, including action steps taken on numerous recommendations to the DHCS and to the participating Dental Plans.

Background—Structure of Existing Program. Presently, Medi-Cal operates dental health managed care in two geographic areas: Los Angeles and Sacramento. Los Angeles operates on a voluntary enrollment basis and Sacramento operates on a mandatory enrollment basis. Initiated in 1994 as a pilot project, the State Department of Health Care Services (DHCS) contracts with five Geographic Managed Care Dental Plans (Dental Plans) to provide Medi-Cal dental services in Sacramento. Each of these Dental Plans is licensed by the Department of Managed Health Care (DMHC) pursuant to the Knox-Keene Health Care Service Plan Act of 1975.

Presently, the five Dental Plans include Liberty Dental, Access Dental, Health Net, Western Dental Services, and Community Dental. Each Dental Plan receives a DHCS negotiated per member per month reimbursement rate (presently about $12) for each recipient enrolled in their plan. Due to the elimination of adult dental benefits in Medi-Cal, other than certain federally required services for adults, the program predominately provides services to children and adolescents (less than 21 years of age). There are about 110,000 children enrolled in the program.

Except for a few aid codes, Medi-Cal recipients in Sacramento are *mandatorily* enrolled in one of the Dental Plans. It is the *only county in the state* that has mandatory enrollment for dental services. Los Angeles County also utilizes managed care plans for the provision of dental services but enrollment is done on a voluntary basis. Only about 15 percent of Medi-Cal recipients in Los Angeles enroll in a dental managed care plan.

Recipients are entitled to receive dental benefits from Dentists within the Dental Plan's provider network. Covered dental services under managed care are the same dental services provided under the Fee-For-Service Denti-Cal Program. These services are to include 24-hour emergency care for severe dental problems, urgent care (within 72-hours), non-urgent appointments (offered within 36-days) and preventive dental care appointments (offered within 40-days).

Dentists who wish to provide services under Geographic Managed Care must a member of one of the Dental Plan's provider networks and must be enrolled in the Denti-Cal Fee-For-Service Program.

In addition, the GMC Dental Subcommittee is actively engaged with the DHCS to significantly revise the state's Request for Proposals (RFP) process used to contract with Dental Plans participating in the GMC Dental Services model.

Background—Summary of Recent Actions by DHCS. The DHCS recognizes improvements to the GMC Dental Services model are needed and Director Douglas has made a personal commitment to this effort. Recent actions have included the following:

- Met with the five dental health plans serving Sacramento to discuss how to implement immediate actions to improve access to dental care for children.
- Provided a March 7th letter (see hand out #1) to dental health plans articulating expectations and necessary improvements.
- Convened stakeholder work group to obtain recommendations for improvement, including suggestions for improving the DHCS draft Request for Application (RFA) which in its final form will be used as the basis for contracting with dental health plans.

Prior Subcommittee #3 Hearing of March 8th. In its March 8th hearing, the Subcommittee questioned the Department of Managed Health Care (DMHC) regarding their oversight role of specialty care plans, including dental plans

Subcommittee Staff Comment and Recommendation. The Sacramento GMC Dental Services model has experienced continued problems concerning access to care, referral to specialty dental care, utilization rates, and Dental Plans meeting performance indicators. A report from 2003, "Sacramento Geographic Managed Care: Eight Years Later" also noted considerable concerns regarding the delivery of dental services under the mandatory enrollment structure. The First 5 report and subsequent recommendations from the GMC Dental Subcommittee have documented that considerable change is necessary.

It is recommended to adopt Senator Steinberg's proposed placeholder trailer bill language in lieu of the Administration's proposed trailer bill language regarding improvements to dental health plan services and to continue discussions over the next two months with stakeholders and the Administration.

The Administration's proposal to expand dental managed care is discussed under the Transition of Healthy Families Children to Medi-Cal issue later in the agenda.

2. Lock-In at Annual Open Enrollment for Medi-Cal Managed Care

Budget Issue. The DHCS is proposing trailer bill language that would change the enrollment model for Medi-Cal managed care beneficiaries who are enrolled in Two-Plan Model and Geographic Managed Care counties to an annual enrollment period; whereby, an enrollee could only change plans once a year.

Beneficiaries would receive written notice 60 days prior to the end of an enrollment year, allowing them to change plans during this 60-day period. If the beneficiary does not elect to change plans, he or she would be required to remain in their plan for one year until the next open enrollment period. Additionally, under this proposal, a beneficiary would have the option to change to an alternate plan within the first 90 days following initial enrollment into a managed care plan.

This proposal would achieve $3.6 million General Fund savings in 2012-13 as the number of initial health assessments and mailings performed annually by plans is reduced. This proposal would be implemented October 1, 2012, and cover the nine remaining months of the first fiscal year and each year thereafter.

Table: Estimated Savings with Enrollment Lock-in Proposal

	2012-13	
	Total Funds	General Fund
Total Cost Under Current System (for nine months)	$10,722,852	$5,361,426
Cost to Change Enrollment System	-600,000	-300,000
Cost to Mail Enrollment Packets	-419,194	-209,597
Cost for New Health Assessment	-1,676,777	-838,389
Defer Managed Care Payment	-891,876	-445,938
Savings Under This Proposal	**$7,135,005**	**$3,567,503**

The total savings for 2013-14 would be $12.1 million. In addition, the state would hold the June 2014 payment to the health plans, which would reduce the savings in 2013-14 for this proposal by $110,704, for a net savings of $11.9 million (about $6 million General Fund) in 2013-14.

It should be noted that this proposal requires an amendment to California's 1115 Medicaid Waiver.

Background. Currently, beneficiaries in Two-Plan Model and Geographic Managed Care counties can change plans at the beginning of any month. Approximately 16,687 enrollees (combined for Two Plan Model and Geographic Managed Care) currently switch plans each month, which totals 200,240 changes per year. This represents 5.6 percent of projected mandatory enrollment.

Commercial health plans, Medicare Advantage and Part D Plans, and the Healthy Families Program all have annual open enrollment periods.

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 since 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;
- Improvement in the monitoring of clinical measures used to assess quality of care, such as, HEDIS® (Healthcare Effectiveness Data and Information System);
- Provides Medi-Cal enrollees with a better opportunity to become familiar with their Health Plan and comfortable with using their Health Plan; and
- Reduces costs associated with multiple plan changes such as: multiple initial health assessments, informing materials (printing and distribution).

Mandatory Enrollment of SPDs into Managed Care. In November 2010, California received federal approval for a Section 1115(b) Medicaid waiver from CMS authorizing (among other provisions) expansion of mandatory enrollment of seniors and persons with disabilities (SPDs) into Medi-Cal managed care. This mandatory enrollment began on June 1, 2011 and will last twelve months. Concerns have been raised regarding the low percentage of enrollees actively selecting their managed care plan versus being defaulted into a plan. About 60 percent of this population has been defaulted into a managed care plan and often do not realize that a change to their health coverage was made. Additionally, there have been challenges regarding an enrollee's ability to continue care with a provider. Guidance provided during the SPD transition to managed care states that enrollees would be able to change plans at any time of the year, as needed.

Subcommittee Staff Comment and Recommendation—Deny Proposal. It is recommended to deny the trailer bill language and to adjust the Medi-Cal budget accordingly. Given the recent challenges of mandatorily enrolling SPDs into managed care, it is important to keep the policy that Medi-Cal managed care enrollees can change health plans at any time. This allows an enrollee the ability to change plans to ensure that his or her health needs are being met.

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

1. Please provide a summary of this request.

3. Federally Qualified Health Center/Rural Health Clinic Payment Reform

Budget Issue. The DHCS proposes to integrate all Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) costs into managed care capitated rates by reforming the payment methodology under Medi-Cal. Under this proposal, payments made to FQHCs and RHCs (participating in Medi-Cal managed care contracts) would change from the prospective payment system (PPS) system--a cost and volume-based payment--to a fixed payment to provide a broad range of services to its enrollees. The "wrap-around" payment funds (discussed later) would also be included in the capitated rate; thereby requiring health plans to be fully responsible for reimbursement to FQHCs and RHCs.

Payments to FQHCs and RHCs for beneficiaries who are both Medicare and Medi-Cal eligible would be exempt from this proposal.

Eliminate Operating Restrictions. In addition, the administration proposes to eliminate current operating restrictions that prevent best practices, such as group visits, telehealth, preforming multiple services on the same day, and telephonic disease management. It argues that eliminating these operating constraints would create efficiencies and allow FQHCs and RHCs to institute best practices.

Efficiency Adjustment and Savings. By removing the operating restrictions, DHCS finds that these centers would realize efficiencies in their practices and; consequently, DHCS would reduce their payment by ten percent. This reduction would generate $26 million General Fund savings in 2012-13 and about $58 million General Fund savings in 2013-14.

In order to realize the budget year savings, the administration is proposing to delay $43.6 million (General Fund) in managed care payments to FQHCs and RHCs into 2013-14.

The DHCS notes that the ten percent reduction is a net reduction to these centers and that health plans would not be able to take an additional administrative cut from this rate.

Federal Waiver. The Administration is seeking a waiver from the federal government to reform the payment methodology and to eliminate the operating restrictions. If the federal government does not approve a waiver of the PPS payment requirements, under this proposal DHCS would continue forward with the proposal to eliminate the PPS "wrap" payments and provide all FQHC/RHC funding for managed care beneficiaries through managed care plan capitation rates. In the absence of a waiver, FQHC operating restrictions would remain in place and plans would be required to pay FQHCs at PPS rates, to the extent that plans use these clinics for services.

Proposed Rate Calculation. The clinic-specific, capitated rate would be calculated using the historical per-beneficiary revenue that the clinic would have received under the PPS system as follows:

- Rate based on a facility's current average plan revenue Per Member Per Month (PMPM) (PPS rate X number of plan beneficiaries X average number of visits)
- Method to adjust plan funding quickly regarding shifts in FQHC utilization
- An efficiency savings of ten percent would be removed from the funding provided to plans and the rate paid to FQHC/RHCs.

After the first year, subsequent capitated rate calculations would be developed based on experience and costs, risk mix, and performance and quality outcomes.

Background. FQHCs and RHCs are community-based centers that provide primary and preventative health care services to medically underserved populations or areas without regard to a patient's ability to pay. In addition to receiving grants from the federal government, these health centers are reimbursed for providing Medicare and Medi-Cal services. There are 681 FQHCs and 293 federally designated RHCs in California. In 2009-10, FQHCs and RHCs represented over 90 percent of Medi-Cal expenditures for clinic-based care. In 2009-10, about 1.6 million Medi-Cal beneficiaries made 6.8 million health center visits and nearly 400,000 beneficiaries made 2.1 million rural clinic visits. Also in 2010, 64 percent of primary care visits in the doctor's office or clinic setting were at FQHCs and RHCs.

Additionally, according to the mental health and substance use needs assessment conducted on DHCS' behalf as part of California's Section 1115 Bridge to Reform waiver approval, FQHCs and RHCs play an important role in the provision of mental health and substance use services in California, particularly for people living in rural areas and for underserved populations such as people experiencing homelessness. In the past, FQHCs were required to either provide mental health and substance use services, or have referral relationships with other agencies that could serve people with mental health and substance use treatment needs. However, all new FQHCs are now required to directly provide these services, making FQHC providers an even more valuable resource for ensuring access to mental health and substance use services. In 2010, 108,597 Californians received mental health services and 21,893 people received substance use services from FQHCs.

FQHCs and RHCs were exempt from the 10 percent provider rate reduction authorized in the 2011-12 budget.

PPS. Federal law requires Medi-Cal to reimburse FQHCs and RHCs based on reasonable costs. The current reimbursement system is based on a prospective payment system (PPS). Under PPS, Medi-Cal generally reimburses centers a per-visit rate, which is adjusted by the Medicare Economic Index annually.

Medi-Cal managed care plans commonly contract with FQHCs and RHCs as part of their provider networks and are required to reimburse FQHCs and RHCs in their networks for providing services to plan beneficiaries at rates that are, at a minimum, comparable to other providers of similar services in the same network. Federal law requires Medicaid programs to make up the difference between negotiated rates paid by managed care plans and a center's guaranteed PPS fee-for-service rate. An annual reconciliation determines the total difference between plan payments and PPS payments for the number of patient visits. These "wrap-around" payments (or supplemental payments) paid by Medi-Cal to FQHCs and RHCs with managed care contracts totaled $229 million General Fund in 2009-10.

In addition, FQHCs operate under restrictions that inhibit the clinic's ability to provide efficient care. Restrictions include:

- Payments limited to visits to certain provider types
- Services limited to those provided within the "four walls" of the clinic
- Restriction against multiple payments for multiple services in the same day

These restrictions are in the California's legal definition of a payable visit under the PPS rate payment system.

Subcommittee Staff Comment and Recommendation–Deny Proposal. This is a major policy proposal with a very aggressive timeline. It would have a substantial impact on the community-based center delivery system.

FQHCs and RHCs are critical to the existing Medi-Cal provider network and the future Medi-Cal expansions with federal health care reform. As exemplified by:

- In 2010, 64 percent of primary care visits for Medi-Cal beneficiaries was provided in FQHCs and RHCs.
- In its "Management Brief: DHCS' Monitoring Plan and Initial Assessment of Healthcare Access for Medi-Cal Beneficiaries" completed in October 2011, DHCS indicates that it found that FQHCs and RHCs treated a much higher average number of Medi-Cal beneficiaries during the year compared to physicians in solo practices and other organized outpatient clinics.
- In 2014 under federal health care reform, it is projected that two to three million individuals will be eligible for Medi-Cal; thereby, further increasing the demand for health care services at these centers.

Consequently, it is critical to protect the sustainability of these centers. The proposed rate cut would likely force some FQHCs and RHCs to close and others to restrict hours and limit patient access at a time when the state should be developing methods to increase capacity and maximize the ability to provide more services.

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

1. Please provide a summary of the proposal.

2. Has DHCS begun discussions regarding this specific proposal with the federal CMS? What has been CMS's feedback?

4. Value-Based Purchasing

Budget Issue. The DHCS is proposing trailer bill to establish a process for Value-Based Purchasing in the Medi-Cal fee-for-service (FFS) system. This proposal would save $75 million General Fund in 2012-13 and annually thereafter. Of the $75 million, $26.6 million is attributable to the savings as a result of Medi-Cal no longer paying for services directly related to potentially preventable hospital admissions (for Medi-Cal managed care), as required by the Affordable Care Act (ACA) (effective July 1, 2012).

Under this proposal, DHCS would implement value-based service design to ensure beneficiary access to necessary health care services by adding services or by identifying and reducing services that do not improve health outcomes, may cause harm to patients, or that are overused and should only be provided under limited conditions. Although this process would allow DHCS to change the way in which providers may deliver services, it would not change the benefits covered under the State Plan.

The proposed value-based service design process encompasses the following:

- Evidence review which shall include systematic reviews and individual studies published in peer-reviewed literature or evidence-based treatment guidelines issued by organizations whose primary mission is to conduct objective analyses of the effectiveness of medical or evidence-based clinical practice guidelines.

- Determination of fiscal effect by analyzing proposals for the costs and savings associated with adding, modifying, limiting, or eliminating services.

- Feasibility analyses to consider administrative and process issues related to the addition, modification, limitation, or elimination of services, such as the cost and timeframe for computer system changes, the staffing and expertise needed to craft utilization policies that limit inappropriate use of a service without interfering with appropriate use of that same service, and the ability to use utilization management.

Stakeholder Input. Under this proposal, DHCS would inform and consult with stakeholders, including health professionals, Medi-Cal providers, and consumer advocacy organizations for input prior to implementing changes pursuant to the Value-Based Purchasing process. DHCS would notify stakeholders of proposed changes to targeted services, rate methodologies and payment policies by regularly updating the Medi-Cal website. Stakeholders would have 30 days to provide written input regarding changes proposed through the Value-Based Purchasing process and, upon request, DHCS would provide a public meeting to hear their comments. DHCS would respond to stakeholder comments. Implementation of proposed changes would occur no sooner than 30 days from the date the department notifies stakeholders of the proposed changes or 30 days from the date a public meeting is held.

Outcome Review. DHCS would monitor policy and program changes to ensure that the department obtains the intended results for achieving value regarding clinical quality

outcomes, access, and cost effectiveness. Where ongoing monitoring indicates results are not as expected or negative, DHCS would modify the intervention accordingly.

Federal Approval. DHCS states it would not implement changes pursuant to the Value-Based Purchasing process until it obtains any necessary federal approvals. DHCS would implement changes in the development of rate methodologies and payment policies only if they comply with applicable federal Medicaid requirements and if federal financial participation is available.

Background. Currently, DHCS must use regulations or statute to add, modify, limit, or eliminate reimbursement and services in the Medi-Cal program. For example, DHCS uses the Medi-Cal Manual of Criteria to define services associated with covered benefits, which is embedded in the California Code of Regulations (CCR). According to DHCS, the regulatory process is time-consuming and ineffective, often taking a year or more for completion. During this processing time, the Medi-Cal program continues to pay for services and utilize payment methodologies that may be ineffective and inefficient. According to DHCS, due to the intensive staff effort required to promulgate regulations, the last formal regulatory update to the Manual of Criteria was on December 6, 2007.

Value-Based Purchasing is an approach that is commonly used in the private sector by large, self-insured companies, major public entities responsible for health care purchasing such as CalPERS, and by purchasing coalitions such as the Pacific Business Group on Health. As such, this proposal seeks to align DHCS with other major health care purchasers.

Health care spending continues to increase at a significant rate, but the increased cost is not always accompanied by an increase in the quality of care or value to the consumer. For example, experts estimate that Medicare wastes 20 to 30 percent of its $500 billion in annual expenditures on treatments and procedures that have minimal or no benefit to the patients.

Subcommittee Staff Comment and Recommendation–Hold Open. While the DHCS argues that the Medi-Cal health care delivery system needs to be able to more rapidly respond to the changing field of health care than the current regulatory process allows, the proposed process is outside the current regulatory framework which has established safeguards to ensure stakeholder participation and disclosure of departmental actions. How this process would ensure an appropriate level of input from stakeholders and accountability to the public and Legislature is unclear. Discussions on striking a balance between the ability to be able to rapidly respond to the changing field of health care and the engagement of stakeholders need to continue.

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

1. Please provide a summary of this proposal.

2. What are the barriers with the current regulatory process?

5. Eliminate Sunset for AB 1629 – Nursing Home Quality Assurance Fee

Budget Issue. The DHCS proposes to eliminate the sunset date for the nursing home quality assurance fee (QAF) program and the rate-setting methodology established under AB 1629 (Statutes of 2004) and; thereby, make this program permanent. The QAF program sunsets on July 31, 2013.

If the QAF program and rate-setting methodology sunset dates are not extended, the department will no longer be authorized to assess and collect the QAF and continue paying facility-specific rates to nursing homes. Maintaining the QAF collection offsets General Fund expenditures and can fund rate increases to the skilled nursing facilities. According to DHCS, if the QAF sunsets, over $400 million in General Fund support could be at risk.

In lieu of the AB 1629 methodology, the department indicates it may have to revert to a flat, non-facility-specific rate system and would be unable to fund enhanced payments through the Quality and Accountability Supplemental Payment System (QASP) due to the General Fund impact. Reverting to a flat rate reimbursement system offers little or no incentive to facilities to maintain or improve quality.

If the department is unable to permanently continue the current rate reimbursement methodology and the QAF program, the state is at risk for potential increases in the General Fund portion of the rate expenditures.

Background. Certain nursing home rates are reimbursed under Medi-Cal using combinations of federal funds, General Fund and revenues collected from Quality Assurance Fees (QAF). Use of QAF has enabled California to provide reimbursement increases to certain nursing homes with *no* added General Fund support.

AB 1629 imposes a QAF on skilled nursing facilities and requires using these funds to leverage a federal match in the Medi-Cal program to provide additional reimbursements to certain nursing facilities that support improvement efforts. The Legislature's goal with AB 1629 and the new reimbursement system was that it would result in improvements in individual access to appropriate long term care services, quality resident care, decent wages and benefits for nursing home workers, a stable workforce, and provider compliance with all applicable state and federal requirements.

California's Nursing Home Quality. A systematic review of how, or if, AB 1629's goals have been met or if quality of care in nursing homes has improved since AB 1629 has not been undertaken. DHCS refers to two studies conducted by the Department of Public Health regarding AB 1629. The first study was conducted in 2007 to cover the three years immediately prior to the passage of AB 1629 to serve as a baseline. The second study was conducted in 2009 and assesses two years after the implementation of AB 1629. Neither study comprehensively reviews how AB 1629's reimbursement methodology impacted the quality of care in nursing homes.

However, research indicates that the quality of care provided in California's nursing homes can still be improved. In its 2010 Snapshot, the federal Agency for Healthcare Research and Quality gave California a "weak" rating in regards to its nursing home care quality. (It has been considered "weak" since the 2007 snapshot.) California scored 26.32 (out of 100) for nursing home care and was below the 25th Percentile (75th Percentile – 60.53; 50th Percentile – 47.37; and 25th Percentile – 31.58) for performance across states. California scored worse than average in 14 out of 19 quality measures and better than average in five of the 19 measures based on 2008 data.

California scored **worse than average** in the following measures:

Measure Name	State Rate	All-State Average	Regional Average
Nursing home long-stay residents - bed/chair bound	5.3	3.5	5.5
Nursing home long-stay residents - with moderate to severe pain	7.5	6.5	7.6
Nursing home long-stay residents - received flu vaccine	82.3	89.9	83.5
Nursing home short-stay residents - received flu vaccine	79.3	82.7	78.7
Nursing home long-stay residents - received pneumococcal vaccine	76.1	86.3	77.6
Nursing home short-stay residents - received pneumococcal vaccine	74.2	79.7	75.2
Nursing home short-stay residents - with moderate to severe pain	26.6	20.3	27.1
Nursing home long-stay residents - physically restrained	8.4	3.4	5.1
Nursing home long-stay residents - high-risk with pressure sores	13.2	11.4	12.0
Nursing home long-stay residents - low-risk with pressure sores	2.2	2.0	2.4
Nursing home short-stay residents - with pressure sores	27.5	18.1	22.9
Nursing home long-stay residents - low-risk with less control of bowels or bladder	56	50.2	56.5
Nursing home long-stay residents - low-risk with urinary catheter left in	6.57	6.2	6.8
Nursing home long-stay residents - with too much weight loss	10.7	8.3	9.6

California scored **better than average** in the following measures:

Measure Name	State Rate	All-State Average	Regional Average
Nursing home long-stay residents - with declining mobility	14.5	15.5	14.8
Nursing home long-stay residents - with increased need for help	13.8	15.4	13.9
Nursing home long-stay residents - with urinary tract infections	7.9	8.8	8.3
Nursing home short-stay residents - with delirium	1.4	2.7	4.0
Nursing home long-stay residents - more depressed or anxious	10.9	13.7	12.0

Subcommittee Comment and Recommendation–Hold Open. The periodic review of this program is important to allow the Legislature, stakeholders, and the Administration the opportunity to review whether and how the reimbursement methodology and QAF are contributing to the goals set forth in AB 1629 including the provision of quality care in nursing homes. It is recommended to leave this item open as discussions continue.

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

1. Please provide a brief summary of the proposal.

2. What is DHCS' assessment of AB 1629's impact on the quality of care in nursing homes?

6. Eliminate Sunset for LEA Medi-Cal Billing Option Program

Budget Issue. The DHCS proposes to (1) delete the current program sunset date of January 1, 2013, for Local Educational Agency (LEA) Medi-Cal Billing Option (LBO) program, (2) eliminate requirements that a baseline LBO funding amount must be met prior to funding LBO contractor costs, and (3) remove the maximum annual funding amount of $1.5 million for contractor costs and makes the annual funding an amount agreed upon between DHCS and the LEA Ad Hoc Workgroup Advisory Committee.

DHCS finds that:

- Eliminating the sunset date clause would reduce the administrative requirements and costs to develop, track, and submit proposed legislation to extend the sunset date.

- Eliminating the baseline requirement prior to funding LBO contract costs would allow DHCS to reduce federal Medicaid payments to fund contractor costs without delay. Not acting could potentially restrict DHCS from generating sufficient funds to cover all necessary contractor costs. DHCS must monitor reimbursements to the LEAs to ensure the baseline requirement is met prior to funding contractor costs required for the LBO program.

- Eliminating the maximum annual funding amount of $1.5 million for contractor costs and making the annual funding an amount agreed upon between DHCS and the LEA Ad Hoc Workgroup Advisory Committee would allow sufficient flexibility to accommodate reasonable cost increases associated with contract services. The current amount, $1.5 million, has remained static since 2001.

Background. California established the LBO program in 1993 to allow school districts to claim federal reimbursement by matching local education dollars already being spent on health services for Medi-Cal children. DHCS and the California Department of Education (CDE), along with a consortium of private foundations, collaborated to develop the LBO program which allows LEAs to generate more funds for services provided to California's children.

DHCS works directly with the LEA Ad Hoc Workgroup Advisory Committee that was organized in 2001 to identify barriers for existing and potential LEA providers and to recommend new LBO program services. Committee members represent urban, rural, large and small school districts, county offices of education, the local education consortium, local educational agencies, and CDE.

In April 2000, the United States Government Accountability Office ranked California in the bottom quartile among states that have school-based Medicaid programs with respect to the amount of its LEA claims per Medicaid-eligible child. In October 2001, SB 231 (Ortiz, Chapter 655, Statutes of 2001) created methods to increase the per-student amount of Medicaid reimbursements received by the State of California.

Subcommittee Staff Comment and Recommendation–Modify.

1. It is recommended to eliminate the sunset date for this program. It is important to ensure that the LBO program is ongoing and uninterrupted since it allows LEA providers to leverage existing local resources with federal reimbursements to support services for students with special needs.

2. It is also recommended to eliminate requirements that a baseline LBO funding amount must be met prior to funding LBO contractor costs. These requirements have not been updated since 2000-01 which restricts DHCS' ability to fund contractor costs.

3. It is recommended to reject the provision to remove the maximum annual funding amount of $1.5 million for contractor costs. Money that is diverted to contractor costs associated with managing the LBO program is money that would otherwise go to schools. It is recognized that this amount has not been updated since 2000-01; however, it was agreed upon between DHCS and the LEA Ad Hoc Workgroup Advisory Committee. AB 2608 (Bonilla) is moving through the policy process and provides the opportunity for DHCS and stakeholders to agree upon updates to this statute.

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

1. Please provide a summary of this proposal.

2. Has DHCS engaged with the LEA Ad Hoc Workgroup Advisory Committee regarding this proposal? Please comment.

7. Redirecting Unpaid Stabilization Funding

Budget Issue. The DHCS proposes to redirect all unpaid private and nondesignated public hospitals' stabilization funding for fiscal years 2005-06 through 2009-10 (including the extension period of the Medi-Cal Hospital/Uninsured Demonstration through October 31, 2010) for purposes of General Fund savings.

Table: Remaining Stabilization Funds (in millions)

Year	Hospital Type	Total Funds	General Fund
2005-06	Private	$10.578	$5.289
2006-07	Private	$19.146	$9.573
2007-08	Non-Designated Public Hospitals	$2.152	$1.076
2008-09	Private	$3.894	$1,947,000
2010-11	Private	$73.764	$36.882
Total		**$109.534**	**$54.767**

Of the $54.7 million General Fund remaining, $11.89 million will be paid to a hospital that incorrectly received underpayments in 2005-06 and 2006-07. The difference, $42.8 million, would be used to offset General Fund expenditures.

Additionally, DHCS proposes to provide the Director of DHCS the authority to utilize a portion of the redirected funding to make payments to hospitals that received Disproportionate Share Hospital (DSH) Replacement underpayments in 2005-06 and 2006-07, if a determination is made that such underpayments occurred.

Finally, DHCS proposes to continue to exercise its powers received from California Medical Assistance Commission's (CMAC) dissolution for the years that have not yet been finalized even though the All Patient Refined-Diagnosis Related Group (APR-DRG) have been implemented.

Background. SB 1100 (Statutes of 2005) established the Medi-Cal Hospital/Uninsured Care Demonstration Project Act which set forth a methodology for distributing the funding made available under the Demonstration. Under SB 1100, additional funding termed "stabilization funding" may be available to private DSH and non-designated public hospitals for the period of the Demonstration Project.

Stabilization payments (STB) cannot be paid out until DHCS completes the final reconciliation of the hospital workbooks. The reconciliation for 2005-06 is scheduled to be finished in 2011-12 and the reconciliations for 2006-07 and 2007-08 are scheduled to be completed in 2012-13.

Under the 2005 Demonstration Project, private DSH and nondesignated public hospitals are permitted to receive stabilization funding as determined under specific formulas. Most of this funding has not been paid out for the entire Demonstration Period. In December 2009, upon

request by private hospitals, an interim STB payment for 2005-06 ($25.5 million) was made to relieve private hospitals' cash crisis.

Hospital Quality Assurance Fee. In 2009, AB 1383 (Statutes of 2009) established the Hospital Quality Assurance Fee (QAF) program and included supplemental payments to all private and nondesignated hospitals up to the available Upper Price Limit (UPL) and provided significant supplemental payments under Medi-Cal managed care. Subsequently, SB 90 (Statutes of 2011) continued the Hospital Quality Assurance Fee program and associated supplemental payments for private hospitals, and AB 113 (Statutes of 2011) instituted an intergovernmental transfer (IGT) program, which funded supplemental payments for non-designated public hospitals.

These programs have resulted in billions of additional revenue being provided to these hospitals. Given the significant additional funding provided under these QAF and IGT programs, DHCS believes that redirecting the unpaid stabilization funding is appropriate to achieve State General Fund savings without impacting beneficiary access or a significant impact on the financial status of the hospitals.

Subcommittee Staff Comment and Recommendation–Approve. This proposal would provide one-time General Fund savings without impacting access or a significant financial impact to the hospitals. The programs discussed above resulted in billions of additional revenue being provided to these hospitals.

In addition, it provides DHCS the authority to correct underpayments to hospitals, if necessary, without impacting the General Fund. This proposal is also necessary to allow DHCS to retain the power to finalize payments made with the authority granted to fulfill the responsibilities transferred from CMAC after the implementation of the APR-DRGs without this change DHCS would be unable to finalize payments previously handled by CMAC.

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

1. Please provide a summary of this proposal.

8. Interest Rates on Medi-Cal Overpayments

Budget Issue. The DHCS is proposing legislation that would require DHCS to assess interest against Medi-Cal provider overpayments at the Surplus Money Investment Fund (SMIF) rate or seven percent per year (annum), whichever is higher. The legislation would also require DHCS to pay interest at the same rate to a provider who prevails in an appeal of a payment disallowed by DHCS.

This would result in $1.5 million ($750,000 General Fund) savings in 2012-13 and $3 million ($1.5 million General Fund) savings in 2013-14.

Background. The Third Party Liability and Recovery Division (TPLRD) is responsible for ensuring that the Medi-Cal program complies with state and federal laws and regulations relating to the legal liability of third parties to pay for health care services to beneficiaries, and for taking all reasonable measures to ensure that the Medi-Cal program is the payer of last resort. TPLRD's Overpayments (OP) Section is responsible for enforcing fiscal compliance with Medi-Cal laws and regulations by Medi-Cal providers and beneficiaries and to recover funds due the Medi-Cal program for overpayments made to those providers and beneficiaries. In fiscal year 2010-11, the OP Section recovered over $204 million (Total Fund).

Overpayment cases are referred to TPLRD by the Audits and Investigations (A&I) Division and by the Medi-Cal Fiscal Intermediary. Once an audit identifies that an overpayment has been made to a Medi-Cal provider, DHCS issues a demand for payment. If the provider does not pay the overpayment in full within 60 days, DHCS assesses interest on outstanding overpayments in accordance with the State Controllers Office's SMIF rate.

The 47-year average for the SMIF rate is 5.5 percent; however, the average SMIF rate over the last 20 years is 2.75 percent. The current SMIF rate is 0.480 percent and is far below the current lending rates of financial institutions and the state's borrowing rate. Since the current borrowing rate is higher than the SMIF rate, providers have little or no incentive to repay overpayments within the first 60 days or to secure financing from an alternate source. Providers opt to either allow DHCS to offset their claims flow until the overpayment is fully reimbursed, make partial payments, or enter into a repayment agreement with DHCS rather than paying the overpayment obligation immediately and/or obtaining financing from a financial institution.

Until recently, federal law required DHCS to return the federal portion of an overpayment to CMS within 60 days of discovery of the overpayment regardless whether DHCS has recovered the overpayment from the provider. In 2010, the Affordable Care Act extended the timeframe states have to reimburse the federal portion of an overpayment to one year from the date of discovery. If the state recovers the overpayment from the provider prior to the one-year deadline, the federal portion must be returned at the time the state receives payment. However DHCS continues to refund federal portion at 60 days due to extensive system changes required to refund at one year. When providers fail to repay overpayment debt before the federal portion is refunded, the state must borrow funds or redirect funds to repay CMS.

Since the state currently borrows at a rate that is higher than the rate charged to providers, the difference must come from funds that DHCS could otherwise allocate to the provision of more services to the Medi-Cal population. The higher the state expenditures are, the more money the state must borrow. In instances where the state does borrow externally, interest rates have been up to 3 percent in recent years. This is much higher than the current SMIF rate.

Other TPLRD recovery programs, such as estate recovery and the collection of quality assurance fees, assess interest on unpaid recovery debt at a rate of seven percent per annum.

It should be noted that the interest rate charged by Medicare for overpayments is 11.5 percent and has been above 10 percent since at least the year 2000.

Subcommittee Staff Comment and Recommendation–Approve. Because interest rates assessed on Medi-Cal provider overpayments are so low, they neither deter provider overbilling, nor do they encourage timely repayment of overpayments. Rather, the low interest rates actually cause a loss of General Fund revenue. These low interest rates afford providers little to no incentive to repay Medi-Cal overpayments promptly or to secure financing from an alternate source to repay the debt. It is recommended to approve this proposal.

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

1. Please provide a summary of this proposal.

9. Hospital Quality Assurance Fee

Budget Issue. In order to extend the Hospital Quality Assurance Fee (QAF) program through 2013, as required by SB 335 (Statutes of 2011), DHCS requests the following:

- To extend 9.5 positions that are set to expire on June 20, 2012 until December 31, 2015 for a cost of $1 million ($471,000 from the Hospital Quality Assurance Revenue Fund and $562,000 in federal funds)
- Contract funds to calculate and validate capitation rates for a cost of $600,000 for 2011-12 and $100,000 for 2012-13 (costs for these contracts would be split equally between the Hospital Quality Assurance Revenue Fund and federal funds)

Table: Estimated Revenue from Hospital Quality Assurance Fee (dollars in millions)

	2011-12	**2012-13**	**2013-14 (6 months)**
QAF Revenue	$2,637	$2,942.3	$1,533

Note: The estimated QAF revenue information is presented on an accrual basis.

Table: Proposed Payments (dollars in millions)

	2011-12	**2012-13**	**2013-14 (6 months)**
Direct Grants to Public Hospitals	$47	$68	$27
Hospital Payments (includes Private and Non-Designated Hospitals, Managed Care Plans, and Mental Health Plans)	$2,591	$7,018	$2,626
Children's Health	$255	$472	$193
DHCS Staff and Administration	$1	$1	$1
Total Payments	$2,894	$7,559	$2,846

Note: The estimated payments are presented on a cash basis. The DHCS Staff and Administration information for 2013-14 reflects the approximate budget authority for 12 months; the rest of the items in 2013-14 represent six month estimates.

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

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

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

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

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

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

- **Children's Health.** As contained in statute, funds are provided for health care coverage of children. The funds are an offset to General Fund support in the Medi-Cal Program for providing services to children. These funds will be matched with federal funds.

- **Department of Health Care Services—9.5 State Staff.** For 2012-13, DHCS requests to extend 9.5 positions to administer this program.

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

  - Develop and secure federal approval for State Plan amendments, fee models.
  - Monitor plans' contracts with hospitals to ensure compliance resulting in pass-through of appropriate funds.
  - Reconcile QAF funds included in the capitation rates paid to managed care plans to actual amounts paid to hospitals.

- Respond to legal issues regarding the QAF program.

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

Statute establishes a per diem fee assessed on every private acute care hospital for every acute, psychiatric, and rehabilitation inpatient day at the following:

- $86.40 per managed care day (other than Medi-Cal)
- $383.20 per Medi-Cal day
- $48.38 per prepaid health plan hospital managed care day
- $214.59 per prepaid health plan hospital Medi-Cal managed care (MCMC) day
- $309.86 per Fee for Service (FFS) day (other than Medi-Cal).

It should be noted that DHCS may alter the specified QAF amount in order to obtain federal CMS approval. As such, the above fee schedule may be altered.

DHCS anticipates receiving CMS approval for this QAF by the end of March or early April.

Subcommittee Staff Comment and Recommendation–Hold Open. The DHCS must obtain federal CMS approval for this program. It is important to obtain an update from DHCS to enable the Legislature to work collaboratively with the Administration to secure federal CMS assistance and approval.

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

1. Please provide a brief overview of the structure for this Quality Assurance Fee (QAF).

2. Please provide an update regarding progress being made with the federal CMS regarding the approval of this QAF.

10. Money Follows the Person

Budget Issue. The DHCS requests to (1) extend three existing limited-term positions (set to expire June 30, 2012) and (2) establish five new limited-term positions to maintain the current Money Follows the Person (MFP) program, meet program benchmarks, expand MFP into additional counties, and implement Minimum Data Set (MDS) 3.0 Section Q (a new federal code requirement that addresses discharge planning for nursing home residents).

The term of the new positions would be from July 1, 2012 to March 31, 2016, to coincide with the federal grant. The cost to extend the existing positions and establish the new positions is $892,000 in federal funds.

The five new positions would:

- Train nursing facilities and Local Contact Agencies (LCAs) on MDS 3.0 Section Q requirements.
- Automate several accounting and data collection activities (staff currently processes every piece of data manually).
- Ensure that CMS mandated Quality of Life surveys are completed correctly and timely.
- Adjudicate treatment authorization requests from home and community-based providers for California Community Transitions participants.

Background. California received a Money Follows the Person grant in January 2007 and developed the California Community Transitions (CCT) project. This grant is to be used to target Medicaid enrollees with disabilities who have continuously resided in hospitals, nursing facilities, and intermediate care facilities for persons with developmental disabilities for three months or longer. The goal is to offer a menu of social and medically necessary services to assist them to remain in their home or community environments. In 2010, MFP transitioned 205 individuals from a health facility into the community.

On October 1, 2010, CMS required certified nursing facilities to begin using a new iteration of the Minimum Data Set (MDS 3.0). MDS is part of the federally mandated process for assessing nursing facility residents upon admission, quarterly, annually, and when there has been a significant change in status. Under Section Q of MDS 3.0, nursing facilities must now ask residents directly if they are “interested in learning about the possibility of returning to the community.” If a resident indicates “yes,” a facility is required to make the appropriate referrals to state designated LCAs.

By providing participants long-term services and supports in their own homes for one full-year after discharge from a health care facility, the state receives an 87 percent federal fund match.

Subcommittee Staff Comment and Recommendation—Approve. The proposal is consistent with Olmstead implementation in California and the positions are warranted. It is recommended for approval.

Questions. The Subcommittee request DHCS to respond to the following questions:

1. Please provide a summary of this proposal.

2. Please discuss your goals for this project.

11. Access Monitoring Program

Budget Issue. The DHCS is requesting two permanent positions to comply with new federal requirements to establish a system for continuously monitoring Medi-Cal beneficiaries' access to health care services. These positions are in addition to the one permanent position to be redirected within DHCS to this program. Additionally, DHCS is also requesting $334,000 in contract dollars to hire consultants to assist with stakeholder meetings and monitoring methodology. The cost of the positions and contract would be $564,000 ($282,000 General Fund and $282,000 Federal Funds).

Background. AB 97 (Statutes of 2011) requires DHCS to implement a 10 percent provider payment reduction. Prior to implementation, DHCS had to seek approval from the federal Centers for Medicare and Medicaid Services (CMS) to modify its Medicaid State Plan via a State Plan Amendment (SPA). New requirements set forth by CMS for approval of SPAs necessitate California to develop and implement a system for monitoring healthcare access for its Medi-Cal beneficiaries.

In the past few months, DHCS has been working with CMS to establish a health care monitoring plan for Medi-Cal's beneficiaries enrolled in fee-for-service. The proposed plan includes 22 measures and focuses on provider availability, service utilization, and outcomes.

Monitoring of these measures would occur on a quarterly basis. DHCS would publish results from a full year of health care access monitoring in the form of an annual report which would be made available to the public. CMS is also requiring that states implement an ongoing mechanism allowing beneficiary feedback, such as information collected through surveys, hotlines or beneficiary Ombudsman offices. Currently, California does not have a mechanism in place to receive information from enrollees pertaining to health care access issues in the Medi-Cal program. Therefore, the addition of a Medi-Cal beneficiary help line similar to that implemented for Medi-Cal Managed Care will be established to meet this new requirement.

Additionally, the Bridge to Reform Waiver requires the department to evaluate health care access for the populations enrolled under the waiver.

Subcommittee Staff Comment and Recommendation – Approve. Based on the recent federal requirements, the state must assure access for program beneficiaries not only when rate adjustments are being proposed, but continuously as a routine part of their operations. Consequently, this proposal is recommend for approval so that DHCS can establish an access monitoring program.

Questions. The Subcommittee request DHCS to respond to the following questions:

1. Please provide an update on the AB 97 lawsuits.

4280 Managed Risk Medical Insurance Board

I. BACKGROUND

The Managed Risk Medical Insurance Board (MRMIB) 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
- Major Risk Medical Insurance Program
- Access for Infants and Mothers Program
- County Children's Health Initiative Matching Program

Healthy Families Program (HFP). Through HFP, children in families earning up to 250 percent (and in select cases up to 300 percent) of FPL receive comprehensive health care coverage that includes dental, vision, and basic mental health care benefits. Families pay a relatively low monthly premium and can choose from a selection of managed care plans for their children.

Pre-Existing Conditions Insurance Program (PCIP). As a result of the federal Affordable Care Act of 2010, California has a contract with the federal Department of Health and Human Services to establish a federally-funded high risk pool program to provide health coverage for eligible individuals. The program will last until December 31, 2013 when the national health reform is set to begin. The program is called the California Pre-Existing Condition Insurance Plan (PCIP). The PCIP offers health coverage to medically-uninsurable individuals who live in California. The program is available for individuals who have not had health coverage in the last 6 months.

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

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.

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.

Budget Overview. The budget proposes expenditures of $965.6 million ($136.2 million General Fund) and 99.7 positions for MRMIB. See table below for more information.

Table: MRMIB Program Funding (dollars in thousands)

Program	2011-12	2012-13	Change
Major Risk Medical Insurance Program	$38,592	$43,015	$4,423
Access for Infants & Mother	$132,156	$127,096	-$5,060
Healthy Families Program	$1,189,770	$444,627	-$745,143
County Health Initiative Program	$1,951	$2,213	$262
Pre-Existing Conditions Plan (PCIP) Program	$320,681	$348,618	$27,937
Totals Expenditures	**$1,683,150**	**$965,569**	**-$717,581**
General Fund	$288,610	$136,213	-$152,397
Federal Funds	$843,812	$358,049	-$485,763
Federal Funds—High Risk Health Insurance	$320,681	$348,618	$27,937
Children's Health & Human Services Special Fund	$123,160	$11,342	-$111,818
Managed Risk Medical Insurance Fund	$38,538	$43,015	$4,477
Other Funds	$68,349	$68,332	-$17

Workforce Cap Plan. Pursuant to Executive Order S-01-10, Control Section 3.90 of the Budget Act of 2010, Budget Letters 10-31 and 10-38, MRMIB was required to reduce its budget by 5 positions and $352,000 ($123,000 General Fund). This executive order called for all departments to take immediate steps to cap the workforce by achieving an additional 5 percent salary savings by July 1, 2010 and maintain the additional salary savings. The WCP savings were measured by personal services dollars, not personnel years.

II. ISSUE FOR DISCUSSION

1. Transition of Healthy Families Children to Medi-Cal – MRMIB and DHCS

Budget Issue. The Governor proposes to shift *all* Healthy Families Program (HFP) children into Medi-Cal over a nine-month period beginning in October 2012. Approximately 870,000 eligible enrollees would move to Medi-Cal in phases between October 2011 and June 2013.

This shift (without any change to the HFP rate, as discussed in the next issue) would be a net cost to the state of about $10 million General Fund in 2012-13 and $43.5 million General Fund in 2013-14. See table below for details on the net fiscal impact to the state with this transition.

Table: Nine-Month Net Impact to State with Healthy Families Program Shift to Medi-Cal (in thousands)

	Total Funds	**General Fund**
MRMIB		
Benefits Savings	-$427,083	-$149,479
Administrative Savings	-$22,782	-$7,974
Premiums	$60,345	$21,121
FQHC Wraparound Payments	-$24,613	-$8,614
MRMIB Total	**-$414,133**	**-$144,946**
DHCS		
Benefit Cost	**$498,258**	**$168,112**
Premiums	-$43,211	-$15,124
Subtotal	**$455,047**	**$152,988**
County Administrative Cost 100-150% FPL	$8,482	$4,241
Other Administrative Cost 150+ FPL	$15,497	$7,749
Subtotal	**$23,979**	**$11,990**
Family Health Impact	-$46,562	-$10,019
DHCS Total	**$432,464**	**$154,959**
Net Impact to State	**$18,331**	**$10,012**

Transition Phase-In. The table below displays the proposed phased-in approach.

Table: Proposed Transition of HFP Enrollees to Medi-Cal

Phase	Impacted Enrollees	Eligibles	Percent of Eligibles	Phase-In Period
1	HFP children with a "matching" Medi-Cal managed care plan	411,506	47 %	October – December 2012
2A	HFP children in a plan that subcontracts for Medi-Cal managed care	271,536	31%	January – March 2013
2B	HFP children in a managed care plan that does not contract or subcontract with Medi-Cal	145,069	16%	January – March 2013
3	HFP children in fee-for-service	49,671	6%	January – June 2013
	TOTAL Children	870,782		

Note: This table does not reflect a growth in the HFP caseload and was a point-in-time estimate.

Table: Proposed Phase-In Schedule

	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-12	May-13	Jun-13
Phase 1	136,889	136,889	136,889	136,889	136,889	136,889	136,889	136,889	136,889
		136,889	136,889	136,889	136,889	136,889	136,889	136,889	136,889
			136,889	136,889	136,889	136,889	136,889	136,889	136,889
Phase 2A and 2B				141,368	141,368	141,368	141,368	141,368	141,368
					141,368	141,368	141,368	141,368	141,368
						141,368	141,368	141,368	141,368
Phase 3				7,182	7,182	7,182	7,182	7,182	7,182
					7,182	7,182	7,182	7,182	7,182
						7,182	7,182	7,182	7,182
							7,182	7,182	7,182
								7,182	7,182
									7,182
Total	136,889	273,778	410,667	559,217	707,767	856,317	863,499	870,681	877,863
2012-13 Enrollment Months									5,556,678

Note: This table reflects a 0.6 percent growth in the HFP caseload.

According to DHCS, all HFP beneficiaries moved into Medi-Cal managed care during Phase 1 will be allowed to keep their provider if their provider is in the plan's Medi-Cal network. HFP beneficiaries transitioning in Phase 2A will be enrolled into a Medi-Cal managed care plan based on their provider's linkage to a plan so those beneficiaries *may* not have to change providers.

However, in Phase 2B, beneficiaries whose providers are not, or will not be, in a Medi-Cal managed care plan network will be covered by the same continuity of care requirements currently in place for the Seniors and Persons with Disabilities population (these requirements are supposed to guarantee a beneficiary can continue to see a provider to receive ongoing treatment for a condition for up to one year after enrollment) will also be applied to the incoming HFP population. These providers must be willing to see the patient and accept payment from the health plan at the Medi-Cal rate.

Dental Managed Care. Furthermore, under this proposal, once the enrollees transition into Medi-Cal for medical care, they will concurrently transition into Medi-Cal for dental coverage. Individuals enrolled in an HFP dental plan would transition to the same dental plan to the extent that the plan is a Medi-Cal dental managed care plan. If the enrollee's HFP dental plan is not a Medi-Cal dental managed care plan, DHCS would be authorized to contract with the dental plan to allow the individuals to enroll in the same plan. These new dental health plans will also be available for voluntary enrollment by existing Medi-Cal enrollees. Individuals who are enrolled in the HFP Exclusive Provider Organization would enroll in the Medi-Cal dental fee-for-service system.

Eligibility Processing. Additionally, the proposal would:

- **County Performance Standards.** Establish new county eligibility reporting and performance standards. Counties would be required to report to DHCS the number of applications and annual redetermination forms processed on a monthly basis, a breakout of applications and annual redetermination forms based on poverty level, final disposition of applications and annual redetermination forms, and average number of days to process applications and annual redetermination forms received directly from the county and from the Single Point of Entry (SPE). DHCS would determine the manner and time period for county submission of reports and would provide enrollment information regarding the transition enrollees to the Legislature within one year of enactment.

- **Single Point of Entry Processing Standard.** Establish a new 10 working day standard for counties for processing applications and redetermination forms received from the SPE and for acting on information received from the SPE that may impact eligibility for individuals with incomes between 150 percent and 250 percent of the federal poverty level (FPL).

- **New Budgeting Methodology for Eligibility Processing.** Develop a new budgeting methodology for eligibility processing in consultation with the counties.

- **Managed Care Performance Standards.** Require Medi-Cal managed care plans into which the HFP enrollees would transition, to meet specified performance standards and comply with all existing performance standards and measurements set forth in the law *prior* to the transition of any children.

- **Continuity of Care.** Require plans to allow the enrollees to remain with their current primary care provider, or report to DHCS how they will provide continuity of care.

New applicants seeking services as of October 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). Counties would make eligibility determinations as they do today for children applying at the local county office.

Children with incomes up to150 percent of FPL would enroll into no-cost Medi-Cal, receive services through the Medi-Cal delivery system and receive ongoing case management through the County.

Children with incomes above 150 percent of FPL and up to 250[1] percent of FPL 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 FPL and up to 250 percent of FPL. 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 details on these processes have not yet been worked out.)

The SPE 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.

Healthy Families children that are eligible for California Children's Services (CCS) will continue to receive CCS under the Medi-Cal program as they do today. Counties will continue to administer CCS for these children and be required to fund the same share of the non-federal share of the CCS costs as they do today for these children with a CCS-eligible condition.

Proposed Benefits of Transition. 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 FPL;
- 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;

[1] 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 of 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 ACA maintenance of effort violation.

- Children at or below 150 percent of FPL 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. It is estimated that 78 percent of children in Healthy Families match to a health plan that currently participates in both Medi-Cal and Healthy Families (either via a contract or subcontract, Phase 1 and Phase 2A);
- 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. Under health care reform, HFP children with incomes under 133 percent of FPL would become Medi-Cal enrollees on January 1, 2014.

LAO Recommendation. The LAO finds that the proposal has merit in that consolidating state health programs would improve continuity of care for families who have one child currently enrolled in HFP and one child enrolled in Medi-Cal because all the children could be enrolled in the same plan together. However, the LAO finds that the proposal also raises concerns regarding the potential for interrupted services for HFP enrollees as they transition to Medi-Cal. As an alternative, the LAO recommends that children in families with incomes between 100 percent and 133 percent of the FPL, who are required to shift to Medi-Cal under ACA in 2014, be shifted to Medi-Cal in 2012-13. This shift would serve as a pilot to test guide future decision making in this programmatic area.

Subcommittee Staff Comment and Recommendation—Hold Open. There are many outstanding issues that still need to be addressed including ensuring access and continuity of care for these children and county eligibility workflow and timeframes. For example, although DHCS estimates that 78 percent of HFP children are enrolled in a plan that currently participates in both Medi-Cal and Healthy Families this estimate assumes these plans will have the capacity to accept these children as Medi-Cal enrollees.

It should be noted that last year's budget act included language requiring the administration to develop a transition plan for the transfer of administrative functions for the operation of HFP (and the Access for Infants and Mothers Program) to the Department of Health Care Services and submit the plan to the Legislature no later than December 1, 2011. This plan has not yet been submitted.

Additionally, as discussed above, under federal health care reform, HFP children with incomes under 133 percent of FPL (approximately 186,000 children as of November 2011) would become Medi-Cal beneficiaries on January 1, 2014. With this proposal, the administration has decided that children in families with incomes *over* 133 percent of FPL should also move to Medi-Cal even though this is not required by health care reform. As implementation of health care reform moves forward, including the development of the Health Benefit Exchange, the Legislature may want to consider if it would be more appropriate for these children in higher income families to obtain coverage from the same provider as their parents.

Generally speaking, based on 2009 HEDIS (Healthcare Effectiveness Data and Information Set) quality measures, HFP and Medi-Cal show relatively little difference in quality of care indicators. Furthermore, each program has historically had its own strengths, for example, most would agree that HFP has provided better access to care than Medi-Cal (HFP's higher reimbursement rate is likely a contributing factor to this) and that the Managed Risk Medical Insurance Board has a stronger focus on children's issues, while Medi-Cal's mental health coverage is more broad than HFP and Medi-Cal has more rigorous due process regarding grievances. If these children are shifted to Medi-Cal, the administration should work to ensure that the strengths of the HFP program are incorporated into the Medi-Cal program.

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. Please discuss how DHCS and MRMIB have coordinated and planned for this proposal.
3. How have DHCS and MRMIB reached out to the various constituency interests to engage in working out the details of this proposal?
4. What are the key short-term aspects that need to occur for this to be an effective transition?
5. What are the longer-term components that need to be addressed?
6. How may the state track progress during a phase-in to ensure that children are being transitioned appropriately? How can access be assured?
7. What key issues have been expressed by health plan providers (provider networks, rates)?

2. Healthy Families Program Rate Reduction

Budget Issue. The administration proposes trailer bill language to require the Managed Risk Medical Insurance Board (MRMIB) to negotiate managed care health plan capitation rates for children receiving health care services in the Healthy Families Program (HFP) at a statewide weighted average capitation rate that is less than or equal to the statewide average capitation rate established by the Department of Health Care Services for health benefits for children up to age 19 in the Medi-Cal program.

The HFP rates are over 25 percent higher (on average) than Medi-Cal rates for children up to age 19. The new rates would be effective October 1, 2012.

With this proposal, the administration estimates $202.1 million ($71 million General Fund) savings in 2012-13 and $279.5 million ($98.2 million General Fund) savings in 2013-14 and annually thereafter.

Background. MRMIB is responsible for negotiating rates with health plans that participate in HFP. The current statewide average benefit cost per month per eligible member (PMPM) for HFP is $103.44. MBMIB negotiates HFP rates with contracting plans during the months of January through April for Board approval in May. These negotiated rates are effectuated annually with an October 1 start date.

In comparison, with this proposal DHCS, estimates that the rate for these children would be $76.86 in Medi-Cal. The table below details the components of the Medi-Cal rate.

Table: Components of Medi-Cal Rate for Children Age 0-19

Managed Care Cap Rate	$62.02
Managed Care Carve Out	$2.58
Fee-For-Service Costs	$0.43
Dental	$11.83
Total	**$76.86**

According to the administration, there are several differences in benefits, contracting, and financing that help explain the lower Medi-Cal rates compared to HFP. The administration finds that these differences explain why the rate change would not lead to disruption in provider and plan participation. Among these differences are:

1. Mental health benefits are fully carved out in Medi-Cal and Medi-Cal plans have no responsibility for these costs. HFP plans are responsible for mental health services until the member was accepted into the county mental health system.

2. Vaccines for Children program funds are available to Medi-Cal members and not to HFP members saving both the Medi-Cal plan, and provider, the cost of vaccines.

LAO Comment. The LAO finds that it is unclear whether or not MRMIB would be able to negotiate a lower rate. It notes that while the benefits offered under HFP and Medi–Cal are largely equivalent, the access to providers may differ between the two programs.

One survey found that when pediatricians who currently see patients enrolled in HFP and Medi–Cal were asked if they would continue to see HFP enrollees after they were transitioned to Medi–Cal, 51 percent replied that they would, while 19 percent replied they would not and 30 percent were unsure. Of pediatricians who currently see patients enrolled in HFP, but not Medi–Cal, 26 percent responded that they would be willing to enroll in Medi–Cal to continue to see those patients, 29 percent said they would not be willing to enroll in Medi–Cal, and 46 percent were unsure. Some pediatricians surveyed expressed concerns regarding differences between HFP and Medi–Cal in terms of rates, administrative procedures, and access to federal vaccine programs and drug formularies.

Overall, the impact of the Governor's proposal on the provider network and beneficiary access to services is unknown, but there would likely be some pediatricians who currently serve HFP enrollees who would not serve these children once they transitioned to Medi–Cal.

Subcommittee Staff Comments and Recommendation–Hold Open. It is unknown how many health plans may be willing to contract with MRMIB for HFP at this reduced rate. It is recommended to get an update from MRMIB on these negotiations.

Questions. The Subcommittee requests MRMIB and DHCS to respond to the following questions:

1. What is the status of MRMIB’s rate negotiations with health plans?

2. What key issues have been expressed from health plan providers regarding this proposal?

3. How does the Administration think it can maintain access while reducing rates?

3. Transfer of MRMIB Programs to the Department of Health Care Services

Budget Issue. The administration proposes to eliminate MRMIB and transfer its programs to DHCS. Specifically, as described earlier, the Healthy Families Program would transfer to DHCS beginning October 2012. The remaining programs, the County Children's Health Initiative Program, Access for Infants and Mothers (AIM), Major Risk Medical Insurance Program (MRMIP), and Pre-Existing Conditions Insurance Plan (PCIP) would transfer to DHCS effective July 1, 2013.

Subcommittee Staff Comment and Recommendation–Hold Open. The trailer bill language describing this proposal is not yet available. Two of the programs proposed to be transferred to DHCS, MRMIP and PCIP, would be eliminated on January 1, 2014 with the implementation of health care reform and the Health Benefit Exchange. Consequently, it is unclear why these programs should be shifted to DHCS for six months before elimination.

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

1. Please provide an overview of this proposal.
2. When will the trailer bill language be made available?

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, March 22 (Room 4203)

A. Department of Health Care Services

I. VOTE ONLY

1. Abolish Four Funds That Are No Longer Used

- Action – Adopt placeholder trailer bill language.
- Vote- 3-0

2. Medi-Cal Coverage of Juvenile Inmate Inpatient Costs

- Action – Approve Administration's proposal.
- Vote- 3-0

3. Medi-Cal Ground Emergency Medical Transportation

- Action – Approve Administration's proposal.
- Vote- 3-0

4. Maternal, Child and Adolescent Health Reductions

- Action – Approve Administration's proposal.
- Vote- 3-0

5. Breast and Cervical Cancer Treatment Program

- Action – Approve Administration's proposal.
- Vote- 2-0 (Senator Emmerson not voting.)

6. Extend Sunset Date for Rogers Amendment

- Action – Adopt placeholder trailer bill language.
- Vote- 3-0

7. Medi-Cal Targeted Case Management

- Action – Approve Administration's proposal.
- Vote- 3-0

8. **Local Educational Agency (LEA) Medi-Cal Billing Option Program – Staff**
   - Action – Approve Administration's proposal.
   - Vote- 3-0

II. ISSUE FOR DISCUSSION

1. **Sacramento Geographic Managed Care: Dental Services**
   - Action – Approve Senator Steinberg's placeholder trailer bill language in lieu of the administration's proposed trailer bill language regarding dental managed care performance measures.
   - Vote- 3-0
2. **Lock-In at Annual Open Enrollment for Medi-Cal Managed Care**
   - Action – Held Open
3. **Federally Qualified Health Center/Rural Health Clinic Payment Reform**
   - Action – Held Open
4. **Value-Based Purchasing**
   - Action – Held Open
5. **Eliminate Sunset for AB 1629 – Nursing Home Quality Assurance Fee**
   - Action – Held Open
6. **Eliminate Sunset for LEA Medi-Cal Billing Option Program**
   - Action – Approve staff recommendation.
   - Vote – 2-0 (Senator Alquist absent.)
7. **Redirecting Unpaid Stabilization Funding**
   - Action – Held Open
8. **Interest Rates on Medi-Cal Overpayments**
   - Action – Approve Administration's proposal.
   - Vote – 2-0 (Senator Alquist absent.)
9. **Hospital Quality Assurance Fee**
   - Action – Held Open
10. **Money Follows the Person**
    - Action – Approve Administration's proposal.
    - Vote – 2-0 (Senator Alquist absent.)

11. Access Monitoring Program

- Action – Held Open

B. 4280 Managed Risk Medical Insurance Board (MRMIB), on page 44 for issues.

1. Transition of Healthy Families Children to Medi-Cal – MRMIB and DHCS

- Action – Held Open

2. Healthy Families Program Rate Reduction

- Action – Held Open

3. Transfer of MRMIB Programs to the Department of Health Care Services

- Action – Held Open

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

March 26, 2012

10:00 AM

Room 4203
(John L. Burton Hearing Room)

Staff: Jennifer Troia

Item	Department
4300	Department of Developmental Services
5170	State Independent Living Council
8885	Commission on State Mandates

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

4300 Department of Developmental Services (DDS)

5170 State Independent Living Council (SILC)

Discussion Agenda

Item Department **Page**

VOTE-ONLY AGENDA

4300 Department of Developmental Services (DDS)

1. Budget Bill Language to Assist with Cash Flow

Budget Issue: DDS proposes budget bill language to increase its authority to borrow from the General Fund (GF) from a limit of $160 million to a limit of $210 million annually. The Department indicates that the change is necessary to keep pace with the dramatic growth in the amount of federal funding supporting its budget (from $29 million in 1988-89 to $1.7 billion in 2011-12). These federal funds are received by the Department as reimbursements and there is a lag between when the services are provided, paid for by Regional Centers, and then reimbursed to the Regional Centers by DDS. Without additional loan authority, the Department indicates that supports provided to over 251,000 Californians with disabilities who are served by Regional Centers may be disrupted because the Regional Centers could be unable to continue paying providers on a timely basis.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the requested budget bill language to increase the authority for DDS's cash flow borrowing.

2. Financial Management Services for Participant-Directed Services

Budget Issue: When a developmental services consumer functions as the managing employer of workers who provide services funded under federal Medicaid Home and Community-Based Services (HCBS) waivers, the federal Centers for Medicare and Medicaid Services (CMS) require that a financial management service (FMS) be offered to assist the consumer (participant) with functions like processing payroll, withholding federal, State, and local taxes, performing fiscal accounting and producing expenditure reports for the participant or family and state authorities. The 2011-12 budget includes $1.8 million ($881,000 GF) to provide FMS for participant-directed services. The proposed 2012-13 budget for these services assumes an increase to $10.7 million ($5.4 million GF) in expenditures for these services.

Reasons for the Increase: The 2011-12 estimates were based on the assumption that the service would cost a flat rate of $95 per month and that only 60 percent of 31,000 monthly vouchers would be managed by an FMS. Subsequently, the Department issued emergency regulations which established a tiered fee from $45 to $95 per month depending on the number of vouchered services utilized by the consumer. The federal Centers for Medicare and Medicaid Services (CMS) also informed the Department that 100 percent participation is mandatory. In addition, the Department found an error in the prior calculation and determined that there will be 175,000 monthly vouchers instead of its prior assumption of 31,000.

Subcommittee Staff Comment & Recommendation: To meet federal requirements, staff recommends that the Subcommittee approve the proposed increase in funding.

3. Capital Outlay Request – Porterville Main Kitchen

Budget Issue: DDS requests, in a capital outlay budget change proposal, authority to reappropriate a total of $25.4 million intended to support the construction of a new 29,000 square foot main kitchen at the Porterville Developmental Center (DC). The Department's authorization to expend those capital outlay funds would otherwise expire on June 30, 2013. The project experienced a delay when a bond sale originally scheduled for December 2010 was cancelled. The sale was later completed in December 2011. The new schedule for construction anticipates that the project will be completed in December 2013.

Subcommittee Staff Comment & Recommendation: Staff recommends approval of the proposed reappropriation of funding for construction of the new main kitchen. This authorization does not alter the anticipated overall cost of the project.

4. Capital Outlay Request – Automatic Fire Sprinkler Systems

Budget Issue: DDS requests, in a capital outlay budget change proposal, $11.4 million GF for construction costs associated with installing automatic fire sprinklers in 14 DC buildings (at the Fairview, Porterville, and Sonoma DCs) that contain nursing and General Acute Care facilities. The project also includes necessary associated work (e.g., asbestos removal, electrical and plumbing renovations). The 2011-12 budget includes $2.0 million GF for preliminary plans and working drawings that informed this new request. According to DDS, the Department of Public health (DPH), which reviews fire/life safety requirements for the federal Centers for Medicare and Medicaid Services, has indicated that it will terminate these facilities' certifications for federal financial participation if compliance is not achieved by August 13, 2013. DDS indicates that approximately $72.3 million annually ($6.0 million each month) in federal funding would be at risk if the project is not completed in time for that deadline.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the requested funds for construction costs associated with installation of automatic fire sprinkler systems.

5170 State Independent Living Council (SILC)

1. Proposed Shift of Federal Aging and Disability Resource Connection Grant Funds

Budget Issue: The budget proposes to shift $149,000 in federal funding for the Aging and Disability Resource Connection program from the 2011-12 to the 2012-13 fiscal year. This represents the amount of unspent funds related to a three-year grant for the expansion of this program given to the SILC by the federal Administration on Aging. The federal government has given its permission for a no-cost extension to allow for expenditure of these remaining funds. No state funds are required because existing in-kind services are used to meet matching requirements.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the shift of federal funds from the 2011-12 to the 2012-13 fiscal year.

DISCUSSION AGENDA

1. Overview of Developmental Services

With proposed 2012-13 funding of $4.7 billion [$2.7 billion General Fund (GF)], the Department of Developmental Services (DDS) administers services for persons with developmental disabilities. The services are provided in the community through 21 Regional Centers and in state-run Developmental Center institutions (DCs). Regional Centers are non-profit organizations that provide diagnosis and assessment of eligibility and help plan, access, coordinate, and monitor consumers' services and supports.

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

Eligibility & Caseload: The developmental services system currently serves approximately 250,000 children and adults who have developmental disabilities. This caseload has grown each year from 2002-03 (when it included 190,000 individuals) to today. To be eligible, an individual must have a disability that began before his or her 18th birthday. The disability must also be: 1) significant, 2) expected to continue indefinitely, and 3) attributable to specified conditions, such as mental retardation,

autism, epilepsy, cerebral palsy, and related conditions. Infants and toddlers (age 0 to 36 months) may also be eligible if they are at risk of having developmental disabilities or if they have a developmental delay. Once they qualify for services under the Lanterman Act, the state provides services and supports to individuals with disabilities throughout their lifetime.

Determination of Services Needed: Services and supports provided for individuals with developmental disabilities range from day programs to transportation or residential care. Determination of which services an individual consumer needs is made through the process of developing an Individualized Program Plan (IPP) (or Individual Family Service Plan if the consumer is an infant/toddler three years of age or younger). 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. Some differences in available services may occur across communities (i.e., Regional Center catchment areas) to reflect the individual needs of consumers, diversity of the regions, availability and types of services overall, access to "generic" services (i.e., services provided by other public agencies), and other factors. Services that are ultimately included in the consumer's IPP are entitlements.

Residential Placements & Trends: Individuals with developmental disabilities have a number of residential options. Ninety-nine percent of DDS consumers receive community-based services and live with parents or other relatives, in their own houses or apartments, or in group homes (of various models) designed to meet their medical or behavioral needs. The state provides these community-based services to consumers through Regional Centers. The two main components of the budget for community services are Regional Center operations and the purchase of services. Operations costs include costs related to conducting eligibility determinations, assessing consumers' needs, developing IPPs, and providing case management. The purchase of services by Regional Centers occurs if an individual does not have private insurance that covers the service and there is no "generic" or publicly provided service available. In other words, the Regional Center is the payer of last resort.

Another approximately 1,800 individuals served by DDS reside in four state-operated developmental centers (DCs) and one state-operated community facility. Consistent with national trends that support integrated services and reduced reliance on state institutions, California has been reducing its use of DCs as a placement for individuals with developmental disabilities for several decades (with the highest number of DC residents in 1968 and declines nearly every year from 1976 to today, as summarized in the table below through point-in-time data from the years reflected). As a result, several DCs have also been closed by the state. Most recently, the Agnews and Sierra Vista DCs were closed to resident occupancy in 2009. As discussed later in this agenda, DDS is currently in the process of transitioning residents from Lanterman Developmental Center into the community and planning to close that facility. In general, this decreased reliance on DC placements has been accomplished by creating new

community living arrangements and by developing new assessment and individual service planning procedures, as well as quality assurance systems.

State Fiscal Year	Total population in DCs
1968	13,355
1978	9,468
1988	6,763
1998	3,958
2008-09	2,317
2009-10	2,212
2010-11	1,979
2011-12*	1,752
2012-13*	1,533

* Estimated

The decrease in DC placements is also consistent with the United States Supreme Court's 1999 decision in *Olmstead v. L.C., et al*, which 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.

Costs Borne by Consumers and Families: The state provides diagnosis and eligibility assessment services free of charge. Once eligibility is determined, most developmental services and supports are also provided at no charge. However, parents whose incomes for their family sizes place them above the federal poverty level are required to pay a sliding scale share of the cost for 24-hour out-of-home placements for children under age 18. There are also co-payment requirements known as "family cost participation" for selected services, including day care, respite, and camping (which has been partially suspended in recent years), when those services are provided to a child who lives in his or her parent's home and who is not eligible for Medi-Cal. This family cost participation policy is implemented by presuming that the parent will obtain and pay out-of-pocket for a portion of the services that would otherwise have been provided by the state. Finally, in a 2011-12 budget trailer bill, the Legislature and Governor enacted a temporary annual family fee of $150 or $200 for specified families with adjusted gross incomes at or above 400 percent of the federal poverty level. This change was estimated to save $7.2 million annually.

Recent Reductions to the System: Over the three years from 2009-10 to 2011-12, DDS GF spending has remained relatively flat, even while the developmental services caseload has grown. In general, this GF cost containment has occurred because of: 1) increased use of federal and other funding sources, 2) a reduction in the rate of payments to service providers (ranging from three to 4.25 percent), and 3) administrative changes, cost-control measures, and some service reductions. The

savings resulting from these changes in the years they were enacted (several of which also result in ongoing, annual savings) combine to total over $1 billion GF.

Summary of Governor's Budget for 2012-13: The budget proposes total expenditures of $4.7 billion ($2.7 billion GF) for DDS. The table below summarizes this information by program area.

	2011-12	2012-13	Difference
BUDGET SUMMARY (in thousands)			
COMMUNITY SERVICES	$3,800,000	$4,064,000	$225,000
DEVELOPMENTAL CENTERS	569,000	559,000	-9,845
HEADQUARTERS SUPPORT	36,000	39,000	2,873
TOTAL, ALL PROGRAMS	**$4,443,000**	**$4,662,000**	**$218,000**
General Fund	$2,480,000	$2,653,000	$173,000
AVERAGE CASELOAD			
Developmental Centers	1,759	1,533	-226
Regional Centers	249,827	256,059	6,232
AUTHORIZED POSITIONS			
Developmental Centers	5,570.5	5,253.0	-317.5
Headquarters	380.5	380.5	0.0

Subcommittee Staff Comment & Recommendation: This item is included for informational and context-setting purposes. No action is recommended.

Questions for the Administration & LAO:

1) Please briefly summarize the most significant changes in the caseload, residential placements, services, and overall budget for the developmental services system.

2. Governor's Budget for Developmental Centers

The two main sources of developmental center (DC) costs are: 1) personnel, and 2) operating expenses and equipment. There are almost 5,600 staff positions authorized for the developmental centers in 2011-12 and close to 5,300 proposed for 2012-13 (a decrease of 317 staff members or six percent). The average monthly number of residents includes almost 1,800 individuals in 2011-12 and just over 1,500 in 2012-13 (226 fewer residents or a decrease of 12.8 percent).

2011-12 Budget Updates: November estimates for the 2011-12 DC budget include $569 million ($293.4 million GF) in total resources. This includes a decrease of $8.1 million ($3.0 million GF) over the enacted budget. Changes include:

- A net decrease of $5.2 million ($2.6 million GF) due to statewide Control Sections that drove adjustments in retirement and health benefits rates, and personal services cost reductions achieved through collective bargaining or actions of the Administration in employee compensation;
- A decrease of $3.0 million ($2.5 million GF) due to updated Quality Assurance Fees paid by DCs;
- A fund shift from federal funding to $2.2 million more GF due to a two month delay in obtaining federal certification of a portion of the Porterville Secure Treatment Program; and
- An increase of $100,000 GF for miscellaneous adjustments, including cell phone reductions and funding changes.

2012-13 Budget Updates: For 2012-13, the Governor's Budget provides $559.2 million ($283.6 million GF) for DCs. Changes include:

- A decrease of $24.5 million ($14.4 million GF) for Level of Care and Non-Level of Care updated staffing. A portion of the staffing updates are counted towards the Administration's statewide operational efficiencies savings plan [Control Section 3.91(b) reductions];
- A net Increase of $4.5 million ($2.7 million GF) due to statewide Control Sections that drove adjustments in retirement and health benefits rates;
- A decrease of $3.0 million ($2.5 million GF) due to updated Quality Assurance Fees paid by DCs;
- An increase of $2.9 million ($1.6 million GF) to retain 28 authorized positions and five temporary help positions for enhanced Lanterman Closure staffing;
- $2.4 million in reimbursement authority for the State Staff in the Community program; and,

- A decrease of $200,000 GF for miscellaneous reductions, including cell phone reductions, as part of statewide efficiencies and funding changes.

Some of these changes are discussed in greater detail below.

Pending Review of Budgeting Methodology: The 2011-12 budget also included uncodified trailer bill language that requires DDS to reimburse the Office of Statewide Audits and Evaluations (OSAE) within the Department of Finance for a review of the budgeting methodology used to establish the annual budget estimates for DCs. The Legislature asked for this review to be completed in the fall of 2011. The review is under way, but results are not yet available. OSAE staff have indicated that they hope to release a report in early May.

Questions for the Administration & LAO:

1) Please explain why DC expenditures on staffing decline at a lower rate (e.g., six percent in 2012-13) than the decrease in the overall resident population (13 percent in 2012-13).

2a. Update on Closure of Lanterman Developmental Center

Budget Issue: As part of the 2010-11 budget, the Legislature and Governor approved a plan to begin the process of safely transitioning the residents of the Lanterman Developmental Center (Lanterman) to other appropriate living arrangements [as determined by their Individual Program Plans (IPP)] and then closing the facility to resident occupancy. The Governor's 2012-13 budget includes $89.8 million ($46.2 million GF) for the operation of Lanterman, including authority for 941 staff positions. The budget assumes that nearly 180 consumers will leave Lanterman and move into the community in 2011-12 and 2012-13. As the number of consumers living at Lanterman declines, the average cost per resident increases, at least in part because some operating costs for the facilities are fixed.

Of the funds budgeted for Lanterman staff, $2.9 million ($1.6 million GF) are proposed to allow for the retention of 28 authorized positions and five temporary help positions that would otherwise be eliminated under budgeting formulas which factor the facility's resident population into the number of authorized positions. DDS indicates that this enhanced staffing is needed because of additional workload caused by the closure process and in order to prevent the remaining residents from needing to move in order for them to reside in units or buildings where the remaining staff are assigned. The retained position authority would include 10 nursing positions, nine administration transition staff to coordinate among Regional Centers, community providers, and Lanterman employees, eight staff to provide other supports identified as necessary for residents, and one staff member to coordinate the State Staff in the Community program. The retained temporary help positions would include five occupational, physical, or speech therapy positions at a cost of $746,200 ($408,444 GF). These

positions are funded under the Department's temporary help blanket authority (and do not include specific position authority).

Finally, the budget includes $2.4 million in reimbursement authority for the State Staff in the Community program associated with Lanterman closure. This program authorizes DDS employees working at Lanterman to work in the community with former residents while remaining state employees for up to two years following the transition of the last resident out of Lanterman. No Lanterman staff are currently working in the community under this program.

Background on Closure Process for Lanterman DC: According to DDS, the transition of each Lanterman resident to other appropriate living arrangements will occur only after necessary services and supports identified in the IPP process are available elsewhere. The closure process is thus focused on assessing those needs and developing community resources to meet them. The Department and 12 Regional Centers that are involved in the closure process use the Community Placement Plan as one tool to help them accomplish those goals. DDS has also received recommendations from three advisory groups that include a Resident Transition Advisory Group, Quality Management Advisory Group, and Staff Support Advisory Group. The Department indicates that its staff meet regularly with parents and family members of Lanterman residents, Lanterman employees, and the involved Regional Centers as well. The Administration has declined to give a target date for closure of the facility as the development of these necessary community resources to ensure a safe and successful transition for each consumer is a continual and complex process.

The 2010-11 budget also included trailer bill language (in SB 853, Chapter 717, Statutes of 2010) to authorize the use of Adult Residential Facilities for Persons with Special Health Care Needs as residential placements for individuals transitioning out of Lanterman, the use of managed health care for those individuals, implementation of an outpatient clinic to provide health and dental services, and the ability to rely on staff working at Lanterman to provide services in the community to former residents of Lanterman. The Adult Residential Facilities for Persons with Special Health Care Needs [commonly called "SB 962 homes" after the legislation that originally authorized them as a part of the plan for closing the Agnews DC (SB 962, Chapter 558, Statutes of 2005)] are designed to serve individuals who have stable but intensive health care needs such that they require the availability of 24-hour licensed nursing staff.

Transitions to Date: In January 2010, when the Department proposed to begin working toward the closure of Lanterman, there were around 400 residents and 1,300 employees at the facility. Currently, there are 277 residents. In that time, eighty-four residents have transitioned from Lanterman to the community, with the largest number (72) moving to Adult Residential Facilities licensed by DSS. As of December 1, 2011, there were just over 1,000 employees at Lanterman. Fifty percent of them are direct care nursing staff, nine percent are Level-of-Care professional staff (e.g., physicians, social workers, teachers), and the remaining 41 percent are Non-Level-of-Care and administrative staff. Twenty-seven percent of the remaining staff have worked at

Lanterman for 20 years or longer, while 38 percent have worked there between 11 and 20 years, and the remaining 35 percent have worked there for 10 or fewer years.

Some Characteristics of Lanterman and Its Residents: There are three levels of care provided in Lanterman facilities: an Acute Care Hospital (for short-term stays with an average of just one resident per day and an average length of stay of 12 days), a nursing facility (where 29 percent of residents live), and an Intermediate Care Facility (where 71 percent of residents live). The majority of consumers residing at Lanterman (59 percent) have lived there for more than 30 years. Only five percent have lived there for less than five years. Six percent of residents are aged 65 or older, 72 percent are between 40 and 65 years old, 19 percent are between 21 and 40 years old, and three percent are between 18 and 21 years old. Seventy-six percent have profound intellectual disabilities and 13 percent have severe intellectual disabilities. The majority of residents have additional disabilities, including 51 percent with epilepsy, 16 percent with autism, and 12 percent with cerebral palsy. Sixty-two percent have also been diagnosed to have a mental illness.

The 84 former residents of Lanterman who have transitioned to the community so far have similar lengths of stay at Lanterman, ages, and disabilities as the overall residential population. Of note, however, more of the individuals who have moved thus far have significant behavioral issues as their primary service need than the overall population of Lanterman residents (42 percent of those who have moved as compared to 19 percent of the overall residential population). Fewer of the individuals who have moved have significant health needs as their primary service need (9 percent as compared with 27 percent). The Department indicates that this is due at least in part to the pace of development of specialized homes (i.e. SB 962 homes) that are equipped to handle these particular health needs.

Subcommittee Staff Comment & Recommendation: Staff recommends holding open the requested funding to support 33 positions (28 with requested position authority and 5 budgeted separately under temporary help blanket authorization) for enhanced staffing at Lanterman DC.

Questions for the Administration & LAO:

1) Please briefly summarize the status of the transition of residents from Lanterman to the community. How does the progress so far compare to the Department's initial expectations with respect to timing?

2) What challenges have the Department and Regional Centers faced during the transition process to date? How have those challenges been addressed? What other challenges does the Department anticipate in the future?

3) Please describe why enhanced staffing and these particular positions are needed at this point.

2b. New Admissions to Developmental Centers and Alternative Residential Options in the Community

Budget Issue: As discussed on pages 7 and 8 of this document, there is an overall trend of decreased reliance on DCs as residential placements for individuals with developmental disabilities. At the same time, there are still 1,500 to 1,800 individuals residing in developmental centers and a number of new admissions to DCs each year. In 2009-10, 126 consumers were admitted to DCs (even while in the aggregate the number of DC residents decreased because of others moving out). In 2010-11, 108 consumers were admitted to DCs. While all DCs have admitted consumers in the last five years, the largest number of these admissions was to the DC in Porterville (including 99 of the 2009-10 admissions and 85 in 2010-11).

Background on Porterville DC: The Porterville DC is unique in that it houses a secure treatment facility as well as a transition treatment program and serves up to 230 residents with developmental disabilities who have been judicially committed to a developmental center because of their behavior in the community and involvement with the criminal justice system. A limit of 230 residents at Porterville was enacted in trailer bill as part of the 2011-12 budget. Prior to that change, there was a cap of 297 residents. Although many of the individuals who reside at Porterville are Medi-Cal eligible, the state does not currently receive federal Medicaid funding for the Secure Treatment Program because this portion of the facility has not been certified by the federal Centers for Medicare and Medicaid Services. The 2011-12 budget assumed savings of $13 million GF from obtaining this certification so that federal funds can be used for the care of some residents in the secure treatment population at Porterville. The Governor's 2012-13 budget assumes an erosion of $2.2 million GF of these savings due to delays in the certification process.

Some Characteristics of Recent Admittees to DCs: In general, the vast majority of individuals admitted to DCs in recent years have co-occuring intellectual disabilities, behavioral issues, and/or psychiatric disorders. More specifically, 65 percent of the individuals assessed to need and/or admitted to a DC between July 2008 and December 2011 were diagnosed to have a mild intellectual disability, with most of the remaining individuals identified as having intellectual disabilities ranging from moderate (11 percent) to severe (four percent) or profound (three percent). The majority (56 percent) were also diagnosed with a psychiatric disorder. Ninety-seven percent had identified behavioral issues that included serious assaultive behavior (observed in the cases of 44 percent of these individuals), vandalism or property destruction (34 percent), maladaptive sexual behavior (29 percent), habitual theft (19 percent), and attempted suicide in recent years (13 percent). Additionally, 20 percent of these consumers had experienced challenges with drug and alcohol abuse and 17 percent experienced abuse or neglect as a child.

Alternative Residential Options in the Community: Consumers of DDS services who do not live with their parents or other relatives, in their own houses or apartments (sometimes with supported living services), or in group homes may reside in a number

of facilities besides DCs, including intermediate care facilities, acute or sub-acute care facilities, or skilled nursing homes.

Consumers who have moved from the Agnews or Lanterman DCs into the community may also reside in homes that were specifically created in order to fill voids in the spectrum of available housing options. Between July 1, 2004 and March 27, 2009, a total of 327 Agnews residents transitioned to living arrangements in the community and 20 residents transferred to other DCs. The Bay Area Housing Plan enabled the involved Regional Centers to acquire and control an inventory of stable and permanent homes in the community for use by these former Agnews residents. The array of housing options under the Plan include family teaching homes and specialized residential homes licensed by the Department of Social Services which are designed to serve consumers with behavioral challenges or intensive health care needs. According to DDS, the average costs borne by Regional Centers for individuals who moved out of Agnews and into specialized residential homes is just over $232,000 annually.[1] Some advocates have suggested that an increased use of these and other community-based options could further reduce the state's reliance on DCs (potentially including its reliance on Porterville to meet forensic treatment needs).

SB 962 Homes: One set of specialized homes created during the Agnews closure process is called "Adult Residential Facilities for Persons with Special Health Care Needs" (commonly referred to as "SB 962" homes). SB 962 homes were established as a pilot project to be implemented at first only for regional centers involved in the closure of the Agnews DC. Given the success of the pilot project, in 2010-11 budget trailer bill, the Legislature and Governor extended the use of these homes to Regional Centers involved in the closure of the Lanterman DC. SB 962 homes provide 24-hour special health care and intensive support services in a home setting that is licensed to serve up to five adults with developmental disabilities. The kinds of special health care needs that are included are nursing supports for feeding and hydration, such as total parenteral feeding and gastrostomy feeding, cardiorespiratory monitoring, tracheostomy care and suctioning, special medication regimes including injection and intravenous medications and other specified services. Intensive support services are defined as when an individual needs physical assistance in performing four or more activities of daily living that include eating, dressing, bathing, toileting, and continence. A licensed nurse or psychiatric technician is required to be awake and on duty 24-hours a day, 7 days per week.

An evaluation published by the University of California, Davis Extension's Center for Human Services in 2010[2] found that SB 962 homes were cost effective when compared with the costs of placement in a DC (saving around $41,000 per individual consumer per year). The evaluators also found that consumers living in SB 962 homes were

[1] These facilities receive variable payments based on rate structures determined by DDS staff, Regional Centers, and Service Providers. It is also possible that there are additional service costs for some of these individuals borne by other state agencies or departments that may not have been previously available to them in DCs.

[2] Available online at this address: https://dds.ca.gov/LivingArrang/docs/962FinalReport.pdf

receiving high quality care and had good access to health care. Further, the report indicated that the SB 962 model contributed in meaningful ways to consumers' health, quality of life, level of functioning, and overall happiness.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee direct the Department to continue working with stakeholders to identify and build upon ways that the state can safely and appropriately reduce its reliance on and new admissions to DCs. As one component of this ongoing work, staff recommends that the Subcommittee adopt placeholder trailer bill language to expand the geographic availability of SB 962 homes statewide.

Questions for the Administration & LAO:

1) Please describe the options available in the community for individuals with complex needs who reside in developmental centers today. How do specialized residential facilities, including SB 962 homes, fit into the continuum of options needed?

2) Please describe the recent trends in developmental center admissions. What changes or reforms might the Administration and Legislature explore in order to strengthen the services available for meeting the needs of individuals with forensic treatment needs?

3. Governor's Budget for Community Services

2011-12 Updates: The state provides community-based services to DDS consumers through 21 nonprofit corporations called Regional Centers. The Governor's budget includes a total of $3.8 billion ($2.2 billion GF) for the provision of these services and supports to approximately 250,000 individuals with developmental disabilities in 2011-12 [a decrease of $146.1 million ($126.4 million GF) from the enacted budget for the current year]. Major changes include:

- A $100 million GF decrease for the second six months of the budget year that was triggered by lower than previously anticipated revenues in December 2011 (with potentially corresponding federal fund decreases dependent on the specific changes made).[3]

- A $47 million decrease ($32.0 million GF) to reflect revised implementation dates of Medi-Cal caps and co-pays and the establishment of an alternative Medi-Cal funded program to replace the Adult Day Health Care (ADHC) program, referred to as Community-Based Adult Services (CBAS), which reduce the impact on the DDS budget.

- A $5.9 million GF increase based on updated operations costs, caseload, utilization, and reimbursement data.

2012-13 Budget Proposal: The Governor's budget for 2012-13 proposes a total of $4.1 billion ($2.4 billion GF) for community-based supports and services, or an increase of $225.4 million ($180.9 million GF) over the revised 2011-12 budget, to serve 256,000 (or 2.5 percent more) consumers. Changes include:

- A $200 million GF decrease reflecting the full-year, ongoing impact of the reduction that was triggered by lower than previously anticipated revenues in December 2011 (with potentially corresponding federal fund decreases dependent on the specific changes made).

- A $162.7 million increase ($115.2 million GF) in regional center Operations and Purchase of Services due to updated caseload and utilization change.

- A $158.2 million increase ($108.4 million GF) to reflect restoration of the 4.25 percent payment reduction for regional center operations and service providers scheduled to sunset June 30, 2012.

[3]Currently, the 2011-12 and 2012-13 reductions of $100 million and $200 million GF, respectively, are reflected in the community services budgets for those years. The final reductions may, however, be taken from any mix of the budgets for community services, developmental centers, and/or DDS headquarters.

- An increase of $50.0 million GF to support developmental services provided to children from birth to age five.

- An $18.9 million decrease ($2.8 million GF) to reflect revised implementation dates of Medi-Cal caps and co-pays and the establishment of an alternative Medi-Cal funded program to replace the Adult Day Health Care (ADHC) program, referred to as Community-Based Adult Services (CBAS), which reduces the impact on the DDS budget.

- A $9.0 million increase ($4.5 million GF) to reflect updated assumptions related to rates for financial management services to account for tiered rates and 100 percent of consumers using the participant-directed option for certain services. In addition, community-based training services were added.

- A $31.1 million decrease ($20.5 million GF) to reflect full-year implementation of the savings proposals adopted in the FY 2011-12 enacted budget.

A few of these changes are discussed in greater detail below.

3a. Expiration of the 4.25 Percent Payment Reduction

Budget Issue: In each of the last several years, the Legislature and Governor have enacted temporary reductions to Regional Center Operations and Purchase of Services funding in order to save General Fund resources. In 2008-09 and 2009-10, the reduction was three percent (for estimated savings in 2009-10 of $60 million GF). In 2010-11, the reduction was increased to 4.25 percent (for estimated savings of $86 million GF). In 2011-12, the 4.25 percent reduction was continued until July 1, 2012 (for estimated savings of $105.6 million GF). There were corresponding federal funding losses each year. The Governor's budget for 2012-13 does not propose to extend these rate reductions. As a result, $158.2 million ($108.4 million GF) is restored to DDS's proposed budget.

The statutory provisions creating the payment reductions also established some exemptions to the reduction, including exemptions for supported employment, the State Supplementary Payment (SSP) supplement for independent living, and services with "usual and customary" rates established in regulations. Other exemptions were allowed if a Regional Center demonstrated that a non-reduced payment was necessary to protect the health and safety of a consumer and DDS agreed.

Many stakeholders have indicated that these rate reductions (particularly when combined with other reductions to the developmental services system) have created significant hardships for Regional Center staff and community-based service providers, which have also resulted in negative impacts on consumers.

Subcommittee Staff Comment & Recommendation: Staff recommends holding open the restoration of funding tied to expiration of the 4.25 percent rate reduction, pending further discussion related to reductions triggered by less than anticipated revenue in 2011-12.

Questions for the Administration and LAO:

1) What have the impacts of the 4.25 percent reduction been – on Regional Centers, service providers, and DDS consumers? What, if any, information has the Department tracked that might help to identify these impacts?

3b. First 5 Funding for Services Provided to Children from Birth to Five Years Old

Budget Issue: In 2009-10, Governor Schwarzenegger vetoed $50 million GF from the budget for developmental services provided to children from birth to age five who have, or are at risk for, developmental delays or disabilities. The California Children and Families Commission (created by Proposition 10 in 1998 and commonly known as the First 5 Commission) then provided $50 million to prevent the loss of services that would otherwise have resulted. The Legislature assumed the continuation of this First 5 funding in the final enacted budgets for 2010-11 and 2011-12.[4] The 2012-13 budget no longer assumes that these First 5 funds will be made available by the Commission and instead includes $50 million GF for these services.

Background on Early Intervention Services Provided to Young Children: Families whose infants or toddlers have certain documented developmental delays or disabilities, or are at risk for developmental delays or disabilities, may qualify for developmental monitoring or early intervention services. Based on the child's assessed needs and the families concerns and priorities (as determined by each child's Individualized Family Service Plan (IFSP) team), early intervention services may include supports such as assistive technology, nursing services, and occupational or physical therapy.

Background on Proposition 10: The Proposition 10 initiative created the California Children and Families Commissions, which rely on revenues generated by state excise taxes on cigarettes and other tobacco products to fund early childhood development

[4] In March 2011, the Legislature passed and the Governor signed AB 99 (Chapter 4, Statutes of 2011), a budget trailer bill which established the Children and Families Health and Human Services Fund and required specified amounts of state and local First 5 funds to be deposited in the fund for the 2011-12 fiscal year. Under this legislation, those funds would have been used to provide health and human services, including direct health care services, to children from birth through five years of age. In response, several local commissions filed a lawsuit to prevent AB 99 from taking effect. A superior court subsequently granted their request and declared AB 99 invalid. The final 2011-12 budget enacted in June 2011 did not rely on the provisions of AB 99, but did continue the assumption made in prior years that the First 5 Commissions would provide $50 million for the continued provision of services to young children that they had funded in 2009-10 and 2010-11.

programs for children up to age five. The state commission (which receives 20 percent of revenues) and county commissions (which receive the remaining 80 percent) operate First 5 programs. In general, these programs fund early childhood development, health, and education services that were designed to be enhancements to previously existing core programs. With the state facing such large deficits in recent years, however, many core programs have been or are proposed to be subject to major reductions or elimination.

Subcommittee Staff Comment & Recommendation: Staff recommends holding this item open, pending further discussions with the Administration and First 5 regarding the potential for continued support by the Commission.

Questions for the Administration & LAO:

1) Please describe the services that First 5 funds have supported since 2009-10.

4. 2011-12 Trigger Reduction

Budget Issue: The 2011-12 budget included trigger provisions that gave the Department of Finance authority to make specified reductions of up to $2.5 billion GF if revenues in the first half of the fiscal year were lower than previously anticipated. Among the trigger provisions that ultimately took effect was a reduction of $100 million GF in funding for developmental services.

The authorizing trailer bill (SB 73, Chapter 34, Statutes of 2011) directed the Department to consider a variety of strategies including savings attributable to caseload and expenditure adjustments, unexpended contract funds, or other administrative savings to meet the target "with the intent of keeping reductions as far away as feasible from consumer's direct needs, services, and supports, including health, safety, and quality of life." SB 73 indicated that the Department could utilize input from broad-based workgroups to develop proposals as necessary. The trailer bill also required that "any savings or reductions identified shall be reported to the Joint Legislative Budget Committee within 10 days of the reduction as directed within Section 3.94 of the Budget Act of 2011."

The Administration indicated in December that the Department expected, on a one-time basis, to achieve the $100 million GF savings within the administrative categories of savings outlined in SB 73 (without the need to propose service reductions or other policy changes that would require statutory changes). At the time, the Administration did not provide specific details on how the reduction would be achieved. Since December, the Administration has provided general information on how some of the reduction might be achieved, but without specific detail or written documentation. The Department indicates that its representatives will be prepared to testify in greater detail during this hearing.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee direct the Administration to provide additional detail, in writing and by April 6, 2012, regarding the reductions expected to comprise the $100 million GF in savings for 2011-12.

Questions for the Administration & LAO:

1) How does the Department plan to achieve the $100 million GF reduction in 2011-12?

5. 2012-13 Trigger Reduction

Budget Issue: The Governor's budget for 2012-13 assumes a reduction of $200 million GF for developmental services that was triggered by lower than anticipated revenue in the first half of 2011-12. The increase in the total amount is reflective of a full-year, ongoing impact (whereas the $100 million GF savings the Department was expected to achieve in 2011-12 occurred with only six months of the year remaining). The Department convened a series of meetings early in 2012 to obtain input from a broad group of stakeholders regarding how to achieve these savings, but indicates that its proposals are not likely to be submitted to the Legislature before the May Revision of the Governor's budget.

Possible Options for Achieving Savings: The Department and stakeholders have raised a variety of possible options to explore, including but not limited to:

1) **Recent legislation:** SB 946 (Steinberg, Chapter 650, Statutes of 2011) requires specified health care service plan contracts and policies to provide coverage for behavioral health treatment for pervasive developmental disorder or autism from July 1, 2012 until July 1, 2014. DDS estimates that these provisions will result in $64 to $69 million GF savings in the state's costs for developmental services in 2012-13. Those savings are not yet accounted for in the Governor's budget for DDS. SB 946 also creates a task force to develop longer-term recommendations related to behavioral health treatment and requires the Department of Managed Health Care, in conjunction with the Department of Insurance, to submit a report from the task force to the Governor and Legislature by December 31, 2012.

2) **Reducing developmental center placements and admissions:** See discussion beginning on page 14.

3) **Uses of technology:** Ideas that have been mentioned include potential uses of telephone or video-conferencing rather than in-person communications.

4) **Enhanced federal funding:** The state has recently submitted an amendment to its federal Medicaid state plan (for the Medi-Cal program in California) that seeks to opt into a new waiver program called the Community First Choice Option (CFCO). This waiver option was created in Section 1915(k) of the federal Social Security Act as a part of federal health care reform (enacted in the Affordable Care Act). Programs operated under the CFCO waiver receive an enhanced federal funding match of 56 percent (six percent over the base matching rate of 50 percent) for the provision of Home and Community-Based Attendant Services and Supports. The plan amendment submitted by the Department of Health Care Services, in collaboration with the Department of Social Services, currently covers personal care and related services that would be provided under the state's In-Home Supportive Services (IHSS) program. To the extent that the state provides similar kinds of personal care services as a component of other programs budgeted under DDS, one question to explore is whether those services could also be provided under the state's planned implementation of the CFCO waiver. Another set of questions has been raised about whether the state could increase the number of consumers served under other Medicaid Home and Community-Based Services waivers.

5) **Continuation of some or all of the 4.25 percent rate reduction:** See discussion beginning on page 18.

6) **Service flexibilities:** Some stakeholders have expressed an interest in creating self-directed service options or other systemic flexibilities that might create a greater degree of choice for consumers and/or provide relief to providers while reducing programmatic inefficiencies.

Subcommittee Staff Comment & Recommendations: First, staff recommends that the Subcommittee hold this item open pending the receipt of proposals from the Administration and additional input from stakeholders.

Second, staff recommends that the Subcommittee direct the Administration to work across health and human services departments (including the Departments of Health Care Services, Social Services, and Developmental Services, as necessary) to identify whether there are developmental services that could be funded under the CFCO waiver, and to provide an update to the Subcommittee on its efforts to do so by the end of April.

Finally, to allow for adequate time to review and respond to forthcoming proposals, staff recommends that the Subcommittee encourage the Department and Administration to work toward submitting proposals for how to achieve this $200 million reduction to the Legislature and to stakeholders by May 1, 2012.

Questions for the Administration & LAO:

1) Please describe the stakeholder process the Department has engaged in to date and the general kinds of ideas the Administration has been exploring in order to achieve this reduction.

2) What are the next steps toward developing and presenting specific proposals? What is the anticipated timing of these next steps?

6. Governor's Budget for DDS Headquarters

Overview of DDS Headquarters' Budget: The budget proposes a total of $38.5 million ($24.5 million GF) in funding for the DDS Headquarters in Sacramento. This represents approximately one percent of the proposed budget for developmental services.

Proposed Changes to the 2011-12 Budget: The Governor's Budget updates the FY 2011-12 funding for headquarters operations to $35.6 million ($23 million GF), a decrease of $3.0 million ($1.6 million GF) compared to the FY 201112 enacted budget. Changes include:

- A net decrease of $2.8 million ($1.5 million GF) due to statewide Control Sections that drove adjustments in retirement and health benefits rates, personal services cost reductions achieved through collective bargaining or actions of the Administration related to employee compensation, and one time savings as part of the Administration's statewide operational efficiencies savings plan [Control Section 3.91(b)]; and,

- A decrease of $100,000 GF due to statewide efficiencies that resulted in decreased building lease and cell phone costs.

Proposed Budget for 2012-13: The Governor's Budget proposes headquarters operations funding in 2012-13 of $38.6 million ($24.6 million GF), a decrease of $100,000 GF compared to the 2011-12 enacted budget. Changes include:

- A net decrease of $300,000 ($200,000 GF) due to statewide Control Sections that drove adjustments in retirement and health benefits rates;

- A decrease of $100,000 ($11,000 GF) due to elimination of one-time operating expenses to shift Limited-Term positions to Permanent positions; and,

- A net increase of $300,000 ($100,000 GF) for miscellaneous adjustments including a technical budget adjustment to move costs for DOJ Legal Services from the budget for Developmental Centers to the budget for Headquarters and cell phone reductions for administrative efficiencies.

6a. Request to Extend and Make Permanent 5 Limited-Term Positions Related to Federal Funding

Budget Issue: The Governor's budget includes $409,000 ($217,000 GF) to establish 4.0 permanent positions and 1.0 two-year, limited-term position that were previously approved as two-year, limited-term positions. The positions (one Career Executive Assignment, two Community Program Specialist IIs, one Senior Accounting Officer Specialist, and one Accounting Officer Specialist) are intended to support the Department's efforts to collect, account for, and maintain federal financial participation in the state's provision of developmental services. Due to a recent hiring freeze, the Department has experienced delays in filling the budgeted positions. Two are filled and three are in varying stages of the hiring process.

Rationale Behind the Request: The Department indicates that since the 1988-89 fiscal year, federal funding for developmental services (budgeted under the Department as Local Assistance/reimbursement funds) has risen from $29 million to $1.7 billion today. Since 2009-10 in particular, the Department has significantly increased its workload related to federal funding as additional federal funding has been used to create GF savings.

Subcommittee Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the requested funding and position authority.

Questions for the Administration & LAO:

1) Please summarize the need for these positions and the consequences to the state and the Department if they are not authorized.

8885 Commission on State Mandates

1. Proposed Repeal of Mandate Related to Counsel in Conservatorship Proceedings

Budget Issue: Under existing law, courts are required to appoint the public defender or private counsel to represent the interests of conservatees, proposed conservatees, or individuals alleged to lack legal capacity in specified legal proceedings if: a) they are unable to retain legal counsel and request appointment of counsel, b) the court determines that the appointment of counsel would be helpful or is necessary to protect the individual's interests, or c) the proceeding is about the establishment of a limited conservatorship. The court is then required to set a reasonable sum for compensating counsel and to determine whether the person can pay some or all of that amount (including payment out of the proceeds of community property at issue in the proceeding, if applicable). When the person lacks the ability to pay counsel, the county is required to do so.

The Administration proposes trailer bill language to repeal these requirements, which it indicates have been suspended since 2009. According to the Administration, these requirements are now standard operating procedures, and the mandate for local jurisdictions to meet them is no longer necessary. If the mandate is not suspended or repealed, the Department of Finance indicates that the state would incur costs of $349,000 GF.

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

Questions for the Administration and LAO:

1) Please explain which aspects of the statutes proposed for repeal create the mandate(s) at issue.

2) How often are courts appointing counsel that is paid for by counties pursuant to these provisions? What, if any, changes in local practice have occurred since the suspension of these statutes in 2009?

3) If these statutes are repealed as proposed, would conservatees, proposed conservatees, or individuals alleged to lack legal capacity continue to be entitled to the appointment of counsel under the circumstances specified in these statutes?

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

Outcomes for March 26, 2012 Hearing

Staff: Jennifer Troia

VOTE-ONLY ITEMS

4300 Department of Developmental Services (DDS)

1. Budget Bill Language to Assist with Cash Flow

Approved (3-0) the requested budget bill language to increase the authority for DDS's cash flow borrowing.

2. Financial Management Services for Participant-Directed Services

Approved (3-0) the proposed increase in funding.

3. Capital Outlay Request – Porterville Main Kitchen

Approved (3-0) the proposed reappropriation of funding for construction of the new main kitchen.

4. Capital Outlay Request – Automatic Fire Sprinkler Systems

Approved (3-0) the requested funds for construction costs associated with installation of automatic fire sprinkler systems.

5170 State Independent Living Council (SILC)

1. Proposed Shift of Federal Aging and Disability Resource Connection Grant Funds

Approved (3-0) the shift of federal funds from the 2011-12 to the 2012-13 fiscal year.

DISCUSSION ITEMS

2. Governor's Budget for Developmental Centers

Informational item. No action taken.

2a. Update on Closure of Lanterman Developmental Center

Voted (3-0) to hold open the requested funding to support 33 positions (28 with requested position authority and 5 budgeted separately under temporary help blanket authorization) for enhanced staffing at Lanterman DC.

Also, directed the Administration to work with Subcommittee staff to identify the general timeframes anticipated for the closure process.

2b. New Admissions to Developmental Centers and Alternative Residential Options in the Community

Directed the Department to continue working with stakeholders to identify and build upon ways that the state can safely and appropriately reduce its reliance on and new admissions to DCs.

As one component of this ongoing work, voted (2-1) to adopt placeholder trailer bill language to expand the geographic availability of SB 962 homes statewide.

3. Governor's Budget for Community Services

Informational item. No action taken.

3a. Expiration of the 4.25 Percent Payment Reduction

Voted (3-0) to hold open the restoration of funding tied to expiration of the 4.25 percent rate reduction, pending further discussion related to reductions triggered by less than anticipated revenue in 2011-12.

3b. First 5 Funding for Services Provided to Children from Birth to Five Years Old

Voted (3-0) to hold this item open, pending further discussion with the Administration and First 5.

4. 2011-12 Trigger Reduction

Directed the Administration to provide additional detail, in writing and by April 6, 2012, regarding the reductions expected to comprise the $100 million GF in savings for 2011-12.

5. 2012-13 Trigger Reduction

Voted (3-0) to hold this item open, pending the receipt of proposals from the Administration and additional input from stakeholders.

Also, directed the Administration to work across health and human services departments (including the Departments of Health Care Services, Social Services, and Developmental Services, as necessary) to identify whether there are developmental services that could be funded under the CFCO waiver, and to provide an update to the Subcommittee on its efforts to do so by the end of April.

Finally, to allow for adequate time to review and respond to forthcoming proposals, encouraged the Department and Administration to work toward submitting proposals for how to achieve this $200 million reduction to the Legislature and to stakeholders by May 1, 2012.

6. Governor's Budget for DDS Headquarters

Informational item. No action taken.

6a. Request to Extend and Make Permanent 5 Limited-Term Positions Related to Federal Funding

Approved (3-0) the requested funding and position authority.

8885 Commission on State Mandates

1. Proposed Repeal of Mandate Related to Counsel in Conservatorship Proceedings

Voted (3-0) to hold this issue open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

April 12, 2012

10:30 AM

Room 4203
(John L. Burton Hearing Room)
Part 1 Health Agenda

(Michelle Baass)

PLEASE NOTE:

Only those 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 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

A. 4265 Department of Public Health

The following issues were discussed at the Subcommittee #3 Hearing on March 8, 2012:

A. Safe Drinking Water State Revolving Fund

- Subcommittee Staff Recommendation—Approve as budgeted.

B. Renewal of Proposition 50 Limited-Term Positions

- Subcommittee Staff Recommendation—Approve as budgeted.

C. Small Water System Program

- Subcommittee Staff Recommendation—Approve as budgeted.

D. California Home Visiting Program

- Subcommittee Staff Recommendation—Approve as budgeted.

E. Maternal, Child and Adolescent Health - Reduction in Federal Funds

- Subcommittee Staff Recommendation—Approve as budgeted.

F. Expand California's Newborn Screening Program

- Subcommittee Staff Recommendation—Approve as budgeted.

G. Federal Special Projects – Position Conversion

- Subcommittee Staff Recommendation—Approve as budgeted.

H. Loan from Childhood Lead Poisoning Prevention Fund

- Subcommittee Staff Recommendation—Approve a $15 million loan from the Childhood Lead Poisoning Prevention Fund (CLPPF) to the General Fund that would be paid back to the CLPPF in 2014-15.

ISSUES FOR DISCUSSION

A. Community Mental Health

I. BACKGROUND

California has a decentralized public mental health system with most direct services provided through the county mental health system. In 2011-12, major changes to the state's oversight and responsibility for these programs were initiated. (These changes are described in detail below.) Prior to 2011-12, the Department of Mental Health (DMH) was the lead state agency responsible for administering state and federal statutes pertaining to mental health treatment programs.

County Mental Health Plans. Counties (i.e., County Mental Health Plans) have the primary funding and programmatic responsibility for the majority of local mental health programs.

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

Specialty Mental Health Services Managed Care. California provides "specialty" mental health services under a comprehensive Waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. These specialty mental health services are "carved out" of the Medi-Cal Program administered by the Department of Health Care Services (DHCS), which provides physical health care.

County Mental Health Plans are the responsible entity that ensures that specialty mental health services are provided. Medi-Cal enrollees *must* obtain their specialty mental health services through the County.

Medi-Cal enrollees may also receive certain limited mental health services, such as pharmacy benefits, through the Fee-For-Service system.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. EPSDT is a federally mandated program that requires the state to provide Medi-Cal beneficiaries under age 21 with any physical and mental health services that are deemed medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, including services not otherwise included in the state's Medicaid plan.

2011 Realignment and Mental Health Services. The 2011-12 budget realigned many public safety and health and human services, including Medi-Cal Specialty Mental Health and

EPSDT. However, in March 2011, the Governor signed AB 100, which amended the Mental Health Services Act (MHSA) to allocate, on a one-time basis, $861 million in MHSA funds to counties to support EPSDT, Medi-Cal Specialty Mental Health managed care, and mental health services provided to special education students. (In separate legislation, the mandate on county mental health departments to provide mental health services to special education students was repealed, thereby transferring the federal mandate back to school districts.) It was the intention that these programs would be fiscally realigned in 2012-13.

Prior to the 2011 Realignment, County Mental Health Plans were funded with 1991 Realignment funds, General Fund, and federal funds and EPSDT was funded by the General Fund and federal funds with the counties paying a 10-percent share of cost above a specified baseline.

In addition to the one-time funding shift of MHSA funding, AB 100 also made changes to MHSA administration, including reducing the percentage amount available from MHSA revenues for state administration from 5 percent to 3.5 percent, requiring monthly distributions from the MHSA Fund, having the "state" (instead of DMH) administer the MHSA Fund, and having the Mental Health Services Oversight and Accountability Committee provide technical assistance to counties. AB 100 was point-in-time legislation that was developed with the intention of coming back to define a process to restructure the state's mental health system.

Administrative Transfer from DMH to Department of Health Care Services. AB 102 (Statutes of 2011, signed by the Governor in June 2011) continued the process to restructure the state's mental health system. AB 102 transfers from DMH to the Department of Health Care Services (DHCS), effective July 1, 2012, the state administrative functions for the operation of Medi-Cal Specialty Mental Health Managed Care, the EPSDT Program, and applicable functions related to federal Medicaid requirements.

It required DHCS, in collaboration with DMH and the California Health and Human Services Agency (Agency), to create a state administrative and programmatic transition plan, in consultation with stakeholders that included specified components to guide the transfer of Medi-Cal Specialty Mental Health managed care and the EPSDT Program to DHCS.

AB 102's legislative intent is that the transfer occur in an efficient and effective manner, with no unintended interruptions in service delivery to clients and families, and that the transfer accomplish improved access to culturally appropriate community-based mental health services; effectively integrate the financing of services to more effectively provide services; improve state accountabilities and outcomes; and provide focused, high-level leadership for behavioral health services within the state administrative structure.

Proposition 63, Statutes of 2004 (Mental Health Services Act). The Mental Health Services Act (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 for Adult and Children's Systems of Care.** This component funds the existing adult and children's systems of care established by the Bronzan-McCorquodale Act (1991). County Mental Health Departments are to establish through its stakeholder process a listing of programs for which these funds would be used. Of total annual revenues, 80 percent is allocated to this component.

- **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. Of total annual revenues, 20 percent is allocated to this component.

- **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. This is funded from 5 percent of the Community Services and Supports funds and 5 percent of the Prevention and Early Intervention funds.

- **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. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of $460.8 million. Counties have 10 years to spend these funds.

- **Capital Facilities and Technological Needs.** This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports, and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of $460.8 million. Counties have 10 years to spend these funds.

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

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

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

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

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 (Systems of Care).** Each county is charged with the responsibility of developing and coordinating a comprehensive system of programs to meet its residents' (children and adults) mental health needs, referred to as systems of care. These programs address the problems of acute and chronic mental disorders.
- **State Hospital Services for County Patients.** Counties contract with the Department of Mental Health (Department of State Hospitals in the budget year) for State Hospital beds for county patients who are civilly committed.
- **Institutions for Mental Disease (IMDs).** The IMDs, administered by independent contractors, generally provide short-term nursing level care to the seriously mentally ill.

II. ISSUE FOR DISCUSSION

1. 2011 Realignment of Medi-Cal Specialty Mental Health and EPSDT

Budget Issue. The Administration proposes to implement the realignment of Medi-Cal Specialty Mental Health services and EPSDT. The 2011-12 budget realigned many public safety and health and human services, including Medi-Cal Specialty Mental Health and EPSDT. However, since AB 100 (as discussed above) provided one-time MHSA funding for Medi-Cal Specialty Mental Health and EPSDT, these programs are not realigned until 2012-13.

The table below identifies the proposed "2011 Realignment" funding for mental health services.

Table: 2011 Realignment Funding – Local Revenue Fund (dollars in millions)

	2011-12		**2012-13**	
	2011 Budget Act	Proposed	June 2011 Estimate	Proposed
Medi-Cal Specialty Mental Health	-	-	$183.7	$188.8
EPSDT	-	-	$629.0	$544.0
1991 Mental Health Responsibilities	$1,083.6	$1,104.8	$1,119.4	$1,164.4

Note: The June 2011 Estimate for EPSDT for 2012-13 reflects full-year implementation of the *Katie A.* lawsuit and the Healthy Families Program transfer to Medi-Cal. Whereas, the proposed 2012-13 EPSDT funding includes only partial year funding (as these changes are proposed to be phased-in in 2012-13).

Medi-Cal Specialty Mental Health. The $5.1 million increase, noted in the table above, in Medi-Cal Specialty Mental Health (i.e., the mental health managed care program) principally reflects a 2.6 percent growth in eligible consumers.

EPSDT Estimate. The EPSDT Local Revenue Fund estimate above reflects:

1. A decrease of $77.3 million (compared to the 2011 Budget Act) based on a forecast of decreased approved claims. Statewide implementation of the Short Doyle Medi-Cal (SDMC) Phase 2 system changes began in January 2010 and billing issues and claim delays occurred throughout 2010 and 2011. The Administration notes that this forecasted decrease could be a result of the implementation of SDMC Phase 2. The Administration expects the May Revise to more accurately reflect claim information as the SDMC Phase 2 system changes will be fully implemented.

2. An increase of $6.1 million for the transition of Healthy Families Program children to Medi-Cal starting in October 2012.
3. An increase of $5.3 million for the *Katie A.* lawsuit, as services to Foster Care youth are anticipated to begin in January 2013 as a pilot for at least one large, medium, and small county. This increase is 20 percent of the full annual implementation cost ($53.5 million) for mental health services related to *Katie A.*

Subcommittee Staff Comment and Recommendation—Hold Open. The trailer bill language regarding the realignment of these mental health services is not yet available. Consequently, the Legislature cannot evaluate the manner in which funds will be distributed to counties for these programs, nor can it evaluate how the Administration has addressed the existing statutes that give counties the voluntary option of contracting with the state to serve as the County Mental Health Plan. Since these programs are realigned, counties would have the responsibility for these programs.

Additionally, concerns have been raised that the Administration's EPSDT figures do not reflect adequate funding for these services and do not include a mechanism to ensure funding for future growth and penetration of these services. It is recommended to hold this item open as it is anticipated that the May Revise estimates will more accurately reflect the true estimate of approved claims for mental health services.

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

1. Please provide an overview of this proposal.

2. Please discuss the differences between the June 2011 EPSDT estimate for the budget year and the Administration's January estimate.

3. What is the status of the trailer bill language regarding the realignment of mental health services?

2. Transfer of State Administration of Medi-Cal Specialty Mental Health

Budget Issue. The Administration proposes trailer bill language to proceed with statutory changes necessary to transfer the administrative functions for Medi-Cal Specialty Mental Health managed care plan services and EPSDT from DMH to DHCS.

Background. AB 102 (Statutes of 2011) transferred the administration of the Medi-Cal Specialty Mental Health Services Program from DMH to DHCS, effective July 1, 2012. The intent of the transfer is to:

- Improve access to culturally appropriate community-based mental health services, including a focus on client recovery, social rehabilitation services, and peer support;
- Effectively integrate the financing of services, including the receipt of federal funds, to more effectively provide services;
- Improve state accountabilities and outcomes;
- Provide focused, high-level leadership for behavioral health services within the state administrative structure.

Effective September 1, 2011, 118.5 DMH Medi-Cal positions were transferred to DHCS.

AB 102 required DHCS, in collaboration with DMH and the California Health and Human Services Agency (Agency), to create a state administrative and programmatic transition plan, in consultation with stakeholders that included specified components to guide the transfer of Medi-Cal Specialty Mental Health managed care and the EPSDT Program to DHCS.

DHCS was required to provide the transition plan to all fiscal committees and applicable policy committees of the Legislature by October 1, 2011. AB 102 required the state administrative transfer to conform to the state administrative transition plan provided to the Legislature. Finally, AB 102 also authorized the transition plan to also be updated by the Governor and provided to the Legislature upon its completion, but no later than May 15, 2012.

DHCS submitted the required transition plan, and two updates to that plan. Issues raised by stakeholders in the October 1, 2011 transition plan included the following:

- That DHCS improve business practices (examples include maximizing the claiming of federal funds; improving the claims reimbursement system, streamlining the cost reporting and settlement processes; eliminating redundancies in the provider certification process; facilitating same day billing for mental and physical health care services; integrating audits; integrating information technology systems; and, reducing processing times);
- That DHCS assure access and improve services (examples include adopting community-based best practices, such as peer support and maximizing the use of social rehabilitation services; increasing the use of telepsychiatry; focusing on prevention and early intervention; ensuring state staff are knowledgeable about mental health services; assuring children's mental health policy expertise; assuring providers can continue to serve clients during and after the transfer; continuing progress in assuring cultural

competence of services; addressing racial, ethnic, and cultural disparities in access to care and outcomes; reducing discrimination and stigma experienced by clients; eliminating disparity in access to services; integrating services; facilitating coordination with non-Medi-Cal mental health services; incentivizing the use of community settings; and assuring accountability in the mental health system and, of its providers and administrators);

- That DHCS ensure stakeholder participation (examples include providing regularly scheduled venues for regular stakeholder engagement; consulting with stakeholders on program changes, efficiencies, regulations, State Plan Amendments, and waiver amendments; engaging stakeholders in ongoing quality improvement, including county representation in assessment of legal issues and court decisions that require county implementation; facilitating stakeholder participation by funding travel to meetings; and, clearly identifying individuals that serve as state contacts for programs and services).

Subcommittee Staff and Recommendation—Hold Open. The Administration's proposal is consistent with state law. However, pieces of this proposed trailer bill language directly relate to the realignment proposal. Given that the Legislature does not yet have the realignment trailer bill language, it is recommended to keep this item open.

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

1. Please provide an overview of this proposal and the planning process that occurred in the summer and fall of last year.

2. Please explain how DHCS plans to address stakeholder concerns and suggestions regarding program improvements and innovations (i.e., the development of a business plan). What is the timeline for this process?

3. Transfer of Non Medi-Cal Community Mental Health Programs

Budget Issue. The Governor's budget proposes to eliminate the Department of Mental Health (DMH), establish the Department of State Hospitals to provide long-term care and services to individuals with mental illness at state hospitals, and redirect funding and positions for all remaining mental health services to other departments.

The reorganization of behavioral health began in 2011-12, as discussed above. The Administration intends that this proposal completes these efforts by transferring the remaining mental health programs to various state departments that perform related or similar functions. The Administration believes the consolidation of mental health, substance use disorder, and physical health at DHCS will provide for a continuum of care for consumers in preparation for health care reform in 2014.

The Administration proposes to transfer the remaining non-Medi-Cal community health programs, including 58 positions and budget authority of $104.7 million ($16.3 million state operations, $88.3 million local assistance) ($15.6 million General Fund) from DMH to six other departments as described in the chart below.

Table: Behavioral Health Reorganization: Department of Mental Health Functions

FUNCTION OR PROGRAM	RECIPIENT DEPARTMENT POSITIONS/TOTAL FUNDING
Financial Oversight, Certification Compliance/Quality Improvement, MHSA State Level Issue Resolution, County Data Collection and Reporting, MHSA Statewide Projects (Suicide Prevention, Student Mental Health Initiative, Stigma and Discrimination Reduction Project), Co-Occurring Disorders, Veterans Mental Health, Substance Abuse and Mental Health Services Administration Block Grant, Projects for Assistance in Transition from Homelessness (PATH), Training Contracts – California Institute for Mental Health (CIMH), California Health Interview Survey (CHIS), Policy Management, MHSA Housing Program, Administrative Staff-Accounting, IT, California Mental Health Planning Council	**Department of Health Care Services** $72.3 million ($256,000 General Fund, $6.9 million Mental Health Services Fund, $65.1 million federal funds) 41.0 Positions
Office of Multicultural Services Disaster Services and Response	**Department of Public Health** $2.3 million Mental Health Services Fund 4.0 Positions
Licensing/Quality Improvement (Mental Health Rehabilitation Centers, Psychiatric Health Facilities)	**Department of Social Services** $1.1 million ($337,000 General Fund, $391,000 Licensing and Certification Fund, $396,000 Reimbursements) 12.0 Positions
Early Mental Health Initiative	**Department of Education** $15 million General Fund 0.0 Positions
MHSA Workforce Education and Training (WET)	**Office of Statewide Health Planning and Development** $12.3 million Mental Health Services Fund 1.0 Positions
Training Contracts – Consumer Groups, MHSA Technical Assistance, MHSA Program Evaluation	**Mental Health Services Oversight and Accountability Commission** $1.7 million Mental Health Services Fund 0.0 Positions

Department of Health Care Services. The majority of existing community mental health programs and functions are proposed to be transferred to a new Division of Mental Health and Substance Use Disorders Services within DHCS. In addition to the transfer of these programs, the Administration proposes to create a new Deputy Director, Mental Health and Substance Use Disorder Services, who would lead this new division. The new Deputy Director would be a Governor's Appointee and would require Senate confirmation. The following functions would be transferred to DHCS:

- **Oversight of Certain MHSA Components.** DHCS would be responsible for the collection of data relating to certain MHSA programs (Full Service Partnerships). In addition, DHCS would be responsible for MHSA state-level issue resolution which is a process by which

consumers and stakeholders have a mechanism to resolve issues related to MHSA. And finally, DHCS would be responsible for MHSA Statewide Prevention and Early Intervention Projects (Suicide Prevention, Student Mental Health Initiative, and Stigma and Discrimination Reduction Programs).

- **Certification of Mental Health Programs at Facilities.** DHCS would assume responsibilities for the certification of mental health treatment programs at Skilled Nursing Facilities with Special Treatment Programs, Community Residential Treatment Systems (also known as Social Rehabilitation Programs), and Community Treatment Facilities.

- **Oversight of Federal Grants.** In addition, DHCS would be responsible for the oversight and administration of federal mental health funds including the Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant and the Projects for Assistance in Transition from Homelessness (PATH). The SAMHSA block grant can be used to establish or expand an organized community-based system of care for providing non-Medi-Cal mental health services to children with serious emotional disturbances and adults with serious mental illness. The state administers this block grant and allocates the funds each year to 58 local county mental health agencies. The county mental health departments and contracted providers deliver a broad array of treatment and support services that include over 150 individual programs supported by the block grant. PATH funds community-based outreach, mental health and substance abuse services, case management, and limited housing services for people experiencing serious mental illness who are experiencing homelessness or are at risk of becoming homeless.

- **Oversight of Contracts and Other Mental Health Programs.** Finally, DHCS would be responsible for the oversight of certain administrative and training contracts related to the above-mentioned programs and the coordination of efforts related to veteran's mental health and co-occurring disorders.

Department of Public Health (DPH). As discussed later in the agenda, the Administration proposes to transfer the Office of Multicultural Services (OMS) to DPH's new Office of Health Equity. Additionally, the $60 million in MHSA funds for the California Reducing Disparities Project (CRDP) would be transferred to DPH. The CRDP is a project under the Prevention and Early Intervention component of the Mental Health Services Act. The initiative is focused on five populations: African Americans; Asian/Pacific Islanders; Latinos; Lesbian, Gay, Bi-sexual, Transgender, Questioning; and Native Americans. The project will develop population-specific reports that will form the basis of a statewide comprehensive strategic plan to identify new approaches to reduce disparities.

This proposal also transfers DMH's Disaster Services Unit to DPH. The Disaster Services Unit is responsible for the statewide coordination of disaster mental health responses to major disasters in support of local mental health agencies. This includes the development and maintenance of the mental health section of the State Emergency Plan and training and technical assistance to local mental health agencies on planning, preparedness, and mitigation for a disaster.

The DPH is the designated lead state agency for public health emergency preparedness and response.

Department of Social Services (DSS). The Administration proposes to transfer DMH's facility licensing and quality improvement efforts to the Department of Social Services (DSS). DMH currently licenses mental health rehabilitation centers (MHRCs) and psychiatric health facilities (PHFs). MHRCs provide community-based intensive support and rehabilitation services designed to assist persons, 18 years or older, with mental disorders who would have been placed in a state hospital or another mental health facility to develop the skills to become self-sufficient and capable of increasing levels of independent functioning. There are currently 20 MHRCs with a total of 1,363 beds.

PHFs offer acute inpatient psychiatric treatment to individuals with major mental disorders in a nonhospital setting. PHFs mainly provide acute psychiatric treatment services to individuals subject to involuntary commitment under the Lanterman-Petris-Short Act. There are 25 PHFs in California with 432 beds. These facilities are locked facilities.

The Administration argues that these facilities are similar to other residential facilities that are licensed by DSS.

Additionally, the Administration proposes to transfer DMH's roles and responsibilities related to Lanterman-Petris-Short Act involuntary holds (pursuant to Welfare and Institutions Code Section 5150) to DSS. These responsibilities include the approval of facilities designated by counties for 72-hour treatment.

Department of Education. The proposal transfers the Early Mental Health Initiative (EMHI) program to the Department of Education. The EMHI is a school-based program funded with Proposition 98 funds. The Senate Budget Subcommittee #1 will discuss this proposed transfer at its April 26 hearing.

Office of Statewide Health Planning & Development (OSHPD). The Administration proposes to transfer the MHSA workforce education and training (WET) component to OSHPD. The MHSA WET targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness.

OSHPD currently operates a mental health loan assumption program and the Administration believes it has the existing infrastructure, experience and technical ability to effectively monitor grants and program activities. The Administration also states that this transfer will increase efficiency, reduce duplication, and align the program with health care reform planning.

Mental Health Services Oversight & Accountability Commission (MHSOAC). The budget proposes to transfer training contracts for consumer groups, technical assistance, and program evaluation to the MHSOAC.

The Administration states that these functions are consistent with the role of the MHSOAC and that placing these functions within the MHSOAC will reduce duplication as the MHSOAC currently has similar contracts with stakeholder entities.

Subcommittee Staff Comment and Recommendation—Hold Open. The proposed reorganization of non-Medi-Cal community mental health is consistent with Legislative action on the 2011-12 budget. However, it is recommended to keep this item open as discussions continue regarding the reorganization and realignment of mental health programs.

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

1. Please provide a summary of this proposal.

2. How has the Administration reached out to stakeholders to solicit feedback on this reorganization?

4. Proposition 63 – Mental Health Services Act

Budget Issue. In addition to the reorganization of non-Medi-Cal community mental health, the Administration's proposed trailer bill language makes changes to the Mental Health Services Act (MHSA), including:

- Changes approval of the MHSA innovation programs from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to the county board of supervisors.
- Removes MHSOAC's authority to issue guidelines for MHSA innovation programs.
- Requires each county mental health program to prepare and submit a three-year plan adopted by its county board of supervisors to MHSOAC.
- Eliminates performance contracts between the state and counties.

Background. AB 100 (Statutes of 2011) made several changes to the Mental Health Services Act (MHSA). These changes include:

- Deleted the requirement that the Department of Mental Health (DMH) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) annually review and approve county plans and updates.
- Deleted the requirement that a county annually update the 3-year plan but still required that there be updates.
- The "state," instead of DMH, would administer the Mental Health Services Fund (MHSF).
- Starting July 1, 2012, the State Controller shall distribute, on a monthly basis, to counties all unexpended and unreserved funds on deposit in the MHSF as of the last day of the prior month.
- Reduced the administrative funds for state departments from 5 percent to 3.5 percent.

AB 100 also contained language specifying that it was the Legislature's intent to ensure continued state oversight and accountability of the MHSA and that in eliminating state approval of county mental health programs, the Legislature expects the state to establish a more effective means of ensuring that county performance complies with the MHSA.

AB 100 Workgroup. Because several changes made by AB 100 needed clarification before they could be implemented, a workgroup was convened in an effort to try to develop consensus recommendations. This workgroup included representatives from DMH; the California Mental Health Planning Council; MHSOAC; the California Mental Health Directors; the National Alliance on Mental Illness; the California Network of Mental Health Clients; the Mental Health Association, California; and United Advocates for Children and Families.

Recommendations from the AB 100 workgroup include:

- Implement the MHSA state level issue resolution process as a mechanism to assure county level compliance with the MHSA values.
- Charge MHSOAC with MHSA performance outcome evaluation.
- Continue MHSA programs through a performance contract.

Performance Contracts. Performance contracts were developed during the 1991 realignment as a way to ensure county accountability. These contracts provide for county assurance and reports and provide a mechanism to address noncompliance.

Subcommittee Staff Comments and Recommendation—Hold Open. It is recommended to hold this item open. Discussions regarding state oversight of MHSA funds and compliance with the MHSA (including the nonsupplantation requirement and MHSA component funding requirements); performance contracts; and the role of the MHSOAC are continuing. Additionally, discussions are still underway between the Administration and counties on how the State's Controller's Office will distribute MHSA funds to counties.

Lastly, it should be noted that SB 1136 (Steinberg) will propose changes to the MHSA and is to be discussed in the Senate Health Policy Committee on April 25, 2012. This legislation pertains to the budget as a follow-up to AB 100 (discussed above) as well as issues raised by the Administration in their proposed trailer bill legislation.

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

1. Please provide an overview of the Administration's proposed changes to the MHSA.

2. What is the Administration's perspective on the role of the state with regards to ensuring the integrity of the MHSA?

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5. Caregiver Resource Centers

Budget Issue. The Administration proposes to eliminate $2.9 million General Fund for the Caregiver Resource Centers (CRCs).

Background. CRCs provide services and supports to families and caregivers of persons with cognitive disorders such as Alzheimer's disease, stroke, dementia, and others. The assistance provided by CRCs allows persons with these disorders to stay in familiar home environments while family members provide care. The 11 CRCs located throughout the state provide free and low-cost services and supports to families regardless of income.

LAO Comment. The LAO finds that the role of CRCs should be considered in the context of the Governor's Coordinated Care Initiative and other state efforts to provide seniors and persons with disabilities with community-based services instead of institutional care. The LAO also notes that CRC administrators report that this proposal would result in a federal funding reduction to CRCs of $3.9 million due to federal matching requirements that would no longer be met.

Subcommittee Staff Comments and Recommendation–Reject. It is recommended to reject this proposal. CRCs provide valuable services to family caregivers. These services enhance family caregivers' ability to provide care over the long-term; thereby, preventing or delaying placement in nursing homes or hospitals. Since DMH is proposed for elimination, it is recommended to transfer the CRC program to DHCS' Long-Term Care Division.

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

1. Please provide a summary of this proposal.

6. California Youth Empowerment Network (CAYEN)

Budget Issue. The 2011-12 budget eliminated the California Youth Empowerment Network (CAYEN) contract at DMH. Concerns have been raised indicating that this elimination was not based on policy, but rather a misunderstanding of how this contract was categorized. The contract was for $250,000 (MHSA funds).

Background. The CAYEN contract supports advocacy efforts for transition-age-youth (age 15-26) regarding the mental health system. CAYEN ensures that counties include transition-age-youth in mental health community planning and that services that young people say work are being identified and put into practice. CAYEN also encourages young people to get involved in their county planning process to make sure the transition-age-youth perspective is incorporated. This contract has been supported since 2007-08.

During the 2011-12 budget deliberations, this contract was eliminated because it was misclassified as an administrative-related contract. The 2011-12 budget reduced the percent of total annual revenues for state administrative expenditures for MHSA from 5 percent to 3.5 percent.

Subcommittee Staff Comment and Recommendation. It is recommended to reinstate this contract for $300,000 at the Mental Health Services Oversight and Accountability Commission. Since severe mental illness most often first manifests during the transition-age-youth years of age, the perspective and consultation of participants in this age group is critical to mental health community planning. The increase of $50,000 (from the original contracted amount) would provide additional funds for youth participants to attend meetings, such as the meetings of the Mental Health Services Oversight and Accountability Commission and meetings with state and county officials, and an inflationary increase.

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

1. Please provide an overview of this contract and the action taken in 2011-12.

2. Does the Administration have any concerns with the reinstatement of this contract?

7. Community Treatment Facilities

Budget Issue. The Administration proposes to eliminate $750,000 General Fund that is paid as a supplemental rate to Community Treatment Facilities (CTFs). The Administration argues that since this is not a statewide program, counties can use local funds to fund these CTFs at their discretion. (There are no federal funds for CTFs.)

Background. Community Treatment Facilities (CTFs) provide secured residential care for the treatment of children diagnosed as being seriously emotionally disturbed (SED). These are locked facilities and provide intensive treatment. Generally, CTFs were created as an alternative to out-of-state placement and state hospitalization for some children.

The Budget Act of 2001, and related legislation, provided supplemental payments to CTFs. The CTF supplemental rate provides additional funding up to a maximum of $2,500 per month, per child. These supplemental payments consist of both state (40 percent or $1,000) and county (60 percent or $1,500) funding.

There are two active CTFs in California:

- Starview Children and Family Services in Los Angeles County (40 beds)
- Vista Del Mar Child and Family Services in Los Angeles County (21 beds)

The San Francisco Community Alternatives Program in San Francisco County is in the process of closing and is performing assessments on all of its clients in order to refer each one to other programs and services in the area.

The $750,000 General Fund supplemental rate was based on three CTFs being operational in the state.

Subcommittee Staff Recommendation—Hold Open*.* It is recommended to hold this item open as discussions continue. Given the state's fiscal situation and since there are only two facilities in the state, it is likely that these costs can be absorbed by counties who use these facilities.

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

1. Please provide a summary of this proposal.

B. 4265-Department of Public Health and 4260-Department of Health Care Services

1. Office of Health Equity

Budget Issue. The Administration proposes to create a new Office of Health Equity (OHE) at the Department of Public Health. This office would take a more comprehensive and integrative approach to address the issues of health disparity and promote healthy communities.

The OHE would be created by consolidating the following entities:

- Office of Multicultural Health (OMH) at DPH
- Office of Women's Health (OWH) at the Department of Health Care Services (DHCS)
- Office of Multicultural Services (OMS) at the Department of Mental Health (DMH)
- Health in All Policies Task Force (HiAP) at DPH
- Healthy Places Team at (HPT) DPH

Proposed Office of Health Equity Organization Chart

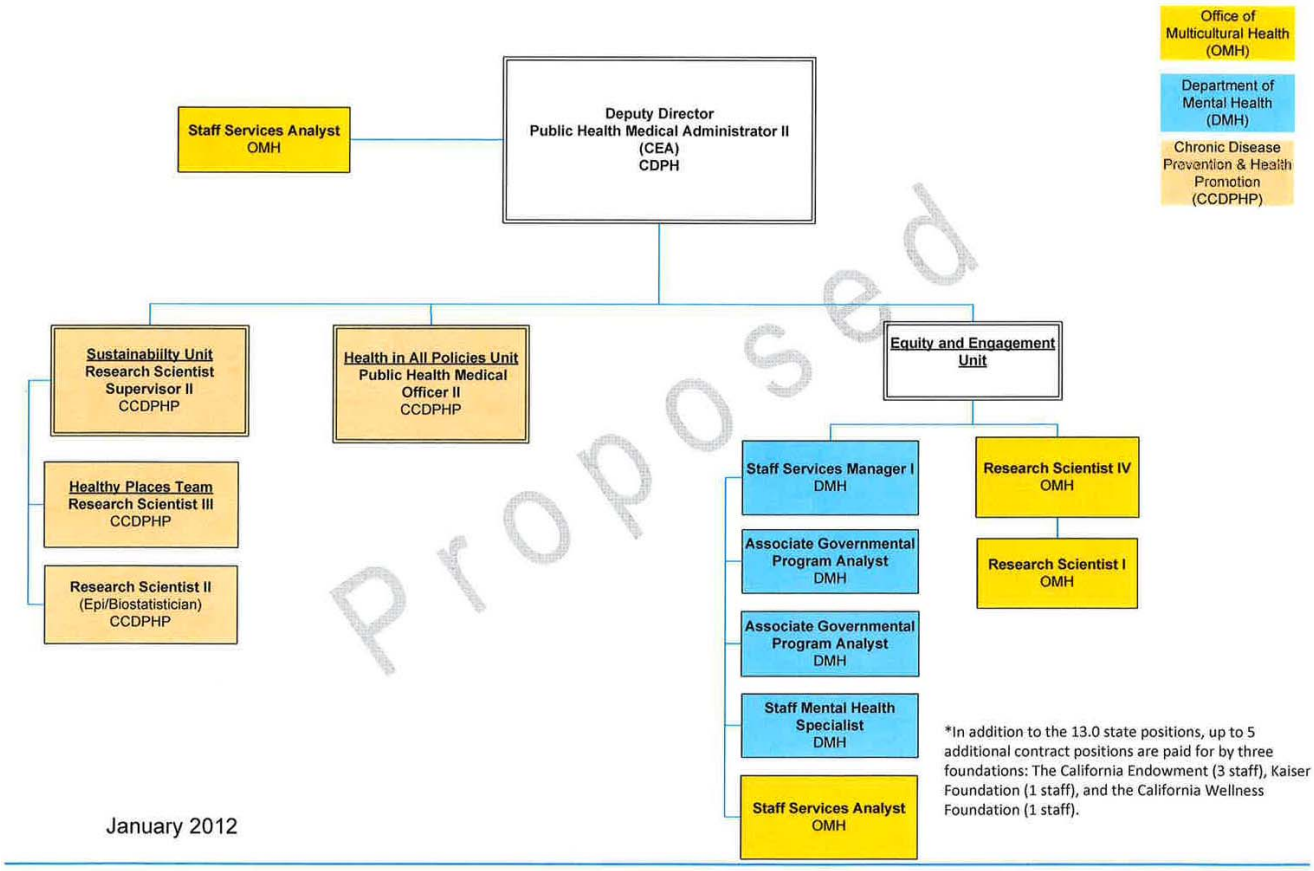


Table: Proposed Office of Health Equity Budget

Office of Health Equity				
Fund Source	**Appropriation Amount**		**Position Classifications**	**Count**
General Fund Program Function Health in All Policies Unit and Healthy Places Team	Personal Services	$268,000	Public Health Medical Officer II	1.0
			Research Scientist III	1.0
	Contracts	0		
	OE&E	38,000		
	Total	**$306,000**	**Position Total**	**2.0**
Mental Health Services Fund Program Function Equity and Engagement Unit (EEU)	Personal Services	$329,000	Staff Services Manager I	1.0
			Associate Governmental Program Analyst	2.0
			Staff Mental Health Specialist	1.0
	Contracts	1,959,000	Master Multi-Provider Cultural Competency; Mental Health Association of California; etc.	
	OE&E	61,000		
	Total	**$2,349,000**	**Position Total**	**4.0**
Federal Trust Fund Program Function Office of Multicultural Health	Personal Services	$199,000	Staff Services Analyst	2.0
			Research Scientist I	1.0
	Contracts	0		
	OE&E	57,000		
	Total	**$256,000**	**Position Total**	**3.0**
Prop. 99 Unallocated Account Program Function Sustainability Unit and Healthy Places Team	Personal Services	$226,000	Research Scientist Supervisor II	1.0
			Research Scientist II	1.0
	Contracts	0		
	OE&E	38,000		
	Total	**$264,000**	**Position Total**	**2.0**
Distributed Administration Program Function OHE Deputy Director and EEU	Personal Services	$316,000	Public Health Medical Administrator II	1.0
			Research Scientist IV	1.0
	Contracts	61,000	• Consultant Contract • Women's Health Survey	
	OE&E	110,000		
	Total	**$487,000**	**Position Total**	**2.0**
Total		**$3,662,000**		**13.0**

Advisory Committee. The proposal requires the OHE to establish an Advisory Committee, which would include "representatives of appropriate state agencies and representatives of appropriate stakeholder communities that represent the diverse demographics of the state." According to DPH, the Advisory Committee would assist the department in the development of the mission, vision, goals, and performance metrics of the OHE.

The following existing advisory bodies would be eliminated:

- The OWH's Women's Health Council
- The OMH's Council on Multicultural Health
- The OMS's Cultural Competency Advisory Committee

The Administration notes that the new OHE Advisory Committee would be representative of the above advisory bodies. It also notes that current committee/council members would be encouraged to apply for the OHE Advisory Committee.

Department of Health Care Services. In addition to the new OHE, the Administration proposes to redirect the five positions at the Office of Women's Health to address healthy equity issues from the health care delivery system perspective at the Department of Health Care Services. According to DHCS, the multiple health care programs at DHCS are complex with multiple eligibility groups, variations in benefits, and a range of business rules. In addition, the scope of programs is expanding substantially with the addition of mental health and substance abuse services. Thus, it takes a sophisticated, in-depth understanding of the various DHCS programs to analyze health disparities and to design appropriate interventions to eliminate them. Specifically, the administration proposes:

Office of Medical Director. DHCS will be directing three positions to work in the Office of the Medical Director. One of these positions (a Medical Program Consultant) would:

1. Develop, plan, and implement programs and policies that advance and improve the health of the population.
2. Optimize the patient care experience.
3. Reduce the per capita cost of care.

Two of the positions (a Research Scientist and Health Program Specialist) would help develop the DHCS Quality Strategy (QS). The QS will align with the National Quality Strategy mandated by the Affordable Care Act. The QS will address important domains including: patient safety, prevention, patient and family engagement, population health, and health disparities. The Research Scientist will analyze large datasets to assist in quality improvement efforts tied to the QS. The Health Program Specialist will focus on developing, monitoring, and evaluating the interventions.

According to the Administration, these three positions would work closely with OHE so that OHE is informed on the issues of disparities in the health care sector and so that DHCS can dovetail with the overall public health approach to eliminating disparities led by OHE.

These positions will be funded via Distributed Administration (or approximately 40 percent General Fund, 60 percent other funds).

New Division of Mental Health and Substance Use Disorders Services. The two remaining positions (Associate Governmental Program Analysts) will be redirected to the new division to serve as cultural competency technical advisors to the County Mental Health Plans. These positions would be funded with MHSA funds.

Coordinated Approach to Health Equity. According to the Administration, by merging the functions of the five entities listed above, the OHE can take a more holistic approach to mental health and public health issues. On the whole, there is a net reduction of one position (the Career Executive Assignment position at the Office of Multicultural Health) with this proposal.

The Administration finds that the functions of the OWH, OMH, and OMS are more critical than ever, as California's population continues to become more diverse and issues of health disparity more pronounced. Several trends and recent developments suggest that the state needs to take a different approach to tackling issues of health disparities by integrating mental health and physical health, expanding the state's understanding of health disparities, and generating economies of scale.

In addition to merging these three Offices, CDPH proposes to consolidate its HiAP Task Force and HPT, both of which currently reside in the Center for Chronic Health and Health Promotion (CCHHP), and integrate them into the new OHE.

The proposed OHE provides an opportunity for the state to leverage multiple existing resources for a more coherent, coordinated, innovative, and systematic approach to work across programs, engage multiple stakeholders and departments, and address critical health issues related to health inequities. Roles of the OHE will include:

- Providing leadership to increase public awareness of health disparities, both in terms of public health and mental health.
- Encouraging the development of programs that address disparities in public health and mental health services and outcomes.
- Implementing policies and programs that result in a sustainable improvement in the health and mental health status of underserved and disparate communities by working with policy makers, insurers, health care providers, mental health providers, and communities.
- Working to eliminate health disparities in California through the collaboration of state agencies, academic institutions, community-based organizations, health and mental health partners, providers and others in the public and private sectors.

Background. Health equity issues are currently addressed in multiple offices and departments in the state.

Office of Multicultural Health (OMH). In August 1993, the OMH was created in the CDPH by Executive Order W-58-93, and established in statute in 1999. Key areas of responsibility for

OMH include health planning and policy development, technical assistance and training, health initiatives/program services, impact of program activities on communities and program evaluation. OMH's mission is to eliminate health disparities and improve access to quality health care for California's diverse populations.

Office of Women's Health (OWH). The OWH was established within the Director's Office of the California Department of Health Services (CDHS) in 1993 by Governor's Executive Order W-57-93. In 1994, the office was permanently established in statute. Subsequent legislation places the OWH in two departments, the DHCS and the CDPH. The mission of the office is to guide women's health policy in an effective and comprehensive fashion to promote health and reduce the burden of preventable disease and injury among the women and girls of California.

Office of Multicultural Services (OMS). The Department of Mental Health's OMS was established in 1998 to coordinate efforts to reduce disparities in access and quality of care for California's racial, ethnic, and cultural un-served and underserved communities. OMS works in partnership with stakeholders to foster change in policy, access, language, clinical practice, research, and intervention practices in mental health programs and services.

Health in All Policies (HiAP). The HiAP Task Force provides a venue for several State agencies and departments to advance multiple goals towards a healthier and more sustainable California. HiAP leverages the various areas of expertise each of these State agencies and departments brings to identify and address the social, political, and environmental determinants of health outcomes in California. Currently, the HiAP Task Force is developing a core set of indicators to measure attributes of a healthy community. HiAP recognizes that the policies and programs of many non-health related agencies have significant impacts on health, both positive and negative. The HiAP Task Force provides a structure for a more systematic exploration of the ways in which agencies across state government can promote better health outcomes through public policy and programs to improve community health environments.

Healthy Places Team (HPT). The HPT serves a coordinating function for multiple programs that address ways to improve health outcomes through urban greening and sustainable communities planning. Additionally, HPT brings together data from multiple sources to develop cross-cutting analysis (e.g. development of a core set of indicators to measure attributes of a healthy community, assessment of the impacts of alternative transportation strategies).

Subcommittee Staff Comment and Recommendation—Hold Open. The goal of the Administration's proposal is valuable and worthwhile. However, the proposed language is vague and provides no metrics to hold this new office accountable for improving health equities. It is recommended to hold this item open as the Administration, stakeholders, and the Legislature work together to strengthen this proposal.

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

1. Please provide a summary of the proposal.

2. What are the department's short-term and long-term goals for OHE?

3. Please describe how the department plans to develop and convene the Advisory Committee.

4. What are some examples of performance metrics that could be used to evaluate the success of the OHE?

5. How does the Administration propose to ensure the OHE works across state agencies and with DHCS, in particular?

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, April 12 (Room 4203)
PART I

VOTE ONLY CALENDAR

Department of Public Health

A. Safe Drinking Water State Revolving Fund

- Action – Approve as budgeted.
- Vote- 3-0

B. Renewal of Proposition 50 Limited-Term Positions

- Action – Approve as budgeted.
- Vote- 3-0

C. Small Water System Program

- Action – Approve as budgeted.
- Vote- 3-0

D. California Home Visiting Program

- Action – Approve as budgeted.
- Vote- 2-1 (Senator Emmerson voting no.)

E. Maternal, Child and Adolescent Health - Reduction in Federal Funds

- Action – Approve as budgeted.
- Vote- 3-0

F. Expand California's Newborn Screening Program

- Action – Approve as budgeted.
- Vote- 3-0

G. Federal Special Projects – Position Conversion

- Action – Approve as budgeted.
- Vote- 2-1 (Senator Emmerson voting no.)

H. Loan from Childhood Lead Poisoning Prevention Fund

- Action – Approve staff recommendation.
- Vote- 2-1 (Senator Emmerson voting no.)

ISSUES FOR DISCUSSION

1. 2011 Realignment of Medi-Cal Specialty Mental Health and EPSDT

- Held open.

2. Transfer of State Administration of Medi-Cal Specialty Mental Health

- Held open.

3. Transfer of Non Medi-Cal Community Mental Health Programs

- Held open.

4. Proposition 63 – Mental Health Services Act

- Held open.

5. Caregiver Resource Centers

- Action – Reject Administration's proposal.
- Vote- 3-0

6. California Youth Empowerment Network (CAYEN)

- Action – Approve staff recommendation.
- Vote- 3-0

7. Community Treatment Facilities

- Held open.

8. Office of Health Equity

- Held open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

April 12, 2012

10:30 AM or
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)
Part 2 Health Agenda

(Joe Stephenshaw)

Department of Alcohol and Drug Programs (4200)

Departmental Overview. The Department of Alcohol and Drug Programs (DADP) provides leadership, policy, coordination, and investments in the planning, development, implementation, and evaluation of a comprehensive statewide system of alcohol and other drug prevention, treatment, and recovery services, as well as problem gambling prevention and treatment services. As the state's alcohol and drug authority, the Department is responsible for inviting the collaboration of other departments, local public and private agencies, providers, advocacy groups, and individuals in establishing standards for the statewide service delivery system.

California's system for the provision of substance use disorder (SUD) services is primarily run at the county level, overseen by the DADP. DADP administers the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, nearly $260 million in 2011-12 with a Maintenance of Effort requirement, and other discretionary grants from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the Parolee Services Network Program, Narcotic Treatment Program, Driving Under the Influence Program, Office of Problem Gambling, and Drug Court Programs. DADP also certifies and licenses SUD providers in the community and, until the transfer approved as part of the 2011 Realignment, administered the Drug Medi-Cal Treatment Program (DMC), which accounted for about a quarter of the functions at the Department.

DADP contracts with counties and direct service providers for the provision of DMC. County participation in DMC is optional, and counties may elect to provide services directly or subcontract with providers for these services. All but approximately 15 California counties currently maintain a program. If a county chooses to not participate in DMC and a certified provider within that county indicates a desire to provide these services, DADP currently executes a service contract directly with the provider.

In 2000, California voters approved the Substance Abuse and Crime Prevention Act, or Proposition 36, which changed state law so that certain adult offenders who use or possess illegal drugs are sentenced to participate in drug treatment and supervision in the community rather than being sentenced to prison or jail, supervised on probation, or going without treatment. From 2001-02 until 2005-06, Prop. 36 provided annual appropriations of $120 million General Fund for related substance abuse treatment programs. The Offender Treatment Program was an adjacent program, and the two programs were funded fully, then partially over the course of the next several years. The 2009-10 Budget included minimal federal funding and no General Fund for the programs. The two programs have remained with no funding since that time.

Drug court programs combine judicial monitoring with intensive treatment services over a period of about 18 months typically for nonviolent drug offenders. In general, these are county-administered programs through which the state provides funding and oversight. There are two main programs – the Drug Court Partnership Act program created in 1998 that supports adult drug courts in 32 counties and the Comprehensive Drug Court Implementation Act program created in 1999 that supports adult, juvenile, family, and some Dependency Drug Courts in 53 counties.

2011 Realignment. California's statewide treatment, recovery and prevention network consists of public and private community-based providers serving approximately 230,000 people annually. The 2011 budget plan realigns several substance abuse treatment programs that were previously funded through the General Fund. The following are the major substance abuse treatment programs realigned:

- Regular and Perinatal Drug Medi–Cal. The Drug Medi–Cal program provides drug and alcohol–related treatment services to Medi–Cal beneficiaries. These services include outpatient drug free services, narcotic replacement therapy, day care rehabilitative services, and residential services for pregnant and parenting women.
- Regular and Perinatal Non Drug Medi–Cal. The Non Drug Medi–Cal program provides drug and alcohol–related treatment services generally to individuals, including women's and children's residential treatment services, who do not qualify for Medi–Cal.
- Drug courts. Drug courts link supervision and treatment of drug users with ongoing judicial monitoring and oversight. There are several different types of drug courts including: (1) dependency drug courts, which focus on cases involving parental rights; (2) adult drug courts, which focus on convicted felons or misdemeanants; and (3) juvenile drug courts, which focus on delinquency matters that involve substance–using juveniles.

As part of the 2011-12 budget plan, funding for specific alcohol and other drug programs was shifted from the state to local governments. A total of about $184 million of DADP programs (Regular and Perinatal Drug Medi–Cal, Regular and Perinatal Non Drug–Medi–Cal, and Drug Courts) were shifted to the counties.

In addition to the fund shifts in 2011 Realignment, administrative functions for the DMC Program that were previously performed by DADP were transferred to DHCS. DHCS, in collaboration with DADP, was required to develop an administrative and programmatic transition plan that includes specified components to guide the transfer of the DMC Program to DHCS.

Issue 1: DADP Governor's Budget Proposals

Governor's Budget. The Governor's budget for 2012-13 proposes to:

1. Provide a permanent funding structure for the programs that were part of the 2011 Realignment, specifically Drug Medi-Cal Treatment Program (DMC Program), Non Drug Medi-Cal, and Drug Courts.

Trailer bill language on a superstructure for realignment has yet to be received from the administration.

2. Propose trailer bill language to proceed with statutory changes necessary to transfer the administrative functions for the DMC Program from DADP to DHCS.

The administration has released its proposed trailer bill language. Stakeholders are reviewing it and reacting with issues and questions around governance, rates, contracts, and regulatory control.

3. Eliminate DADP:

The Governor's budget proposes to eliminate DADP entirely effective July 1, 2012 and redirect funding and positions for certain SUD services to other departments. This proposal would transfer the remaining non-Medi-Cal SUD programs, including 231.5 positions and budget authority of $322.103 million ($32.166 million state operations, $289.937 million local assistance) ($34.069 million General Fund) from the DADP to three departments as described in the chart below. A description of programs affected follows the chart.

The Administration states that the proposal follows the actions taken previously for DADP in the 2011-12 Budget and that the transfer of remaining departmental responsibilities to other state departments will integrate activities within those new placements.

Administration's Proposal: Department of Alcohol and Drug Program Functions

Function or Program	**Recipient Department Positions/Total Funding**
Administration of SAPT Block Grant and other SAMHSA Discretionary Grants, Data Collection Function, Reporting and Analysis, Statewide Needs Assessment and Planning, Program Certification, Technical Assistance and Training, Substance Abuse Prevention Activities, Resource Center, Parolee Services Network	**Department of Health Care Services** $305.572 million ($285.937 local assistance, $19.635 state operations) 161.5 Positions
Counselor Certification, Narcotic Treatment Programs, Driving Under the Influence Programs, Office of Problem Gambling	**Department of Public Health** $12.002 million ($4.0 local assistance, $8.002 state operations) 34.0 Positions
Program Licensing	**Department of Social Services** $4.529 million (all state operations) 36.0 Positions

Current Proposal Lacks Detail. The current elimination proposal lacks detail on (1) real program outcomes that are goals for the reorganization, (2) the readiness and appropriateness of receiving departments to take on the DADP positions, functions, and oversight, (3) accountability and transparency in the implementation of this elimination and transfer, and (4) assurances that the elimination and shifting will not disrupt services for consumers, patients, and providers dependent on current DADP functions. Policy and oversight considerations require time and attention, and are further challenged without a detailed proposal.

Fiscal Assessment. The proposal from the Administration contains no cost savings as a result of the DADP elimination and attendant transfer of all functions to three departments. Without a thoughtful, thorough transition plan to understand how this transfer would occur over a phased-in period and under what principles and terms, it is difficult for the Legislature to evaluate the Administration's proposal.

Provider Concerns. Stakeholder's have raised concerns regarding the Administration's DADP proposals, including; 1) sustainability of substance use programs and funding, 2) the maintenance of a statewide approach to the DMC programs, and 3) the logic of transferring certain DADP functions to separate departments.

Recommendation. Hold open.

Department of Mental Health (4440)

The Department of Mental Health (DMH) operates five state mental hospitals and two psychiatric programs within state prisons (California Medical Facility and Salinas Valley State Prison), which provide inpatient mental health treatment. Four of the mental health hospitals – Napa, Metropolitan (Norwalk), Atascadero, and Patton (San Bernardino) – were constructed more than 50 years ago. In 2005, DMH opened the Coalinga Mental Hospital to provide treatment for sexually violent predators. DMH also oversees a variety of state and local public mental health programs. In 2011, funding for some local mental health services was realigned to counties.

The majority of the state hospital population, approximately 92 percent, is forensic or penal code related. Major categories of state hospital patients include:

- Judicial commitments directly from superior courts - Not Guilty by Reason of Insanity (NGI) and Incompetent to Stand Trial (IST)
- Civil commitments as Sexually Violent Predators (SVPs)
- Referrals/transfers from California Department of Corrections and Rehabilitation (CDCR) including Mentally Disordered Offenders (MDOs) and Parolees
- Civil commitments from counties under the Laterman-Petris-Short Act

On May 2, 2006, the United States Department of Justice (USDOJ) and the State reached a settlement concerning civil rights violations at four state mental hospitals. The judgment called for Metropolitan State Hospital, Napa State Hospital, Patton State Hospital, and Atascadero State Hospital to implement an “Enhancement Plan” to improve conditions. Coalinga was not covered by the agreement because it had just opened, but it has similar reforms in place now. The extensive reforms required by the five-year Consent Judgment were to ensure that individuals in the hospitals are adequately protected from harm and provided adequate services to support their recovery and mental health.

The USDOJ conducted its investigation pursuant to the Civil Rights of Institutionalized Persons Act of 1980 (CRIPA). This statute allows the federal government to identify and root out systemic irregularities such as those identified in this case, rather than focus on individual civil rights violations.

In November of 2011, the USDOJ released Patton State Hospital and the Atascadero State Hospital from oversight, deeming them in compliance with the bulk of the consent judgment's demands. However, DOJ officials asked a judge to extend federal oversight of Napa State Hospital and Metropolitan State Hospital, saying the facilities have failed to comply with critical provisions of the consent judgment.

In July of 2011, DMH commissioned a report to assist in the proposal for a state mental hospital department to be included in the 2012-13 Governor’s Budget. The scope of the project was to recommend the administrative structure for a state mental hospital department, to identify processes that might be organized differently for better performance and accountability, and to collect information on the department’s budget deficit. The report was released in December 2011.

The Governor's budget proposes to eliminate DMH, proposes to create the Department of State Hospitals (DSH), and transfer responsibility for community mental health programs to other state departments. The budget includes $1.4 billion from all fund sources and 9,861.3 positions to support 6,439 patients in 2012-13.

(dollars in millions)

Program	Positions	Funding
In-Patient Services Program	9,594.7	$1,411.6
Evaluations and Forensic Services	75.1	$21.4
Legal Services	24.7	$5.6
Administration	166.8	$16.7
Distributed Administration	-	-$16.7
Total	**9861.3**	**$1,438.6**

The budget proposes to transfer the majority of community mental health programs for DMH to the Department of Health Care Services (DHCS). In total, the budget transfers $104.7 million from DMH to other state departments or entities, as follows:

(dollars in millions)

Department	Function/Program	Positions	State Ops.	Local Assist.	Total
Health Care Services (DHCS)	Financial Oversight, Certification Compliance, Quality Improvement, Mental Health Services Act (MHSA) State Functions, County Data Collection and Reporting, Suicide Prevention, Co-Occurring Disorders, Veterans Mental Health, Substance Abuse and Mental Health Services Administration Block Grant, Projects for Assistance in Transition from Homelessness, Training Contracts, CA Institute for Mental Health, CA Health Interview Survey, Policy Management, Admin Staff, CA Mental Health Planning Council	41	$11.1	$61.2	$72.3
Social Services (DSS)	Licensing/Quality Improvement (Mental Health Rehabilitation Centers, Psychiatric Health Facilities)	12	$1.1	$-	$1.1
Mental Health Services	Training Contracts – Consumer Groups, MHSA Program Evaluation	-	$1.7	$-	$1.7

Oversight and Accountability Commission					
Public Health	Office of Multicultural Services, Disaster Services and Response	4	$2.3	$-	$2.3
Education (CDE)	Early Mental Health Initiative	0	$-	$15.0	$15.0
Office of Statewide Health Planning and Development	Mental Health Services Act Workforce Education and Training	1	$.1	$12.2	$12.3
Totals		**58**	**$16.3**	**$88.4**	**$104.7**

Violence Related Costs. Over the past approximately fifteen years, the state hospitals' population has changed dramatically, becoming an increasingly "forensic" population with civil commitment in decline. Now, approximately 92 percent of the state hospital population is forensic, a result of key laws being passed, including: 1) legislation in 1995 (AB 888 Rogan and SB 1143 Mountjoy), which established a new category of civil commitment for sexually violent predators (SVPs), which requires certain SVP criminal offenders, upon release from prison, to be placed in state hospitals for treatment; and, 2) Proposition 83 ("Jessica's Law"), passed by voters in 2006, increased criminal penalties for sex offenses and eased the way for more SVPs to be placed in hospitals. As a result of these laws, and consequential changes to the population, violence in the hospitals has increased substantially. In 2010, there was an average of 23 incidents of violence per day toward patients or workers, and almost three staff injuries per day. In 2009, an employee at Napa State Hospital was killed by a patient.

Safety issues are discussed in more detail below, however it is important to note here that there are several increased costs that result from the population being almost entirely criminal in nature:

- Jessica's Law more than doubled the workload related to screening and evaluating sex offenders for SVP commitments;

- Outside hospitalization costs have risen substantially, largely due to patients harming themselves or others. Hospitalization costs rose an average of ten percent per year between 2008-09 and 2010-11, from $9.5 million to $41.4 million; and,

- Increased security measures, such as alarm systems, have become necessary to protect both patients and staff. The alarm systems are quite sophisticated and costly. Other types of

safety upgrades are also necessary and costly given that the hospitals were not constructed for a violent, forensic population.

Unfunded Overtime
Overtime costs nearly doubled between 2005-06 and 2010-11, increasing from $58.6 million to $110 million, an average annual increase of 17.5 percent per year. Since, 2005-06, the DMH has spent over $500 million on overtime costs. Increasing violence has resulted in increased worker's compensation claims. Worker's compensation claims drive overtime costs as state hospitals must meet federal and state patient-to-staff ratios.

Lack of Budget Transparency. The DMH explains that while the deficits can be attributed to costs rising simultaneously with resources diminishing, they also describe a budgeting process, which failed to reflect the true and full costs of the state hospitals. According to the DMH, the division responsible for hospital oversight has been preoccupied with complying with the CRIPA court order, at the expense of more accurate and responsible budget work. The DMH states that this division "lacked the knowledge and leadership to address and resolve the emerging deficit." In response to years of inadequate and inaccurate budgeting, the DMH has tried to build a more accurate "workload budget" in order to reveal and convey the actual costs of the hospitals continuing to do what they already do. This workload budget revealed a $180 million shortfall from the existing appropriation. The DMH discovered the following core functions at State Hospitals that have been unfunded activities, and therefore funding is being proposed for these purposes, though estimates will be updated in May Revision:

Enhanced Observations. The DMH is requesting $30,684,039 GF in 2011-12 and 2012-13 to address unfunded operating enhanced observation expenses resulting from the redirection of core unit staff that is backfilled by additional staff who are needed to maintain basic licensing ratios. Enhanced observation of a patient is required when: 1) a patient's behavior is determined to cause a danger to either the patient or other people; 2) a medical condition dictates increased observation; or, 3) a patient is transported outside the hospital for medical care. As discussed previously in this agenda, as the state hospitals population has become almost entirely a forensic population, aggressive behavior and violence have increased substantially, thereby increasing the need for enhanced observation.

Admission Assessments. The DMH is requesting $6,340,175 GF in 2011-12 and 2012-13 to cover unfunded operating expenses resulting from the required admission assessment. The CRIPA Consent Judgment requires assessments to be performed on all patients admitted to a state hospital in the following disciplines: psychiatry, psychology, rehabilitation therapy, nursing, social work, and nutrition. A complete medical history and physical are also required. Each hospital maintains an "admission suite" to process the assessments for new patients. The DMH is requesting this augmentation to offset the costs of temporary help and overtime incurred by the redirection of both core admission suite staff and staff that perform the assessments.

Operating Expenses & Equipment. The DMH is requesting $45,069,000 GF in 2011-12 and 2012-13 for increased OE&E costs. According to the DMH, OE&E costs have increased significantly since 2006-07, primarily as a result of the following:

1. The opening of CSH;

2. Backfilling up to 500 beds with patients committed as Mentally Disordered Offenders and Incompetent to Stand Trial, two very unstable populations;

3. Flat OE&E funding for SVPP and VPP; and,

4. OE&E base reductions leading to insufficient annual price increases.

The amount of the funding request was determined by averaging actual expenditures for 2005-06 and 2006-07 to establish base expenditures. The annual expenditure amount was determined by averaging annual expenditures for 2007-08 through 2011-12.

Savings Proposals. Given the recent deficits and current shortfall, either resources have to be increased or expenditures reduced, and, in light of the state's overall fiscal condition, the DMH is therefore proposing the following state hospitals' savings strategies:

Elimination of 619 Positions. According to the DMH, 80-90 percent of all state hospital costs are salaries and other staff benefits and costs. Therefore, the majority of savings ($122.6 million in 2011-12 and $193.1 million 2012-13) would come from a proposed reduction of 619.5 positions within the state hospital system, of which 230 are filled and 370 vacant.

Reduction to patient staff ratio for ICF Treatment Teams. The majority of positions being eliminated (for GF savings of $21.2 million Current Year and $68.1 million Budget Year) are a result of a proposed reduction in the required staff to patient ratio specific to Treatment Teams, which are made up of a group of medical professionals who, together as a team, act as case managers for patients. These professionals are not the "front line" staff who supervise and interact with patients, one on one, on a daily basis. The ratio for the teams used to be one team per 35 patients, and was reduced to 1 team per 25 patients per the CRIPA court ordered Enhancement Plan. The DMH explains that this lower ratio was necessary in order for the team members to be able to complete increased documentation requirements, also included in the CRIPA Enhancement Plan, which also can be reduced at this point in time, according to the DMH. The DMH explains that the level of documentation required by CRIPA has not proven necessary, and therefore can be reduced, thereby allowing Treatment Teams sufficient time to handle a larger patient caseload. Related to staffing ratios, AB 2397 (Allen) would require a minimum ancillary clinical staff-to-patient ratio of 1 to 25 for each applicable staff classification.

The SEIU has raised concerns regarding the staff reductions and changes being implemented by the DMH. In general, SEIU states that the DMH is moving forward very rapidly without regard for the impacts of the staffing changes and without sufficient communication efforts with SEIU. They also state that staff have been moved into new positions for which they are unqualified and for which they are receiving no training.

Pharmacy Costs. The proposed State Hospitals budget assumes savings of $2 million Current Year and $13 million Budget Year by requiring the use of generic drugs as much as possible. The DMH is also exploring the use of a third party receiver, mirroring the practice utilized by the CDCR.

Increase to County Bed Rate. Counties pay the State approximately $500 per patient per day for civil commitments to state hospitals and, according to the DMH, the amount counties pay is below the cost of care for the hospitals, and below private sector and Medi-Cal rates. The difference is made up with state GF and therefore the DMH proposes to bridge this gap by increasing the county bed rate, for GF savings of $20 million in 2012-13. This savings estimate is preliminary in that the DMH states that they, in consultation with counties and hospitals, will be developing a methodology to accurately calculate the per-patient cost over the next two months, and will present a revised proposal and savings estimate at May Revise.

Adult Education Program Elimination. The proposed State Hospitals budget assumes savings of $3.6 million and a reduction of 46.8 positions in 2012-13 by eliminating the Adult Education Program, an optional program for hospitals. Subcommittee staff has asked the DMH to provide detail on the specifics of this program at each hospital, including what subjects are taught and how many patients participate in the program.

Other Savings. The proposed State Hospitals budget includes many other changes to the operations of state hospitals; please refer to the attached chart (Attachment B) provided by the DMH that details all of the changes and related savings and positions reductions. The total savings from all of the proposals is $122.6 million in 2011-12 and $193.1 million in 2012-13.

Issue 1: Department Administration

As described above, the state hospitals have fallen victim to a combination of rising costs, largely attributable to a more aggressive and violent hospital population, and decreasing resources, thereby leading to increasing and regular budget deficits. Nevertheless, the DMH, in its 2011 audit of the hospitals, also found weaknesses in management both at the state level and within the hospitals, which also have contributed to inaccurate and incomplete budgets that fail to reflect the true operational costs of the hospitals. Therefore, the quality of management should be addressed at the same time that additional resource reductions are being made to the hospitals. The Department's current leadership is new, yet temporary. The DMH report includes the following observations:

- "Headquarters is thinly staffed with a limited capacity for analysis; hospital administrative structures are also thinly staffed, especially in fiscal oversight functions;
- The division charged with hospital oversight was preoccupied with complying with the federal CRIPA court order;
- Hospitals have performed better than headquarters, but they lack robust, shared fiscal management systems and training;
- Headquarters' executive structure should be revised to replace the existing Long-Term Care Supports division with an operations division and a clinical division; and,

- There are a number of organizational and process changes the department can make to improve fiscal management and help avoid deficits in the future."

LAO Recommendation

The LAO highlights the fact that many of the problems identified by the OSAE audit in 2008-09 still have not been addressed and were identified again by the DMH's own investigation in 2011. Therefore, the LAO is recommending additional oversight in the form of another OSAE audit of the department beginning in January 2013. The LAO suggests that the audit should cover:

1. What measures are being taken to ensure proper fiscal controls and whether those measures are effective;

2. A detailed look at vacancies and their impact on the state budget and hospital performance;

3. A detailed review of the personnel needs by hospital; and,

4. An analysis of patient aggression and the impact of the new security measures.

Staff notes that the Department of Finance would like to work to further define the scope of the audit.

Recommendation. Adopt placeholder TBL for an OSAE follow-up audit of the state hospitals, as recommended by the LAO.

Issue 2: Hospital Safety

Background. A substantial source of increased costs in the state hospital system is the increased violence that is occurring as a result of the population becoming almost entirely a forensic population. The DMH reports that at NSH in 2010-11, patients committed 75 physically aggressive acts against staff, and there were nearly four times as many patient-on-staff assaults, and twice as many patient-on-patient aggressive incidents, than in the prior year. In October of 2010, a patient assault resulted in the death of an employee. The number of aggressive acts for just calendar year 2010 is outlined in the table below.

Aggressive Acts in State Hospitals in 2010		
Hospital	Aggressive Acts Against Staff	Aggressive Acts Against Others
NSH	928	2,688
PSH	1,208	2,894
MSH	1,324	2,438
ASH	415	647
CSH	719	707
TOTAL	**4,594**	**9,374**

Cal/OSHA has had significant and ongoing involvement with the State Hospitals as a result of insufficient protections for staff. The LA Times reported on March 2, 2012 that Cal/OSHA has issued nearly $100,000 in fines against Patton and Atascadero State Hospitals, alleging that they have failed to protect staff and have deficient alarm systems. These citations are similar to citations levied in 2011 against Napa and Metropolitan State Hospitals. Cal/OSHA found an average of 20 patient-caused staff injuries per month at Patton (2006-2011) and eight per month at Atascadero (2007-2011), including severe head trauma, fractures, contusions, lacerations, and bites. The DMH explains that they are working closely with Cal/OSHA to resolve the issues and to take all necessary corrective measures to protect staff at all of the State Hospitals.

The State has both a legal and moral obligation to take necessary measures to protect both patients and staff in the hospitals. The DMH explains that in all of the proposed changes and position eliminations to achieve cost savings, there are no proposed reductions to "front-line" staff and no reductions to hospital police officers. Moreover, the 2011-12 budget includes $5.4 million and added positions to implement Grounds Presence Teams and Grounds Safety Teams. Specifically:

1. ***Grounds Presence Teams (GPTs).*** GPTs are utilized at Napa and Metropolitan State Hospitals. GPTs are comprised of psychiatric technicians responsible for direct supervision of patients throughout the "secure treatment areas." They supplement hospital police officers during emergencies and patrol the campus grounds. They provide crisis intervention, detection of safety and security issues, redirect inappropriate activities or behavior, monitor all individuals entering and exiting the facility, perform periodic searches throughout the grounds, and implement and oversee health and safety procedures. The cost for the GPTs is $2.2 million and 28 new positions were requested to create the GPTs.

2. ***Grounds Safety Teams (GSTs).*** GSTs are comprised of hospital police officers (HPOs) who report directly to the Chief of Police. GSTs respond to safety issues, including reports of suspected contraband. The 2011 May Revise requested $3.2 million and 50 new positions for GSTs at Napa, Metropolitan and Patton State Hospitals.

Per the current proposal, the state is also in the process of implementing new, far more sophisticated alarm systems at the State Hospitals, as described below.

PDAS Implementation Time-Line		
Completion of:	**MSH & PSH**	**CSH & ASH**
Service Contract	July 2012	July 2013
Hardware contract	July 2012	July 2013
Site survey & design	Sept. 2012	Sept. 2013
Network build out	March 2013	March 2014
Training	April 2013	April 2014
Deployment	May 2013	May 2014

Governor's Proposal. The Governor's budget contains the following requests:

Napa State Hospital (NSH)

The DMH is requesting $446,000 GF ongoing, and 2.5 positions for maintenance of the Personal Duress Alarm System (PDAS) pilot that is being installed at NSH. The PDAS system at NSH is expected to be complete by the end of June 2012.

NSH is serving as the pilot program for upgraded PDAS, and therefore implementation is underway at NSH. $4 million was approved in the 2011-12 budget, which did not include resources for maintenance and operation for the wireless network infrastructure, management of the wireless intrusion detection and prevention system, management of the alarm system, around-the-clock monitoring of the PDAS, or the annual license renewal, all of which would be covered by this request.

Metropolitan State Hospital (MSH) & Patton State Hospital (PSH)
The DMH is requesting $22.76 million GF ($22.2 million one-time and $566,000 on-going) and 5 permanent positions to install and support PDAS for MSH and PSH.

Atascadero State Hospital (ASH) & Coaling State Hospital (CSH)
The DMH is anticipating costs of approximately $22.4 million GF ($20.6 million one-time and $1.8 million on-going) and the need for 4 permanent positions to install and support PDAS at ASH and CSH in 2013-14.

Recommendation. Approve as budgeted.

Issue 3: *Coleman* Class Action Lawsuit

Background. *Coleman* is a lawsuit brought against CDCR asserting that they were not providing adequate mental health care to inmates. As a result, when inmates require in-patient mental health care, they are referred to the DMH, which refers them to either Salinas Valley Psychiatric Program (SVPP) or the Vacaville Psychiatric Program (VPP). Significant waiting lists have developed at these two facilities, resulting in the court directing California to address the waiting lists on a faster time-line. Over the past two years, the DMH and CDCR have worked closely with the *Coleman* "special master" to develop a plan to reduce or eliminate the waiting lists at the SVPP and VPP. The DMH and CDCR jointly submitted a proposed three-pronged approach to the court, which approved of the plan. Specifically, to reduce the waiting lists, the DMH and CDCR have begun: 1) moving patients who have been stabilized to ASH; 2) moving other patients who are deemed very stable to CSH; and, 3) converting the "L Wing" of the California Medical Facility (which houses the VPP) to an Intermediate Care Facility Level of Care to accommodate over 100 temporary patients.

The *Coleman* also directed the CDCR and the DMH to construct and activate a 64-bed Intermediate Care Facility (ICF) for Level IV/high custody inmate/patients, no later than September 2011. The CDCR and DMH chose to meet this requirement by expanding the VPP within the California Medical Facility. The DMH states that the management and operational infrastructure are in place to support this expansion at the VPP, and that these positions are necessary to provide the appropriate groups and activities, maintain acceptable regulatory standards of nursing care and security, and provide for 24-hour support services.

In October of 2009, the CDCR signed a Resolution of Approval with the Federal Receiver for the *Plata* Court, which oversees inmate medical care, to construct 1,722 medical and mental health beds.

The California Health Care Facility (CHCF) is scheduled to begin patient admissions by July 2013, and be completed to full occupancy by December 2013. The CHCF in Stockton will be operated as a fully integrated correctional medical facility by the DMH, CDCR, and the Federal Receiver. The DMH will be responsible for 475 beds for High Custody/Level IV inmates/patients, to be referred to as the Stockton Psychiatric Program (SPP), which are part of the *Coleman* bed-plan. The SPP will begin accepting patients in July of 2013.

Governor's Proposal. *Coleman* Waitlist. The Governor's Budget proposes $13.9 million GF and 139.7 positions (132.7 PYs) in 2011-12 and $27.3 million and 289.2 positions (274.7 PYs) in 2012-13 to reduce the *Coleman* waitlist, as outlined above.

64-Bed Expansion. The Governor's Budget proposes $2.5 million GF and 23.7 positions for the last phase of staffing for the court ordered 64-bed high custody ICF. This policy was initially approved as part of the 2011 Budget Act.

Stockton Psychiatric Program. The Governor's Budget proposes $7.99 million GF and 75.9 positions (72.1 PYs) to phase in the remainder of staff for activation from January 1 through June 1, 2013. This is a partial year request for 2012-13 and grows to $90.6 million and 783 positions (743.8 PY) in 2013-14.

Staff Comment. Although significant General Fund expenses, these proposals represent costs of court mandates, including previously approved court mandated projects.

Recommendation. Approve, as budgeted, 1) the proposal to reduce the Coleman waitlist, 2) staffing for the 64-bed Intermediate Care Facility in Vacaville, and 3) staffing to operate the mental health beds at the California Health Care Facility in Stockton.

Issue 4: Incompetent to Stand Trial Pilot Expansion

Background. As established by a 1960 Supreme Court decision, all individuals facing criminal charges must be mentally competent to help in their defense, meaning that the defendant both understands the charges against him and has sufficient mental ability to help in his or her own defense. A subsequent US Supreme Court decision in 1972 ruled that Incompetent to Stand Trail (IST) patients may not be held for more than a reasonable period of time necessary to determine the probability that the patient will attain competence in the near future. Generally, when a defendant is found incompetent to stand trial, he or she will be ordered to undergo treatment at a state hospital to restore competency. However, if no hospital space is available, defendants are placed on a statewide waitlist and held in county jail until space becomes available.

In order to protect a defendant's right to due process, state law requires state hospitals to admit, examine, and report to the court on the likelihood of competency restoration within 90 days of the defendant's commitment. In a 2010 case called *Freddy Mille v. Los Angeles County*, the Second District Court of Appeal ruled that persons determined to be IST must be transferred to a state hospital within a "reasonable amount of time" in order to comply with this 90-day statutory requirement. Further, the courts have recommended that the transfer of IST defendants be

completed in no more than 35 days. Nevertheless, significant shortages of space and staff at the state hospitals have resulted in substantial delays and waiting lists for the transfer of IST defendants. In 2008-09, defendants waited an average of 68 days and some transfers are taking as long as 162 days, despite the court orders and recommendations of 35 days. Waiting lists average 200-300 IST defendants at any given time.

Insufficient hospital space is largely a reflection of staffing shortages in the hospitals. Despite aggressive recruitment and retention efforts, the DMH has been unable to fill key personnel classifications such as psychiatrists. Some hospitals report vacancy rates as high as 40 percent in these categories. The hospitals have had to resort to using overtime by existing hospital staff and private contractors to fill the gap, which has contributed to overall increasing hospital costs.

Pilot Project. The 2007 Budget Act included $4.3 million for a pilot program to test a more efficient and less costly process to restore competency for IST defendants by providing competency restoration services in county jails, in lieu of providing them within state hospitals. This pilot was implemented in San Bernardino County, via a contract between the DMH, San Bernardino County, and Liberty Healthcare Corporation. Liberty provides intensive psychiatric treatment, acute stabilization services, and other court-mandated services. The State pays Liberty $278, well below the approximately $450 cost of a state hospital bed. The county covers the costs of food, housing, medications, and security through its county jail. The results of the pilot have been very positive, including: 1) treatment begins more quickly than in state hospitals; 2) treatment gets completed more quickly; 3) treatment has been effective as measured by the number of patients restored to competency but then returned to IST status; and, 4) the county has seen a reduction in the number of IST referrals. San Bernardino County reports that it has been able to achieve savings of more than $5,000 per IST defendant, and therefore total savings of about $200,000. The LAO estimates that the state achieved approximately $1.2 million in savings from the San Bernardino County pilot project.

Governor's Proposal. The Governor's Budget assumes a $3 million GF savings expected to result from treating IST patients in county jails rather than in state hospitals, per the success of a pilot program in San Bernardino County. Therefore, the DMH is proposing trailer bill language to expand the San Bernardino pilot project, which is expected to result in the $3 million in savings.

LAO Report and Recommendation. The Legislative Analyst's Office produced a thorough report, *An Alternative Approach: Treating the Incompetent to Stand Trial*, in January 2012 on this issue. Given the savings realized for both the state and the county, as well as the other indicators of success in the form of shortened treatment times and a deterrent effect reducing the number of defendants seeking IST commitments, the LAO recommends that the pilot program be expanded, specifically by expanding the existing contract with Liberty into Los Angeles, Kern, and San Diego Counties, all of which commit a high number of IST defendants to ASH and PSH. While recommending the expansion of the pilot, the LAO nevertheless questions the soundness of the $3 million savings estimate put forth by the DMH.

A policy bill, AB 1693 (Hagman), has been introduced to implement the LAO's recommendation to expand the San Bernardino County pilot program by mandating participation by Los Angeles and Kern Counties. The Assembly Appropriations Committee estimates that start-up costs would be approximately $1 million, which would be offset within one year by savings of approximately $4 million

GF. As stated above, the DMH also has proposed trailer bill language to expand the pilot statewide, but on a voluntary basis.

Staff Comment. Although there appear to be questions with the assumptions used by the department to reach the savings estimate of $3 million, there is sufficient evidence to suggest that an appropriate expansion of this program should allow the DMH to realize their savings target.

Recommendation. Adopt placeholder trailer bill language to expand the IST pilot program.

Issue 5: Division of Juvenile Justice Closure

Background. The DMH has been providing mental health services to wards of the former California Youth Authority since the 1980s. Funding was provided in 2002-03 for operation of a 24-bed Correctional Treatment Center for wards (under the age of 21) requiring an intermediate level of inpatient mental health care at the Division of Juvenile Justice's Southern Reception Center and Clinic (SRCC). In 2011, the CDCR announced that the SRCC facility would close by November 2011 due to the ward population decreasing as a result of legislative changes and CDCR restructuring changes. The Correctional Treatment Center was also closed in light of the closing of the SRCC.

Governor's Proposal. The Governor's Budget proposes a reduction of $2.7 million in reimbursements in 2011-12 and $3.6 million in 2012-13 and ongoing, and elimination of 37.4 positions (35.5 PYs) in 2011-12 and 49.9 positions (47.9 PYs) in 2012-13, due to the closing of the SRCC.

Recommendation. Approve as budgeted.

Issue 6; Network Capacity Augmentation

Background. The DMH is experiencing frequent network failures resulting in the loss of patient data. Any losses of patient data can negatively impact medication and treatment plans. The DMH intends for this capacity increase to occur concurrently with a change in the site-to-site communications service provider, as required by the Office of Technology Services. The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires data contained in this network to be secure and accessible. The DMH explains that the current network capacity is inadequate causing the system to experience frequent failures. The inadequate capacity also results in the inability to maintain offsite backups of data, and therefore the DMH cannot recover data during a system failure and the loss of data can occur. State law requires state agencies to migrate from existing site-to-site communications network services to CGEN as part of the CTA, IT consolidation effort. The new vendor is CGEN, and the cost will increase by $422,244, for a total cost of $778,020 annually.

Governor's Proposal. The Governor's Budget proposes a one-time 2012-13 augmentation of $10,500 and $422,244 ongoing to increase network capacity in order to protect patient data.

Recommendation. Approve as budgeted.

Issue 7: HIPAA Compliance

Background. In 2001-02, the DMH established the Health Insurance Portability and Accountability Act (HIPAA) Project office (HPO) with five staff members. At that time, the HIPAA requirements did not require staff with technical expertise in Information Technology, which is now needed to address information security activities associated with protecting electronic patient health data. The DMH no longer has a designated HPO, but maintains the five HIPAA positions. The resources requested will be used to perform IT security activities, which require knowledge of applying technical safeguards to protect electronic patient medical information. The DMH states that failure to implement and stay current with HIPAA requirements will put the state at risk of privacy breaches resulting in identity theft and federal fines of $50,000 per incident, up to a maximum of $1,500,000 per year.

Governor's Proposal. The Governor's Budget proposes to establish 3 positions to achieve compliance with HIPAA requirements. The DMH states that it will establish the 3 positions administratively effective April 1, 2012, using existing HIPAA funds (unspent HIPAA funding from prior years) with a total Budget Year cost of $332,000.

Recommendation. Approve as budgeted.

Issue 8: Staff Counsel Position Request

Background. As described earlier in this agenda, IST defendants are committed to state hospitals, and some of these individuals need medication in order to reduce the risk of violence. According to the DMH, approximately 60 percent of IST patients who are admitted to a state hospital without a court order to administer involuntary medication will commit aggressive acts upon themselves, other patients, or hospital staff. Previously the law did not provide an avenue for hospitals to medicate these individuals unless it was considered an emergency. AB 366 (Allen), Chapter 654, Statutes of 2011 allows treating psychiatrists at the state hospitals to certify and provide antipsychotic medication, and authorizes continuing administration of the drugs for 21 days if the administrative law judge agrees with the certification. This allows the hospitals to administer antipsychotic medications while the hospitals await involuntary medication orders from the Superior Court. AB 366 requires the DMH to implement the hearing process by either hiring administrative law judges or by contracting with an agency like the Office of Administrative Hearings to conduct these hearings for the DMH. AB 366 also requires that the patients be represented at the administrative hearing, hence creating the need for these attorneys.

Governor's Proposal. The Governor's Budget proposes a 2012-13 one-time GF augmentation of $1.2 million for 2 Staff Counsel I positions (1.9 PY) to represent the DMH in administrative hearings involving the state hospitals for involuntary medication of individuals who are Incompetent to Stand Trial (IST) as mandated by AB 366. The DMH anticipates that this proposal may generate savings that could be used to fund costs in the future.

LAO Recommendation. The Legislative Analyst's Office recommends that the requested positions be approved on a limited-term basis as the department explores ways to streamline the process.

Recommendation. Approve as budgeted.

Issue 9: Staff Counsel Positions for SVP, IST & Involuntary Treatment Hearings

Background. In 2009, the Office of the Attorney General (AG) determined that the DMH Legal Office must provide the DMH with legal representation in "non-complex" matters, including hearings related to Sexually Violent Predator (SVP) release, IST defendants release, involuntary treatment and subpoenas. The AG has restricted the number of lawsuits for which it will provide legal services to the DMH.

Historically, the AG has provided legal representation to the DMH, and other State Departments, for litigation and court appearances. In September of 2009, the AG informed DMH of policy changes that would substantially reduce the amount of legal services provided by the AG to DMH as a result of reduced resources within the AG. In the spring of 2010, the Administration requested 6 new legal positions at a cost of $3,076,000 GF to respond to the reduction in representation by the AG. The Legislature instead approved of $1.2 million in funding and budget bill language requiring the AG to provide all necessary legal representation to DMH. In 2011, the DMH requested $2.1 million for legal services to be performed by the AG.

The Administration states that the AG has informed DMH that it does not have sufficient resources to handle all of the health and human services workload and tort costs. DMH states that if sufficient funding is not provided, the DMH will be subject to serious and significant legal consequences, such as default judgments up to millions of dollars; court findings that carry fines and expose the DMH Director to contempt findings; and DMH hospitals being unable to obtain court authority for involuntary medication or medical treatment that psychiatrists or physicians have found necessary for the patients.

The Administration explains that there are several state departments that used to benefit from legal representation from the AG, for which the AG has reduced or eliminated legal services.

As a result, the DMH has requested additional Staff Counsel positions for the past two years, requests that have been denied or reduced by the Legislature. Therefore, the DMH has entered into costly contracts with private attorneys. According to the DMH, without sufficient legal counsel to file petitions and make court appearances, the DMH, State and Governor are at risk of significant and damaging legal consequences.

Governor's Proposal. The Governor's Budget proposes $604,000 GF and 6.0 positions (4.0 Staff Counsel 1 positions and 2 Legal Secretary positions) to represent the DMH in SVP court matters, IST hearings, involuntary treatment hearings, and hearings related to subpoenas.

Recommendation. Approve as budgeted.

Issue 10: Staff Counsel Positions for Personnel Actions

Background. Currently, the Department of Personnel Administration (DPA) represents the DMH in personnel appeals to the State Personnel Board. The DMH referred 156 personnel appeals in 2010-11 and as of October 2011, the DMH referred 99 new appeals. Over the previous three years, there has been an average of 128 personnel appeals per year. Currently there are 114 personnel files open. The DMH spends approximately $75,000 per month on DPA attorney services. According to the DMH, many other state agencies handle their own legal representation in these matters, including the CDCR. Therefore, primarily for purposes of cost savings, the DMH is proposing to hire two entry-level attorney positions that will substantially reduce the cost of this legal work.

Governor's Proposal. The Governor's Budget proposes $251,000 GF and 2.0 Staff Counsel I positions to represent the Department in personnel actions involving DMH employees who are represented currently by the DPA. The Administration estimates this proposal will result in average annual savings of $649,000; the amount the DMH historically has paid the DPA for representation in these matters.

Recommendation. Approve as budgeted.

Issue 11: Mentally Disordered Offender Program Positions

Background. The Mentally Disordered Offender (MDO) Act was enacted in 1986 and created a mandatory mental health forensic evaluation and treatment program for inmates who have severe mental disorders that are not in remission at the time of their parole. The MDO program receives referrals from the CDCR institutions of inmates to be forensically evaluated to determine if they meet MDO criteria. Inmates who are found to meet MDO criteria are sent to a state hospital for treatment as a condition of parole. The DMH has contracted for most of these evaluation services since the start of the program. Civil service evaluators have been utilized primarily for emergency referrals when time is short, as they have greater availability. CDCR policies and court decisions continually increase the number of referrals to the DMH of inmates who are scheduled to parole in less than two weeks. This increase in the number of emergency referrals has prompted the need for additional civil service positions in order to ensure prompt completion of the evaluations.

Governor's Proposal. The Governor's Budget includes position authority for 2.0 positions (1.9 PYs) for the MDO Program evaluation services. Funding for these positions will be redirected from approved external contract funds (by reducing the number of contracted positions). The 2 positions will be administratively established in the Current Year.

LAO Recommendation. The Legislative Analyst's Office recommends that the requested positions be approved on a limited-term basis and that DMH and CDCR should work together to improve the referral process.

Recommendation. Approve as budgeted.

Issue 12: Sexually Violent Predator Evaluator Services

Background. The Sexually Violent Predator Act (SVPA), AB 888 (Rogan), Chapter 763, Statutes of 1995, requires the DMH to perform forensic evaluations of Sexually Violent Predators (SVP) referred by the CDCR to determine if the offenders meet statutory criteria as a SVP. The Sex Offender Commitment Program (SOCP) administers the SVPA and, since the inception of the program in 1996, has contracted for evaluation services. In March of 2008, the State Personnel Board issued an administrative ruling that the DMH was not in compliance with Government Code Section 19130(b)(3), because it had failed to make a reasonable, good faith effort to hire qualified civil service employees to perform the evaluations. Since then, the DMH has experienced difficulty in attracting and recruiting qualified civil service employees. SOCP referrals increased dramatically after the implementation of Jessica's Law in 2006. Nevertheless, the DMH states that it is not yet known whether referrals will increase or decrease and expects that the SOCP will know more in time for the May Revision. The following chart contains the most recent data as provided by the CDCR.

Sex Offender Referrals Received by DMH from CDCR
(as of 3/12/2012)

Month/Year	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
July	42	43	760	540	540	896	716
August	63	40	696	544	437	785	1,084
September	48	69	601	801	718	941	856
October	60	236	562	590	532	706	639
November	29	593	474	363	459	599	200
December	44	571	461	624	696	837	233
January	41	708	510	603	772	655	208
February	37	733	786	514	791	681	291
March	44	695	663	527	814	773	108
April	57	842	694	530	612	1,593	
May	50	1,270	596	405	575	1,466	
June	68	1,068	628	807	494	601	
Total	**583**	**6,868**	**7,431**	**6,848**	**7,440**	**10,533**	**4,335**

Governor's Proposal. The Governor's Budget proposes authority for 16.0 positions in 2012-13 and an additional 20.0 positions in 2013-14 to support SVP evaluator services. Funding of $3.4 million in 2012-13 and $8.4 million in 2013-14 is to be redirected from external contract funds (by reducing the number of contract positions) and no additional funding is being requested. Ten of the positions will be administratively established in 2011-12, but would be temporary until legislative approval is granted.

LAO Recommendation. The Legislative Analyst's Office notes that SOCP referrals are trending down in the current year. As such, they are recommending that the requested positions be approved on a limited-term basis to allow for future trend analysis.

Recommendation. Approve as budgeted.

Issue 13: Job Analysis Unit Positions

Background. A Job Analyses (JA) is required to be performed prior to administration of exams, per an array of state and federal laws, regulations, and case law, including: the Civil Rights Act of 1964, American with Disabilities Act, Uniform Guidelines on Employee Selection Procedures Requirements, State Personnel Board (SPB) Rule 50, and more. The SPB states that a new JA is required every five years and a new JA must be completed prior to exam administration.

The DMH has not conducted full or complete JAs on any of its more than 300 classifications, bringing it to the attention and scrutiny of the SPB which states that the "mini" JA used by the DMH is substandard and fails to adequately meet standards. The SPB states that none of DMH's exams may stand up to scrutiny under appeal, which has severely hampered the Department's ability to conduct exams and hire for critical positions. Moreover, the DMH's inability to conduct JAs, conduct examinations, test and hire qualified staff jeopardizes the ability to meet the mandates of both the *Coleman* Case and the CRIPA Consent Judgment. The DMH may face substantial fines, further litigation, and Federal receivership.

The DMH states that it is far from having sufficient resources to conduct the exams that support the recruitment and hiring of staff for the 12,000 employee state hospital system in conformance with required civil service procedures governed by the SPB. In September 2011, the state hospitals and psychiatric programs were surveyed and identified 314.8 positions system-wide that were unable to be filled due to the lack of recruitment due to exam issues. The DMH's exam backlog has had a severe adverse impact on the hospital system's ability to fill positions. This has led the hospitals to rely on high cost overtime and medical registries to fill level of care positions, thereby subjecting the DMH to union unfair labor practice charges of employment being given to non-civil servants for functions that should be performed by state employees.

Governor's Proposal. The Governor's Budget proposes $375,000 and 4.0 positions (3.8 PYs) to establish a Job Analysis unit to meet the ongoing testing and hiring needs of the State Hospitals.

Recommendation. Approve as budgeted.

Issue 14: Napa State Hospital Fire Alarm

Background. According to the DMH, the existing Fire Alarm Control Panels and Field devices at Napa are outdated and no longer meet the National Fire Protection Association (NFPA) codes and 2007 California Fire Code (listed in Title 24, Part 9 Section 202, Occupancy Classification, [B]

Institutional Groups I-1.1, I-2 and I-3). The existing Fire Alarm Control Panels and Field devices are not compatible with the current manufacturer's Fire Alarm Control Panels built to 2003 UL 864 9th Edition-Standard for Control Units and Accessories for Fire Alarm Systems. The existing Fire Alarm Control Panels and field devices are no longer listed by the State Fire Marshall's Office. For these reasons, the DMH asserts, the Fire Alarm Systems require replacement to protect the patients, staff, and visitors. According to the Administration, the fire alarms in all of the State Hospitals are in need of upgrades; they are proposing to start with Napa because it has experienced the greatest number of problems and failures. The 2011 Budget Act includes $2.2 million GF for the preliminary plans and working drawing phase of this project.

Governor's Proposal. The Governor's Budget proposes $15.6 million to replace the fire alarm systems in several buildings at Napa that do not meet NFPA codes, UL standards or the State Fire Marshall requirements.

Recommendation. Approve as budgeted.

Issue 15: Napa & Metropolitan SNFs Fire Sprinklers

Background. The federal Centers for Medicare and Medicaid Services issued new regulations that require all long-term care facilities to be equipped with sprinkler systems by August 13, 2013. According to the DMH, this new requirement is based on evidence of an 82 percent reduction in the chance of death, when a fire occurs and sprinklers are present. Fire sprinkler installations will require review and approval by the Office of Statewide Health Planning. The DMH requested $2.1 million GF for this purpose in 2011.

Governor's Proposal. The Governor's Budget includes $14.1 million to install fire sprinklers in Skilled Nursing Facility buildings at Metropolitan and Napa state hospitals.

Recommendation. Approve as budgeted.

Issue 16: Napa & Patton New Main Kitchens

Background. These capital outlay projects are in progress, and the funding has already been appropriated in prior years, however the DMH is in need of authority to continue the appropriation in order to continue to use the funds and finish the projects.

Governor's Proposal. The Governor's Budget re-appropriates $62.1 million in bond funds to build and fully equip new main kitchens at Napa and Patton to accommodate modern cook/chill food preparation systems and all dietary support facilities.

Recommendation. Approve as budgeted.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

April 12, 2012

10:30 AM or
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

OUTCOMES

(Joe Stephenshaw)

Outcomes

Department of Alcohol and Drug Programs

1. DADP Governor's Budget Proposals – pages 2-5

1. **Motion:** Hold Open.

Department of Mental Health – State Hospitals

State Hospital Overview, including Savings Proposals – pg 6-11

1. **Motion:** Hold Open.

State Hospital Voting Items

Issue 1 – Department Administration – pages 11-12 - Adopt placeholder trailer bill language for an OSAE follow-up audit of the state hospitals, as recommended by the LAO. Approved, 3-0

Issue 2 – Hospital Safety – page 12-14 Approve as Budgeted. Approved 3-0

Issue 3 – Coleman Class Action Lawsuit – pages 14-15 – Approve all three issues related to the *Coleman* lawsuit. Approved 3-0

Issue 4 – Incompetent to Stand Trial Pilot Expansion – pages 15-17 – Adopt placeholder trailer bill language to expand the IST pilot program. Approved 3-0

Issue 5 – Division of Juvenile Justice Closure – page 17 – Approve as Budgeted. Approved 3-0

Issue 6 – Network Capacity Augmentation – page 17-18 – Approve as Budgeted. Approved 3-0

Issue 7 – HIPAA Compliance – page 18 – Approve as Budgeted. Approved 3-0.

Issue 8 – Staff Counsel Request – page 18 – Approve as budgeted. Approved 2-0 (Emmerson not voting)

Issue 9 – Staff Counsel for SVP, IST & Involuntary Treatment Hearings – page 19 - Approve as Budgeted. Approved 3-0

Issue 10 – Staff Counsel for Personnel Actions – page 20 – Approve as Budgeted. Approved 3-0

Issue 11 – Mentally Disordered Offender Program Positions – page 20 – Approve as Budgeted. Approved 2-1 (Emmerson No)

Issue 12 – Sexually Violent Predator Evaluator Services – Page 21 – Approve as Budgeted. Approved 2-1 (Emmerson No)

Issue 13 – Job Analysis Unit Positions – page 22 – Approve as Budgeted. Approved 2-1 (Emmerson No)

Issue 14 Napa State Hospital Fire Alarm – pages 22-23 – Approve as Budgeted. Approved 3-0

Issue 15: Napa and Metro SNFs Fire Sprinklers – page 23 – Approve as Budgeted. Approved 3-0

Issue 16 – Napa and Patton New Kitchens – page 23 – Approve as Budgeted. Approved 3-0

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

April 19, 2012

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

Room 4203
(John L. Burton Hearing Room)

Staff: Jennifer Troia

Item	**Department**
0530	Health & Human Services Agency, Office of Systems Integration
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 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 *)

VOTE-ONLY AGENDA

Department of Social Services

Fingerprint Licensing Fee Exemption

Budget Issue: The Governor's budget proposes to avoid $1.4 million GF annually by permanently allowing the Departments of Justice and Social Services to charge fingerprinting fees (currently set at $35) to applicants for a license to operate a small community care facility (other than a foster family home) or a family day care facility. The fingerprinting is part of a criminal background check used to help ensure the safety of clients receiving care. Each year since 2003-04, the Legislature and Governor have amended the law to temporarily lift a statutory prohibition on charging the fee to the applicants (as opposed to absorbing its costs).

Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the Administration's proposal to the extent that it continues to lift the statutory prohibition on charging this fee in 2012-13, but reject the proposal to make that change permanent.

Proposed Changes to Distribution of Child Health & Safety Fund

Budget Issue: The budget proposes savings of $501,000 GF from trailer bill language to redirect revenues collected through a specialized license plate program to fund additional DSS licensing activities related to children's day care programs. These resources would otherwise be used to prevent unintentional injuries to children, such as drowning or poisoning.

AB 3087 (Chapter 1316, Statutes of 1992) established the *Have a Heart, Be a Star, Help Our Kids* specialized license plate program. Revenues from these license plate fees, totaling $4.1 million in 2009-10 and $4.0 million in 2010-11, are deposited into the Child Health & Safety Fund. State law (Welfare & Institutions Code Sections 18285 and 18285.5) specifies how those revenues are distributed. Currently, the first 50 percent supports specific DSS responsibilities for child day care licensing. Of the remaining 50 percent, up to 25 percent supports child abuse prevention and the rest supports programs that address injury prevention. Under the Governor's proposal, those remaining funds would instead be used for additional day care licensing activities, as well as injury prevention efforts.

Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the proposed trailer bill language to redirect a portion of the Child Health & Safety Fund revenues.

DISCUSSION AGENDA

CHILD WELFARE SERVICES

Overview of Child Welfare Services (CWS) and Adoptions Programs

Total Budget for CWS: The CWS system includes child abuse prevention, emergency response to allegations of abuse and neglect, supports for family maintenance and reunification, and out-of-home foster care. The system includes federal, state, and county agencies, juvenile courts, and private providers of care and services. Federal and state laws establish the legal, regulatory, and fiscal frameworks that govern the roles and responsibilities of these entities and individuals. In general, CWS programs are some of the more highly regulated among federally supported human services programs.

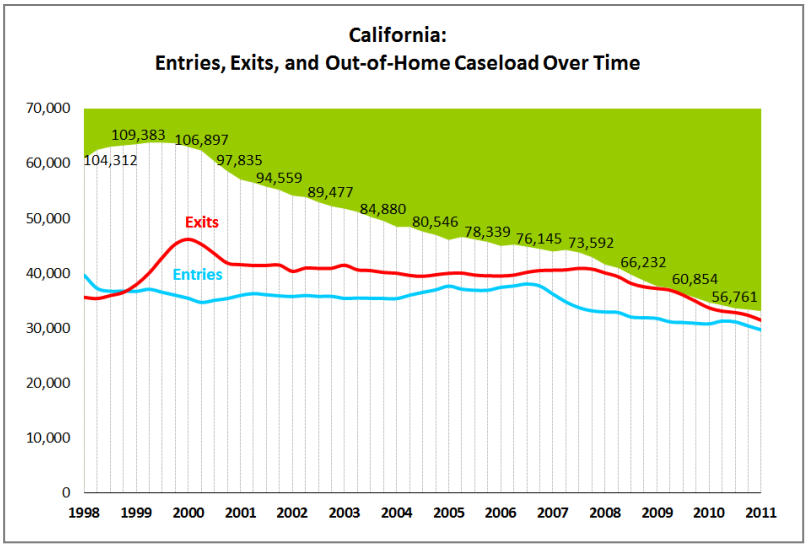
The total 2011-12 budget for CWS (excluding Adoptions) is $5.2 billion [$2.5 billion federal funds, $1.6 billion 2011 realignment funds, and $1.1 billion county funds]. Around half of those funds support counties to administer or provide these programs and half support payments to families and other providers of foster care.

Total Budget for Adoptions Programs: The total 2011-12 budget for adoptions programs includes $121 million ($64 million 2011 realignment funding). DSS regulates, provides oversight, and maintains records for: 1) adoptions that occur through public agencies, 2) adoptions that occur through private agencies, 3) independent adoptions that are handled by a private attorney, and 4) adoptions of children from other countries. Before the 2011 realignment, there were seven DSS district offices that also directly provided agency adoption services to 28 counties and independent adoption services to 55 counties. The remaining counties were licensed by DSS to provide those services directly.

Caseload Trends:[1] In 2011, county child abuse hotlines received calls from mandated reporters of abuse or neglect or other concerned individuals regarding 476,000 children (out of 9.3 million estimated to be living in the state). By the end of the year, 85,000 of those referrals were ultimately determined to be "substantiated". In many cases, the issues were resolved after families participated in services or took other remedying actions. In close to 30,000 cases, however, the agency removed children from their homes and the children became dependents of the court.

[1] Data in this agenda on caseload and characteristics from *Child Welfare Services Reports for California*. Retrieved 4/7/2012, from University of California at Berkeley Center for Social Services Research website. URL: http://cssr.berkeley.edu/ucb_childwelfare.

As illustrated below, the number of children in out-of-home foster care in California has dropped every year since 1998. On October 1, 1998, there were approximately 117,000 children in foster care in California. By that same time in 2011, the caseload was close to half of that figure. An additional 8,400 children in 1998 and 4,600 children on in 2011 were in foster care under the supervision of probation departments as a result of their juvenile delinquency status. The Department attributes much of the caseload decline to upfront efforts to prevent the need for out-of-home care and back-end efforts to find permanence for children in care more quickly, including initiatives related to adoption and the support of relative guardianships through the state's Kinship Guardianship Assistance Payments (Kin-GAP) program.



A Few Characteristics of Children In Foster Care: As of January 2012, 61 percent of children in foster care had been in care for less than two years, while 17 percent had been in care for longer than five years. Nearly half were identified as Hispanic/Latino, while a quarter were identified as White/Caucasian and nearly a quarter as Black. A smaller number were identified as Asian/Pacific Islander (2 percent) and Native American (one percent).[2]

Exits from Foster Care: More than half of children exiting foster care are reunified with their parents or other caregivers. Around 18 percent are adopted. Another 14 percent emancipate into adulthood and seven percent enter into a guardian's care. The rates of adoption are higher for children under the age of 6 and rates of guardianship are higher for children aged six to 15 years old.

[2] Compared to the overall population of children in California, this reflects over-representation of children identified as Black (24 percent in foster care compared with 6 percent in the state) and under-representation of children identified as Hispanic/Latino and White/Caucasian (47 compared to 54 percent and 25 compared to 29 percent, respectively). Children identified as Native American are also over-represented (two compared to less than one percent), while Asian/Pacific Islanders are under-represented (two percent in foster care compared with 11 percent in the state). There are a number of federal, state, and local initiatives that include work to reduce these disproportionalities and other identified disparities.

Performance Measures & Accountability: The federal Administration for Children and Families (ACF) conducts Child & Family Services Reviews (CFSRs) of states' child welfare systems, which include assessments of compliance with outcome measures related to the safety, permanency, and well-being experienced by children and families who come into contact with CWS, as well as systemic factors. ACF performed its most recent CFSR in California in 2008. The state did not achieve substantial conformity (compliance in 95 percent of cases) with any of the outcome measures, but did achieve substantial conformity with three out of seven systemic factors. According to ACF, challenges included high caseloads and turnover of social workers, an insufficient number of foster homes and lack of caregiver support and training, a lack of statewide implementation of practice innovations, and a lack of needed services (e.g., mental health and substance abuse treatment).

In response, DSS developed a Program Improvement Plan (PIP) to improve outcomes and hopefully avoid federal fiscal penalties. The state's PIP included goals for expanding or strengthening a number of practices, including efforts to support permanency across a child's time in foster care and to improve caregiver recruitment, training, and support, as well as staff and supervisor training. Beginning in 2009-10 [with $22.2 million ($12.7 million GF) that year], the budget has included resources to support some of the PIP's goals. The Department indicates that the state has now met its targets for improvement, except with respect to placement stability. If the state fails to meet its target for improvements in placement stability by July 1, 2012, it may incur a penalty of up to $10 million GF (although the penalty is not likely to exceed $5 million GF in 2011-12 or 2012-13).

The Child Welfare System Improvement and Accountability Act (AB 636, Chapter 678, Statutes of 2001) also created a statewide accountability system that became effective in 2004. It includes 14 performance indicators related to safety, permanency, and well-being. All 58 counties receive quarterly reports on their outcomes, conduct self-assessments, and develop System Improvement Plans (SIPs). Counties that are not in compliance receive technical assistance from teams of state and peer-county administrators. If DSS determines that a county is "substantially failing" to comply, the department can notify the local welfare director and Board of Supervisors and allow time for corrective action. If that fails to resolve the issues, the DSS director can bring seek injunctive relief or take administrative actions, such as imposing sanctions, withholding funds, or directly assuming temporary responsibility for administering the county's programs. Since the enactment of AB 636, DSS has not sought injunctive relief or imposed any of these administrative sanctions.

Recent Budget Actions: In 2009-10, the Legislature and Governor made ongoing reductions of around $36.5 million GF (and in some cases additional corresponding federal funds) in the CWS system. The reductions that took effect impacted costs for the automated system that supports CWS, the Transitional Housing Program Plus, AAP payments, and FFA rates. A 10 percent reduction

in the rates paid to group homes did not, however, take effect as a result of litigation. When Governor Schwarzenegger signed the budget in 2009, he also used a line-item veto to make an unallocated reduction of $80.0 million GF (as well as any matching funds lost as a result) to CWS and foster care. The Legislature restored this funding in the 2010-11 budget, but it was again vetoed by the Governor.

The 2010-11 budget also included $51.7 million GF and the 2011-12 budget included $17.4 million GF for court-ordered increases to group home monthly payment rates and foster family and related monthly payment rates, respectively. As discussed in greater detail later in this agenda, the 2011-12 budget also realigned $1.6 billion in state funding for the CWS, foster care, and adoptions programs, to the counties.

Staff Comment and Recommendation: This is an informational item, and no action is required.

Questions for DSS:

1) What are some factors that led to the declining foster care caseload over the last decade or two? How are caseload trends expected to look in the near future?

2) Please summarize the Program Improvement Plan (PIP) process and the state's progress to date on meeting its goals. What challenges do we continue to face? What are the potential penalties if the state's performance does not improve sufficiently?

2011 Realignment of CWS and Adoptions Programs

Budget Issue: The 2011 public safety realignment package included realignment of approximately $1.6 billion in funding and responsibility for California's Child Welfare Services (CWS) and adoptions programs to the counties. The General Fund (GF) resources that became realignment funding reflected state costs for the following programs (many of which have other matching funding as well):

Program	Description	Realignment Funds (Formerly GF) In 2011-12 Budget
Child Welfare Services	Services to ensure the safety of children, including emergency response to allegations of abuse or neglect	$670 million
Foster Care	Administration of and monthly assistance payments for out-of-home care and supervision	$433 million
Adoption Assistance Program (AAP)	Monthly assistance payments to families who have adopted children who meet specified criteria for special needs	$387 million
Adoptions Programs	Adoption-related services, oversight, and record-keeping	$64 million[3]
Child Abuse Prevention	Efforts to prevent abuse and neglect and increase public awareness	$13 million

Funding for a limited number of CWS-related programs or activities, including the automation system that supports CWS, Tribal-State IV-E agreements, and the licensing of children's residential placements, was not included in the realignment. Additionally, for the first year of implementation in 2011-12, no changes were made to state law governing CWS and adoptions programs.

Before the 2011 realignment, non-federal costs for these programs were shared by the state and counties in various ratios--with the highest county share of 60 percent for foster care and lowest of 25 percent in AAP. Under the 2011 realignment, all non-federal costs are instead funded by specified revenues (a percent of the existing state sales tax and vehicle license fee revenues) that are directed to the counties. One result of this redirection is that the state no longer counts those revenues toward calculation of the minimum level of funding for education that is guaranteed under law enacted by a 1988 ballot initiative (Proposition 98).

[3] These costs do not include $6 million associated with Agency Adoptions.

While the revenue stream for the 2011 public safety realignment is ongoing, the program-specific allocations of the revenue were specified for only 2011-12. For CWS and adoptions programs, the resulting county-specific allocations for that year were developed by the Administration in consultation with counties and intended to be consistent with how they would have been distributed before this new realignment. Under this model, for CWS, the base funding counties receive is tied to social worker caseload standards originally established in 1984. For Adoptions, the base funding is tied to 1996-97 performance agreements. Additional funding is tied to specific programs and estimates of the costs to implement statutory requirements.

In addition to the need to establish a financial architecture and program, as well as county-specific allocations, for public safety realignment in 2012-13 and future years, additional questions about whether there are CWS-related financial and programmatic flexibilities, fiscal incentives, accountability mechanisms, and/or changes in the role of the state that should result from the realignment need to be addressed.

Sufficiency of Base Funding: In 2011 and again this year, counties and stakeholders have expressed concern that the $1.6 billion base realignment funding for CWS and adoptions programs underfunds those programs. Some of this concern stems from the above-mentioned 2009-10 veto of $80.0 million GF. Additional concerns relate to the extension of foster care services to non-minor dependents ages 18 to 21 (phased in over three years beginning January 1, 2012), which the Administration unintentionally failed to account for in its original calculations, as well as the need to fund lower social worker caseloads and cost increases related to litigation. On the other hand, the Administration indicates that the base continues to include around $70 million that the counties are no longer required to spend on the provision of residential care to students with special needs[4], as well as some funding that would have otherwise been a one-time carryover.

2012-13 Proposals: The Governor's 2012-13 budget proposes constitutional protection for revenues dedicated to the 2011 public safety realignment package and a permanent funding structure for base and growth funding. The structure would establish two accounts in the County Local Revenue Fund: 1) a Support Services Account, and 2) a Law Enforcement Services Account. The Support Services Account would contain two Subaccounts, including one for Protective Services (Child Welfare and Adult Protective Services).

The Governor proposes to allocate program growth on roughly a proportional basis first among the Accounts and then among the Subaccounts. Within each Subaccount, federally required programs would receive priority funding if

[4] As a result of budget changes in recent years, the responsibility to pay for those residential placements shifted from the counties to schools.

warranted by caseload and costs. Further, CWS would be a priority for growth once base programs are established, which over time could result in $200 million in additional funds.

The Governor also proposes some flexibility for the counties to move money among Subaccounts, including the transfer of up to 10 percent between Subaccounts within the Support Services Account. Transfers would be valid for only one year and would not increase the base of any program.

Roles of the State and Counties: Before the 2011 realignment, California already carried out the day-to-day responsibilities of its front-line CWS programs at the county level, with some variation between county programs. At the same time, DSS was responsible for oversight, statewide policy, regulation development and coordination, technical assistance, and federal compliance related to those programs. Even after this realignment, the state must maintain many of these same responsibilities to meet federal requirements. Prior to realignment, the state was also at risk for the full costs of any federally imposed penalties for failure to meet the requirements established pursuant to the Child and Family Service Reviews described earlier in this agenda. The Administration's proposals for 2012-13 do not currently include provisions to alter this financial responsibility.

In 2011, the Administration also established a goal of a 25 percent reduction in state operations costs across programs included in the 2011 realignment. The Administration has not yet proposed any related reductions in DSS staffing or operations costs. The Department indicates, however, that reductions in the adoptions program are likely to be the most notable result of realignment.

Transitions In Adoptions Programs: Before the 2011 realignment, there were seven DSS district offices that provided agency adoption services to 28 counties and independent adoption services to 55 counties. The remaining counties were licensed by DSS to provide those services directly. Thus far, 11 counties have expressed their intent to transition, at some point in 2012-13, to the use of realignment funding to directly provide adoption services that were previously provided by DSS.

Staff Comment & Recommendation: Staff recommends holding these issues open. Staff further recommends that the Subcommittee encourage the Administration to provide forthcoming proposals related to the 2011 realignment of CWS and Adoptions programs as soon as possible (and ideally before the May Revision).

Questions for the Administration & LAO:

1) Given the specificity of many federal requirements, how much financial and programmatic flexibility do the state and counties have in delivering child welfare services? What might change in the wake of realignment?

2) What changes in fiscal reporting or accountability mechanisms might be appropriate to consider in light of realignment?

3) How would the state and counties respond to a drop in the revenues dedicated to CWS under realignment? What might the impacts of such a loss in funding for these programs be?

4) How are the state and counties working to minimize any risks of disruptions to adoptions programs during impending transitions from state to county service provision?

Overview of Foster Care Placements

The next items included in this agenda relate to the use of group homes and foster family agency-certified (FFA) homes as placements for children in foster care. The use of those placement types cannot easily be addressed in isolation from the larger continuum of placement options in which they exist. This section provides some basic background on that continuum.

County child welfare and probation agencies are generally responsible for making decisions about where children in out-of-home foster care reside. DSS regulations require agencies to attempt to place children in placements along the following priority order: 1) the home of the child's noncustodial parent, relatives, or extended family members; 2) foster family homes licensed by counties or certified by foster family agencies (FFAs); 3) group homes; and 4) specialized treatment facilities. As depicted in the chart below, this is also generally the ordering of less to more costly placement types.

With funding for enhanced social work and administration to support FFA-certified homes, FFAs were created to provide an alternative to group home care. Group homes have 24-hour staffing and licensed capacities to house at least six (and in a few instances up to over 200) children. They are generally intended to provide a structured environment for children with more intensive needs. However, as discussed in further detail below, actual use of these placement types varies and sometimes depends on other factors (e.g., their ready availability or families' preferences for additional social work support).

<table>
<tr><th>Most Common Placement Types</th><th>Percent of Children in Foster Care on 1/1/12*</th><th>Range of Basic Monthly Payment Rates</th><th>Potential Supplements for Children who Qualify</th><th>Administration and Social Worker Cost Built into Rate</th></tr>
<tr><td>Kin caregiver**</td><td>33%</td><td rowspan="3">Age 0-4 -- $621
Age 15-19 -- $776</td><td rowspan="3">Age 0-19 -- $200 to $2,000</td><td>$0</td></tr>
<tr><td>Guardian</td><td>11%</td><td>$0</td></tr>
<tr><td>Foster Family Home</td><td>9%</td><td>$0</td></tr>
<tr><td>Foster Family Agency-Certified Home</td><td>26%</td><td>Age 0-4 -- $373
Age 15-19 -- $522</td><td>Age 0-4 -- $189
Age 15-19 -- $189</td><td>Age 0-4 -- $868
Age 15-19 -- $968</td></tr>
<tr><td>Group Home</td><td>10%</td><td>Level 1 -- $2,118
Level 12 -- $8,974</td><td>$0</td><td>$0</td></tr>
</table>

* This column includes both child-welfare and probation-supervised foster children.
** The Kin caregiver population that is not federally eligible for AFDC-FC instead receives a monthly TANF grant of $345 (based on a child-only CalWORKs grant).

These rates are intended to cover the costs of care and supervision. Although many other supports and services can be critical to the success of these living arrangements (e.g., mental health services for the child or family, respite care for

caregivers), eligibility for those services is not generally tied to the type of placement in which a child resides. A number of recently developed or emerging programs, including wraparound and treatment foster care, attempt to improve the planning processes for integrating placements and supportive services. Additionally, the Department indicates that the settlement agreement stemming from a recent lawsuit, *Katie A. v. Bonta*, will result in improvements in access to mental health services for children in foster care.

Placement Trends: The chart below displays two point-in-time break-downs of where children in child-welfare and probation-supervised foster care were residing:

Date	# of Children in Foster Care	Proportion Living with Kin	Proportion in Licensed Foster Homes	Proportion in FFA-Certified Homes	Proportion in Group Homes
Oct. 1, 1998	117,000	39%	16%	15%	9%
Oct. 1, 2011	60,150	32%	9%	26%	10%

Staff Comment & Recommendation: This is an informational section for background and context-setting purposes. No action is required.

Questions for the Administration & LAO:

1) What opportunities does realignment present for the state and counties to change utilization of or funding for different placements (and related services) along the continuum?

2) What is the state's role in supporting the counties' efforts and ensuring that the most appropriate placements are made possible?

Group Home Rate-Setting & Reform

Budget Issue: Beginning in 2010-11, the budget has included $195.8 million ($51.7 million GF) to fund a court-ordered increase of 32 percent in the monthly payment rates for group homes. The court order also requires the state to annually adjust these rates based on the California Necessities Index. In 2012-13, group home rates are proposed to range from $2,158 to $9,146 per child, per month.

In response to this increased cost and other concerns about the use of group home placements in California, as well as the need for DSS to redirect staff toward developing alternative placement options, the 2010-11 budget included: 1) a moratorium, with some allowable exceptions, on the licensing of new group homes or approvals of rate or capacity increases for existing providers; and 2) a statutory requirement for DSS to establish a stakeholder workgroup to develop recommended revisions to the existing group home rate-setting system. The 2010-11 budget also included authority for a three-year, limited-term position and $250,000 ($125,000 GF) for consulting and contracts to support these activities.

The moratorium was subsequently extended in trailer bill language through the end of 2012. The Governor's budget proposes to make it permanent and to limit future exceptions to higher-level group homes [licensed at a Rate Classification Level (RCL) of 10 or over on a scale of one to 14]. To date, DSS has not convened the required rate-setting workgroup.

Background on Group Home Utilization & Rate-Setting: Parallel with the decline in the number of children in foster care, the number of children living in group homes has dropped in recent years (from 10,900 in 1998 to 6,100 in 2012). At the same time, as a proportion of overall foster care placements, group home placements (mainly for children ages 11 to 17) have remained steady at around six to 10 percent.

Since 1991, there have been fourteen RCLs that determine the rates of payment for individual group homes, with level one being the lowest. The RCL system is intended to measure the level and intensity of services, with increased payment based on the number of hours staff spend on child care and supervision, social work, and mental health treatment services, as well as their experience and education levels. In 2011-12, 11 percent of licensed group home beds are classified at an RCL of 9 or lower. Just over half (52 percent) are classified at an RCL of 12.

Rationale for Proposed Changes to Moratorium: DSS indicates that the existing moratorium on rate or capacity increases and the licensure of new group homes is working to contain growth in group home programs that are no longer needed and is supporting a focus on developing higher-level group home

capacity for shorter stays and improved outcomes, as well as family-based alternative placements and services. The Department also indicates that the rationale for not allowing exceptions for group homes at lower RCLs is that foster youth whose needs can be met by lower level group homes should instead be served in family-based settings. From when the rate-setting moratorium was enacted through the beginning of 2012, counties have requested 28 exceptions. DSS has granted all of these exception requests (just two of which applied to expansion or new licensure of group homes below RCL 10).

The Required Workgroup & Congregate Care Reform: The Department indicates that it has not yet convened the statutorily required workgroup related to revisions in group home rate-setting because of other demands on its resources, as well as its interest in focusing first on reforms to congregate care and to the existing continuum of placement options. However, the Administration has not yet indicated its more specific goals or the anticipated timelines and key milestones related to these reform efforts, nor how and when the statutorily required rate-setting workgroup would fit into those larger efforts.

Reforms related to the use of, or measurable outcomes of, group care have been a consistent theme in child welfare in California for over a decade. There has generally been consensus that group care should be used sparingly, on a temporary basis, and when youth have a high need for structure and treatment or rehabilitation. Yet advocates and researchers continue to raise concerns that these principles are not consistently applied and that there may be other unintended consequences of the state's continued use of group home care.

Staff Comment & Recommendation: Staff recommends holding open the proposed changes to the moratorium on specified group home rate-setting activities. Staff also recommends that the Subcommittee request a more detailed report from the Administration on its reform efforts related to congregate care and other placement options, including how and when the statutorily required rate-setting workgroup will be convened.

Questions for the Administration & LAO:

1) How do the proposed changes to the moratorium support the state and counties in meeting children and youth's needs?

2) What efforts are being made to encourage the placement of more foster youth, including probation-supervised foster youth, in supported, family-based settings?

3) What does the Department hope to accomplish in its larger reform efforts and by when? When does the Department plan to convene the required group home rate-setting workgroup?

Use of Foster Family Agencies (FFAs)

Budget Issue: While the actual number of children living in homes certified by foster family agencies (FFAs)—typically private, nonprofit organizations that recruit, train, certify and support foster families—has declined from 18,000 to 15,200 in the last 12 years, the proportion of children in foster care who reside in these placements has increased from 18 to 29 percent. The Bureau of State Audits (BSA) recently released a report (available online at: http://www.bsa.ca.gov/reports/summary/2011-101.1) that concluded that this proportional increase in reliance on FFAs, which were originally intended to provide alternatives to more costly group home placements, has instead been accompanied by a drop in the use of less costly foster family homes licensed by counties. Given the difference in costs between FFA-supported placements and foster family home rates, the BSA estimated additional annual costs for foster care payments that resulted from this shift, including $61 million (all funds) in 2010.

FFA Rates: FFA rates in 2010-11 averaged $1,643 per child, per month. These rates include payments to certified foster families, as well as a 40 percent fee paid to the agencies on a monthly basis for recruitment, training, and other administration. An association of FFA providers recently filed a lawsuit alleging that FFA rates, which have been raised infrequently since 1998 and were reduced by 10 percent as a part of the 2009-10 budget, are not adequate to cover the costs of providing that care and supervision.

Use of FFAs: Children of all ages are living in FFA-certified foster homes (with the largest number between the ages of three and 10). The BSA points out in its report that DSS does not require county placing agencies to document the treatment needs of these children. Officials in the counties audited acknowledged that these needs are only one factor in making FFA placements; other factors they identified included the ability to place large sibling groups, a scarcity of licensed foster homes, and off-hour placement convenience.

Legislation from 1999 (SB 160, Chapter 50, Statutes of 1999) required research on the use of and differences between licensed foster family and FFA-certified homes. A resulting 2001 study by the University of California, Davis reviewed a sample of over 700 children in these placements and found that:

- FFA foster parents received greater support and supervision than county-licensed families. They had almost three times as frequent contact with their primary social worker and were more likely to report satisfaction with that social worker.

- Most foster parents encountered one of the systems first and stayed with it.

- Among those who were informed and who had a choice, families that opted for licensure by counties did so to avoid intense and what they perceived as

intrusive supervision. Those choosing FFAs wanted the supports provided by the FFAs.

- FFA foster parents tended to be somewhat younger and more frequently married. Among licensed foster families, African Americans were over-represented, while Hispanic/Latino families were under-represented.

BSA Recommendations: The BSA recommends that DSS analyze FFA rates and provide reasonable supports for each component, especially administrative fees. Additionally, its report recommends that the Department create and monitor compliance with clear requirements specifying that children placed by FFAs must have elevated treatment needs that would require a group home placement if not for care provided through an FFA. Finally, the BSA recommends that county placing agencies be allowed to retain and redirect a portion of the state funds that would be saved if they are able to reduce their reliance on FFA placements (which they arguably can already do, depending on the ongoing structure of the 2011 realignment).

Staff Comment & Reccomendation: No specific actions are recommended at this time.

Questions for the BSA, Administration & LAO:

1) Please describe how FFA-certified foster homes were intended to be used and how they are being used today.

2) How are FFA rates structured? BSA: What concerns did you identify about the basis for those rates? DSS: What is your response to those concerns?

3) BSA: What are your recommendations for improving placement-related decision making, particularly with respect to the use of FFAs?

   DSS: What is your response to those recommendations and how do you see FFAs best fitting into the continuum of foster care placements available to meet children's needs?

Proposed Changes to Dual-Agency Rates

Budget Issue: The Governor's budget proposes to apply annual cost-of-living adjustments (COLAs) to monthly rates for care and supervision paid on behalf of approximately 3,100 children who are dependents who are living in foster care because of abuse or neglect and who are also eligible to receive services related to a developmental disability (or for infants and toddlers, related to a developmental delay or risk of disability). The proposal would adjust these "dual agency" rates retroactively for a 2011-12 COLA of 1.9 percent at an estimated cost of $2.0 million. The proposed 2012-13 COLA of 3.2 percent would result in additional estimated costs of $3.4 million.

Dual-Agency Rates: Dual agency rates were developed in 2007 by DSS in collaboration with stakeholders and the Department of Developmental Services. In recognition of the complex needs of children served in both systems, the basic rates paid for their care and supervision are significantly higher than other foster care rates (i.e., $2,006 per month for dual-agency children ages three and older).

Related Actions Taken Last Year and Rationale for Proposal: The 2011-12 budget increased by around 30 percent the monthly rates paid to licensed foster families. The increase, along with annual cost-of-living adjustments (COLAs), was required by a court order in *California State Foster Parent Association, et al v. John A. Wagner, et al*. Correspondingly, changes were made to related rates paid for other permanent family placements, including specified adoptions and guardianships. The Administration did not, however, identify the need to clarify how foster family home rate changes should impact rates paid on behalf of children served by both the foster care and developmental services systems until too late in last year's budget process for any changes to be fully vetted. When the issue was raised, some advocates expressed concern that dual-agency rates should increase by a parallel degree in recognition of prior-year COLAs that had not been granted and in order to maintain the degree of difference between basic and dual-agency foster family rates (in addition to increasing based on 2011-12 and future COLAs).

Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the proposal to apply 2011-12 and 2012-13 COLAs to dual-agency rates.

Questions for the Administration & LAO:

1) Please briefly summarize the rationale for the proposal.

AUTOMATION ISSUES

Child Welfare Services/Case Management System (CWS/CMS)

Budget Issue: The Governor's budget proposes $81.5 million ($37.4 million GF) for the maintenance and operations of the Child Welfare Services/Case Management System (CWS/CMS), which is the statewide automation system that supports the state's child welfare services programs. The previously authorized development of a replacement CWS/Web system was suspended in the 2011-12 budget. A related report on next steps and a timeline for implementing any needed changes to the state's CWS automation plans was due to the Legislature in January 2012. The final report was delivered on April 18th.

Background on CWS/CMS: CWS/CMS was fully implemented and transitioned to its operational phase in 1998. DSS has overall responsibility for the system, including providing project and program direction to the Office of Systems Integration (OSI). OSI provides information technology expertise and is responsible for implementation and day-to-day operations of the system. The current contract for CWS/CMS runs through November 2016, with potential extensions of up to 3 years.

Background on CWS/Web: The CWS/Web project was initiated in order to update outdated technology, improve efficiency, and better comply with federal requirements. In the 2011-12 budget, the Governor proposed and the Legislature approved the suspension of its development to achieve cost savings. Along with this suspension, the budget included trailer bill language in Assembly Bill (AB) 106 (Chapter 32, Statutes 2011) requiring the Administration to study and report on the degree to which the CWS/CMS system: 1) complies with current law, 2) supports current CWS practice, and 3) links to other needed information. The report was also required to include recommendations about the best approach(es) and next steps for addressing any critical missing functionalities in CWS/CMS, which could include building functionality into the current system, restarting the CWS/Web procurement, or developing a new procurement. The Administration developed a CWS Automation Study Team (CAST) in response to these requirements. The CAST included representatives from DSS, OSI, and the County Welfare Directors Association. The team also consulted with legislative staff.

Staff Comment & Recommendation: Staff recommends that the Subcommittee hold this issue open.

Questions for the Administration & LAO:

1) Please summarize the results of the study and recommendations related to the current status and future plans for CWS/CMS and/or CWS/Web.

2) Has the federal government identified any system requirements that might alter the direction that the state pursues with respect to the future of CWS/CMS and/or CWS/Web?

Case Management, Information, and Payrolling System (CMIPS) II for In-Home Supportive Services (IHSS)

Budget Issue: OSI requests, in a budget change proposal, $97,968 for one limited-term Senior Information Systems Analyst to replace an expiring position. DSS requests, in a budget change proposal, $929,000 ($464,000 GF) for an additional one-year extension of eight existing limited-term positions to support development of the Case Management Information Payrolling (CMIPS) II automation system. OSI and the Department indicate that the requested positions are necessary to ensure continuity of knowledge and meet a heavy programmatic workload during the final phases of the system's development. Additionally, the Administration seeks authority to delay some project costs from the 2011-12 to the 2012-13 fiscal year.

Background on CMIPS II & Rationale for Position Requests: CMIPS is the automated, statewide system that handles payroll functions for all IHSS providers. The current vendor (formerly Electronic Data Systems, 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 was due in part to the vendor's technical difficulties in getting data to convert accurately from the old to the new system. The vendor has since submitted a new plan for compliance with data conversion requirements and a revised schedule.

The Administration indicates that at this point its Coordinated Care Initiative proposals, including the proposal to integrate IHSS and other long term care services and supports into Medi-Cal managed care, do not alter its planned uses for CMIPS II.

Updated Schedule for CMIPS II Implementation: The CMIPS II project has completed system design, coding, and functional testing. The project plans to complete user acceptance testing and roll-out the system to 58 counties and DSS starting in the summer of 2012, with the last phase anticipated to go live in June, 2013.

Subcommittee Staff Comment & Recommendation: Staff recommends holding this issue open, pending additional information and requests that the Administration has indicated are forthcoming in the May Revision.

Questions for the Administration & LAO:

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 the IHSS program?

3) Please describe whether (and how) the roll-out schedule for CMIPS II implementation interacts with the proposed timeline for integrating long-term care supports and services into managed care under the Coordinated Care Initiative.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

Hearing Outcomes from April 19, 2012

Staff: Jennifer Troia

Department of Social Services

Fingerprint Licensing Fee Exemption

Voted 3-0 to approve the Administration's proposal to the extent that it continues to lift the statutory prohibition on charging this fee in 2012-13, but reject the proposal to make that change permanent.

Proposed Changes to Distribution of Child Health & Safety Fund

Held open the proposed trailer bill language.

2011 Realignment of CWS and Adoptions Programs

Held these issues open and encouraged the Administration to provide forthcoming proposals as soon as possible.

Group Home Rate-Setting & Reform

Held open the proposed changes to the moratorium on specified group home rate-setting activities. Also requested information and updates from the Administration on reform efforts related to congregate care and other placement options, including how the required rate-setting workgroup will fit in.

Proposed Changes to Dual-Agency Rates

Voted 2-1 (Emmerson no) to apply the proposed COLAs to dual-agency rates.

Child Welfare Services/Case Management System (CWS/CMS)

Held this issue open.

CMIPS II for In-Home Supportive Services (IHSS)

Held this issue open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

April 26, 2012

9:30 AM or
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

(Michelle Baass and Jennifer Troia)

PLEASE NOTE:

Only those 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 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

4260 Department of Health Care Services

The following issues were discussed at the Subcommittee #3 Hearing on March 22, 2012 (http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/SUB3/3222012Sub3AgendaMRMIB_DHCS.pdf):

1. **Lock-In at Annual Open Enrollment for Medi-Cal Managed Care**
   - Subcommittee Staff Recommendation—Reject Administration's proposal.

2. **Federally Qualified Health Center/Rural Health Clinic Payment Reform**
   - Subcommittee Staff Recommendation—Reject Administration's proposal.

3. **Redirecting Unpaid Stabilization Funding**
   - Subcommittee Staff Recommendation—Approve Administration's proposal.

As discussed at the March 22, 2012 hearing, the hospital quality assurance fee and the intergovernmental transfer program have resulted in billions of additional revenue being provided to these hospitals. See table below for the Administration's estimates of the net benefits of these programs in comparison to the proposed loss in stabilization funding.

	4/2009-12/2010	1/2011-6/2011	7/2011-12/2013	**Total Net Benefit of QAF and IGT**	**Proposed Loss in Stabilization Funding**
Private Disproportionate Share Hospitals					
Hospital Quality Assurance Fee (QAF) Net Benefit	$1.3 billion	$600 million	$3.2 billion	**$5.1 billion**	**$107 million**
Non-Designated Public Hospitals (District)					
Hospital QAF Net Benefit	$60 million		$46.5 million	**$198 million**	**$2 million**
Intergovernmental Transfer (IGT) Program Benefit		$17 million	$75 million		

4. **Access Monitoring Program**
   - Subcommittee Staff Recommendation—Approve Administration's proposal.

ISSUES FOR DISCUSSION

A. 4260 Department of Health Care Services

1. Default Managed Care Plan Assignment

Budget Issue. The Administration intends to change how it selects a default managed care plan when a Medi-Cal enrollee does not make a health plan selection. The Administration proposes to consider health plan cost in addition to quality of care and safety net population factors as part of the default algorithm. Specifically, the default algorithm would be adjusted to increase defaults to low cost plans by 5 percent.

Savings would be recognized based on the shift of beneficiaries that would have been defaulted to the higher cost plans under the normal default ratios to lower cost plans. General Fund savings for 2012-13 are projected to be $2.4 million and $5.8 million for 2013-14.

This default algorithm would be implemented for Geographic Managed Care (GMC) and Two-Plan counties with the exception of Kings and Madera counties. Managed care is new in these counties and consequently, plans in these counties are currently paid the same capitation rate since health plan quality data is not yet available. It is anticipated that beginning on January 1, 2013, plans in these two counties would use the proposed default algorithm (as health plan quality data would be available).

Background. When a Medi-Cal enrollee does not select a Medi-Cal managed care plan, a default health plan is assigned. Currently, the default algorithm defaults beneficiaries into a plan based health plan quality (6/8 of the weighting, using six HEDIS measures) and safety net population factors (2/8 of the weighting). This algorithm is based on Family and Seniors and Persons with Disabilities (SPD) aid categories. DHCS has regulatory authority to determine how assignments of default beneficiaries are to be made.

In 2011, 40 percent of new Medi-Cal managed care enrollees were defaulted into a health plan. See table below for more specific information.

Table: New Medi-Cal Managed Care Enrollee Health Plan Assignment for 2011

Plan Type	New Enrollment	Choice		Defaults					
				Linked to Prior Plan		Auto Assigned Using Algorithm		Combined Defaults	
	Totals	Totals	% Total Enroll	Totals	% Total Enroll	Totals	% Total Enroll	Totals	% Total Enroll
GMC	230,801	143,974	62%	26,440	11%	60,387	26%	86,827	38%
Two-Plan	1,336,706	796,620	60%	189,135	14%	350,951	26%	540,086	40%
Combined	1,567,507	940,594	60%	215,575	14%	411,338	26%	626,913	40%

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue regarding the Administration's proposals to expand Medi-Cal managed care.

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

1. Please provide an overview of this proposal.

2. Align Managed Care Policies for Retroactive Medi-Cal

Budget Issue. The Administration proposes to shift a County Organized Health System (COHS) health plan's responsibility for the retroactive period of Medi-Cal to the Fee-For-Service (FFS) system. This proposal would result in a one-time savings of $57 million General Fund in 2012-13 and annual ongoing savings thereafter of $7.6 million General Fund.

DHCS is working with the COHS health plans to adjust their capitation rates to no longer account for the retroactive period (since these costs would now be paid under FFS).

Background. Medi-Cal covers the costs of medical services provided to beneficiaries during a retroactive period of 90 days before their enrollment into Medi-Cal.

Medi-Cal managed care is delivered through three models for its full-scope of services. These are:

- **County Organized Health System.** A County Organized Health System (COHS) is a local agency created by a county board of supervisors to contract with the Medi-Cal program. There are 14 counties in the COHS model. (COHS counties are: Marin, Mendocino, Merced, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Solano, Sonoma, Ventura, and Yolo.)
- **Two-Plan Model.** Under the Two-Plan model, each designated county has two managed care plans: a local initiative and a commercial plan. (Two-Plan counties are: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.)
- **Geographic Managed Care.** There are two Geographic Managed Care (GMC) counties in the state. In both counties (Sacramento and San Diego), the Department of Health Care Services (DHCS) contracts with several commercial plans to provide choices to the enrollees.

The three models of Medi-Cal managed care handle payment for retroactive periods differently. Currently COHS health plans receive an adjustment in their capitation rates for the cost of the retroactive period. In contrast, Two-Plan and Geographic Managed Care health plans do not receive an adjustment to their capitation rates for this cost. Instead, these costs are paid by the FFS system.

Subcommittee Staff and Recommendation—Approve. It is recommended to approve this item. No issues have been raised.

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

1. Please provide an overview of this proposal.

2. What is the status of the department's discussions with COHS health plans on the rate adjustment?

3. Eliminate Gross Premium Tax Sunset Date for Medi-Cal Managed Care Plans

Budget Issue. The Administration proposes trailer bill language that eliminates the sunset date for the existing gross premiums tax (GPT) imposed on Medi-Cal managed care plans. The Administration estimates that this will generate $161.8 million in General Fund savings in 2012-13 and $259.1 million in General Funds savings in 2013-14.

The GPT is expected to generate $352 million in revenues. Half of the revenues, or about $176 million, will be matched with federal funds to provide for an increase in capitation payments to Medi-Cal managed care plans.

The revenue under the GPT will continue to increase in 2012-13 and 2013-14 with the expansion of managed care to Seniors and Persons with Disabilities, the proposed integration of long term care benefits into managed care, the proposed transition of Healthy Families Children into Medi-Cal, the proposed integration of Federally Qualified Health Center (FQHC) payments into managed care and the expansion of Medi-Cal to childless adults in 2014 (as required by federal health care reform).

Table: Gross Premium Fund Transfer to the General Fund (in millions)

Gross Premium Tax Applications	
Base Medi-Cal Managed Care Program	$106.5
SB 335 - Hospital Fee	31.2
2012-13 Budget Proposals	
Coordinated Care Initiative	$10.7
Healthy Families Program Transition to Medi-Cal	5.9
FQHC Payment Reform	7.5
Total	**$161.8**

Background. The GPT on Medi-Cal managed care plans was authorized by AB 1422 (Statutes of 2009) for the period of January 1, 2010 through December 31, 2010 and is a GPT on the total operating revenue of Medi-Cal managed care plans. The GPT was extended through July 1, 2011 by SB 853 (Statutes of 2010). Subsequently, ABX1 21 (Statutes of 2011) extended the sunset date to July 1, 2012.

The GPT provides a funding source for the Healthy Families Program (HFP) by adding managed care plans to the list of insurers subject to California's GPT of 2.35 percent. The GPT enables the state to draw down federal moneys, allocated according to the federal medical assistance percentage (FMAP), to fund children's health services under the HFP.

SB 335 (Statutes of 2011) implemented a new hospital quality assurance fee (QAF) program on hospitals from July 2011 to December 2013. The new QAF program provides for increased payments to managed health care plans which will increase the total operating revenue of the Medi-Cal managed care plans.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions regarding proposals that directly impact the GPT, such as the transition of Healthy Families children to Medi-Cal and the Coordinated Care Initiative, are still open.

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

1. Please provide a summary of this proposal.

4. Community-Based Adult Services Program

Budget Issue. The Administration proposes $289.1 million ($144.6 million General Fund) for the transition of Adult Day Health Care (ADHC) benefits in 2011-12 and $166.3 million ($83.1 million General Fund) in 2012-13. The current year estimate accounts for continuing ADHC benefits until March 1, 2012.

Background. AB 97 (Statutes of 2011) eliminated ADHC as an optional Medi-Cal benefit to provide for an estimated $170 million in General Fund savings in 2011-12. The 2011 budget provided $85 million (General Fund) to provide for a temporary transition program for existing ADHC enrollees to other Medi-Cal appropriate services. As part of this transition, the Legislature provided for the development of policy legislation to create a federal Waiver program, but the Governor vetoed this budget bill language.

Settlement Agreement. Consequently, through the summer and fall of 2011, the Administration developed a transition plan for existing ADHC beneficiaries. However, as part of the settlement of a lawsuit that challenged the elimination of the ADHC benefit, an agreement was reached between the state and the plaintiffs to phase out the ADHC program and replace with a new program called the Community-Based Adult Services (CBAS) that will provide necessary medical and social services to those with the greatest need. CBAS will be provided as a Medi-Cal managed care benefit no sooner than July 1, 2012.

CBAS Eligibility. At the time of the settlement, DHCS had estimated that roughly half of the "settlement class" (approximately 40,000 individuals who received ADHC services on or since July 1, 2011 through February 29, 2011) would qualify for CBAS; however, it is now estimated that approximately 80 percent of the class would be eligible.

Eligibility to participate in CBAS would be determined by state medical professionals on the basis of medical need, and the benefits provided would be coordinated with managed care plans. The CBAS program was originally expected to be implemented on March 1, 2012, but was not implemented until April 1, 2012, because of delays in getting federal CMS approval.

CBAS Providers. Additionally, as part of the settlement, DHCS will primarily use non-profit providers for CBAS services. CBAS Standards of Participation require, after July 1, 2012, a CBAS provider to convert to a non-profit entity unless it meets one of the following exceptions:

1. The for-profit CBAS provider offers program specialization that meets the specific health needs of CBAS-eligible participants not otherwise met by any other CBAS provider in the participants' geographic area.

2. The for-profit CBAS provider's operation is necessary to preserve an adequate number of CBAS providers for CBAS-eligible participants to transition without interruption in services due to wait lists.

3. DHCS determines that a provider needs additional time beyond July 1, 2012, to complete its conversion to non-profit status.

After July 1, 2012, DHCS retains the discretion to reexamine whether one of the above-listed exceptions for a for-profit CBAS provider still applies to that CBAS provider, and in doing so, DHCS may withdraw the exception as needed.

With the CMS delay of the state's waiver approval by one month, DHCS delayed advising CBAS centers on specific criteria related to the non-profit exceptions until April. DHCS has started conversations with provider representatives and will release additional information about these requirements to providers/stakeholders in the coming weeks.

DHCS has received 275 CBAS provider applications. Of these, 268 have been approved, 3 have been denied, and 4 have been withdrawn. As of April 16, 2012, there are 260 open CBAS centers in the state. (In December 2011, there were 271 ADHC centers in the state.) Of the 268 approved centers, 193 are for-profit CBAS providers and 75 are non-profit CBAS providers.

Contempt Motion. At the end of March 2012, Disability Rights California (DRC) filed a contempt motion stating that DHCS had not been following the terms of the settlement agreement. Since then, DRC and DHCS have come to agreement on the following:

- Both sides agree that DHCS will not be required to conduct further presumptive eligibility reviews.
- Both sides agree that a denial of presumptive eligibility is not appealable at a fair hearing.
- Both sides agree that the 37,000 people with disabilities and seniors who are part of the settlement class and were determined ineligible for the new CBAS program prior to April 1, 2012, who were not eligible to receive CBAS-pending, but who prevail at their respective fair hearings, will be deemed eligible CBAS retroactive to the date of CBAS implementation, April 1, 2012.
- The DHCS will coordinate with DRC and the California Department of Social Services State Hearings Division to offer optional telephonic hearings for the settlement class.

The other issue discussed in the contempt motion is the quality assurance process for the more than 315 eligibility determinations from 13 ADHC centers. A workgroup from DHCS and ADHC representatives have met and are still working toward an agreement. If an agreement is not reached, a court hearing is scheduled for April 27, 2012.

Subcommittee Staff Comments and Recommendation—Hold Open. As discussed above, there was a one month delay in the implementation of CBAS and 80 percent (rather than 50 percent) of those who received ADHC services are estimated to be eligible for CBAS. As a result, the estimates for the transition period will be updated by DHCS at May Revise. Consequently, it is recommended to hold this item open.

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

1. Please provide a brief review of the transition of ADHC to CBAS.

2. Please provide an update regarding the contempt motion and the outstanding issue to be resolved.

5. Expand Medi-Cal Managed Care to All Counties

Budget Issue. Beginning in June 2013, the Administration proposes to expand Medi-Cal managed care into the 28 rural counties that are now Fee-For-Service (FFS) (see table below). This proposal would result in General Fund savings of $2.7 million in 2012-13 and $8.8 million in 2013-14.

Table: Medi-Cal Fee-For-Service Counties

County	Number of Medi-Cal Eligibles	County	Number of Medi-Cal Eligibles
Alpine	204	Modoc	1,866
Amador	4,095	Mono	1,143
Butte	47,834	Nevada	10,452
Calaveras	6,106	Placer	28,269
Colusa	4,271	Plumas	2,971
Del Norte	7,706	San Benito	9,334
El Dorado	17,216	Shasta	38,039
Glenn	6,610	Sierra	458
Humboldt	25,208	Siskiyou	9,759
Imperial	54,563	Sutter	21,724
Inyo	3,213	Tehama	16,049
Lassen	4,544	Trinity	2,628
Lake	16,556	Tuolumne	7,511
Mariposa	2,599	Yuba	18,857
		Total	**369,785**

Request for Information. On March 30, 2012, DHCS released a Request for Interest (RFI) in providing Medi-Cal managed care services in the 28 FFS only counties. In the RFI, DHCS is requesting managed care health plans to express their interest in providing Medi-Cal covered services (with a complete provider network) in five ways: (1) in the 26 contiguous county region, (2) in a combination other than in all 26 contiguous counties, (3) in three regions (Northern, Central, and Border), (4) in San Benito and/or Imperial counties, and (5) in an alternate proposal. Responses to this RFI must be submitted by April 23, 2012.

Previous Geographic Managed Care Expansions. The Budget Act of 2005 authorized the DHCS to expand the Medi-Cal managed care program to 13 new counties: El Dorado, Imperial, Kings, Lake, Madera, Marin, Merced, Mendocino, Placer, San Benito, San Luis Obispo, Sonoma, and Ventura. Expansion to all of these counties has not yet occurred and in some of the cases where it did occur, it took three years longer to implement. For example, Ventura County's original implementation date was April 1, 2008; however, the implementation did not occur until July, 1, 2011. Expansion has not occurred in Imperial, San Benito, and El Dorado Counties based on consultation with the counties' local stakeholders, nor has it

occurred in Placer County because two of the three interested health plans were unable to participate.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue between the Administration and stakeholders on the feasibility of expanding managed care throughout the state. Given the past difficulties in expanding managed care into rural counties; it is unclear how the Administration's proposal is feasible.

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

1. Please provide a summary of this proposal.

2. What is the proposed timeline to implement this proposal?

3. Has the department received any responses to the RFI (which were due April 23, 2012)?

4. What lessons did the department learn from the past geographic managed care expansion?

B. 4260 Department of Health Care Services & 5180 Department of Social Services

1. Coordinated Care Initiative

Budget Issue. The Governor's budget includes a Coordinated Care Initiative for Medi-Cal enrollees. With this initiative, the Administration intends to improve service delivery for the 1.1 million people eligible for both Medi-Cal and Medicare (dual eligibles) and 330,000 additional Medi-Cal enrollees who rely on long-term services and supports (LTSS).

The Coordinated Care Initiative is composed of the following proposals:

A. **Expansion of Dual Eligible Demonstration Project.** Expand the enrollment of dual eligibles into Medi-Cal managed care from the four demonstration pilots (as provided under SB 208, Statutes of 2010) to up to 10 counties in 2013 and statewide by 2015.

B. **Integration of Long-Term Supports and Services into Medi-Cal Managed Care.** Integrate home- and community-based long-term supports and services (LTSS) into Medi-Cal managed care for Medi-Cal enrollees in up to 10 counties in 2013 and statewide by 2015.

It should be noted that although these proposals are intertwined as proposed by the Administration, they could be acted upon separately by the Legislature.

The Administration's January proposal assumed that Medi-Cal LTSS benefits would be included as part of the managed care benefit for *all* Medi-Cal beneficiaries (dual eligibles and Seniors and Persons with Disabilities) starting in January 2013 with 1/12 phased-in per month. The phase-in would have been completed by December 31, 2013.

Under a February revision to the Governor's initiative, the Administration proposes to phase LTSS into the Medi-Cal managed care system beginning January 1, 2013, with the 10 counties selected to be part of the dual eligibles demonstration in the first year. Starting January 1, 2014, these services would become managed care benefits in the remaining 20 Medi-Cal managed care counties (or any number of sites as determined by DHCS) as the dual eligibles demonstration project is expanded to those counties. Finally, on January 1, 2015, the remaining 28 counties (or as many as are left) would transition to include these LTSS as part of the Medi-Cal managed care benefit

The Administration's savings estimates (in the chart below) reflect the January proposal's timeline for integrating LTSS. These estimates will be updated at May Revision.

The Administration estimates that the state would realize $621.7 million General Fund savings in 2012-13 and $1 billion General Fund savings in 2013-14.[1] Savings in the budget year are a result of the deferral of Medi-Cal payments until the next fiscal year.

Coordinated Care Initiative Savings (dollars in millions)

	2012-13		2013-14	
Coordinate Care Initiative Components	**Total Funds**	**General Fund**	**Total Funds**	**General Fund**
Medicare Shared Savings	-$42.1	-$42.1	-$543.7	-$543.7
Integration of LTSS into Medi-Cal Managed Care	332.4	166.2	-287.4	-143.7
Defer Managed Care Payment	-1,102.5	-568.1	-625.1	-312.6
Delay FFS Check-write	-355.5	-177.7	-104.2	-52.1
Total	-$1,167.7	-$621.7	-$1,560.4	-$1,052.1

Since DHCS is budgeted on a cash basis (expenses are counted when they are paid, not when the service was delivered), the incorporation of wrap-around payments for these proposals into the managed care capitation rates will result in an initial first year cost to DHCS, with savings achieved in each subsequent year. To address this cost, the administration is proposing a one-time deferral of managed care payments to the next fiscal year.

Please also note that the Coordinated Care Initiative was discussed at the Senate Budget and Fiscal Review Committee hearing on February 23, 2012. The materials for that hearing can be found at:
http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/FullC/2232012SBFRHearingAgendaMediCal%20ManagedCareIHSSIntegration.pdf

Additionally, there is a detailed discussion of the Administration's January proposal in the Senate Budget and Fiscal Review Committee's Overview of the 2012-13 Budget Bill, starting on page 3-1:
http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/overview/OverviewOfThe2012_13BudgetBillSB957.pdf

[1] The savings estimates in this document reflect the Governor's January proposal and do not reflect a more gradual phase-in of the integration of long-term supports and services proposed by the Administration in February. Updated estimates will not be available until the May Revise.

A. Expansion of Dual Eligibles Demonstration Project

BUDGET PROPOSAL

The Administration proposes to expand the enrollment of dual eligibles into Medi-Cal managed care from the four demonstration pilots (as provided under SB 208, Statutes of 2010) to up to 10 counties in 2013, to the remaining 20 Medi-Cal managed care counties (or any number of sites as determined by DHCS) in 2014, and to the remaining 28 counties (or as many as are left) in 2015.

BACKGROUND

Medi-Cal uses a variety of service delivery and payment systems. Originally, the primary payment mechanism was fee-for-service (FFS). Under FFS, a Medi-Cal enrollee obtains services from an approved Medi-Cal provider who is willing to take him/her as a patient for the service and accepts the Medi-Cal payment rate set by the state. In contrast, under Medi-Cal managed care, the Medi-Cal enrollee receives a defined package of benefits through a managed care plan. The plan is paid a per member capitated rate for each enrollee. Medi-Cal managed care currently covers approximately 4.3 million Medi-Cal enrollees in 30 counties.

Medi-Cal managed care is delivered through three models for its full-scope of services. These are:

- **County Organized Health System.** A County Organized Health System (COHS) is a local agency created by a county board of supervisors to contract with the Medi-Cal program. There are 14 counties in the COHS model. (COHS counties are: Marin, Mendocino, Merced, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Solano, Sonoma, Ventura, and Yolo.)
- **Two-Plan Model.** Under the Two-Plan model, each designated county has two managed care plans: a local initiative and a commercial plan. (Two-Plan counties are: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.)
- **Geographic Managed Care.** There are two Geographic Managed Care (GMC) counties in the state. In both counties (Sacramento and San Diego), the Department of Health Care Services (DHCS) contracts with several commercial plans to provide choices to the enrollees.

Mandatory Enrollment of Seniors and Persons with Disabilities into Managed Care. In November 2010, California received federal approval for a Section 1115(b) Medicaid waiver from Centers for Medicare and Medicaid Services (CMS) authorizing (among other provisions) expansion of mandatory enrollment of seniors and persons with disabilities (SPDs) into Medi-Cal managed care. This mandatory enrollment began on June 1, 2011, and will last 12 months. Approximately 20,000 people per month are being enrolled. Prior to this, enrollment into managed care was mandatory for children and families in the 30 counties with managed care and SPDs in the 14 COHS counties.

Dual Eligibles Demonstration Project. Chapter 714, Statues of 2010 (SB 208), directs the California Department of Health Care Services (DHCS) to create new models of coordinated care delivery for dual eligibles through four pilot projects. To assist with this process, California received a $1 million planning grant from CMS' Office of the Duals and the federal Center for Medicare and Medicaid Innovation.

To implement SB 208, DHCS is planning the California's Dual Eligibles Demonstration Project, a three-year demonstration launching on January 1, 2013. Sites that were interested in participating in the demonstration had to submit their applications to DHCS by February 24, 2012.

Demonstration Sites. On April 4, 2012, DHCS announced that Los Angeles, Orange, San Diego, and San Mateo counties were selected to participate in the demonstration project. Additionally, it was announced that contingent on approval of the Administration's Coordinated Care Initiative proposal, as well as readiness reviews and preparations, the state's proposed demonstration project materials call for implementing the demonstration in up to six additional counties: Alameda, Contra Costa, Riverside, Sacramento, San Bernardino, and Santa Clara.

Table: Dual Eligible Demonstration Counties

County	Model	Dual Eligible Population	Health Care Plan(s)
Demonstration Counties			
Los Angeles	Two-Plan	373,941	L.A. Care and Health Net
Orange	COHS	71,588	CalOptima
San Diego	GMC	75,724	Care 1st, Community Health Group, Health Net, and Molina Healthcare
San Mateo	COHS	13,787	Health Plan of San Mateo
Subtotal		**535,040**	
Potential Demonstration Counties			
Alameda	Two-Plan	47,247	Alameda Alliance for Health and Anthem Blue Cross
Contra Costa*	Two-Plan	22,182	Contra Costa Health Plan and Anthem Blue Cross
Riverside	Two-Plan	49,635	Inland Empire Health Plan and Molina Healthcare
Sacramento*	GMC	45,588	Anthem Blue Cross, Health Net, Kaiser Permanente, and Molina Healthcare
San Bernardino	Two-Plan	53,279	Inland Empire Health Plan and Molina Healthcare
Santa Clara	Two-Plan	49,757	Santa Clara Family Health Plan and Anthem Blue Cross
Total		**802,728**	

*It should be noted that Sacramento County and Contra Costa County did not meet the mandatory requirements to be considered a qualified applicant. As a GMC county, Sacramento was required to submit applications from at least two health plans, but only one application was submitted by Molina Healthcare Plan. Similarly, as a Two-Plan county, Contra Costa County was required to submit applications from both plans, but only Contra Costa Health Plan submitted an application. Consequently, it is unclear how these two counties could qualify to participate in this demonstration.

Timeline. The table below reflects the Administration's proposed timeline to implement the Demonstration Project.

Month	Activities
April 2012	• Announce Demonstration Sites • Post Draft Demonstration Proposal for 30-day public comment period • Stakeholder Workgroups meet (April – August) • Demonstration Sites develop local stakeholder process
May 2012	• State submits Demonstration Proposal to federal CMS • CMS posts Demonstration Proposal for 30-day public comment period
June 2012	• CMS approves Demonstration Proposal • Rate negotiations begin with CMS
July 2012	• CMS and DHCS finalize Memorandum of Understanding • Demonstration Sites receive readiness tool and draft rates
August 2012	• DHCS and the Department of Managed Health Care conduct readiness review (July – August)
September 2012	• Demonstration Sites execute 3-way contract with DHCS and CMS • First beneficiaries' notices mailed
October 2012	• Enrollment materials mailed
January 2013	• Enrollment begins in up to 10 counties (those identified in the table above)
January 2014	• Enrollment begins in the remaining 20 Medi-Cal managed care counties
January 2015	• Enrollment begins in the 28 counties that are currently fee-for-service

Memorandum of Understanding. It is anticipated that in July 2012, DHCS and CMS will finalize the Memorandum of Understanding (MOU). This MOU will define how the demonstration project will be implemented and operated and detail requirements such as the procedures related to state and federal contract management, uniform appeals and hearing processes, and uniform encounter data reporting. It is very important to note that this MOU, as proposed by the Administration, would take precedence over existing state statute and regulations. There would be no opportunity for Legislative oversight of this final agreement.

Demonstration Stakeholder Workgroups. To support the development and implementation of the Dual Eligibles Demonstration, DHCS is collaborating with state offices and external

partners on the development of a series of stakeholder workgroups. These workgroups have started meeting and are expected to meet through August. These workgroups include:

- ***Beneficiary Notifications, Appeals, and Protections*** - This workgroup will make recommendations on the enrollment process for the demonstration project including specific text and design principles for beneficiary notices. The workgroup will also provide feedback on coordinated appeals and grievance procedures in order to ensure a more coordinated process, while maintaining beneficiary protections.

- ***Provider Outreach and Engagement*** - This workgroup will make recommendations about provider participation in demonstration sites, and will identify strategies to expand managed care plans' provider networks.

- ***Mental Health and Substance Use Integration*** - This workgroup will focus on understanding and summarizing essential elements required for successful implementation of integrated mental health and substance use services in the demonstration counties.

- ***In-Home Supportive Services Coordination*** - This workgroup will focus on the development of contract requirements between health plans and county In-Home Supportive Services (IHSS) entities to ensure the readiness and functioning of the new integrated program. The goal of the workgroup is the development of a patient-centered care model that ensures consumer protections.

- ***Long-Term Services and Supports Integration*** - This workgroup will provide recommendations for how to integrate Home and Community-Based Services (HCBS) in an organized system of care, including recommendations for LTSS network adequacy standards and coordination of community resources. In particular, the group will consider issues around Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP), and other HCBS waivers.

- ***Fiscal and Rate Setting*** - This workgroup will support actuaries' understanding of program components and capitation rates for managed care plans, while recognizing that rate setting is fundamentally a proprietary and confidential effort between plans, the state, and federal government.

- ***Quality and Evaluation*** - This workgroup will develop recommendations on quality and outcome measurements and design of the evaluation for the demonstration.

BUDGET IMPACT

Medicare Shared Savings. The Administration estimates $42 million in General Fund savings in 2012-13, $412 million in General Fund savings in 2013-14, and growing savings in out- years. To determine the Medicare Shared Savings, the Administration made the following assumptions (among others):

- The state will share savings 50:50 with the federal government.
- Inpatient hospital utilization will drop by 15 percent in 2012-13, 20 percent in 2013-14, 20 percent in 2014-15, and 20 percent in 2015-16.
- Skilled Nursing Facility (SNF) utilization will drop by 5 percent in 2012-13, 5 percent in 2013-14, 5 percent in 2014-15, and 5 percent in 2015-16. This applies only to those enrollees not currently in a SNF.
- Physician utilization will increase by 4 percent in 2012-13, 5 percent in 2013-14, 5 percent in 2014-15, and 5 percent in 2015-16.
- Pharmaceutical utilization will increase by 2 percent in 2012-13, 2 percent in 2013-14, 2 percent in 2014-15, and 2 percent in 2015-16.

While CMS has indicated its intent to share Medicare savings with the state, it is unclear how these savings will be split. Almost half of the out-year savings (over $400 million General Fund) is attributable to sharing savings with Medicare. If CMS does not agree to share savings 50:50 with the state, there could be a major reduction in the savings achieved with this proposal.

General Fund Savings from Medicare Shared Savings (in millions)

	2012-13 (six months)	**2013-14**	**2014-15**	**2015-16**
Medicare Shared Savings	$42.1	$412.7	$556.1	$651.9

These assumptions are generally based on DHCS' rate development experience for Medi-Cal-only SPDs transitioning from fee-for-service into managed care and reflect a two-year phase-in of savings for hospital and physician utilization. Furthermore, DHCS assumes 1) managed care plans need time to gain experience with this new Medicare rate structure before they can achieve full savings, 2) a number of months of increased care coordination may need to take place before savings are achieved, and, 3) most of the savings from SNF utilization for this population are reflected in the proposal to integrate LTSS into managed care.

These project savings are similar to the experience of the Health Plan of San Mateo (HPSM) when it coordinated its care for high-risk Medicare Special Needs Plan members in 2008. According to HPSM's application to become one of the demonstration projects, it indicated that its coordination of services for high-risk Medicare Special Needs Plan members revealed:

- A 45 percent decrease in the percent who had at least one non-psychiatric hospitalization;
- A 31 percent decrease in the percent who had at least one emergency room visit;
- An 11 percent decrease in the average length of stay; and
- A 42 percent decrease in the number of emergency room visits per member.

Subcommittee Staff Comments and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue and as the proposal is refined. As previously raised, the Legislature should consider the following issues as it evaluates this proposal:

- **Challenges Identified in Mandatory Enrollment of SPDs into Managed Care.** The mandatory enrollment of SPDs into managed care that is still underway has identified challenges with ensuring that beneficiaries receive uninterrupted and coordinated care. For example, policies allowing beneficiaries to remain with their fee-for-service provider because of medical instability appear to have been misunderstood and inconsistently applied. Additionally, given that about 60 percent of SPDs were defaulted into a managed care plan, it is likely that more beneficiary and provider outreach and education are necessary to ensure continuity of care.

- **Consumer Protections and Continuity of Care Assurances Are Critical.** The Administration's goals of enrolling dual eligibles into managed care include: (1) improving the beneficiary's health care, quality of life, and satisfaction with the health care system by eliminating fragmentation and inefficiencies that result from the incongruities between Medicare and Medi-Cal, (2) developing financial models that drive streamlined and coordinated care through shared savings and the elimination of cost shifting, and (3) promoting and measuring improvements in health outcomes. While these are important goals, it is critical to ensure that consumer protections and quality measures are in place to ensure that enrollees receive uninterrupted quality care especially given that dual eligibles have significant health care needs.

- **Significant Work Needs to Be Done with Federal Government.** Integrating Medicare and Medi-Cal services and financing will require a considerable amount of time and effort. These programs have different policies, standards, and appeals processes. Although representatives from CMS have been involved in the discussions regarding the dual eligibles pilots, navigating the differences between these programs will be challenging. For example, since federal law prohibits the mandatory enrollment of Medicare beneficiaries into managed care, the Administration is proposing a passive enrollment of these individuals whereby if the enrollee does not opt-out upon initial enrollment then the dual eligible would be enrolled into a managed care plan and given the option to return to FFS for Medicare benefits after six months.

- **Need for Implementation Monitoring Plan.** The Administration's proposal does not include details on how it plans to monitor the implementation of the demonstration project. As was learned from the mandatory enrollment of SPDs into managed care and the transition of ADHC benefits, it is critical to develop a process to monitor and assess the rollout of new policies. Monitoring helps determine the need for further action, possible changes, and actions for improvement.

Although DHCS has initiated workgroups to begin to address these issues, the final policies on continuity of care, beneficiary notification, enrollment, health plan readiness, performance measures, and the medical exemption process, for example, will not be defined until later this year. This timing does not provide any guarantees to the Legislature as it currently considers this proposal. Consequently, the Legislature may want to consider developing checkpoints and mechanisms to ensure that the implementation of the demonstration project has a process

to observe and learn from actual experiences that may need to be changed or unintended consequences that need to be avoided.

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

1. Please provide an overview of the dual eligibles demonstration proposal.

2. Please highlight some of the public comments regarding the draft proposal.

3. Has the Administration considered developing a process to observe and learn from the implementation of the demonstration project to inform the future transition of additional counties? If so, please describe.

4. Please describe the key factors that will be used to assess whether a health plan is ready to participate in the demonstration project.

5. Has CMS signaled any wiliness to share 50 percent of the Medicare savings with the state?

B. Integration of Long-Term Supports and Services into Medi-Cal Managed Care

BUDGET PROPOSAL

Under a February revision to the Governor's Coordinated Care Initiative, the Administration proposes to phase long-term supports and services (LTSS) into the Medi-Cal managed care system beginning January 1, 2013, with the 10 counties selected to be part of the dual eligibles demonstration in the first year. Starting January 1, 2014, these services would become managed care benefits in the remaining 20 Medi-Cal managed care counties (or any number of sites as determined by DHCS) as the dual eligibles demonstration project is expanded to those counties. Finally, on January 1, 2015, the remaining 28 counties (or as many as are left) would transition to include these LTSS as part of the Medi-Cal managed care benefit. (To conform to the Adult Day Health Care (*Darling v. Douglas*) settlement agreement, CBAS would become a managed care plan benefit in all managed care counties no sooner than July 1, 2012.)

The Administration's January proposal assumed that Medi-Cal LTSS benefits would be included as part of the managed care benefit for all Medi-Cal beneficiaries (dual eligibles and SPDs) starting in January 2013 with 1/12 phased-in per month. The phase-in would have been completed by December 31, 2013. The Administration's savings estimates (in the chart above) reflected that timeline. Those estimates will be updated at May Revision.

LTSS Programs Proposed to be Included as Managed Care Benefit. The following LTSS programs are proposed to be included in the Medi-Cal managed care benefit:

- In-Home Supportive Services (IHSS)
- Multi-purpose Senior Services Program (MSSP)
- Inpatient nursing facility and subacute care facility
- Nursing Facility/Acute Hospital Waiver Service
- HIV/AIDS Waiver Services
- Assisted Living Waiver Services
- In-Home Operations Waiver Services

Home-and community-based waiver services for adults with developmental disabilities are carved-out of this proposal.

Integration of IHSS. Recently, the Administration has indicated that its proposal would not change the counties' roles with respect to assessing, authorizing, and making determinations related to IHSS eligibility or with respect to enrolling providers and conducting quality assurance activities. This work by the counties would, however, be accomplished under contract with and on behalf of managed care health plans. Health plans would also be able to authorize additional IHSS hours. The Administration has additionally indicated that there would be a grievance and appeals process for IHSS consumers (although details related to that proposed process are not yet specified).

The Administration's recently proposed trailer bill language also does not alter the existing rights of IHSS consumers to hire, fire, and manage their care providers. In some cases ("as needed"), the Administration proposes for counties, consumers, health plans, and potentially others to additionally participate in "care coordination" teams.

Finally, under the Administration's proposal, counties would continue to participate in the non-federal share of costs for the IHSS program. The Administration intends for counties' shares to be equal to what they would have been in the absence of changes under the Care Coordination Initiative. To that end, its proposed trailer bill directs the Department of Finance, in consultation with the California State Association of Counties, to establish a base year and annual growth factor to determine each county's maintenance of effort requirement. To the extent that total IHSS expenditures increase as a result of changes other than growth in caseload or authorized hours, the Administration proposes for counties to bear the full costs of the non-federal portion of the increase.

Integration of MSSP. In the first year (2013), the Administration proposes to have demonstration counties contract with existing MSSP sites to provide continuing care coordination to plan enrollees who are MSSP participants. In years two and three (2014 and 2015), as managed care plans and the Demonstration expand to all counties, MSSP programs' care coordination functions would become more fully integrated into the plans' care coordination systems. In other words, the plans would have flexibility to determine how best to meet those needs (e.g., by continuing to contract with MSSP sites or integrating MSSP case managers into the plans' staff), and MSSP may not necessarily continue to exist as a discrete program.

Populations Affected. The LTSS integration into managed care would apply to most Medi-Cal enrollees, including dual eligibles and Medi-Cal only SPDs. The following Medi-Cal enrollees would continue to receive Medi-Cal services, including LTSS, on a FFS basis:

- Individuals who have other health care coverage,
- Children in the state's Foster Care Program,
- Enrollees of Program of All-inclusive Care for the Elderly (PACE),
- Enrollees of the AIDS Healthcare Foundation, and
- Other populations as determined by the Department of Health Care Services (DHCS).

LTSS Universal Assessment Tool in 2015. In conjunction with Departments of Social Services and Aging, DHCS proposes to establish, no later than June 1, 2013, a stakeholder workgroup to design, develop, and test a Universal Assessment tool. The universal assessment process would be used for all home and community-based services, including IHSS. It would build upon the IHSS Uniform Assessment process, Hourly Task Guidelines, and other appropriate home and community based services assessment tools. The stakeholder workgroup would include, but not be limited to, beneficiaries and their representatives, managed care health plans, counties, providers, and legislative staff.

Beginning January 1, 2015, or upon completion of design, development, testing, and training related to the universal assessment tool, managed care plans, counties, and home- and

community-based service providers would be required to use the tool to determine the home and community based service needs of their members. Counties would use this tool to continue performing the IHSS assessment and authorization processes, including final determinations of IHSS hours, on behalf of the Medi-Cal managed care health plans and in accordance with statutory provisions for IHSS eligibility.

This universal assessment process for home- and community-based services would be in addition to the assessment process used by managed care health plans when beneficiaries initially enroll in managed care.

Outcome Evaluation. The Administration intends to evaluate this initiative and be able to compare outcomes and performance across counties. Additionally, the federal government intends to evaluate the related dual-eligible demonstration project and compare it to similar initiatives taking place in other states. At the same time, the Administration intends to finalize performance measures to monitor quality and cost only after significant input from multiple stakeholders. It notes that there are several principles that will guide the development of these measures, including that they must be implementable in time for initial enrollment in January 2013.

Some potential improvement targets identified by the Administration include:

- An increase in the number of beneficiaries participating in and receiving care coordination
- An increase in the number of health risk and behavioral health screenings
- An increase in the number of beneficiaries with care plans
- Improved access to home- and community-based services
- Reduced hospital utilization, emergency room utilization, skilled nursing facility utilization, and long-term nursing facility placements
- Improved beneficiary satisfaction.

Demonstration sites will be accountable for provider performance and health outcomes within their systems. These entities will be responsible for collecting and using performance and outcome data to drive changes in care delivery as necessary to ensure that beneficiaries are receiving high quality care that improves health outcomes. These entities will also be required to share performance and outcome data with the State. Additionally, each health plan shall have a process for soliciting and incorporating stakeholder input into its quality improvement process, such as stakeholder committees.

Administration's Proposed Authority to Discontinue Integration. The Administration's proposed trailer bill language grants the Director of DHCS sole discretion to terminate some or all of the changes to LTSS described above if she or he determines that quality of care, efficiency, or cost effectiveness of services is being jeopardized. If such a termination were to occur, all contracts executed pursuant to the proposed statutory provisions would also be terminated. In addition, if the Director of Finance determines, on September 1 of any year, that the proposed statutory provisions have caused utilization changes that increase state costs,

the Director would notify the Joint Legislative Budget Committee and the affected state Departments would be required to discontinue implementation of the proposed provisions.

BACKGROUND ON LTSS

Medi-Cal provides long-term care services in both institutional (nursing home) and home and community-based settings. California's long-term care services include:

- **Nursing Facilities.** The 2011-12 Medi-Cal budget includes over $4 billion (total funds) in nursing facility expenditures. Nursing facilities provide continuous skilled and supportive care on a 24-hour basis. Such care is comprised of inpatient treatment, including physician, skilled nursing, dietary, pharmaceutical, and activity services.
- **IHSS.** With a 2011-12 budget of $5.0 billion ($1.4 billion GF), the IHSS program provides personal care services to approximately 440,000 qualified low-income individuals who are blind, aged (over 65), or who have disabilities. IHSS services include tasks like feeding, bathing, bowel and bladder care, meal preparation and clean-up, laundry, and paramedical care. These services frequently help program recipients to avoid or delay more expensive and less desirable institutional care settings. Currently, county social workers determine eligibility for IHSS after conducting a standardized in-home assessment, and periodic reassessments, of an individual's ability to perform specified activities of daily living. Once eligible, the recipient is responsible for hiring, firing, and directing an IHSS provider or providers. At the end of 2011, there were just over 366,000 working IHSS providers. In approximately 72 percent of cases, IHSS recipients chose a family member to provide care.
- **MSSP.** With a budget of $40.5 million ($20.2 million General Fund), MSSP provides case managed services for frail, elderly clients who wish to remain in their own homes and communities. Clients must be age 65 or older, eligible for Medi-Cal, and certified (or certifiable) as eligible to enter into a nursing home. Teams of health and social service professionals assess each client and develop an individualized care plan. The core MSSP service is care coordination, but other services, such as housing assistance or adult day social care, can also be provided with MSSP funds. The Department of Aging currently oversees MSSP and contracts with local entities that directly provide services. The program serves approximately 12,000 clients per month.
- **Community-Based Adult Services (CBAS) program.** The CBAS program will replace the Adult Day Health Care (ADHC) program on April 1, 2012. AB 97 (Chapter 3, Statutes of 2011) eliminated ADHC services from the Medi-Cal program effective July 1, 2011. A class action lawsuit sought to challenge the elimination. A settlement of the lawsuit was reached that establishes a new program, CBAS. CBAS is a community-based day program providing health, therapeutic, and social services designed to serve those at risk for being placed in a nursing home.
- **Home- and Community-Based (HCB) Waiver programs.** HCB waiver programs are alternatives for individuals who would otherwise require care in a nursing facility

or hospital. For example, the In-Home Operations Waiver provides home and community based services to Medi-Cal eligible persons with severe disabilities requiring acute care in a hospital for more than 90 days.

Currently, Medi-Cal managed care health plans bear limited financial risk for enrollees who are placed in long-term care institutions, such as nursing homes, and for the most part, do not currently cover home and community based services. Long-term institutional services currently are only covered under Medi-Cal FFS.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue and as the proposal is refined. As previously raised, the Legislature should consider the following issues as it evaluates this proposal:

- **Integration of Medical and Social Services Valuable Goal, but Complex.** Long-term care has traditionally been dominated by the medical model, in which focus is placed primarily on an individual's disease or condition rather than their overall needs. However, this model fails to take into account the effect an individual's behavioral health and social supports has on their physical health. Some of the most successful long-term care programs are those that integrate medical and social services, and in doing so, improve a person's health status and overall quality of life. Furthermore, most studies have found that managed long-term care programs reduce the use of institutional services and increase the use of home and community based services relative to fee-for-service programs. In addition, the current fragmented system of programs and services can leave enrollees on their own to link their needs with available services.

  Making a health plan responsible for the delivery of all benefits, health and social, could lead to better care coordination. However, this integration is a complex endeavor and there are significant programmatic and implementation issues that must be addressed. For example, blending federal, state, and local funding streams into a health plan rate payment would be challenging. It would be important to ensure transparency of this process.

- **Need for Ongoing Stakeholder Engagement.** Several stakeholders have expressed concerns regarding or opposition to the broad scope and short timelines included in the Governor's LTSS integration proposal. While the Administration has begun a workgroup process that is expected to last until July to engage stakeholders in the refinement of this proposal, it would also be important to ensure that there is a process for ongoing stakeholder engagement as the proposal is implemented.

- **Need to Monitor Outcomes and Make Informed Decisions.** If LTSS were to become managed care benefits, it would be important for the state to develop measures to evaluate enrollee outcomes and to ensure that managed care plans are not cutting long- term care services and costs inappropriately. It would also be important for the capitation payment to be set at the right level to encourage plan behavior that leads to improved health outcomes. Additionally, even with recent changes to propose a slower

initial phase-in of implementation, the Administration's proposal does not require Legislative action over time to incorporate and build upon experiences gained and outcomes monitored as the changes roll out. The Administration is instead seeking upfront authority for all of the phases.

- **Legislative Analyst's Office (LAO) Identifies Significant Implementation Issues.** The LAO's review of the Administration's January proposal found that in concept coordinating care for these enrollees has merit because it attempts to address the problems with the fragmented system of delivering medical care and LTSS. But the LAO also identified implementation issues that must first be addressed, such as ensuring proper oversight and rate development for managed care plans, maintaining continuity of care for enrollees, and determining the level of program control granted to plans. As a result, the LAO recommended against making decisions at this time to expand the dual eligible demonstration statewide and make LTSS managed care benefits statewide.

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

1. Please provide a summary of this component of the proposal.

2. Are the proposed changes to the delivery of long-term care supports and services intended to be a demonstration or permanent policy changes?

3. When would care coordination teams be utilized and who would decide upon the participants in those teams? What decisions might the teams make?

4. How might the proposed appeal and grievance processes applicable to IHSS be different than existing processes?

5. What would happen in the event that the Directors of DHCS or Finance used their sole discretion to terminate all, or part, of the proposed changes to the delivery of long-term supports and services?

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, April 26 (Room 4203)

VOTE ONLY CALENDAR

Department of Health Care Services

1. **Lock-In at Annual Open Enrollment for Medi-Cal Managed Care**
   - Action – Reject Administration's proposal.
   - Vote-3-0
2. **Federally Qualified Health Center/Rural Health Clinic Payment Reform**
   - Action – Reject Administration's proposal.
   - Vote-2-1 (Senator Emmerson voting no.)
3. **Redirecting Unpaid Stabilization Funding**
   - Action – Approve as budgeted.
   - Vote-2-1 (Senator Emmerson voting no.)
4. **Access Monitoring Program**
   - Action – Approve as budgeted.
   - Vote-2-1 (Senator Emmerson voting no.)

ISSUES FOR DISCUSSION

A. Department of Health Care Services

1. **Default Managed Care Plan Assignment**
   - Held open.
2. **Align Managed Care Policies for Retroactive Medi-Cal**
   - Action – Approve as budgeted.
   - Vote -3-0

3. **Eliminate Gross Premium Tax Sunset Date for Medi-Cal Managed Care Plans**

    - Held open.

4. **Community-Based Adult Services Program**

    - Held open.

5. **Expand Medi-Cal Managed Care to All Counties**

    - Held open.

B. 4260 Department of Health Care Services & 5180 Department of Social Services

1. **Coordinated Care Initiative**

    A. Expansion of Dual Eligibles Demonstration Project

        - Held open.

    B. Integration of Long-Term Supports and Services into Medi-Cal Managed Care

        - Held open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 10, 2012

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

Part 1 of the Agenda
(Michelle Baass)

PLEASE NOTE:

Only those 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 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 3-10

A. 0530 California Health and Human Services Agency

1. Extend Sunset Date for Office of HIPPA Implementation

Budget Issue. Through a Spring Finance Letter, the Administration proposes to extend the sunset date for the California Office of Health Information Integrity (CalOHII) from January 1, 2013 to June 30, 2016. Additionally, CalOHII proposes a reduction in its budget of $751,000 for the elimination of two positions and a reduction in contract funds.

Under this proposal, total funding for CalOHII would include $1.973 million General Fund, $1.2 million Reimbursements, and $10.5 million from the California Health Information Technology and Exchange Funds and total positions would be 19.

Background. CalOHII is tasked with overseeing all statewide activities to comply with the federal Health Insurance Portability and Accountability Act (HIPPA). Specifically, CalOHII is tasked with:

- Statewide leadership, coordination, policy formation, direction, and oversight responsibilities by impacted state departments;
- Full authority relative to state entities to establish policy, provide direction to state entities, monitor progress, and report on HIPPA implementation efforts; and
- Responsibility for determining which provisions of state law concerning personal health information are preempted by HIPPA for state agencies.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this item. No issues have been raised.

B. 2400 Department of Managed Care

1. Premium Rate Review Cycle II Federal Grant

Budget Issue. The DMHC requests 2 two-year limited-term positions and an increase of federal expenditure authority of $755,000 for 2012-13, $691,000 for 2013-14, and $72,000 for 2014-15 to administer the Health Insurance Premium Rate Review Cycle II Federal Grant. These positions and spending authority would be used to enhance DMHC's capabilities in collecting premium rate data, improving rate filing requirements, enhancing the rate review process, reporting data to the federal government, and disclosing rate information to consumers.

This item was discussed at the Subcommittee#3 Hearing on March 8, 2012: http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/SUB3/382012Sub3DMHC_OSHPD_DPH_DHCS_FamilyHealth.pdf

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this item. No issues have been raised.

C. 4140 Office of Statewide Health Planning and Development

1. Retention and Evaluation Activities (REA) Initiative

Budget Issue. Through a Spring Finance Letter, OSHPD requests an increase in federal fund expenditure authority of $162,000 in 2012-13 for the REA Initiative. Current year funding for this project was approved through the Section 28 Budget Revision process. The REA Initiative requires grant funds to be expended by September 30, 2013.

Background. The REA Initiative is a federally funded program that allows states to perform activities to retain clinicians in underserved communities and analyze the impact of such activities. OSHPD's Primary Care Office is administering this initiative.

Subcommittee Staff Comment and Recommendation—Approve. Approve Administration's proposal.

D. 4260 Department of Health Care Services

1. HIV Transition Incentive Program

HIV Transition Incentive Program. In order to assure that persons with HIV make their transitions of coverage from Ryan White to the Low Income Health Program (LIHP) with continuity of quality care, without loss of either core or other critical services, and with minimal disruption to critical patient/provider relationships, the Department of Health Care Services submitted a section 1115 Demonstration amendment to create the HIV Transition Incentive Program. Under the HIV Transition Incentive Program, $150 million would be available annually in 2011-12 and 2012-13 and $75 million in 2013-14 for the development of projects that support the LIHP systems' efforts to address the continuity of care, care coordination, and coverage transition issues for persons with HIV. DHCS is still working with the federal government on the requested amendment.

At the March 8, 2012 Subcommittee #3 hearing, the Subcommittee approved the following action:

- Add a Health Program Specialist II position at the Department of Health Care Services to manage the HIV Transition Incentive Program and coordinate with DPH's Office of AIDS. This position would be funded using county funds (via certified public expenditures) and federal funds.

Subcommittee Staff Comment and Recommendation. Based on discussions with the department, it is recommended to redirect an existing vacant Health Program Specialist II position created for LIHP instead of adding a new position.

E. 4265 Department of Public Health

1. Healthcare Acquired Infections Public Reporting

Budget Issue. The DPH proposes an increase of $493,000 Licensing and Certification Fund for four positions (that will be redirected from within DPH) for the statutorily required public reporting of health care associated infections (HAIs) by hospitals. These positions would be funded through an increase in licensing fees paid by General Acute Care Hospitals (GACHs).

These positions would be used to meet the workload associated with the increase in the number of surgical procedures that must be reported by hospitals. When the program was created, DPH determined that only three types of surgical site infections must be reported. However, DPH's recent interpretation of statute increased the number of reportable types of surgical site infections to 29; thereby causing a more than 12-fold increase in workload (from 71,000 surgical procedures to more than 900,000).

Background. DPH created the HAI Program in 2009 to implement (1) SB 739 (Spier), Statutes of 2006; (2) SB 158 (Florez), Statues of 2008; and (3) SB 1058 (Alquist), Statutes of 2008. The program is required to take specific actions to protect against HAI in GACHs statewide, these include:

- Receiving reports from hospitals on implementation of infection surveillance, infection prevention process measures, and the occurrence of HAI.

- Providing reports with the above information to the public on an annual basis.

The program originally included 12 authorized positions.

According to the department, in California's GACHs, HAIs account for an estimated 240,000 infections, 13,500 deaths, and $3.1 billion in excess health care costs annually.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised with this proposal and workload is justified.

2. Reduction of Preventable Medical Errors and Medication Errors Contract

Budget Issue. The DPH proposes to fund a contract with the University of California to support efforts to reduce preventable medical errors and associated health care costs in licensed health care facilities. The quality improvement activities would focus on medication errors and aim to identify solutions to medication safety system vulnerabilities. The contract would be for a total of $1 million spread equally over three fiscal years. The funding for this contract would come from the Internal Departmental Quality Improvement Account (IDQIA).

The purpose of the contract is to:

- Identify common medication safety vulnerabilities.

- Identify solutions (e.g., evidence-based practices) to medication safety vulnerabilities that are proven to reduce medication errors.
- Identify and build upon current medication safety activities occurring at the hospital and long-term care level through a collaborative approach.
- Identify and propose mechanisms to promote rapid dissemination of proven medication safety strategies.
- Reduce the number of medication errors occurring in health care facilities.

Background. SB 1312 (Alquist), Statutes of 2006, authorized DPH to impose penalties for hospitals for deficiencies constituting immediate jeopardy. These penalties are deposited into the IDQIA. Funds in the IDQIA must be expended for quality improvement activities initiated by the Licensing and Certification (L&C) Program at DPH.

Between January 2007 and November 2010, L&C issued 170 administrative penalties for hospital deficiencies constituting immediate jeopardy. Medication error/pharmacy error was the primary cause for an administrative penalty, accounting for 48 penalties, or 28.2 percent of all issued administrative penalties.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised with this proposal and use of these funds to identify strategies to reduce the number of medication errors is justified as this is one of the most commonly cited penalties.

3. Close Southern California Laboratory

Budget Issues. The DPH proposes to close its Southern California Laboratory (Temple Street building) due to health and safety concerns related to the building's code and seismic deficiencies. The closure of the Temple Street building would generate savings of $180,000 ($57,000 General Fund) in 2012-13 and $360,000 ($114,000 General Fund) in future years from various funds.

DPH programs would transition out of the building on July 1, 2012.

Background. The DPH owns and operates two laboratory/office buildings: one in Northern California (the Richmond Laboratory) and one in Southern California (the Temple Street building). In 1988, the Department of Health Services (now DPH) purchased the Temple Street building for $1.3 million. Four DPH programs occupied this building: the Environmental Laboratory Accreditation Program, the Environmental Management Branch, the Food and Drug Branch, and the Drinking Water Radiation Laboratory Branch. In addition, DPH leases space to the Department of Toxic Substance Control's (DTSC) Environmental Health Laboratory Program.

Three separate infrastructure studies of the Temple Street building have been conducted. The first two studies, completed in 1986 and 1991, identified numerous deficiencies and determined that the building did not meet various building standards. The third study,

conducted in 2006, concluded that it would not be cost-effective to renovate the existing building given its many structural deficiencies.

Additionally, both DPH and DTSC have received health and safety complaints from employees and grievances from the California Association of Professional Scientists. Since 2009, DPH has been systematically relocating DPH programs out of the Temple Street building into other DPH space in Southern California.

Subcommittee Staff Comment and Recommendation—Approve. Given the health and safety risks posed by this building, it is recommended to approve this item. De-commissioning costs for the Temple Street building are not yet know and cannot be determined until all occupants are out of the building. (It is anticipated that it DTSC might need up to one year to vacate the premises.)

4. Special Fund Efficiencies

Budget Issue. Through a Spring Finance Letter, DPH requests the following changes:

a. **Health Statistics Special Fund.** Reduce expenditures of the Health Statistics Special Fund by $534,000 in order keep expenditures in line with revenue.

b. **Water Device Certification Program.** Eliminate the Water Device Certification Program (-$382,000). Currently, water devices require third party approval in addition to State certification. That approval is provided by an independent testing organization that has been accredited by American National Standards Institute (ANSI) or by the federal government.

   California is only one of six states nationally that require water device products to have State certifications. According to DPH, eliminating California certification will have minimal impact on public health, as products will still require third party approval before being offered for sale in California.

c. **Registered Environmental Health Specialist Fund.** Reduce expenditures of the Registered Environmental Health Specialist Fund by $68,673 to reflect the reduced workload associated with a reduction in the number of applications to process.

d. **Retail Food Safety and Defense Fund.** Eliminate the existing Retail Food Safety and Defense Special Fund and redirect the deposits of user fees (about $21,000) for retail food related activities collected by DPH to the existing Food Safety Special Fund. DPH is charged with ensuring the safety of the food supply, including responsibilities in the area of retail food safety. The California Retail Food Code provides DPH with the responsibility to oversee the statewide implementation of a retail food safety program with primary enforcement of the retail food code conducted by local health departments.

Depositing retail food safety related user fees into this fund is consistent with the existing use of the Food Safety Fund and will provide DPH and the state with some cost savings through the elimination of one special fund that has to be monitored and tracked on an ongoing basis.

e. **Recreational Health Fund Program.** Eliminate the Recreational Health Fund and Program ($237,000). DPH notes that while the program was designed to sunset in 2014, its proposed elimination with the 2012-13 Budget is supported by the work already completed by DPH. This includes providing statewide information and guidance memos to Local Environmental Health Departments (LEHDs) for their use and for distribution to owners of public pools and spas and their contractors, as well as working with the California Conference of Directors of Environmental Health (CCDEH) to develop a pool owners compliance form and instructional materials distributed to LEHDs and pool owners, operators, and contractors. Eliminating this program at the state level will place the responsibility of implementing the elements contained within statue related to the federal Virginia Graeme Baker Pool and Spa Safety Act and federal safety standards with the LEHDs.

f. **California Prostate Cancer Research Fund.** Eliminate the California Prostate Cancer Research Fund. This fund was created to deposit voluntary contributions made by taxpayers in excess of their tax liability. This fund did not collect enough voluntary contributions to remain on the State Income Tax check-off list. No further revenues are being generated.

g. **Sexual Violence Victim Services Fund.** Eliminate the California Sexual Violence Victim Services Fund. This fund was created to deposit voluntary contributions made by taxpayers in excess of their tax liability. This fund did not collect enough voluntary contributions to remain on the State Income Tax check-off list. No further revenues are being generated.

Budget Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised with these proposals.

F. 4440 Department of Mental Health

1. Transition of Community Mental Health – Technical Adjustments

Budget Issue. Through a Spring Finance Letter, the Department of Mental Health (DMH) is requesting a technical adjustment on the transfer of resources not identified in prior budget change proposals supporting the transition of community mental health functions from DMH to other state entities. This request proposes to:

- Add two positions and $189,000 ($94,500 General Fund) to the Department of Health Care Services (DHCS) (and the corresponding reduction to DMH) to reflect a transfer of resources from DMH to DHCS to support account receivable activities.
- Increase $865,000 General Fund to DMH (and the corresponding reduction to DHCS) to reflect a correction on the share of federal financial participation previously identified.

Subcommittee Staff Comments and Recommendation—Approve. These are technical changes and recommended for approval.

ISSUES FOR DISCUSSION

A. 4265 Department of Public Health

1. Licensing and Certification (L&C) Program

Background. The Licensing and Certification (L&C) Program develops and enforces State licensure standards, conducts inspections to assure compliance with federal standards for facility participation in Medicare and/or Medi-Cal, and responds to complaints against providers licensed by the DPH.

In 2006, the L&C Program began a transition to migrate from General Fund support to a fee-based program, coupled with applicable federal funding. Only State departments that operate long-term care facilities are appropriated General Fund support for the purpose of licensing and certification activities. Existing statute provides the framework for calculating the annual licensing and certification fees for each of the various health care facilities.

Existing statute requires the L&C Program to annually publish a Health Facility License Fee Report (DPH Fee Report) by February of each year. The purpose of this annual DPH Fee Report is to provide data on how the fees are calculated and what adjustments are proposed for the upcoming fiscal year.

The DPH Fee Report utilizes the requirements of existing statute for the fee calculations, and makes certain "credit" adjustments. The DPH notes that these "credits" are most likely one-time only and that when fees are calculated based solely on the statutorily prescribed workload methodology as contained in statute.

The "credits" are applied to offset fees for 2012-13 and total $12.2 million. They are as follows:

- $3.7 million credit for miscellaneous revenues for change in ownerships and late fees collected in 2010-11.
- $8.5 million credit from the program reserve (which is largely a result of vacancies due to the state's hiring freeze).

The fees must also take into consideration various incremental cost adjustments for 2012-13, including budget change proposals (discussed above in the Vote Only section of this Agenda), employee retirement and worker's compensation, facility space for field offices and related aspects.

Additionally, in order to prevent major variations in fee amounts year to year, DPH is ensuring that a facility type's fee increases or decreases by only 5 percent.

The DPH Fee Report of February 2012 proposes slight changes to fees as shown in the Table below.

Table: Proposed Licensing and Certification Fee Schedule (February 2012)

Facility Type	Fee Category	2011-12 Fee	Proposed Fee 2012-13	Difference
Acute Psychiatric Hospitals	per bed	$280.61	$266.58	-$14.03
Adult Day Health Centers	per facility	$4,384.13	$4,164.92	-$219.21
Alternative Birthing Centers	per facility	$3,131.83	$2,975.27	-$156.56
Chemical Dependency Recovery	per bed	$187.01	$191.27	$4.26
Chronic Dialysis Clinic	per facility	$3,766.62	$3,578.29	-$188.33
Community-Based Clinics	per facility	$756.17	$718.36	-$37.81
Congregate Living Facility	per bed	$297.14	$312.00	$14.86
Correctional Treatment Centers	per bed	$546.38	$573.70	$27.32
General Acute Care Hospitals	per bed	$280.61	$266.58	-$14.03
Home Health Agencies	per facility	$4,542.60	$4,315.47	-$227.13
Hospice	per facility	$4,795.92	$4,641.96	-$153.96
Intermediate Care Facility (ICF)	per bed	$297.17	$312.00	$14.83
ICF—DD Habilitative, DD Nursing	per bed	$552.76	$580.40	$27.64
ICF-Developmentally Disabled	per bed	$552.76	$580.40	$27.64
Pediatric Day Health/Respite	per bed	$197.90	$188.01	-$9.89
Psychology Clinic	per facility	$1,406.34	$1,476.66	$70.32
Referral Agencies	per facility	$4,597.90	$4,368.01	-$229.89
Rehabilitation Clinic	per facility	$247.00	$259.35	$12.35
Skilled Nursing Facility	per bed	$297.14	$312.00	$14.86
Special Hospitals	per bed	$280.61	$266.58	-$14.03
Surgical Clinic	per facility	$2,368.57	$2,487.00	$118.43

Background on Fee Methodology. Licensing fee rates are structured on a per "facility" or "bed" classification and are collected on an initial license application, an annual license renewal, and change of ownership. The fees are placed into a special fund—Licensing and Certification Special Fund.

The fee rates are based on the following activities:

- Combines information on projected workload hours for various mandated activities by specific facility type (such as skilled nursing home, community-based clinic, or hospital).
- Calculates the State workload rate percentage of each facility type to the total State workload.
- Allocates the baseline budget costs by facility type based on the State workload percentages.
- Determines the total proposed special fund budget cost comprised of baseline, incremental cost adjustments, and credits.
- Divides the proposed special fund cost per facility type by the total number of facilities within the facility type or by the total number of beds to determine a per facility or per bed licensing fee.

The DPH Fee Report provides considerable detail regarding these calculations, as well as useful data on L&C workload associated with the various types of health care facilities, along with a clear description regarding the details of the methodology. This report can be found at:

http://www.cdph.ca.gov/pubsforms/fiscalrep/Documents/LicCertAnnualReport2012.pdf

Questions. The Subcommittee has requested the L&C Program to respond to the following question:

1. Please provide a brief summary of the L&C Fees, including the key credits and adjustments.

a. Special Fund Efficiencies – Eliminate State Mandates for Health Facilities

Budget Issue. Through a Spring Finance Letter, DPH proposes to eliminate current State mandates regarding health facility inspections and complaint investigations and; consequently, to eliminate 25 Health Facility Evaluator Nurses (HFENs) and $4.6 million from the Licensing and Certification Fund.

Specifically, the proposal seeks to make the following changes:

- Delete the requirement that L&C inspect (unannounced) health facilities to ensure they are in compliance with state laws and regulations at least every two years. Remove the requirement that for certain types of hospitals, the inspection team must include a physician, registered nurse, and persons experienced in hospital administration and sanitary inspections.

- Eliminate the State mandated timeframe in which L&C must respond to a complaint and instead use federal timeline requirements.

Complaint Type	State Requirement	Federal Requirement
Immediate Jeopardy	24 hour	48 hour
Non-Immediate Jeopardy—High	10 day	10 day
Non-Immediate Jeopardy—Low	10 days	At next visit to facility for certification

- Eliminate the State mandated timeframe in which L&C must complete a complaint investigation (45 days). Since federal law does not specify a timeframe, there would be no timeframe in which L&C must complete a complaint investigation.

- Eliminate State law that requires that inspections of long-term health care facilities (nursing homes) that are certified by the Medicare program or the Medicaid program include a survey for California statutes and regulations to the extent that California statutes and regulations provide greater protection to residents, or are more precise than federal standards, as determined by the department.

- Eliminate the State requirement that Adult Day Health Care Centers be inspected at least every two years. DPH would retain the authority to inspect these centers as needed.

- Eliminate the State requirement that clinics (primary care, dialysis, surgery, rehabilitation, alternate birthing centers, psychology, and pediatric day health respite care) be inspected at least once every three years.

Background—Health Facilities. SB 1301 (Alquist), Statutes of 2006, requires the reporting of serious medical errors (adverse events) to DPH and establishes timeframes for both reporting of these events and follow-up investigations. The law also requires L&C to make an on-site inspection within 48 hours of receipt of a written or oral complaint that indicates an ongoing threat of imminent danger of bodily harm or death.

Background—Long-Term Care Facilities/Nursing Homes. SB 1312 (Alquist), Statutes of 2006, requires the DPH to inspect all licensed long-term care health facilities to ensure compliance with state laws and regulations to the extent that those standards provide greater protection to residents or are more precise than federal standards.

Prior to the passage of SB 1312, long-term care health facilities that were certified to participate in the Medi-Cal Program were exempt from periodic state licensing inspections. SB 1312 removed that exemption.

To ensure maximum effectiveness of inspections conducted, SB 1312 also mandated the L&C Program to identify all state law standards for staffing and operation of long-term care health facilities.

Examples of state standards that provide greater protection to residents or are more precise than federal standards include:

- Requirements on the administration of medications.
- The use of restraints only upon written order by a physician or other person lawfully authorized to prescribe care.
- Requirements on health records and admission records.

Federal and State Survey Processes. The survey protocols for conducting a federal certification survey are prescribed by the federal CMS. The DPH surveyors are "graded" for compliance with those protocols by periodic and direct observations by the federal CMS specialists. The DPH performance is measured by the average length of time taken for the federal survey, the timeliness of submitting the survey findings to the facility, and the timeliness of obtaining an acceptable plan of correction.

The federal CMS does not permit violations of state licensing standards to be included in the federal certification survey documents. Failure to comply with federal standards can jeopardize the federal grant funds the state receives for the L&C Program.

Table: Skilled Nursing Facilities - Number of Surveys and Deficiencies

State Fiscal Year	# of State Re-licensure Surveys	# of State Deficiencies Cited	Average # of State Deficiencies Cited per Survey	# of Federal Re-certification Surveys	# of Federal Deficiencies Cited	Average # of Federal Deficiencies Cited per Survey
2007-08	53	286	5.4	947	16,088	16.99
2008-09	90	470	5.22	1,014	17,589	17.35
2009-10	128	783	6.12	913	15,504	16.98
2010-11	347	2,138	6.16	929	15,890	17.1
Total	**618**	**3,677**		**3,803**	**65,071**	

Background—L&C Investigation Workload. As of March, 2012, L&C's workload related to long-term care facilities includes approximately:

- 4,000 complaint investigations initiated but not closed.
- 2,100 facility-reported incident investigations that have not been initiated.
- 4,500 facility-reported incident investigations that have been initiated but not closed.

As of March 2012, L&C's workload related to non-long term care facilities (primarily hospitals) includes approximately:

- 2,200 complaint investigations that have not been initiated.
- 2,300 complaint investigations that have been initiated but not closed.
- 4,000 facility-reported incident investigations that have not been initiated (approximately 850 are Adverse Events, of which about 554 are pressure ulcers).
- 3,500 facility-reported incident investigations initiated but not closed (approximately 1,000 are Adverse Events, of which approximately 560 are pressure ulcers).

According to DPH, complaints and facility-reported incidents that have not been initiated largely include reports that do not indicate a probability of harm (e.g., billing or privacy issues). L&C is not in compliance with the mandate to close investigations of about 530 Adverse Events within 45 days of initiation.

Subcommittee Staff Comment and Recommendation—Reject. State laws provide greater protections for California residents. These protections address patient safety and quality of care and as research shows, are key components of reducing medical costs. This proposal provides no relief to the General Fund, nor does it offset facilities licensing fees because these savings would remain in the Licensing and Certification Fund reserve. It is recommended to reject this proposal.

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

1. Please provide an overview of this proposal.

2. Please provide examples of state safeguards that provide greater protection to residents of nursing facilities that are more stringent than federal requirements.

3. What would be the impact on patients with this proposal?

b. L&C's Role in the Money Follows the Person Program

Oversight Issue. Concerns have been raised that L&C survey staff are not proactively reviewing data and follow-up action taken by staff at nursing facilities regarding a nursing home resident's desire to return back to the community.

Background. California received a Money Follows the Person (MFP) grant in January 2007 and developed the California Community Transitions (CCT) project. This grant is to be used to target Medicaid enrollees with disabilities who have continuously resided in hospitals, nursing facilities, and intermediate care facilities for persons with developmental disabilities for three months or longer. The goal is to offer a menu of social and medically necessary services to assist them to remain in their home or community environments. In 2010, MFP transitioned 205 individuals from a health facility into the community.

On October 1, 2010, CMS required certified nursing facilities to begin using a new iteration of the Minimum Data Set (MDS 3.0). MDS is part of the federally mandated process for assessing nursing facility residents upon admission, quarterly, annually, and when there has been a significant change in status. Under Section Q of MDS 3.0, nursing facilities must now ask residents directly if they are "interested in learning about the possibility of returning to the community." If a resident indicates "yes," a facility is required to make the appropriate referrals to state designated local community organizations.

By providing participants long-term services and supports in their own homes for one full-year after discharge from a health care facility, the state receives an 87 percent federal fund match.

On March 22, 2012, this Subcommittee approved a budget proposal by the Department of Health Care Services to expand the Money Follows the Person program into additional counties.

Subcommittee Staff Comment. Given DHCS' effort to expand Money Follows the Person to additional counties in the state and the enhanced federal funding that is associated with returning a person to the community under this program, it is critical that all state department staff coordinate their efforts to ensure the success of the MTP program.

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

1. Do L&C surveyors monitor how a nursing home resident responds to this question and whether or not nursing facility staff make the appropriate referral to the community liaison?

2. Are there any proactive steps DPH could take (e.g., district office memos) to encourage surveyors to review this information and ensure that nursing facility staff are taking the appropriate action?

2. Transfer of Direct Service Programs to Department of Health Care Services

Budget Issue. The DPH proposes to transfer three direct services programs to the Department of Health Care Services (DHCS) effective July 1, 2012. These programs are the Every Women Counts (EWC) Program, the Prostate Cancer Treatment Program, and the Family Planning Access Care and Treatment (FPACT) Program. These programs would be transferred to the Health Care Benefits and Eligibility Division at DHCS.

DPH proposes to transfer $16.5 million General Fund, $77.2 million federal funds, and $33.3 million in special funds and 33.6 positions to DHCS. (There is no proposed reduction to funding or positions.)

The Administration notes that these three programs provide direct health care services to individuals and have eligibility requirements designed to serve low-income Californians, thus align more closely with the scope of services provided by DHCS. Additionally, as federal health care reform is implemented, the transferring of these programs to DHCS will facilitate a more seamless transition to Medi-Cal enrollment and maximize opportunities to leverage federal Medicaid funds to cover the costs currently supported with state funds.

Background. When the Department of Health Services was split in 2007 into DHCS and DPH, DPH retained EWC, the Prostate Cancer Treatment Program, and FPACT because of the strong nexus between these programs and DPH's core preventative health and outreach activities.

Every Woman Counts Program. EWC provides cancer screening services for low income under-insured and uninsured women. Through EWC, women receive free clinical breast exams, mammograms, other breast cancer diagnostic testing, pelvis exams, and Pap tests, with the intended outcome to reduce breast and cervical cancer deaths. EWC enrolls women age 25 and older for cervical cancer prevention screening and women age 40 and older for breast cancer screening and diagnostic services.

Prostate Cancer Treatment Program. The Prostate Cancer Treatment Program helps underserved men receive free prostate cancer treatment services through Improving Access, Counseling and Treatment (IMPACT) for Californians with Prostate Cancer program. UCLA has administered the IMPACT program since 2001.

Family Planning Access Care and Treatment Program. FPACT was established by the Legislature in 1996 to fill a gap in health care for underinsured and uninsured. The objectives of this program are to reduce the rate and cost of unintended pregnancies, increase access to publicly funded family planning for low-income Californians, increase the use of effective contraceptive methods by clients, and promote improved reproductive health.

Subcommittee Staff Comment and Recommendation—Approve. Moving these direct health services programs to DHCS makes sense particularly with federal health care reform. No issues have been raised regarding this proposal.

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

1. Please provide an overview of this proposal.

2. How does the Administration plan to ensure that the public health focus of these programs is not lost?

3. How does this proposal position the State in preparation for health care reform?

3. Kids' Plate – Childhood Injury Prevention

Budget Issue. The budget includes $494,000 in local assistance from the Child Health and Safety Fund for DPH. According to the Administration, these funds cannot be distributed to local entities because DPH does not have administrative expenditure authority over the funds (there is no state operations funding for the department for these funds).

Background. AB 3087 (Chapter 1316, Statutes of 1992) established the *Have a Heart, Be a Star, Help Our Kids* specialized license plate program. Revenues from these license plate fees, totaling $4.1 million in 2009-10 and $4.0 million in 2010-11, are deposited into the Child Health & Safety Fund. State law (Welfare & Institutions Code Sections 18285 and 18285.5) specifies how those revenues are distributed. Currently, the first 50 percent supports specific Department of Social Services responsibilities for child day care licensing. Of the remaining 50 percent, up to 25 percent supports child abuse prevention and the rest supports programs that address injury prevention. It should be noted that under a Department of Social Services' budget proposal, more funds would be allocated for child day care licensing activities to achieve $501,000 in General Fund savings.

DPH has been receiving funds from this license plate program since 1996-97 and entered into a contract with San Diego State University Research Foundation (SDSURF) to distribute these funds to local organizations for activities related to the prevention of unintentional childhood injuries and accidents. When the department went to renew its contract with SDSURF in July 2010, the Department of General Services (DGS) raised two issues with the contract. First, DGS indicated that the nature of the contract was creating a role for SDSURF as a fiscal agent for the state (since SDSURF was not a state entity, but rather a nonprofit associated with the San Diego State University) and that this was not appropriate. Second, DGS argued that DPH was contracting out work that could be done by state employees. These issues could not be worked out, and; consequently, this contract expired in 2010-11.

Since the end of the grant program contract managed by SDSURF, DPH has initiated one-time-only grants to conduct small-scale projects like Bike to School Day Events, childhood pedestrian safety education and awareness, child passenger safety fitting stations, and education for parents on safe sleeping practices and on the need for pool barriers. The DPH secured assistance from outside agencies/partners to help with outreach to solicit applications and in preparing agreements. DPH indicates that this method for awarding grants is not sustainable as an ongoing approach.

Subcommittee Staff Comment and Recommendation. In order to ensure that these funds are distributed to local entities for childhood injury prevention efforts and to maximize the amount of funding available for the local entities, the following actions are recommended:

1. Allow for up to 5 percent of DPH's allocation from Child Health and Safety Fund to be used for state operations for administration.

2. Direct DPH to create a regional grant program for these funds. DPH would issue a Request for Assistance (RFA) for entities interested in regionally coordinating the distribution of this grant funding. The regional entity would also be responsible for providing actual services (in order to avoid DGS' concerns discussed above). The goal of this regional grant program would be to maximize the amount of funding local entities receive for activities related to childhood injury prevention, such as child passenger safety, bicycle safety, and unintentional injury prevention. There would be no more than three regions (north, south, and central) to reduce the amount of state funds necessary to execute these grants. Additionally, it should be noted that since these are local assistance funds, they are not required to be bid out competitively, per section 3.17 of the State Contract Manual. In order to reduce the administrative overhead of this grant program, the regional grantees could be awarded under a two-year term and have the option to extend the contract for an additional two-years based on satisfactory performance.

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

1. Please provide a brief overview of this issue.

2. Does the Administration have any concerns with the Subcommittee Staff recommendation?

B. 4140 Office of Statewide Health Planning and Development

1. Mental Health Loan Assumption Program (MHLAP) Increase Awards

Budget Issue. Through a Spring Finance Letter, OSHPD requests an increase of $5.1 million (Mental Health Services Act Fund) for loan assumption awards and two new permanent positions to manage the increased workload associated with the doubling of awards. The increased funding allows the Health Professions Education Foundation's Mental Health Loan Assumption Program to double the annual number of awards from 600 to 1,200 and expand the eligibility criteria to better meet the workforce needs of each county's public mental health system.

Background. Approved by voters in 2004, the Mental Health Services Act (MHSA) imposes a 1 percent tax on personal income in excess of $1 million to support the public mental health system. One of the components of the MHSA is the Workforce, Education, and Training (WET) Program. WET assists counties in developing and maintaining a culturally competent workforce capable of providing client and family-driven services. MHLAP is one of the programs funded by WET. MHLAP provides loan repayments of up to $10,000 to mental health practitioners in exchange for a 12-month service obligation in California's public mental health system. Eligible professions include licensed psychologists, registered psychologists, postdoctoral psychological assistants, licensed clinical professional counselors, licensed marriage and family therapists, and others.

Funding for awards has increased from $2.5 million in 2008-09 to $5 million in 2010-11 and would increase to $10 million in 2012-13 with approval of this proposal. Awards are reviewed and scored by MHLAP's Advisory Committee, which is comprised of representatives of the County Mental Health Directors Association, licensing board, academia, and community organizations.

Table: Summary of Mental Health Loan Assumption Applications and Funding

Workload Measure	2008-09	2009-10	2010-11	2011-12	Total
Applications Received	1,065	1,269	1,011	1,659	5,004
Applications Awarded	283	309	474	550-600	1,666
Amount Requested	$58.3 million	$76.7 million	$66.4 million	$105.6 million	$307.1 million
Amount Awarded	$2.2 million	$2.3 million	$4.4 million	$5.0 million	$13.9 million

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. The demand for loans (as displayed in the table above) for mental health professionals willing to serve in the public mental health system is evident.

Questions. The Subcommittee has requested OSHPD to respond to the following question:

1. Please provide an overview of this proposal.

C. 2400 Department of Managed Health Care

1. Transfer Department of Managed Health Care and Office of Patient Advocate to the California Health and Human Services Agency

Budget Issue. Through a Spring Finance Letter and in compliance with AB 992 (Monning), Statutes of 2011, the Administration proposes to transfer DMHC to the California Health and Human Services Agency (CHHSA) and to separate the Office of Patient Advocate (OPA) from DMHC to become an office within CHHSA.

Although AB 922 specifies a January 1, 2012 transfer of DMHC from the Business and Transportation Agency to CHHSA, the Administration is proposing to make this transfer effective July 1, 2012, as it notes that from the state budgeting perspective it is more efficient to reflect the transfer of the budget appropriation at the beginning of a fiscal year.

Specifically, this proposal requests:

1. The transfer of DMHC's budget authority of $53.097 million and 366.0 authorized positions from the Business, Transportation and Housing Agency to CHHSA;

2. The separation of the Office of Patient Advocate (OPA) from the DMHC to become an independent entity within the CHHSA, transferring its budget authority of $2.184 million and 12.0 positions from the DMHC to the OPA;

3. The transfer of 1.0 DMHC position to the Department of Health Care Services (DHCS) and $242,000 to the OPA to reimburse DHCS for its IT services (and a corresponding increase in DHCS' reimbursement authority);

4. The transfer of 1.0 DMHC position to the Department of Social Services (DSS) and $80,000 to the OPA to reimburse DSS for its administrative services support.

Background. The OPA was created in AB 78 (Gallegos), Statutes of 1999, in order to help health plan enrollees secure the health care services to which they are entitled. The OPA develops and distributes educational materials describing enrollee rights and responsibilities, and compiles and publishes an annual public quality of care report card on health plans.

AB 922 establishes the Office of Patient Advocate Trust Fund to support OPA's current and expanding activities. Funding for OPATF will be provided by the transfer of monies from the Managed Care Fund and the California Department of Insurance's (CDI's) Insurance Fund such that funding contributions will be based on the number of covered lives enrolled in health plans regulated by the DMHC and enrolled in health insurance policies regulated by the CDI in proportion to the total number of covered lives in California. This applies to both full-service health plans and specialty health plans. It is anticipated that CDI will contribute about 10.5 percent of funding for OPA.

Additionally, AB 922 expands OPA's duties effective January 1, 2013. These expanded duties include:

- Providing outreach and education about health care coverage, including how to apply, costs, renewal processes, transitions between programs and information and assistance with different coverage programs;

- Coordinating with other state and federal agencies on implementation of the Affordable Care Act (ACA);

- Referring consumers to the appropriate regulatory agencies for filing complaints, grievances, claims, or payment problems; and,

- Tracking and analyzing data on consumer issues, including demographic data, source of coverage, regulator, complaint resolution, and timeliness of resolution; the OPA will provide this data to the federal government in accordance with the ACA.

The Administration is not seeking increased expenditure authority or positions for these expanded duties at this time and anticipates that starting in January 2013, OPA will work with CHHSA to develop a plan to coordinate its efforts with those of DHCS, the Health Benefit Exchange, the Managed Risk Insurance Boards, and local entities.

Subcommittee Staff Comment and Recommendation—Approve. This proposal implements AB 922 and helps prepare the state for federal health care reform. It is recommended for approval.

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

1. Please provide an overview of this proposal.

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, May 10 (Room 4203)

VOTE ONLY CALENDAR

A. 0530 California Health and Human Services Agency

1. Extend Sunset Date for Office of HIPPA Implementation

- Action – Approve Administration's proposal.
- Vote – 3-0

B. 2400 Department of Managed Care

1. Premium Rate Review Cycle II Federal Grant

- Action – Approve Administration's proposal.
- Vote – 2-1 (Senator Emmerson voting no)

C. 4140 Office of Statewide Health Planning and Development

1. Retention and Evaluation Activities (REA) Initiative

- Action – Approve Administration's proposal.
- Vote – 3-0

D. 4260 Department of Health Care Services

1. HIV Transition Incentive Program

- Action – Approve Subcommittee Staff recommendation.
- Vote – 3-0

E. 4265 Department of Public Health

1. Healthcare Acquired Infections Public Reporting

- Action – Approve Administration's proposal.
- Vote – 3-0

2. Reduction of Preventable Medical Errors and Medication Errors Contract

- Action – Approve Administration's proposal.
- Vote – 3-0

3. Close Southern California Laboratory

- Hold open.

4. Special Fund Efficiencies

- Action – Approve Administration's proposal for all funds except the Licensing and Certification Fund (this fund is a separate item in the Issues for Discussion section).
- Vote – 3-0

F. 4440 Department of Mental Health

1. Transition of Community Mental Health – Technical Adjustments

- Action – Approve Administration's proposal.
- Vote – 3-0

ISSUES FOR DISCUSSION

A. Department of Public Health

1. Licensing and Certification (L&C) Program

a. Special Fund Efficiencies – Eliminate State Mandates for Health Facilities (Licensing and Certification Fund)

- Action – Reject Administration's proposal.
- Vote – 2-1 (Senator Emmerson voting no.)

b. L&C's Role in the Money Follows the Person Program

- Informational item.

2. Transfer of Direct Service Programs to Department of Health Care Services

- Action – Approve Administration's proposal.
- Vote – 3-0

3. Kids' Plate – Childhood Injury Prevention

- Action – Approve Subcommittee Staff recommendation.
- Vote – 3-0

B. 4140 Office of Statewide Health Planning and Development

1. Mental Health Loan Assumption Program (MHLAP) Increase Awards

- Action – Approve Administration's proposal.
- Vote – 3-0

C. 2400 Department of Managed Health Care

1. Transfer Department of Managed Health Care and Office of Patient Advocate to the California Health and Human Services Agency

- Action – Approve Administration's proposal.
- Vote – 2-1 (Senator Emmerson voting no.)

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 10, 2012

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

Room 4203
(John L. Burton Hearing Room)

Staff: Jennifer Troia &
Brady Van Engelen

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 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 *)

VOTE-ONLY AGENDA

5160 Department of Rehabilitation (DOR)

1. Rehabilitation Appeals Board

Budget Issue: The Governor proposes to achieve savings and efficiencies from eliminating the Rehabilitation Appeals Board (RAB), which currently reviews appeals filed by applicants for, or consumers of, DOR services. The associated responsibilities would be transferred to impartial hearing officers (IHOs) through an interagency contract with the Office of State Hearings or another state entity. The Administration estimates that contracting with IHOs will save around $30,000 ($6,000 GF). Additional background is available in the Subcommittee's agenda from March 15th (online at http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/SUB3/31512AgendaforCDA_DOR_DSS.pdf).

Staff Comment & Recommendation: Staff recommends approving the Administration's proposal to change the appeals process so that impartial hearing officers review appeals, rather than the Rehabilitation Appeals Board. Correspondingly, staff also recommends approving modifications to the proposed trailer bill language intended to safeguard the due process rights and needs of appellants (including unrepresented parties). The language, which would be refined as part of the trailer bill process and would rely in large part on examples from statutes that apply to developmental services and special education appeals processes, would:

- Provide for appeals to be heard by impartial hearing officers who have no conflict of interest and who are knowledgeable about federal and state laws and regulations applicable to DOR services and the Vocational Rehabilitation program.
- Require DOR to contract with another department, office, or entity for the provision of independent hearing officers.
- Provide that the time and place of the hearing be agreed upon by the appellant and the hearing officer and be reasonably convenient to the appellant and their designated representative, if applicable. This may include conducting all or part of the fair hearing by alternatives other than in person, if agreed upon by the appellant and if the alternative means allows for full participation.
- Provide, among other procedural allowances and requirements, that the hearings will not be conducted according to the technical rules of evidence and those related to witnesses and that all testimony shall be under oath.
- Outline basic procedural and adjudication expectations for hearing officers, including the consideration of presentation of viewpoints about the issues of disagreement, examination of the evidence presented during the hearing, and issuance of a decision including findings and grounds to the parties within 30 days of the completion of the hearing.

- Provide for training of hearing officers to include, but not be limited to, information on protecting the rights of consumers at administrative hearings, emphasizing how to fully develop the appeal record with consumers who are representing themselves or who are represented by another who may also require additional support.
- Permit implementation by emergency regulations until January 1, 2014, after which time implementation should be completed using the regular rule-making process and review by the Office of Administrative Law.

5180 Department of Social Services (DSS)

1. Child Health & Safety Fund

Budget Issue: The budget proposes savings of $501,000 GF from trailer bill language to redirect a portion of revenues collected through a specialized license plate program to fund additional DSS licensing activities related to children's day care programs. These resources would otherwise be used to prevent unintentional injuries to children, such as drowning or poisoning.

AB 3087 (Chapter 1316, Statutes of 1992) established the *Have a Heart, Be a Star, Help Our Kids* specialized license plate program. Revenues from these license plate fees, totaling $4.1 million in 2009-10 and $4.0 million in 2010-11, are deposited into the Child Health & Safety Fund. State law (Welfare & Institutions Code Sections 18285 and 18285.5) specifies how those revenues are distributed. Currently, the first 50 percent supports specific DSS responsibilities for child day care licensing. Of the remaining 50 percent, up to 25 percent supports child abuse prevention and the rest supports programs that address injury prevention. Under the Governor's proposal, those remaining funds would be used for additional day care licensing activities in addition to injury prevention efforts.

Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the Governor's proposal to redirect $501,000 in Child Health & Safety Fund resources as additional support for day care licensing activities. Correspondingly, staff recommends making technical changes to the proposed trailer bill language to specify this dollar amount and to embed the change into the section of the statute that currently addresses other licensing activities. As a result, specified licensing activities would receive 50 percent plus $501,000 in funding before the remaining funds would be distributed to the other specified programs.

2. Moratorium on Group Home Rate-Setting

Budget Issue: Beginning in 2010-11, the budget has included $195.8 million ($51.7 million GF) to fund a court-ordered increase of 32 percent in the monthly payment rates

for group homes. The court order also requires the state to annually adjust these rates based on the California Necessities Index. In 2012-13, group home rates are proposed to range from $2,158 to $9,146 per child, per month. In response to this increased cost and other concerns about the use of group home placements in California, as well as the need for DSS to redirect staff toward developing alternative placement options, the 2010-11 budget included a moratorium, with some allowable exceptions, on the licensing of new group homes or approvals of rate or capacity increases for existing providers, as well as additional statutory changes detailed in the Subcommittee's agenda from March 19, 2012. The moratorium was subsequently extended in trailer bill language through the end of 2012. The Governor's budget proposes to make it permanent and to limit future exceptions to higher-level group homes [licensed at a Rate Classification Level (RCL) of 10 or over on a scale of one to 14].

Staff Comment & Recommendation: Staff recommends approving the Administration's proposal to make the moratorium and exceptions framework permanent. Staff also recommends approving the Administration's proposal to narrow the allowable exceptions with respect to RCLs one through nine. However, staff recommends refining this second part of the action to apply the new restrictions temporarily (for the 2012-13 fiscal year) and in a more limited way. Specifically, no exceptions would be allowable with respect to the establishment of new RCL one through nine group homes or approval of capacity increases for existing providers of homes at those levels. As a result, the existing exceptions process would continue to be available to group homes with an RCL of one to nine during 2012-13 for the purposes of seeking a change in rate classification only. The intent is to gain experience with these new restrictions before making a decision about whether to extend or make them permanent. This action would conform to action recently taken by the Assembly on this issue.

8885 Commission on State Mandates

1. Proposed Repeal of Mandate Related to Counsel in Conservatorship Proceedings

Budget Issue: Under existing law, courts are required to appoint the public defender or private counsel to represent the interests of conservatees, proposed conservatees, or individuals alleged to lack legal capacity in specified legal proceedings if: a) they are unable to retain legal counsel and request appointment of counsel, b) the court determines that the appointment of counsel would be helpful or is necessary to protect the individual's interests, or c) the proceeding is about the establishment of a limited conservatorship. The court is then required to set a reasonable sum for compensating counsel and to determine whether the person can pay some or all of that amount (including payment out of the proceeds of community property at issue in the proceeding, if applicable). When the person lacks the ability to pay counsel, the county is required to do so.

The Administration proposes trailer bill language to repeal the statutes that create these requirements, which it indicates include mandates that have been suspended since 2009. According to the Administration, these requirements are now standard operating procedures, and the mandate for local jurisdictions to meet them is no longer necessary. If the mandate is not suspended or repealed, the Department of Finance indicates that the state would need to pay $349,000 GF in prior year claims costs. Advocates and representatives of the courts have raised concerns about the proposal to repeal these laws because they indicate that courts have long been (and are still) guided by the statutory framework that establishes the grounds and procedures for appointing counsel. This issue was discussed during the Subcommittee's March 19th hearing.

Background on Conservatorships and Limited Conservatorships: A conservatorship can be established by California courts when a judge appoints a responsible person or organization (called the "conservator") to make decisions for another adult (called the "conservatee") who is not able to care for him or herself and/or to manage his or her own finances. Conservatorships are most commonly established based on the laws of the California Probate Code, including those that are the subject of this proposal. General conservatorships are frequently established for elderly individuals, but can also be established for younger adults who have serious impairments. Limited conservatorships can be utilized when adults with developmental disabilities do not need the comprehensive assistance that is offered by a general conservatorship, but do need assistance in some decision-making. [Another kind of conservatorship, commonly known as a Lanterman-Petris-Short (LPS) conservatorship can be used for adults with serious mental disorders who are "gravely disabled" and unable to provide for their food, clothing, or shelter.]

Conservators of a person are required to arrange for the conservatee's care and protection, including making decisions about where the conservatee will live and receive meals, health care, etc. Conservators of an estate are required to manage the conservatee's finances, including controlling their assets, collecting income, paying bills, and investing money.

Staff Comment & Recommendation: Given the concerns raised by stakeholders regarding the reliance of courts and advocates on this statutory framework and the significance of the individual rights at issue, staff recommends rejecting the proposed trailer bill language to repeal these sections of statute.

DISCUSSION AGENDA

5180 Department of Social Services (DSS)

1. Los Angeles Eligibility Automated Determination, Evaluation & Reporting (LEADER) Replacement System (LRS)

Budget Issue: LEADER is one of three existing consortia systems that comprise the Statewide Automated Welfare System (SAWS). 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. The LEADER system serves Los Angeles (LA) County, while a consortium called C-IV serves 39 additional counties and another called Cal-WIN serves the remaining 18 (though each system houses information for roughly one-third of the statewide caseload). The total 2011-12 maintenance & operations (M&O) budget for SAWS is $178 million ($91 million GF/TANF). The 2011-12 M&O costs for LEADER include $31 million ($15 million GF/TANF).

In 2011, OSI estimated a total cost of $370.2 million over four years ($196.1 million GF/TANF, $147.3 million federal funds and $26.8 million county funds) for development and implementation of a new system to replace LEADER (LRS). Prior to that time, around $6 million ($2 million GF) in planning funds had been spent on the project. As a part of its May Revision in 2011-12, the Administration proposed suspending LRS development. At the time, the Administration also reported that the federal government had indicated it would not approve funding for the project until it received, reviewed, and approved of the state's long-term plan for its overall eligibility system. The final budget, however, continued $31.7 ($12 million GF) for LRS planning and development work in 2011-12. Trailer bill language (Chapter 13, Statutes of 2011) also directed OSI to migrate the 39 counties currently in the C-IV consortium to the new LRS. As a result, LRS would replace both LEADER and C-IV, and the state would have a two-consortia SAWS system.

The Governor's January budget for 2012-13 includes $35.3 million for LRS, but the Department notes that final funding will be subject to federal approval of the project and applicable federal financial participation rates and cost allocation formulas.

The Need to Replace LEADER: 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 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 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 indicates that LRS would streamline LA's business practices, eliminate duplicative data entry, and minimize errors. The Legislature first appropriated funding to support the planning process for a new system to replace LEADER in 2005-06. The project has since been delayed several times.

2009 Trailer Bill Language: The 2009 budget included trailer bill language (in Chapter 7, Statutes of 2009) that directed the Departments of Health Care Services and Social Services to develop a plan to streamline the eligibility determination process for health and human services programs. The trailer bill also established a goal of minimizing the number of information systems performing eligibility functions, including a required analysis of the costs, benefits, and risks of moving to a single statewide system. After initial efforts to implement this language, the Schwarzenegger Administration suspended its work to create the required plan. And as indicated above, the direction to consolidate to a two-consortia system was enacted later (following upon the completion of a consolidation from four to three systems in 2010). When the planned migration of C-IV was enacted, however, these older statutes regarding the need for a plan to streamline eligibility processes were not amended or repealed.

LAO Report: In a February report entitled "Consolidating California's Statewide Automated Welfare Systems," the LAO notes that the 2012 trailer bill language establishing the requirement to migrate C-IV into the new LRS system does not require the Administration to develop a feasibility study report (FSR), cost-benefit analysis, or other plan, but rather directs the Administration to oversee the migration "under the LRS contract." As a result, the Administration has indicated its intent to include the migration work as a part of its contract with the chosen LRS vendor (Accenture LLP). The LAO recommends that the Legislature instead reconsider alternative procurement processes for the C-IV migration, including reopening the LRS procurement, planning the migration as a separate project, or breaking the migration into multiple contracts.

The LAO also recommends consideration of a "cost reasonableness assessment" or study conducted by contracted experts who collect data on the costs of other public and private sector efforts and extrapolate to determine whether the proposed costs for a project are within the realm of reasonableness. The Franchise Tax Board recently used a cost-reasonableness assessment to validate the costs of its Enterprise Data to Revenue project. That project has an estimated total cost of $520 million. A six-week cost reasonableness assessment (at a cost of $75,000) indicated that the vendor's proposed costs were within the range of reasonableness.

Finally, the LAO recommends that the Legislature improve its oversight of LRS development and the new migration project by requiring more frequent reporting from the Administration on the project's progress (in addition to the existing requirement for an annual report on the implementation of SAWS more generally).

Staff Comment & Recommendation: Staff recommends that the Subcommittee hold open the overall budget for LRS and the C-IV migration, and:

1) Adopt the requirement for a cost-reasonableness assessment to be conducted with respect to whether the costs proposed by the vendor for migrating C-IV into the new LRS system are within range of reasonableness based on the proposed project requirements and risks, among other factors.

2) Adopt supplemental reporting language directing the Administration to conduct regularly scheduled briefings with legislative staff, and to offer updates during budget Subcommittee hearings, as efforts to develop LRS and migrate C-IV continue.

3) Repeal outdated trailer bill language regarding eligibility system streamlining from 2009 (in Chapter 7 of that year's statutes, as described above).

Questions for DSS & OSI:

1) What is the latest anticipated timeline for developing and implementing LRS?

2) What has been done to date with respect to planning for the migration of C-IV into LRS? What can you say about the anticipated timeline and costs for that migration?

3) What has the state heard from the federal government regarding its approval of funding for LRS and for the migration of C-IV?

Questions for LAO:

1) Please summarize your recommendations, including the recommendation to conduct a cost reasonableness assessment.

5175 Department of Child Support Services (DCSS)

Department Overview

The mission of the California Child Support Program is to enhance the well-being of children and the self-sufficiency of families by providing professional services to locate parents, establish paternity, and establish and enforce orders for financial and medical support. The Child Support Program is committed to ensuring that California's children are given every opportunity to obtain financial and medical support from their parents in a fair and consistent manner throughout the state. The Child Support Program is committed to providing the highest quality services and collection activities in the most efficient and effective manner.

The Department of Child Support Services is the single state agency designated to administer the federal Title IV-D state plan. The Department is responsible for providing statewide leadership to ensure that all functions necessary to establish, collect, and distribute child support in California, including securing child and spousal support, medical support and determining paternity, are effectively and efficiently implemented. Eligibility for California's funding under the Temporary Assistance to Needy Families (TANF) Block Grant is contingent upon continuously providing these federally required child support services. Furthermore, the Child Support Program operates using clearly delineated federal performance measures, with minimum standards prescribing acceptable performance levels necessary for receipt of federal incentive funding. The objective of the Child Support Program is to provide an effective system for encouraging and, when necessary, enforcing parental responsibilities by establishing paternity for children, establishing court orders for financial and medical support, and enforcing those orders.

Child Support Administration: The Child Support Administration program is funded from federal and state funds. The Child Support Administration expenditures are comprised of local staff salaries, local staff benefits, and operating expenses and equipment. The federal government funds 66 percent and the state funds 34 percent of the Child Support Program costs. In addition, the Child Support Program earns federal incentive funds based on the state's performance in five federal performance measures.

Child Support Automation: Federal law mandates that each state create a single statewide child support automation system that meets federal certification. There are two components of the statewide system. The first is the Child Support Enforcement (CSE) system and the second is the State Disbursement Unit (SDU). The CSE component 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. In addition, it funds the local electronic data processing maintenance and operation costs. The SDU provides

services to collect child support payments from non-custodial parents and to disburse these payments to custodial parties.

Department of Child Support Services 2012-13 Budget Overview

Fund Source	**2010-11**	**2011-12**	**2012-13**
General Fund	$308.34	$320.41	$313.23
Federal Trust Fund	$498.10	492.96	$459.83
Child Support Collections Recovery Fund	$206.96	$217.12	$225.62
Reimbursements	$0.12	$0.17	$0.12
Total Expenditures	**$1,013.53**	**$1,030.67**	**$998.79**
Positions	525.6	573.5	573.5

1. Revenue Stabilization

Background: In the 2009-10 Governor's Budget, the administration proposed an augmentation of $18.7 million ($6.4 million GF) for Local Child Support Agencies (LCSAs) to maintain revenue generating caseworker staffing levels in order to stabilize child support collections. The Legislature approved the request for this funding in the 2009 Budget Act and directed that 100 percent of the new funds be used to maintain revenue generating caseworker-staffing levels. For Fiscal Year 2009-10, the initial augmentation year, the General Fund share of the allocation was $6.4 million dollars; the return to the General Fund was $8.9 million dollars, a return on investment of $2.5 million dollars.

Collection data for Fiscal Year 2010-11 indicates the revenue stabilization funds continue to have a positive effect of maintaining statewide child support collections levels. In Fiscal Year 2010-11, LCSAs were able to retain 239 of the originally retained 245 revenue generating caseworker staff with the revenue stabilization funding. This number was calculated based on a 2.4 percent reduction to actual total caseworker staffing in 2010-11. Child support collections would have declined by this amount had staff not been retained. This would have been 4.1 percent less than the 2009-10 collections for this same time period. For the $6.4 million General Fund investment, the Department states that $9 million in General Fund assistance collections were retained in 2010-11, yielding a net return of $2.6 million General Fund to the state.

According to the DCSS, the LCSAs continue to routinely incorporate these early intervention activities in their work on cases. The Department believes the early intervention activities contribute to the stabilization of the collection levels given the economy. LCSAs will continue to use early intervention activities in their casework as well as other individual efforts to improve collections.

Questions for the Administration:

1) Please describe the Revenue Stabilization Funding and the impact that the General Fund contribution has had on collections to date.

2) Please describe what, if any, impact utilizing early intervention strategies which were a condition of receiving this funding, have had on the child support collection process.

Staff Recommendation: Item included for informational purposes.

2. Child Support Automation

Background: Beginning in 2008, the California Child Support Automation System was fully implemented. Total cost of the application was approximately $1.5 billion dollars and took nearly eight years to implement. Shortly thereafter, the application received its federal certification as the statewide automation system. The Department of Child Support Services is responsible for maintaining the functionality of the automation system and also responsible of ensuring the LCSAs have access to the system.

The 2012-13 Budget includes a request for $99.34 million to support the Department's Child Support Automation System. Of that, $14.97 million will be directed towards the State Disbursement Unit, the remaining $84.37 million will be directed towards the other component of the Automation System, the Child Support Enforcement System. This request reflects a reduction of $4.5 million dollars ($1.5 million in General Fund) in the 2012-13 Budget when compared to the 2011-12 Budget. The Department has completed the procurement of a new Service Provider contract for the State Disbursement Unit (SDU), which has lowered contract rates below the existing rate.

The Department, in conjunction with the California Technology Agency, is required to annually submit a report that highlights the following components:

- Breakdown of funding elements for past, current, and future years.
- Description of active functionalities and how they support efforts in child support collections.
- Review of current considerations and their relationship to federal law and policy.
- Description on future, planned changes to the Automation System and how they support greater collections for the state, receipt of payment for the family, and enhance work activities.

Questions for the Administration:

1) Please provide us with a brief update on the Automation System project to date.

Staff Recommendation: Item included for informational purposes.

3. Suspension of County Share

Governor's Budget Request: The Governor's 2012-13 Budget includes a suspension of Child Support collections in 2012-13. The suspension is accompanied by trailer bill language. The county share of collections is estimated to be $34.5 million in 2012-13. Under this proposal, the entire non-federal portion of child support collections will benefit the General Fund on a one-time basis, much like the proposal adopted in 2011-12.

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.

The 2011–12 budget package suspended the county share of collections for one year, which results in an increase in General Fund revenue of about $24 million in the budget year. Typically, when Local Child Support Agencies collect child support on behalf of families receiving CalWORKs, the county retains a portion (2.5 percent) of the collections. Based on the most recent DCSS survey of counties, 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.

Questions for the Administration:

1) Please explain the impact that this proposal will have on counties and the various county-based programs.

Staff Recommendation: Hold Open.

4. Health Insurance Incentives

Governor's Budget Request: The Administration, through trailer bill language, proposes to eliminate the requirement to provide an incentive to LCSAs of $50 per case

for obtaining third-party health coverage/insurance for cases that have never had - and/or have lapsed - coverage/insurance rather than pursuing an additional time-limited extension.

Background: Pursuant to Welfare and Institutions Code Section 14124.93, DCSS is to provide an incentive to LCSAs for obtaining third-party health coverage/insurance for cases that have never had - and/or have lapsed - coverage/insurance. These incentives have been suspended since fiscal year 2002-03; the suspension ends after 2011-12. This Section has been amended three times over the past ten years to suspend the health insurance incentive payments to the LCSAs due to budget constraints.

Staff Comment: These incentives, when not suspended, are paid for with 100 percent General Fund (GF). There are no federal matching funds available. The budgeted amount for 2001-02 for these incentives was $3.0 million GF. Current data is not readily available on the costs as the form that LCSAs submitted the data on was discontinued in 2002-03.

Staff Recommendation: Reject proposed trailer bill language and suspend health insurance incentives for three more years.

5. Performance Incentives

Governor's Budget Request: The Administration proposes, through trailer bill language, to eliminate statute which states that the top ten performing LCSAs, as defined per Family Code Section 17704, are to receive an incentive equal to five percent of the state's share of their LCSA's assistance recoupment. Additionally, the request, through trailer bill language, asks that the department provide no further incentive funds to be transferred to the LCSAs.

Background: As noted above, pursuant to Family Code Section 17706, effective with fiscal year 2000-01, the top ten performing LCSAs, as defined per Family Code Section 17704, are to receive an incentive equal to five percent of the state's share of their LCSA's assistance recoupment. These incentives have been suspended since 2002-03; the suspension ends after 2011-12.

Staff Comment: Family Code Section 17706 has been amended three times over the past ten years to suspend the top ten performance incentive payments to the LCSAs due to budget constraints.

Staff Recommendation: Reject trailer bill language and suspend performance incentives for three more years.

6. Investment Authority

Governor's Budget Request: The administration has requested an amendment to Family Code (FC) section 17311.5 in order to provide specific investment authority to DCSS. The trailer bill language accompanying this request provides investment authority to the department. DCSS holds funds for the child support payments it has disbursed to the participants of the child support program until such time as they are negotiated. The non-negotiated child support payments are held in an Investment Sweep Account (ISA) outside the state treasury.

Background: Funds in the ISA are invested each night in funds that comply with Section 16430 of the Government Code. Undisbursed child support funds are held in the Child Support Payment Trust Fund and are invested by the state treasury in the Surplus Money Investment Fund. The administration also states that statutory change will also resolve a contract issue with the vendor responsible for collecting and disbursing child support collections. Additionally, investing collections funds would maximize the utilization of these funds. In an effort to provide more clarification regarding this issue, DCSS is seeking explicit legislative authority. The ISA account average daily balance is over $30 million. Absent investment, the account will require collateralization, which the administration asserts will create a budget pressure on the state.

According to the Department of Finance, absent investment authority, the account would require collateralization. Utilizing collateralization creates additional budget pressure by increasing future contracting costs. Increased contracting costs would result given that a vendor would need to provide collateral to the over $30 million (average daily balance) residing in the account—which could lead to the need for increased budgeted resources by DCSS.

Staff Recommendation: Adopt proposed trailer bill language for 2012-13 only, with review after the one year regarding its extension or permanent nature. In addition, staff recommends that the Subcommittee direct the administration to begin a discussion with Banking and Finance policy staff regarding this issue to obtain counsel and advice on the propriety of the proposal in the budget and whether such a change should be sought permanently as part of a policy bill.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 10, 2012
Agenda II - Outcomes

5160 Department of Rehabilitation (DOR)

1. Rehabilitation Appeals Board

Approved (3-0) the Administration's proposal to change the appeals process so that impartial hearing officers review appeals, rather than the Rehabilitation Appeals Board. **Correspondingly**, approved modifications to the proposed trailer bill language intended to safeguard the due process rights and needs of appellants (including unrepresented parties). The language, which will be refined as part of the trailer bill process and will rely in large part on examples from statutes that apply to developmental services and special education appeals processes, will:

- Provide for appeals to be heard by impartial hearing officers who have no conflict of interest and who are knowledgeable about federal and state laws and regulations applicable to DOR services and the Vocational Rehabilitation program.
- Require DOR to contract with another department, office, or entity for the provision of independent hearing officers.
- Provide that the time and place of the hearing be agreed upon by the appellant and the hearing officer and be reasonably convenient to the appellant and their designated representative, if applicable. This may include conducting all or part of the fair hearing by alternatives other than in person, if agreed upon by the appellant and if the alternative means allows for full participation.
- Provide, among other procedural allowances and requirements, that the hearings will not be conducted according to the technical rules of evidence and those related to witnesses and that all testimony shall be under oath.
- Outline basic procedural and adjudication expectations for hearing officers, including the consideration of presentation of viewpoints about the issues of disagreement, examination of the evidence presented during the hearing, and issuance of a decision including findings and grounds to the parties within 30 days of the completion of the hearing.
- Provide for training of hearing officers to include, but not be limited to, information on protecting the rights of consumers at administrative hearings, emphasizing how to fully develop the appeal record with consumers who are representing themselves or who are represented by another who may also require additional support.
- Permit implementation by emergency regulations until January 1, 2014, after which time implementation should be completed using the regular rule-making process and review by the Office of Administrative Law.

5180 Department of Social Services (DSS)

1. Child Health & Safety Fund

Approved (3-0) the Governor's proposal to redirect $501,000 in Child Health & Safety Fund resources as additional support for day care licensing activities. **Correspondingly**, approved technical changes to the proposed trailer bill language to specify this dollar amount and to embed the change into the section of the statute that currently addresses other licensing activities. As a result, specified licensing activities would receive 50 percent plus $501,000 in funding before the remaining funds would be distributed to the other specified programs.

2. Moratorium on Group Home Rate-Setting

Approved (3-0) the Administration's proposal to make the moratorium and exceptions framework permanent. Also approved the Administration's proposal to narrow the allowable exceptions with respect to RCLs one through nine. However, refined this second part of the action to apply the new restrictions temporarily (for the 2012-13 fiscal year) and in a more limited way. Specifically, no exceptions will be allowable with respect to the establishment of new RCL one through nine group homes or approval of capacity increases for existing providers of homes at those levels. As a result, the existing exceptions process would continue to be available to group homes with an RCL of one to nine during 2012-13 for the purposes of seeking a change in rate classification only. The intent is to gain experience with these new restrictions before making a decision about whether to extend or make them permanent. This action would conform to action recently taken by the Assembly on this issue.

1. Los Angeles Eligibility Automated Determination, Evaluation & Reporting (LEADER) Replacement System (LRS)

Held open the overall budget for LRS and the C-IV migration, and took the following actions:

1) Adopted (3-0) the requirement for a cost-reasonableness assessment to be conducted with respect to whether the costs proposed by the vendor for migrating C-IV into the new LRS system are within range of reasonableness based on the proposed project requirements and risks, among other factors.

2) Adopted (3-0) supplemental reporting language directing the Administration to conduct regularly scheduled briefings with legislative staff, and to offer updates during budget Subcommittee hearings, as efforts to develop LRS and migrate C-IV continue.

3) Repealed (2-1, Emmerson no) outdated trailer bill language regarding eligibility system streamlining from 2009 (in Chapter 7 of that year's statutes, as described in the agenda).

8885 Commission on State Mandates

1. Proposed Repeal of Mandate Related to Counsel in Conservatorship Proceedings

Rejected (2-1, Emmerson no) the proposed trailer bill language to repeal these sections of statute.

5175 Department of Child Support Services (DCSS)

1. Revenue Stabilization

Item included for informational purposes

2. Child Support Automation

Item included for informational purposes

3. Suspension of County Share

Governor's Budget Request: The Governor's 2012-13 Budget includes a suspension of Child Support collections in 2012-13. The suspension is accompanied by trailer bill language. The county share of collections is estimated to be $34.5 million in 2012-13. Under this proposal, the entire non-federal portion of child support collections will benefit the General Fund on a one-time basis, much like the proposal adopted in 2011-12.

Item Held Open

4. Health Insurance Incentives

Governor's Budget Request: The Administration, through trailer bill language, proposes to eliminate the requirement to provide an incentive to LCSAs of $50 per case for obtaining third-party health coverage/insurance for cases that have never had - and/or have lapsed - coverage/insurance rather than pursuing an additional time-limited extension.

Staff Recommendation: Reject proposed trailer bill language and suspend health insurance incentives for three more years.

Staff Recommendation Approved 3-0

5. Performance Incentives

Governor's Budget Request: The Administration proposes, through trailer bill language, to eliminate statute which states that the top ten performing LCSAs, as defined per Family Code Section 17704, are to receive an incentive equal to five percent of the state's share of their LCSA's assistance recoupment. Additionally, the request, through trailer bill language, asks that the department provide no further incentive funds to be transferred to the LCSAs.

Staff Recommendation: Reject trailer bill language and suspend performance incentives for three more years.

Staff Recommendation Approved 3-0

6. Investment Authority

Governor's Budget Request: The administration has requested an amendment to Family Code (FC) section 17311.5 in order to provide specific investment authority to DCSS. The trailer bill language accompanying this request provides investment authority to the department. DCSS holds funds for the child support payments it has disbursed to the participants of the child support program until such time as

they are negotiated. The non-negotiated child support payments are held in an Investment Sweep Account (ISA) outside the state treasury.

Staff Recommendation: Adopt proposed trailer bill language for 2012-13 only, with review after the one year regarding its extension or permanent nature. In addition, staff recommends that the Subcommittee direct the administration to begin a discussion with Banking and Finance policy staff regarding this issue to obtain counsel and advice on the propriety of the proposal in the budget and whether such a change should be sought permanently as part of a policy bill.

Staff Recommendation Approved 3-0

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 21, 2012

10:00 AM
Room 3191

(Michelle Baass)

PLEASE NOTE:

Only those 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 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

A. 4260 Department of Health Care Services

1. Medi-Cal Estimate Update—Technical Adjustments (DOF Issue 120)

May 2012 Medi-Cal Estimate. It is requested that the adjustments noted below be made to the following budget bill items to reflect a variety of caseload and cost changes not highlighted in the other Medi-Cal proposals:

1. Item 4260-101-0001 be decreased by $707,126,000 and reimbursements be decreased by $475,205,000
2. Item 4260-101-0080 be decreased by $57,000
3. Item 4260-101-0890 be increased by $1,229,902,000
4. Item 4260-101-3168 be increased by $8,009,000
5. Item 4260-105-0001 be increased by $3,216,000
6. Item 4260-106-0890 be decreased by $13,798,000
7. Item 4260-111-0001 be decreased by $302,000 (Every Woman Counts)
8. Item 4260-113-0001 be decreased by $2,778,000
9. Item 4260-117-0001 be increased by $3,315,000
10. Item 4260-107-0890 be decreased by $61,000
11. Item 4260-113-0890 be decreased by $10,105,000
12. Item 4260-117-0890 be increased by $22,334,000

Subcommittee Staff Comment & Recommendation—Approve. It is recommended to approve the above adjustments, with any changes to conform as appropriate to other actions that have been or will be taken. This is a technical adjustment.

2. Medi-Cal Provider Payment Reductions (DOF Issue 126)

Budget Issue. The May Revision proposes to increase General Fund expenditures by $174 million to reflect a change in the implementation date from March 1, 2012 to October 1, 2012, due to current court injunctions barring implementation of rate reductions.

Background. AB 97 (Statutes of 2011) requires the Department to implement a 10% provider payment reduction, which will affect all services except hospital inpatient and outpatient services, critical access hospitals, federal rural referral centers and FQHCs/RHCs, services provided through the Breast and Cervical Cancer Treatment and Family Planning, Access, Care and Treatment (Family PACT) programs, and hospice services. Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services and payments funded by certified public expenditure and intergovernmental transfer are exempt.

On December 28, 2011, the U.S. District Court, Central District of California, issued preliminary injunctions in the cases of *California Hospital Association, et al. v. Douglas et al.* and *Managed Pharmacy Care, et al. v. Sebelius, et al.* against the implementation of AB 97 payment reductions for distinct part nursing facilities and pharmacy services. In compliance with these injunctions, the Department is prohibited from implementing these reductions.

On January 10, 2012, the same court issued a preliminary injunction in the case of *California Medical Transportation Association v. Douglas, et al.* prohibiting the Department from implementing AB 97 payment reductions for nonemergency medical transportation providers.

On January 31, 2012, a preliminary injunction was issued in the case of *California Medical Association, et al. v. Douglas, et al.* against the implementation of AB 97 payment reductions for physicians, clinics, dentists, pharmacists, ambulance providers, and providers of medical supplies and durable medical equipment. In compliance with this injunction, the Department is prohibited from implementing these reductions.

Appeals in all four cases have been filed.

On February 22, 2012, the United States Supreme Court issued its decision in the *Douglas v. Independent Living Center* Medi-Cal payment reductions cases. The 5/4 majority opinion vacated all of the Ninth Circuit decisions that were before it and remanded the cases to the Ninth Circuit Court of Appeals to reassess the plaintiffs' preemption/Supremacy Clause claims in light of the Centers for Medicare & Medicaid Services (CMS) approval of the State Plan Amendments (SPA) at issue in a number of those cases. The Supreme Court also strongly indicated that, on remand, the Ninth Circuit should show deference to CMS decisions to approve the SPAs, noting that CMS approval "carries weight".

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this item to reflect DHCS's estimate on the implementation date of these reductions.

3. Family Health Estimate – CHDP, CCS, GHPP (DOF Issue 199)

Budget Issue. The May Revision proposes an overall net increase of $5.8 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 May Revision 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 $99.7 million ($68.2 million General Fund, $23.1 million federal Safety Net Care Pool, $8 million Rebate Fund, and $452,000 Enrollment Fees) are proposed for 2012-13. This includes a $2.4 million General Fund increase from the January budget due to the costs of Kalydeco for the treatment of patients, six years of age and older, with cystic fibrosis and a reduction of $2.5 million in Safety Net Care Pool funds. Total caseload is 858 people.
- *California Children's Services Program (CCS).* Total expenditures of $230.4 million ($68.9 million General Fund and $161.5 million federal funds) are proposed for 2012-13. Total caseload is estimated to be 29,624 children.
- *Child Health & Disability Prevention (CHDP) Program.* Total expenditures of $2.76 million ($2.7 million General Fund, and $22,000 Children's Lead Poisoning Prevention Funds) are proposed for 2012-13. Total caseload is estimated to be 42,228 children.

In addition, the May Revision proposes a reduction of $41.1 million ($10.2 million General Fund) by shifting children in the Healthy Families Program 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 October 1, 2012. *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.*

Subcommittee Staff Comment and Recommendation—Adopt May Revision. No issues have been raised regarding this estimate package for these three programs. *This action will be adjusted to conform where necessary to any action taken with regards to the transition of Healthy Families Program enrollees into the Medi-Cal Program.*

Please note that the Administration's proposal to add a financial eligibility test for the CCS Medical Therapy Program will be discussed at the May 24, 2012 Subcommittee #3 hearing.

4. CMAC Staff Transition

Budget Issue. The budget proposes trailer bill language to create a transition plan for the staff of the California Medical Assistance Commission (CMAC) and redirects the twelve non-commissioner positions, in their exempt status, to DHCS on July 1, 2012. These positions would be funded with $658,000 General Fund and $657,000 federal funds.

The CMAC staff will continue to operate the Selective Provider Contracting Program (SPCP) until the new inpatient hospital payment system based on diagnosis-related groups (DRG) is implemented. Upon implementation of the DRG payment system, the twelve exempt positions will be abolished, at which point the CMAC staff shall be transferred into civil service classifications, for which they are eligible, within DHCS.

Background. CMAC is responsible for negotiating contracts under the SPCP for Medi-Cal fee-for-service (FFS) hospital inpatient services statewide. AB 102 (Statutes of 2011) dissolved CMAC and transferred its resources and functions to DHCS effective July 1, 2012. Additionally, DHCS was required to develop and implement a new payment system based on diagnosis-related groups and submit a CMAC resource transition plan to be included in the 2012-13 Budget.

Subcommittee Comment and Recommendation—Approve. This proposal is consistent with state law. No issues have been raised regarding this proposal. It is recommended for approval.

5. Privacy and Security of Medi-Cal Information

Budget Issue. The DHCS requests the extension of ten limited-term positions that are scheduled to expire on June 30, 2012. These staff would continue to perform the ongoing workload of managing, protecting, and securing confidential Medi-Cal eligibility information, ensuring compliance with the requirements of the federal Social Security Administration (SSA), and monitoring access to the Medi-Cal Eligibility Data System (MEDS). The total cost of these resources is $1.4 million ($585,000 General Fund).

These positions would perform the following workload (beyond June 30, 2012):

- Maintenance of Data Sharing Agreements with SSA. DHCS entered into an ongoing agreement with SSA on July 1, 2010. New security requirements are added annually as part of this contract and DHCS staff needs to ensure continued compliance. DHCS must continually assess data sharing requirements to analyze reports containing SSA data as well as MEDS access to ensure compliance with SSA requirements.

- Contract with County Welfare Departments. DHCS has entered into agreements with each of the 58 county welfare departments regarding the confidentiality of MEDS data. DHCS requires continued staff resources to monitor and ensure compliance.

- Assess and Monitor County Security Compliance. DHCS must perform onsite security reviews of all 58 counties and their County Welfare Department offices, approve corrective action plans, and advise and work with counties on remediation efforts.

- Facilitate Access for Other State Agencies and Business Partners. DHCS serves as the lead California agency to transmit federal SSA data and other public assistance program eligibility data contained in MEDS to other state agencies. DHCS needs continued staff resources to provide system access and negotiate and monitor access levels.

Background. DHCS is the single state agency responsible for the administration of the Medi-Cal program, and as such, must monitor and protect the privacy and security of Medi-Cal information. Additionally, DHCS has entered into a data sharing agreement with SSA and must comply with data sharing requirements.

Subcommittee Staff Comment and Recommendation–Approve. No issues have been raised regarding this proposal. The workload for these positions is justified.

6. Positions for HIPAA

Budget Issue. The DHCS is requesting to change 14 limited-term positions to permanent to address new Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules and maintain adherence to state and federal privacy requirements. The requested positions would cost $1.9 million ($723,000 General Fund).

Though HIPAA was enacted at the federal level in 1996, both the health care industry and the federal CMS have recognized that HIPAA requirements are far more difficult to implement than originally estimated and have ongoing impacts for all subsequent system changes, requiring longer time periods to fully comply. Several HIPAA rules are still pending release and several have been updated by the federal CMS and required system changes.

Background. HIPAA, enacted in 1996, outlines a process to achieve national uniform health data standards and health information privacy in the U.S. It requires the adoption of standards by the federal Secretary of Health and Human Services to support the electronic exchange of a variety of administrative and financial health care transactions. The federal government has published and continues to publish, multiple rules pertaining to the implementation of HIPAA. These rules will be published in waves and over the next several years. Among the standards are:

- Electronic transaction and data elements for health claims and equivalent encounter information, claims attachments, health care payment and remittance advice, health plan enrollment and disenrollment, health plan eligibility, health plan premium payments, first report of injury, health claim status and other items;
- Unique identifiers for individuals, employers, health plans and health care providers for use in the health care system;
- Code sets and classification systems for the data elements of the transactions identified (conversion of all local codes to national standard codes); and
- Security and Privacy standards for health information.

New HIPPA regulations released in January 2009, often referred to as “HIPAA-2” because of the major change in standards, identified significant revisions to the transactions and code set standards under HIPAA including:

- All HIPAA-covered transactions must begin using the International Classification of Diseases, 10th Edition, (ICD-10) by October 2013 for patient diagnoses and inpatient medical procedures. The more than 800 percent increase in codes included in the new standard will impact the way virtually every clinician and facility bills for health care services. For payers, such as Medi-Cal, it will impact numerous program policies, claim payment edits, the ability to analyze data, and make program decisions going forward.

Additionally, the Affordable Care Act includes significant HIPAA-related changes regarding HIPAA update frequency, operating rules, transaction standards, health plan certification requirements, and penalties for noncompliance.

Subcommittee Staff Comment and Recommendation–Approve. While it was originally established as a temporary program, HIPAA activities have grown into an ongoing workload for DHCS. Workload for these positions is justified. It is recommended for approval.

7. Every Women Counts Technical Adjustment (DOF Issue 109)

Budget Issue. In the May Revision, the DHCS requests a technical adjustment to shift $1.3 million ($1.2 million Breast Cancer Control Account and $50,000 federal funds) State Operations funding to Local Assistance for the Every Women Counts (EWC) Program. This conforms to DHCS budgeting structure and provides accountability of Fiscal Intermediary costs.

The Governor's January budget proposed the transfer of EWC from the Department of Public Health to DHCS. This Subcommittee adopted this proposal on May 10, 2012.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended for approval.

8. Eliminate the Advisory Committee on Genetically Handicapped Persons

Budget Issue. In the May Revision, the DHCS proposes to eliminate the Advisory Committee on Genetically Handicapped Persons. This advisory committee was established in 1974 when the Genetically Handicapped Persons Program (GHPP) was created.

No person has ever been appointed to this committee and it has never been convened.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the elimination of this advisory committee and to modify the Administration's proposed trailer bill language to give the DHCS Director the authority to expand the list of conditions covered by the program without the guidance of the advisory committee.

9. Radiology Rate Reduction

Budget Issue. SB 853 (Statutes of 2010) mandates that rates for radiology services may not exceed 80 percent of Medicare rates, effective October 1, 2010. In the Governor's January budget, DHCS estimated that it would begin implementation of the law in February 2012.

However, in the May Revision, DHCS now estimates that it would not begin implementation of this law until September 2012 because of inadequate staffing and other workload priorities.

Subcommittee Staff Comment and Recommendation. It is recommended to score an additional $6.6 million ($3.3 million General Fund) in savings by directing DHCS to begin implementation of this law in July 2012.

10. FQHC/RHC Audit Staffing

Budget Issue. The May Revision assumes no savings as a result of the reconciliation audits of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) by DHCS audit staff. DHCS notes that these three limited-term auditor positions expire on June 30, 2012; and consequently, the estimate does not reflect any savings as a result of these audits.

Background. The department received three limited-term positions to perform audit activities for FQHC/RHC providers to account for the increasing number of providers and to fulfill statutory audit deadlines.

Subcommittee Staff Comment and Recommendation. Since this Subcommittee rejected the Administration's proposal to reform how FQHCs and RHCs are paid, it would still be important to ensure that audits are conducted to evaluate if these providers were paid an amount equal to their prospective payment system rate. It is recommended to redirect existing staff at DHCS to perform this workload and recognize $6.1 million ($3.1 million General Fund) in savings in 2012-13 as a result of the audit findings.

11. Medi-Cal Electronic Health Records – State Match

Background. The federal ARRA Stimulus Program, authorized in 2009, included funding for investments in health information technology (HIT) designed to modernize the delivery of health care services. Known as the HITECH Act, core elements of this program include incentive payments administered through Medicare (by the federal CMS) and Medi-Cal to encourage physicians, hospitals and other providers to adopt EHRs. The Medi-Cal EHR incentive payments are 100 percent federally funded. In addition, CMS provides 90 percent of the funds to operate the program. Over 9,200 California providers have registered to receive these incentive payments totaling more than $168 million. Additionally, 219 hospitals have also registered, and of these, 106 have already received federal incentive payments totaling $153 million and 34 others have been approved for payments totaling $65 million.

While the incentive payments are 100 percent funded by the federal government, the operating costs of the Medi-Cal EHR Incentive Payment Program require a 10 percent match by the state in order to draw down an additional 90 percent funding from the federal CMS. For the past year, the matching funds needed to startup the Medi-Cal EHR Incentive Payment

program have been provided by the California HealthCare Foundation (CHCF) in anticipation that the State would determine a sustainable solution to obtaining the minimal funds needed to operate the program. CHCF has notified the state that effective July 1, 2012, it will no longer be able to provide funds to operate the program. Therefore, unless a minimum of $188,529 is allocated by the state in 2012-13 to continue to operate the program, the State is in jeopardy of forfeiting hundreds of millions of dollars in federal funds.

Subcommittee Staff Comment and Recommendation. It is recommended to redirect $190,000 General Fund budgeted for Other Administration (postage and printing costs) to be used as the state match to operate the Medi-Cal EHR Incentive Payment Program. California providers are able to receive millions of dollars in federal funds as a result of this program.

12. Eliminate Sunset for LEA Medi-Cal Billing Option Program

Budget Issue. The DHCS proposes to (1) delete the current program sunset date of January 1, 2013, for the Local Educational Agency (LEA) Medi-Cal Billing Option (LBO) program, (2) eliminate requirements that a baseline LBO funding amount must be met prior to funding LBO contractor costs, and (3) remove the maximum annual funding amount of $1.5 million for contractor costs and makes the annual funding an amount agreed upon between DHCS and the LEA Ad Hoc Workgroup Advisory Committee.

Subcommittee Staff Recommendation—Reject. On March 22, 2012, this Subcommittee approved a modified version of this proposal. It is now recommended to reject this proposal (to conform to the action taken in Assembly Budget Subcommittee #1).

B. 4265 Department of Public Health

1. Licensing and Certification Program Estimate Update (DOF Issue 650)

Budget Issue. The May Revision reflects a decrease of $1.2 million ($1.3 million General Fund and $112,000 reimbursement fund increase) for the Licensing and Certification Program.

The reduction in General Fund is a result of technical workload adjustments for state-owned facilities.

Subcommittee Staff Comment and Recommendation—Approve. This is a technical adjustment, no issues have been raised.

2. Proposition 99 – Research Account Adjustment (DOF Issue 502)

Budget Issue. In the May Revision, DPH proposes a $1.049 million reduction in Proposition 99 Research Account funding ($936,000 for support of the California Cancer Registry and $113,000 for community outreach efforts for the California Cancer Registry). This proposal aligns Proposition 99 revenues with expenditures.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to adjust expenditures to reflect Proposition 99 revenues.

3. Expand California's Newborn Screening Program

Budget Issue. The DPH requests 10 permanent positions and the associated $5.3 million in state operations expenditure authority (from the Genetic Disease Testing Fund) to implement Assembly Bill 395, Chapter 461, Statues of 2011, which requires DPH to add Severe Combined Immunodeficiency (SCID) to the panel of disorders screened for by the Genetic Disease Screening Program Newborn Screening Program. The screening for SCID began on January 1, 2012.

This item was heard at the Subcommittee #3 Hearing on March 8, 2012.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is consistent with state law and is recommended for approval.

4. Women, Infant, and Children (WIC) Program (DOF Issue 553)

Budget Issue. The May Revision includes an increase of $26 million from the WIC Manufacturer Rebate Fund in 2012-13, and a corresponding decrease in federal expenditure authority. The increase in rebate funds is a result of a new contract award for infant formula rebates effective August 1, 2012. Federal law requires the use of WIC manufacturer rebate revenues prior to using federal WIC food funds.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this adjustment. It is recommended for approval.

C. 4280 Managed Risk Medical Insurance Board

1. County Health Initiative Matching Fund Caseload Update (DOF Issue 301)

Budget Issue. The May Revision reflects an increase to the County Health Initiative Matching Fund ($15,000) and federal funds ($29,000) as a result of a slight increase in program enrollment.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal.

2. AIM Caseload and Funding Update (DOF Issues 201 and 202)

Budget Issue. The May Revision includes adjustments to the Access for Infants and Mothers (AIM) budget to reflect a shift of program funding from state funds to federal funds and a reduction in Proposition 99 revenue transfers due to a decrease in program costs.

The MRMIB is no longer pursuing the option of using fee-for-service for AIM because federal funds cannot be claimed for post-partum care. In contrast, the current managed care bundled rate includes post-partum care (as well as labor and delivery) and MRMIB can claim federal funds for the entire bundled rate.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal.

3. Major Risk Medical Insurance Program (DOF Issue 402)

Budget Issue. As a condition for obtaining federal funding for the Pre-Existing Condition Insurance Plan (PCIP), the state must meet the maintenance of effort requirements to maintain Managed Risk Medical Insurance Program annual funding of $31.8 million (effective 2011-12). Consequently, the May Revision requests an increase in Proposition 99 funds ($226,000) to ensure that’s level of state funding meets these requirements.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal.

ISSUES FOR DISCUSSION

A. 4265 Department of Public Health

1. AIDS Drug Assistance Program (ADAP) Estimate Update (DOF Issues 561 and 651)

Budget Issue. The May Revision updates expenditures for the ADAP program. See table below.

Table: Comparison of January and May Estimates for ADAP for Budget Year (dollars in thousands)

Fund Source	January Budget	May Revise	Difference
General Fund	$4,446	$4,843	$397
AIDS Drug Rebate Fund	245,520	300,756	55,236
Federal Funds – Ryan White	102,572	113,605	11,033
Reimbursements-Medicaid Waiver	49,300	17,150	-32,150
Proposed New Premiums	2,000	1,361	-639
Total	**$403,838**	**$437,715**	**$33,877**

This updated estimate reflects the following:

- An increase in federal Ryan White funding of $11 million. This includes $2.6 million awarded on April 9, 2012 for ADAP Earmark and Ryan White Part B ADAP Supplemental federal funds and $8.4 million for the 2012 Ryan White Part B ADAP Supplemental Grant.
- The impact of full implementation of the “non-legacy” Low Income Health Program (LIHP) County Programs on ADAP. It is estimated that 1,991 ADAP clients will shift to LIHP in the non-legacy counties for an ADAP savings of $20.9 million. This was not accounted for in the January estimate.
- The impact of implementation of the legacy LHIP County Programs on ADAP. It is estimated that 8,076 ADAP clients will shift to LIHP in the legacy counties for an ADAP savings of $66.7 million. This updated estimate reflects the delay of implementation of the LIHP in Los Angeles and Alameda counties (estimated to begin July 1, 2012). The January estimate projected a larger shift of ADAP clients to LIHP in the current year and did not reflect the delayed implementation.
- An increase in the rebate percentage from an estimated 48 percent in January to 50 percent in the May Revision. Generally, for every dollar of ADAP drug expenditure, the program estimates it will obtain 50 cents in rebates. This 50 percent level is based on an average of rebate collections (both “mandatory” and “supplemental” rebates).
- A change to the Administration’s share-of-cost (SOC) budget proposal, to eliminate the SOC for ADAP clients with private insurance due to antiretroviral manufacturer’s co-pay assistance programs, delaying the implementation date to October 1, 2012.

Subcommittee Staff Comment and Recommendation. It is recommended to approve the updated May Revision estimate of ADAP with the exception of the share-of-cost proposal. This share-of-cost proposal was rejected by Subcommittee #3 on March 8, 2012.

Given the uncertainty of when ADAP clients may transition to LIHP, it is recommended to adopt placeholder uncodified trailer bill language to require the Department of Public Health to report to the Joint Legislative Budget Committee by October 1, 2012 on if any of the projections or assumptions used to develop ADAP's estimated budget for the Budget Act of 2012-13 may result in a potential funding shortfall or an inability of ADAP to provide services to eligible ADAP clients. If a potential funding shortfall occurs before October 1, 2012 and ADAP is unable to provide services to eligible ADAP clients, the Department of Public Health shall provide notification to the Joint Legislative Budget Committee within 15 calendar days of this determination.

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

1. Please provide an overview of the May Revision estimate for ADAP and discuss the key changes.

2. Transition of Ryan White/ADAP Clients to LIHP

Background. At the March 8, 2012 Subcommittee #3 hearing, concerns were discussed regarding OA's oversight and engagement in the transition of ADAP clients to LIHP. As a result of these concerns the Subcommittee #3 adopted placeholder trailer bill that would strengthen consumer protections for ADAP clients as they transition to LIHP and create a stakeholder advisory committee to give expert advice on transition policy decisions.

Since the March hearing, DPH, in conjunction with the Department of Health Care Services (DHCS), has:

- Conducted weekly calls with stakeholders (e.g., DHCS, HIV advocates, California Conference of Local AIDS Directors, California Association of Public Hospitals, County Health Executives Association of California, and county LIHP administrators).
- Created a Ryan White/LIHP stakeholder advisory committee which includes providers, case managers, HIV advocates, California Conference of Local AIDS Directors, California Association of Public Hospitals, County Health Executives Association of California, LIHP administrators, and HIV-positive consumers. This group will provide input on transition policy decisions and guidance.
- Issued guidance memos, summaries of topics discussed during monthly stakeholder calls, FAQs and resources which are posted to OA's website. See LIHP information.
- Conducted training sessions for ADAP enrollment workers and will host a series of trainings for Ryan White case managers and benefit counselors (beginning in May and to be completed before June 2012).
- Reached out to counties and HIV advocates to develop county specific consumer information sheets. These sheets will provide comprehensive guidance to clients including all of the client-relevant information about processes and procedures for a successful transition to LIHP.
- Created, based on feedback from HIV advocates, an ADAP to LIHP transition flowchart that visually displays the process and will serve as a good reference for ADAP enrollment workers, Ryan White case managers, Ryan White benefit counselors, and others for explaining the LIHP application process to clients. This chart can be found at: http://www.cdph.ca.gov/programs/aids/Documents/ADAPMMLIHPFlowchart.pdf

Additionally, it has worked with DHCS and counties on establishing grace periods to allow ADAP clients to submit proof that they have submitted a LIHP application to the county and to provide proof of the LIHP application determination. During these grace periods, ADAP pays for client medications. This grace period policy includes:

- If the client does not provide proof of a LIHP application within a 30-day grace period, then the client's ADAP eligibility is suspended but the next time they visit an ADAP pharmacy, the client receives one "last 30-day prescription fill".

- If the client provides proof of a LIHP application, then the client receives a county-specific LIHP application processing grace period (duration is determined by each county) ADAP pays for medications during this LIHP grace period. For example, Contra Costa County has a 45-day grace period and Orange County has a 90-day grace period. ADAP covers the cost of medications during these county-specific grace periods.

- If the client visits an ADAP pharmacy after the county-specific application processing grace period has expired, then again the client will received one "last 30-day prescription fill."

Subcommittee Staff Comment and Recommendation. Since March, DPH has taken steps to ensure continuity of care and minimal disruption to patient/provider relationships for persons with HIV that are eligible for LIHP. It is recommended to adopt the following placeholder trailer bill language to ensure these efforts are continued:

Section 15917 is added to the Welfare and Institutions Code:

(a) By no later than August 1, 2012, the State Department of Public Health, in collaboration with the State Department of Health Care Services, shall provide guidance on the transfer of clients living with HIV/AIDS from Ryan White funded programs to the Low Income Health Program (LIHP). This guidance shall be provided to LIHP participating counties, providers, and clients as applicable. This guidance shall conform to the provisions of Special Terms and Conditions of the section 1115(a) California Bridge to Reform Medicaid Demonstration to provide timely access to coordinated health care services to all LIHP enrollees. The guidance shall also minimize disruption of services to clients.

(b) The State Department of Public Health together with the State Department of Health Care Services shall consult with community representatives to obtain expert advice on policy decisions regarding the transition of clients living with HIV/AIDS from Ryan White funded programs to LIHP. This consultation shall inform the creation of the guidance described in paragraph (a). The State Department of Public Health and the State Department of Health Care Services shall communicate with these representatives on how their advice is used and how final decisions were made.

This proposed language would be included within the statutory requirements for the Low Income Health Program (Sections 15909 – 15916).

Questions. The Subcommittee has requested DPH to respond to the following question.

1. Please provide a summary of DPH's efforts on this issue since March.

3. Public Health Laboratory Training Program (DOF Issue 602)

Budget Issue. The May Revision proposes to eliminate the Public Health Laboratory Training Program for a savings of $2.2 million General Fund.

This program provides local assistance grants to subsidize training, support, outreach and education, and provides funding for doctoral candidate stipends and post-doctoral fellowships for individuals training for public health laboratory directorships.

Fifteen individuals currently participate in this program:

- Assistant Laboratory Directors (4) – These individuals are currently obtaining required supervisory and management experience and are within two years of completing the multiyear program and then obtaining a job in a California local health jurisdiction as a Lab Director.

- Post-doctoral Fellows (6) - This group has completed their PhD and are enrolled in a post-doctoral fellowship program. They are currently employed at the DPH Microbial Disease Lab or the L.A. County Public Health Lab. They are in the process of obtaining board certification. After post-doctoral training, the subsequent two years will be gaining management experience as Assistant Lab Directors (above).

- Doctoral Students (5) - These students are several years into their training and have agreed to work for several years in a public health setting after completion of their training.

Background. There are 36 local public health labs in California. Public health lab directors must meet state and federal requirements to run a lab that tests human specimens as well as have the leadership and public health training needed to oversee the functions of a laboratory that protect the health of the public. Federal law (the Clinical Laboratory Improvement Amendments of 1991) requires that public health lab directors have a doctoral degree, national board certification, and four years of supervisory experience post-doctorate. (Lab directors that were in place prior to 1991 that do not meet these requirements were grandfathered-in and do not need to meet these requirements.)

Subcommittee Staff Comment and Recommendation. Given the state's fiscal situation, it is recommended to approve this proposal. It is also recommended to adopt placeholder language to encourage the department to seek foundation support and to work with the local health jurisdictions on alternative funding sources for this program.

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

1. Please provide an overview of this proposal.

2. Has the department explored alternative funding sources for this program?

4. Close Southern California Laboratory

Budget Issues. The DPH proposes to close its Southern California Laboratory (Temple Street building) due to health and safety concerns related to the building's code and seismic deficiencies. The closure of the Temple Street building would generate savings of $180,000 ($57,000 General Fund) in 2012-13 and $360,000 ($114,000 General Fund) in future years from various funds. DPH programs would transition out of the building on July 1, 2012.

There are currently eight DPH positions working at this location (six scientists and two support positions). DPH has indicated that it is working with these employees to find other state positions in southern California or to relocate them to the Richmond Laboratory.

Background. The DPH owns and operates two laboratory/office buildings: one in Northern California (the Richmond Laboratory) and one in Southern California (the Temple Street building). In 1988, the Department of Health Services (now DPH) purchased the Temple Street building for $1.3 million. Four DPH programs occupied this building at the time: the Environmental Laboratory Accreditation Program; the Environmental Management Branch; the Food and Drug Branch; and the Drinking Water Radiation Laboratory Branch.

Remaining Programs at Temple Street Building. Since 2009, DPH has been systematically relocating DPH programs out of the Temple Street building to other DPH space throughout southern California. Currently, the Drinking Water Radiation Laboratory Branch (DWRLB) is the only remaining DPH program in this building. In addition, DPH leases space to the Department of Toxic Substance Control's (DTSC) Environmental Health Laboratory Program.

Deficiencies with Temple Street Building. Three separate infrastructure studies of the Temple Street building have been conducted. The first two studies, completed in 1986 and 1991, identified numerous deficiencies and determined that the building did not meet various building standards. The third study, conducted in 2006, concluded that it would not be cost-effective to renovate the existing building given its many structural deficiencies.

Additionally, both DPH and DTSC have received health and safety complaints from employees and grievances from the California Association of Professional Scientists. Since 2009, DPH has been systematically relocating DPH programs out of the Temple Street building into other DPH space in Southern California.

To address the issues with the Temple Street building, DPH evaluated the following options:

- **Retrofitting Temple Street Building.** In 2006, the Department of General Services (DGS) contracted with a firm to evaluate the most cost effective method to address the Temple Street building's deficiencies. The firm concluded that given the numerous structural deficiencies retrofitting was not a viable option and that constructing a new lab at another location was a better option.
- **Construction of New Laboratory.** In 2006, DGS provided DPH with a $100 million cost estimate to acquire another property and construct a new laboratory facility. Given the state's fiscal constraints, this was not a feasible option.

- **Lease Laboratory Space.** In 2008, DPH engaged DGS to lease laboratory space in the private real estate market. While there were available properties, the estimated costs for tenant improvements (to turn the property into a lab) were estimated at $1.6 million General Fund with ongoing annual General Fund costs of $325,000.
- **Sublease Laboratory Space from Another Jurisdiction.** DPH also explored the option to sublease lab space from other jurisdictions within Los Angeles County. However, due to a lack of available space, security issues, and potential conflict of interest between DPH's oversight role of local drinking water programs, this was not an option.

Subcommittee Staff Comment and Recommendation—Approve. Although concerns have been raised that the eight employees may not find the exact state job in southern California, given the health and safety risks posed by this building, it is recommended to approve this item. Additionally, given the costs to open a new lab in southern California (i.e., rent a location and make tenant improvements), staff concurs with the department's efforts to consolidate this lab's functions with the Richmond lab and other DPH labs in southern California (e.g., the Drinking Water Program's lab in Glendale).

Finally, given that the DWRLB is a reference laboratory, the need to perform time-sensitive water testing for water systems is very minimal. DPH plans for overnight shipments of samples from southern California to the Richmond Laboratory. Moreover, in cases of emergency events, DPH has already established agreements with local laboratories for laboratory emergency response purposes and the Richmond Laboratory maintains a portable laboratory that can be mobilized as needed to respond to any emergency event throughout the state.

De-commissioning costs for the Temple Street building are not yet know and cannot be determined until all occupants are out of the building. (It is anticipated that DTSC might need up to one year to vacate the premises.)

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

1. Please provide an overview of this proposal.

2. Please discuss the department's efforts in regards to working with the individuals employed at the Temple Street building to find other state jobs in southern California or relocating to the Richmond Laboratory.

5. Biomonitoring Fund Shifts

Budget Issue. The DPH requests a fund shift to support the California Environmental Contaminant Biomonitoring Program (CECBP). Currently, all eight DPH CECBP positions are funded by the Toxic Substances Control Account (TSCA). This request would result in two positions being supported by TSCA and six positions being supported by the Birth Defects Monitoring Program Fund, Air Pollution Control Fund, Department of Pesticide Regulation Fund, and the Childhood Lead Poisoning Prevention Fund.

Table: Proposed Funding for Biomonitoring Program

Fund	Amount
Toxic Substances Control Account	$242,000
Birth Defects Monitoring Program Fund	$240,000
Childhood Lead Poisoning Prevention Fund	$240,000
Department of Pesticide Regulation Fund	$205,000
Air Pollution Control Fund	$204,000

This request is being made as TSCA (a Department of Toxic Substances Control account) does not have sufficient revenues to support the fund's projected expenditure authority.

Rationale for Special Funds. The Administration has provided the following rationale for the use of these special funds for this program.

- **Birth Defects Monitoring Program Fund.** The causes of most birth defects remain unknown. The Birth Defects Monitoring Program was established to provide information on the incidence and trends of birth defects, stillbirths, and miscarriages, and data on whether these adverse reproductive outcomes are associated with environmental hazards, as well as to develop appropriate prevention strategies. Biomonitoring can detect chemicals capable of causing birth defects and impaired fetal development and, thus, inform public health and environmental policies to reduce such exposures, and also help focus etiologic research by university and government scientists.

  CECBP measures toxic chemical levels in people, including pregnant women and fetuses (i.e., in umbilical cord blood). A principal focus of the CECBP has been on chemicals in consumer products, some of which are currently regulated and others not. Ultimately, CECBP data will help shape California regulatory programs intended to reduce exposures to fetotoxic chemicals.

- **Childhood Lead Poisoning Prevention Fund.** The Childhood Lead Poisoning and Prevention Program (CLPPP) is a comprehensive approach to identify occurrences of high blood lead levels and reduce excessive lead exposures in children. Blood testing is the only method to quantitatively determine health risks of lead exposure. CLPPF already provides support to the Department of Public Health (DPH) Environmental Health Laboratory (EHL) for lead testing. EHL staff currently: (a) provide reference blood lead analyses for confirmatory testing of children with clinical lead

poisoning; (b) perform lead analyses of environmental samples (e.g., paint chips, dirt, toys, etc.) for case investigations and management; (c) certify proficiency of clinical laboratories; (d) serve as technical experts on current and emerging testing methods; and (e) ensure quality assurance. The additional resources to be provided to CECBP will support core CLPPP activities by offering enhanced surveillance on the prevalence, risk factors, and geographic occurrence of high childhood blood lead levels, and identifying populations where childhood lead exposures are especially significant. EHL can test all CECBP samples collected (from infants, children and pregnant women) for lead. These results will offer community-based and population-based surveillance data to augment clinic-based screening, among several other enhancements to the CLPP.

- **Air Pollution Control Fund and Department of Pesticide Regulation Fund.** The Air Pollution Control Fund (APCF) and the Department of Pesticide Regulation Fund (DPRF) primarily support the broad spectrum of regulatory and other activities of the Air Resources Board (ARB) and the Department of Pesticide Regulation (DPR), respectively. Both ARB and DPR include among their responsibilities assessing exposure to air pollutants and pesticides, and educating the public about such exposures.

  The CECBP objectives include measuring and tracking trends in human exposure to chemicals and making this information public in summary form, which can help inform environmental regulatory policies. The CECBP "designated" and "priority" chemicals comprise a variety of air pollutants and pesticides. Among the air pollutants are metals (e.g., antimony, arsenic, lead, and mercury), volatile organic chemicals, diesel exhaust, and polycyclic aromatic hydrocarbons (PAHs). Also included are cyclosiloxanes, which have been introduced statewide in dry cleaning establishments as perchloroethylene has been phased out to comply with an ARB regulation. All major pesticide classes or their metabolites are within the CECBP universe of chemicals to measure, including organophosphates, carbamates, pyrethroids, and fungicides. The DPH EHL is currently measuring PAHs, metals, and multiple classes of pesticides in blood and urine specimens from biomonitoring participants. Over time, the CECBP will be developing additional advanced laboratory methods to measure other air pollutants and pesticides. This information can help inform the ongoing efforts of the ARB and DPR to assess and regulate human exposure to the chemicals under their jurisdictions, providing a logical nexus between the CECBP and both the APCF and the DPRF.

Background. The CECBP was established by SB 1379 (Perata), Statutes of 2006. The legislation provides for DPH, the Office of Health Hazard Assessment, and the Department of Toxic Substances Control to conduct the program collaboratively, with DPH as the lead entity. The program's overall purpose is to measure and track levels of environmental chemicals in California residents as a way to inform policy makers and to alert them to the presence and associated health risk of chemicals in the environment, home, and workplace.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal. The Administration has identified appropriate fund sources to support the California Environmental Contaminant Biomonitoring Program.

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

1. Please provide an overview of this proposal.

2. Please provide a status update of the biomonitoring summary report that is to be completed by July 2012.

B. 4280 Managed Risk Medical Insurance Board

1. Healthy Families Program Caseload Update (DOF Issue 102, 103, 104, 111, 112)

Overview. In the May Revision, MRMIB estimates that if no HFP children are transferred to Medi-Cal, the projected caseload for HFP is 878,112. This is an increase of 5,185 children over the current year, and represents a 0.6 percent annual growth rate over the current year.

Funding for the full HFP caseload (878,112) for 2012-13 would be $1.1 billion ($381.7 million General Fund, $727.5 million federal funds, $8.1 million in reimbursements, and $8.7 million from the Children's Health and Human Services Fund).

The average benefit cost per month per eligible member under HFP is $101.77.

The May Revision also reflects an increase in General Fund due to HFP enrollees selecting higher cost plans and increased program expenditures due to wraparound payments to Federally Qualified Health Centers and Rural Health Clinics.

Copayment and Premium Increases Savings Erosion. Additionally, MRMIB requests an increase of $22.8 million General Fund and $42.4 million in federal funds to reflect the full year erosion of budget year savings previously adopted by the Legislature related to premiums and copayments for the Healthy Families Program (HFP).

The Governor' January budget assumed premiums would have increased by $14 per child for children in families with income between 200 percent and 250 percent of the federal poverty level (FPL) and by $18 per child for children in families with income between 200 percent and 250 percent of FPL. However, the federal government has indicated that this increase would be a violation of the state's maintenance of effort requirements imposed by federal health care reform.

The Governor's January budget also assumed increased copayments for emergency room visits from $15 to $50. However, in the May Revision, the Administration has altered this proposal to assume only $15 for non-emergency visits to the emergency room. Since HFP plans already impose an emergency room copayment of $15, there are no longer savings attributable to this proposal.

Managed Care Organization Tax – Technical Adjustment. Finally it should be noted that May Revision reflects an increase of $2.6 million General Fund as a result of a reduction of managed care organization (MCO) tax revenue carryover from the current year.

LAO Comment. Based on its analysis of HFP enrollment data, the LAO finds that the Governor's projection of continued flat enrollment into HFP is reasonable.

Subcommittee Staff Comment & Recommendation—Approve. It is recommended to approve the adjustments to funding for HFP, with any changes to conform as appropriate to other actions that have been or will be taken.

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

1. Please provide an update on the HFP caseload and growth trend.

2. Transition of Healthy Families Children to Medi-Cal – MRMIB and DHCS

Budget Issue. In the January budget, the Governor proposed to:

- Shift *all* Healthy Families Program (HFP) children into Medi-Cal over a nine-month period beginning in October 2012. Approximately 878,000 eligible enrollees would move to Medi-Cal in phases between October 2011 and June 2013.
- Require the Managed Risk Medical Insurance Board (MRMIB) to negotiate managed care health plan capitation rates for children receiving health care services in the Healthy Families Program (HFP) at a statewide weighted average capitation rate that is less than or equal to the statewide average capitation rate established by the Department of Health Care Services for health benefits for children up to age 19 in the Medi-Cal program.

Estimated Savings. In the May Revision, the Administration updates its estimates on this transition and rate reduction and estimates that these proposals would result in total savings of $48.6 million General Fund savings (the January estimate was $64.4 million General Fund savings). Since under the May Revision the Administration estimates that the average per-member per-month cost of a Medi-Cal enrollee increased from $76.86 to $83.81, the Administration's January proposed savings were reduced under the May Revision. This new rate includes additional Medi-Cal administrative costs and accounts for mental health benefits that are carved out of the Medi-Cal managed care rate.

Dental Managed Care. Additionally, it should be noted that the Administration's proposal included the expansion of Medi-Cal Dental Managed Care as the individuals enrolled in an HFP dental plan would transition to the same dental plan to the extent that the plan is a Medi-Cal dental managed care plan. If the enrollee's HFP dental plan is not a Medi-Cal dental managed care plan, DHCS would be authorized to contract with the dental plan to allow the individuals to enroll in the same plan. These new dental health plans will also be available for voluntary enrollment by existing Medi-Cal enrollees.

Proposed Benefits of Transition. The Administration finds that the key benefits of this consolidation of HFP and Medi-Cal would be the following:

- Enrollment for children would be simplified with a unified program of coverage for all eligibles up to 250 percent of FPL;
- 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 FPL 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. It is estimated that 78 percent of children in Healthy Families match to a health plan that currently participates in both Medi-Cal and Healthy Families (either via a contract or subcontract, Phase 1 and Phase 2A);
- 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. Under health care reform, HFP children with incomes under 133 percent of FPL would become Medi-Cal enrollees on January 1, 2014.

Subcommittee Staff Comment and Recommendation. It is recommended to (1) reject the Administration's proposed shift of all HFP children to Medi-Cal, (2) reject the expansion of Medi-Cal Dental Managed Care, and (3) reject the trailer bill language requiring MRMIB to reduce HFP rates.

Instead, it is recommended to adopt placeholder trailer bill language to shift HFP children with incomes under 133 percent of the federal poverty level (or in families with Modified Adjusted Gross Income under 138 percent of the federal poverty level) to Medi-Cal beginning October 2012. This recommendation is consistent with federal ACA, as HFP children with incomes under 133 percent of FPL would become Medi-Cal beneficiaries on January 1, 2014.

These HFP children would be shifted to Medi-Cal in phases (see table below) in an effort to address provider continuity.

Table: Transition of HFP Children to Medi-Cal

Phase	Impacted Enrollees	Eligibles	Phase-In Period
1	HFP children with a "matching" Medi-Cal managed care plan	88,232	October – December 2012
2A	HFP children in a plan that subcontracts for Medi-Cal managed care	54,164	January – March 2013
2B	HFP children in a managed care plan that does not contract or subcontract with Medi-Cal	36,429	March - May 2013
3	HFP children in fee-for-service	7,632	June 2013
	TOTAL Children	186,457	

Note: This table does not reflect a growth in the HFP caseload and was a point-in-time estimate.

It is also recommended to adopt placeholder trailer bill language to facilitate the transition of children to appropriate dental services, whether it is Fee-for-Service Medi-Cal or a continuation in existing dental managed care arrangements in Los Angeles and Sacramento counties.

This recommendation results in $27.3 million ($10.8 million General Fund) savings.

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

1. Please provide an overview of the Administration's updated proposal.

2. How has the Administration worked with stakeholders since January on identifying and addressing key issues regarding the transition of HFP children to Medi-Cal?

3. Transfer of MRMIB Programs to the Department of Health Care Services

Budget Issue. The administration proposes trailer bill language to eliminate MRMIB and transfer its programs to DHCS. Specifically, the Healthy Families Program would transfer to DHCS beginning October 2012. The remaining programs, the County Children's Health Initiative Program; Access for Infants and Mothers; Major Risk Medical Insurance Program; and Pre-Existing Conditions Insurance Plan would transfer to DHCS effective July 1, 2013.

Subcommittee Staff Comment and Recommendation–Reject. It is recommended to reject this proposal. Given the recommendation to reject the Administration's proposal to shift the entire HFP program to Medi-Cal, MRMIB will continue to oversee HFP as well as other programs.

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

1. Please provide an overview for this proposal and a discussion of the Administration's rationale for eliminating MRMIB.

C. 4150 Department of Managed Health Care

1. DMHC's Role in Coordinated Care Initiative (DOF Issue 103)

Budget Issue. In the May Revision, DMHC requests 13 positions and $1.1 million (Managed Care Fund), including $77,500 for consultant services, to address the new workload attributable to the evaluation of plan readiness and oversight of health plans for the Governor's Coordinated Care Initiative.

The requested positions are:

- **Help Center – 8 positions** (These positions would begin January 1, 2013.)
    - 1 Health Program Specialist II
    - 1 Nurse Evaluator II
    - 1 Associate Governmental Program Analyst
    - 5 Consumer Assistance Technicians

  These positions would respond to consumer phone calls and correspondence, resolve complaints, and develop technical assistance guides for medical surveys.

- **Division of Licensing – 4 positions** (These positions would begin July 1, 2012.)
    - 2 Staff Counsels
    - 1 Health Program Specialist
    - 1 Associate Health Program Adviser

  These positions would review health care service plan filings for compliance with statutory, regulatory, and contract requirements, conduct network adequacy assessments, and review utilization patterns.

- **Division of Financial Oversight – 1 position** (This position would begin July 1, 2012.)
    - 1 Corporation Examiner

  This position would perform financial analysis and review of materials submitted with health care service plan filings. This analysis includes a review of fiscal viability impacts.

In addition, DMHC will utilize a medical consultant to prepare for the medical surveys and to conduct the anticipated 25 Independent Medical Reviews generated by the dual eligibles enrolling in managed care plans.

The DMHC anticipates submitting a 2013-14 proposal to request additional positions as permanent resources to handle the ongoing workload.

Background. The Governor's budget and May Revision includes a Coordinated Care Initiative for Medi-Cal enrollees. The Coordinated Care Initiative would expand the enrollment of dual eligibles into Medi-Cal managed care from the four demonstration pilots (as provided under SB 208, Statutes of 2010) to up to 8 counties in 2013 and statewide by 2015 and integrate home- and community-based long-term supports and services (LTSS) into Medi-Cal managed care for Medi-Cal enrollees in up to 8 counties in 2013 and statewide by 2015.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue related to the Coordinated Care Initiative.

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

1. Please provide an overview of this proposal.

2. Please describe what new factors would be included in the survey.

2. Medi-Cal Dental Managed Care Program (DOF Issue 102)

Budget Issue. In the May Revision, the DMHC requests 3 positions and $295,000 from the Managed Care Fund to expand DMHC oversight of licensed dental managed care plans participating in the Medi-Cal Dental Managed Care (DMC) program.

DMHC intends to plan, prepare, and develop tools and documents to conduct annual financial audits and dental surveys in place of the normal three-year audit/survey schedule. These are new annual audits and surveys of nine dental managed care plans would also include a new scope of work for DMHC. For this workload, DMHC is requesting one Health Program Specialist II (effective January 1, 2013) and one Corporation Examiner (effective January 1, 2013) and $83,000 in consultant services to develop audit guides and survey tools.

Additionally, this proposal addresses the increased workload resulting from the transfer of Healthy Families Program (HFP) children to Medi-Cal and Medi-Cal Dental Managed Care, commencing on October 1, 2012. It is anticipated that there will be an increase in the number of enrollee inquiries, correspondence and complaints received by the Help Center. For this workload, DMHC requests one Staff Services Analyst.

Background. DHCS and DMHC contract with five Geographic Managed Care (GMC) Plans and eight Prepaid Health Plans (PHP) that provide dental services to Medi-Cal enrollees in Sacramento and Los Angeles counties. The DMHC licenses dental managed care plans.

No Oversight of Medi-Cal DMC Plans. In February 2012, a Sacramento Bee article describing significant access and quality of care problems in the dental GMC program in Sacramento County generated an increase of consumer complaints to DMHC's Help Center and concern about the lack of access to dental care for children in that county.

At the March 22, 2012 Subcommittee #3 hearing, this Subcommittee adopted trailer bill legislation proposed Pro Tem Senator Steinberg to increase DMHC's oversight of DMC plans. DMHC is initiating immediate investigations ("non-routine audits") of the five GMC plans in Sacramento to evaluate access to care and provider network adequacy. DMHC is absorbing this immediate workload using existing resources; however, to address these concerns on an ongoing basis and to have the resources to perform annual on-site dental surveys and financial examinations, DMHC is submitting this proposal.

Prior to non-routine audits described above, DMHC did not directly survey Medi-Cal DMC products. Additionally, DMHC did not review, assess, or evaluate the plan's performance of their Medi-Cal DMC contractual deliverables; request, review, or evaluate DMC's enrollment data, quality issues, network adequacy, language assistance, or any other potential barriers to care.

Expansion of Medi-Cal DMC. The Governor's January budget proposes to transition all HFP enrollees to Medi-Cal beginning October 1, 2012. This will result in the addition of about 875,000 HFP enrollees into the Medi-Cal dental program. It is estimated that about 387,000 of

the HFP enrollees will enroll in the Fee-For-Service (FFS) dental program and about 488,000 HFP enrollees will enroll in the Medi-Cal DMC program. This increase in the number of Medi-Cal DMC program enrollees is expected to increase DMHC's workload with respect to providing oversight of quality of care and network adequacy through dental surveys of dental plans and responding to enrollee grievances, appeals, and complaints.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal as the workload is justified by the new scope of work (monitoring for Medi-Cal DMC contract deliverables and a review for barriers to care) and more frequent oversight of DMC plans by DMHC.

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

1. Please provide an overview of this proposal.

2. Please provide an update on the current year non-routine surveys of Medi-Cal Dental Managed Care plans.

D. 0530 California Health and Human Services Agency and 4260 Department of Health Care Services

1. CalHEERS Integration with the State's Public Assistance Systems

As required by the Affordable Care Act (ACA), states must establish an insurance exchange or use a federally established exchange. California's Health Benefit Exchange (Exchange) was established by AB 1602 (Perez, Statutes of 2010) and SB 900 (Alquist, Statutes of 2010). The Exchange is an independent state that is required to facilitate the purchase of qualified health plans by individuals and small employers no later than January 1, 2014. The California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) is the Exchange's enrollment system to purchase qualified health plans. Recently released proposed federal regulations, require coordination between Exchanges, Medicaid, and Children's Health Insurance Programs to ensure a seamless, integrated process for individuals seeking health coverage under an Exchange.

Overview of Administration's May Revision CalHEERS Proposal. The Administration has various proposals related to the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). The Office of Systems Integration and DHCS proposals are discussed below. The Department of Social Services also requests budget bill language and expenditure authority. This request will be discussed at the Subcommittee #3 hearing on May 22, 2012.

a. Office of Systems Integration – Request for Project Management Staff

Budget Issue. In the May Revise, the Administration requests trailer bill language, budget bill language, and 16 limited-term positions for its Office of Systems Integration (OSI) to provide project management services for the CalHEERS Project (and the corresponding reimbursement authority from the California Health Benefit Exchange). These costs ($2.5 million) will be reimbursed by the Health Benefit Exchange Board.

Trailer Bill Language. OSI requests trailer bill language to provide OSI the authority to provide project management of the CalHEERS Project.

Budget Bill Language. OSI requests budget bill language to allow expenditure of funds upon approval of DOF and notification to the Joint Legislative Budget Committee and to allow DOF to augment the OSI budget to accommodate increased funding provided by the California Health Benefit Exchange. The following budget bill language is requested for 0530-001-9732:

Provisions:

X. Of the funds appropriated in this item, $2,543,000 is to support the system changes necessary to implement federal health care reform. These funds are not authorized for expenditure under approved by the Director of the Department of Finance. The Director of Finance shall provide notification in writing to the Joint Legislative Budget Committee of any

expenditure approved under this provision not less than 60 days prior to the effective date of the approval. This 60-day notification shall include a plan for the system changes necessary to implement the requirements of the federal Affordable Care Act.

X. The Director of Finance is authorized to approve current year increases in the Office of System's Integration's expenditure authority to accommodate increases in funding provided by the California Health Benefit Exchange for services related to the California Healthcare Eligibility, Enrollment, and Retention System project. Any such increases shall occur no sooner than 30 days after notification in writing of the necessity therefor to the Joint Legislative Budget Committee, or not sooner than whatever lesser time after notification the chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine.

Positions. According to the Administration, the request for staff is consistent with that of other large scale IT projects which OSI has been involved in implementing, and includes the following positions:

1. Project Director (Exempt) - Oversees the development and implementation of the CalHEERS Project, providing leadership and strategic direction to the CalHEERS Project to ensure organizational objectives are achieved. Plans, directs and oversees the project to ensure deliverables and functionality are achieved.

2. Assistant Project Director (DPM IV) - Assists the Project Director in overseeing all aspects of the CalHEERS Project. Directs and oversees staff responsible for oversight of the CalHEERS project design, development, and implementation.

3. Project Management Services Manager (DPM III) - Plans and directs the activities of the CalHEERS Project Administrative and Project Management Support Teams. This position is responsible for defining and managing administrative support functions such as procurement, contract, and financial management and is also responsible for overseeing the prime vendor's project management office. Provides general leadership and supervision to the CalHEERS Project Administration and Project Management Support units.

4. Project Support Analyst (Sr. ISA) - Plans, organizes, coordinates and manages a variety of the most complex activities and services. Will oversee the tracking of the Prime Contractor and consultant contract deliverables for the project. Also oversees the monitoring of contract compliance, participates in negotiations, facilitates amendments, and reviews work authorizations and invoices. Also, responsible for tracking and coordinating deliverable approvals.

5. Project Support Analyst (Sr. ISA) - Plans, organizes, coordinates and manages a variety of the most complex activities and services. Will oversee the tracking of the prime contractor and consultant contract deliverables for the project. Also oversees the monitoring of contract compliance, participates in negotiations, facilitates amendments, and reviews work authorizations and invoices. Also responsible for tracking and coordinating deliverable approvals.

6. Procurement/Contract Analyst (Sr. ISA) - Responsible for development of plans and procedures for all CalHEERS Project IT contracts, and associated deliverables, materials, etc. Ensures contractual obligations are met and provides continual review to ensure that all terms and conditions are in compliance. Also responsible for directing, preparing, and reviewing the most complex IT and non-IT competitive procurements, ensuring adherence to state laws and regulations, Executive Orders, Administrative Orders, and Management Memos.

7. Financial Analyst (Sr.ISA) - Responsible for managing and tracking project budget/costs and for performing financial tasks following federal and state laws, regulations, and guidelines related to the project's fiscal responsibilities.

8. System Development Support and Implementation Manager (DPM III) - Plans, organizes and directs all the activities of the CalHEERS Application Development and Technical Architecture teams which include both state and consultant staff. Works in partnership with stakeholders to ensure all program and technical needs are defined and reflected in the design, development, and implementation of the CalHEERS solution.

9. Application Development Lead (Sr. ISA) - Ensures the business requirements and functionality of the CalHEERS solution meets the needs of the Health Benefit Exchange, Department of Health Care Services, the Managed Risk Medical Insurance Board, and other program stakeholders.

10. Interface Management (Sr. ISA) - Provides leadership and oversight for interface activities, in coordination with the Systems Integrator. Oversees stakeholder management and coordination, identifies risks, and utilizes findings in developing mitigation strategies.

11. UAT Testing (Sr. ISA) - Supports preparation of test plans, test scenarios and test transactions to be executed by State, county, and other stakeholder staff. Reviews test results from contractor testing and State, county, and other stakeholder staff testing. Provides comments, recommendations and other input directed at error correction, risk management and quality assurance.

12. Organization Change Manager (Sr. ISA) - Executes activities related to change management frameworks. Carries out activities required for project team engagement, organizational readiness, stakeholder management, training classes, communication activities, and leadership alignment. Builds change management capability with the project team and stakeholder deployment teams.

13. Technical Architecture (SSS III) - Technical specialist who is responsible for ensuring the CalHEERS Project architecture fits within the CalHEERS project requirements, the State's overall architecture strategy and meets the needs of the state, counties, and other stakeholders.

14. Executive Assistant (EA) - Provides assistance to the Project Director and project management staff by conducting analytical research on sensitive program issues,

responding to inquiries, ensuring timely and accurate delivery of products and ensuring the accurate development and release of sensitive and confidential communications. Assists with travel, schedules, and all logistics of high-level meetings.

15. Agency Information Officer Health Information Technology Liaison (Sr. ISA) - Facilitates the development of the CHHSA governance structure consistent with CalHEERS, Health Information Exchange, and Health Information Technology governance structures to effectively leverage the SOA architecture and processes that will be built as part of CalHEERS.

16. SAWS Liaison (DPM III) – Supports the CalHEERS Project in the areas of interface management, issue and risk management, and project governance. Recommends changes to draft deliverables and approval or disapproval of final deliverable documents. Participates in strategic and tactical planning and maintains principles for OSI and project sponsor decision-making on issues with multi-departmental and statewide impact.

b. Department of Health Care Services – Medi-Cal & CalHEERS Integration (DOF Issue 112)

Budget Issue. In the May Revision, the DHCS requests the following related to CalHEERS:

- Budget bill language to allow expenditure of funds to implement CalHEERS.
- The establishment of 12 two-year limited-term positions, effective October 1, 2012, to support the planning, design, development, implementation, and ongoing maintenance of the Medi-Cal eligibility and enrollment system changes and integration with CalHEERS and county eligibility consortia systems.
- Funding to implement changes to the MEDS system for CalHEERS.
- Funding for the Medi-Cal's portion of the state's costs for CalHEERS.

Table: DHCS Funding Requests Related to CalHEERS

Purpose	Federal Funds	General Fund	Total Funds
Establish 12 positions for Medi-Cal eligibility changes and CalHEERS integration	$1,000,000	$224,000	$1,224,000
MEDS changes and interfaces with CalHEERS	1,446,300	160,700	1,607,000
Medi-Cal's associated costs for CalHEERS development	9,421,200	1,046,800	10,468,000
Total	$11,867,500	$1,431,500	$13,299,000

Budget Bill Language. DHCS requests budget bill language to allow expenditure of funds upon approval of DOF and notification to the Joint Legislative Budget Committee (JLBC) and to allow DOF to augment DHCS' expenditure authority in order to implement of CalHEERS upon notification to JLBC (this notification would include a plan for the expenditures). The following budget bill language is requested:

A Budget Bill Language to Item 4260-001-0001

Provisions:

X. Of the funds appropriated in this Item, $224,000 is to support the system changes necessary to implement federal health care reform. Notwithstanding Provision 2 of this item, these funds are not authorized for expenditure until approved by the Director of Finance. The Director of Finance shall provide notification in writing to the Joint Legislative Budget Committee of any expenditure approved under this provision not less than 60 days prior to the effective date of the approval. This 60-day notification shall include a plan for the system changes necessary to implement the requirements of the federal Affordable Care Act.

Add Budget Bill Language to Item 4260-101-0001

Provisions:

X Of the funds appropriated in this Item, $1,206,000 is to support the system changes necessary to implement federal health care reform. These funds are not authorized for expenditure until approved by the Director of Finance. The Director of Finance shall provide notification in writing to the Joint Legislative Budget Committee of any expenditure approved under this provision not less than 60 days prior to the effective date of the approval. This 60-day notification shall include a plan for the system changes necessary to implement the requirements of the federal Affordable Care Act.

X. The Director of Finance is authorized to approve current year increases in this item for expenditures necessary for implementation of the California Healthcare Eligibility, Enrollment and Retention System project. The Director of Finance shall provide notification in writing to the Joint Legislative Budget Committee of any expenditure approved under this provision not less than 60 days prior to the effective date of the approval. This 60-day notification shall include a plan for the system changes necessary to implement the requirements of the federal Affordable Care Act.

Positions. As part of this proposal, DHCS requests the following positions:

- The Medi-Cal Eligibility Division is requesting three two-year limited-term positions to support the planning, development, implementation, and evaluation of Medicaid eligibility rules and enrollment simplification provisions as required by federal health care reform. These positions are eligible for the regular administrative federal financial participation (FFP) rate of 50 percent.
- The Information Technology Services Division is requesting nine two-year limited-term positions to support the planning, design, development, implementation, and ongoing maintenance of the Medi-Cal eligibility enrollment system changes and integration with CalHEERS and county eligibility consortia systems. These positions are eligible for enhanced FFP at a rate of 90 percent through December 31, 2015. Beginning January 1, 2016, these positions are eligible for 75 percent FFP rate for on-going maintenance and operations of the new system components.

MEDS Changes. The DHCS requests $1,446,300 ($160,700 General Fund) to implement changes to the MEDS system for CalHEERS. The MEDS system is the statewide database which includes eligibility information for Medi-Cal, CalWORKs, and CalFRESH. It will be necessary to interface between MEDS and CalHEERS. The state will receive enhanced federal funding (90 percent federal participation) for these changes.

Medi-Cal's Share of Funding for CalHEERS Project. The DHCS requests $10.5 million ($1 million General Fund) to support Medi-Cal's share of the costs to implement CalHEERS. Medi-Cal's associated costs for the development and implementation of CalHEERS is 17 percent (of the state's 10 percent).

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on the CalHEERS Project.

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

1. Please provide an overview of these proposals and discuss why the Administration is requesting such broad authority for future expenditures.

2. What is the overall goal of the CalHEERS Project?

3. What will be the role of each state department?

E. 4260 Department of Health Care Services

Medi-Cal Caseload and Budget – May Revision Update – Informational Item

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. The May Revision proposes total expenditures of $59.7 billion ($14.4 billion General Fund) for 2012-13 which represents *an increase* of $12.8 billion (total funds), or 27.4 percent more than the current-year.

Medi-Cal caseload is projected to be 8,246,300, which represents a 7.9 percent increase compared to current year (and reflects the full transition of HFP children into Medi-Cal).

Table: Medi-Cal Funding Summary (dollars in millions)

	2011-12 Revised	2012-13 Proposed	Difference	Percent
Benefits	$43,917.9	$56,282.6	$12,364.7	28.2%
County Administration (Eligibility)	2,630.1	3,072.0	441.9	16.8%
Fiscal Intermediaries (Claims Processing)	318.9	350.5	31.6	9.9%
Total-Local Assistance	**$46,866.9**	**$59,705.1**	**$12,838.2**	27.4%
General Fund	$15,460.9	$14,405.6	-$1,055.3	-6.8%
Federal Funds	$28,663.0	$36,242.0	$7,579.0	26.4%
Other Funds	$2,743.0	$9,057.0	$6,314.0	230.2%

LAO Comment. Based on its review of recent caseload data, the LAO finds that the Administration's revised estimates of Medi-Cal caseload are reasonable. The majority of the caseload changes reflect lower caseload for families with children enrolled in Medi-Cal. On average, individuals who are included in these eligibility categories are some of the least expensive Medi-Cal beneficiaries.

1. Eliminate Gross Premium Tax Sunset Date for Medi-Cal Managed Care Plans

Budget Issue. The Administration proposes trailer bill language that eliminates the sunset date for the existing gross premiums tax (GPT) imposed on Medi-Cal managed care plans. In the May Revision, the Administration estimates that this will generate $188.4 million in General Fund savings in 2012-13.

The GPT is expected to generate about $376 million in revenues. Half of the revenues, or about $188 million, will be matched with federal funds to provide for an increase in capitation payments to Medi-Cal managed care plans.

Table: Gross Premium Fund Transfer to the General Fund (in millions)

Gross Premium Tax Applications	
Base Medi-Cal Managed Care Program	$138.3
SB 335 - Hospital Fee	31.2
2012-13 Budget Proposals	
Coordinated Care Initiative	$12.9
Healthy Families Program Transition to Medi-Cal*	4.3
FQHC Payment Reform*	1.5
Total	**$188.4***

*It should be noted that this Subcommittee rejected the Administration's proposal for FQHC Payment Reform; consequently, the General Fund offset would be reduced by this amount. Additionally, as discussed earlier in this agenda, it is recommended that only a portion of Healthy Families Program children be transitioned to Medi-Cal, this would result in a reduction to the above estimated General Fund offset.

(Please note that there is a managed care organization tax technical adjustment to the Healthy Families Program listed under the MRMIB section of this agenda.)

Subcommittee Staff Comment and Recommendation. It is recommended to:

- Reject the Administration's trailer bill language to eliminate the sunset date for the GPT.
- Adopt placeholder trailer bill language that extends the GPT sunset date for two years.

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

1. Please provide a summary of this proposal.

2. Non-Emergency ER and Prescription Drug Copay (DOF Issue 121)

Budget Issue. The May Revision proposes to increase General Fund expenditures by $555 million due to an erosion of savings from mandatory copayments for Medi-Cal services, pursuant to AB 97 (Statutes of 2011) that were not implemented because the state did not receive federal CMS approval.

Revised Non-Emergency ER Copay. Additionally, DHCS is proposing legislation to implement a $15 copayment for non-emergency use of the emergency room (ER). AB 97 implemented a mandatory copayment of $50 for non-emergency room use of the ER. Pending approval from the federal CMS, this copayment would be implemented in the managed care setting and would not apply to those who are in the Family Planning, Access, Care, and Treatment program. The hospital would collect the $15 copayment from enrollees at the time of service, and the hospital would be reimbursed the appropriate Medi-Cal reimbursement rate minus the $15 copayment. This copay would result in $7.1 million General Fund savings in the budget year.

Pharmacy Copay. Finally, DHCS is proposing legislation to implement a $3.10 copay for non-preferred drugs. AB 97 implemented a mandatory copay of $3 per prescription for preferred drugs and a $5 per prescription for non-preferred drugs. Pending approval from the federal CMS, this copayment would be implemented in the managed care setting and would not apply to those who are in the Family Planning, Access, Care, and Treatment program. The pharmacy would collect the $3.10 copayment from enrollees at the time of service, and the pharmacy would be reimbursed the appropriate Medi-Cal reimbursement rate minus the $3.10 copayment. This copay would result in $13.1 million General Fund savings in the budget year.

The DHCS estimates that both these copays would be implemented January 1, 2013.

Subcommittee Staff Comment and Recommendation—Approve. The DHCS is not able to implement the copays required by AB 97 because it did not receive federal approval. It is recommended that the Medi-Cal estimate reflect this savings erosion. Additionally, it is recommended to approve the Administration's proposed non-emergency room ER and pharmacy copay.

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

1. Please provide a summary of this proposal.

2. Please discuss why DHCS finds that these copays would receive CMS approval.

3. County Medi-Cal Eligibility Processing

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 General Fund savings of $43.1 million by not providing a cost-of-living adjustment (COLA) to the counties for a savings of $13.1 million and recognizing $30 million savings as a result of the reconciliation of 2009-10 county administrative expenditures.

Two years following the end of the fiscal year, county administration expenditures are reconciled to the county administration allocation for the applicable fiscal year. Counties have one year from the end of a quarter to amend their quality administrative claim, which is used by DHCS for its reconciliation process.

Report to Legislature on Updated Budgeting Methodology Not Provided. It should also be noted that AB 102 (Statutes of 2011) required DHCS to report to the Legislature on an updated methodology for county administrative expenditures on March 1, 2012. This report has not been received. This updated methodology was necessary for several reasons:

- The Affordable Care Act (health care reform) 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 eligible populations.

- The federal ACA also requires implementation of streamlined eligibility processing procedures to help facilitate the enrollment of individuals into coverage.

- 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.

Last year, DHCS stated 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. It is recommended to approve DHCS' proposal to not include a COLA for county administration and to recognize the reconciliations collections for a General Fund savings of $43.1 million and to adopt placeholder trailer bill language to implement the COLA savings. The state has not provided a cost-of living adjustment since 2008-09 and given the state's fiscal situation it is recommended to not provide this adjustment in the budget year. It is also recommended to get an update from DHCS on its efforts to update this budgeting methodology.

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

1. Please provide a summary of the DHCS' activities related to revising the county administrative cost budget methodology.

2. What is the timeline for updating this budgeting methodology?

4. Coordinated Care Initiative (DOF Issue 124)

Budget Issue. The Governor's January budget included a Coordinated Care Initiative for Medi-Cal enrollees. With this initiative, the Administration intends to improve service delivery for the 1.1 million people eligible for both Medi-Cal and Medicare (dual eligibles) and 330,000 additional Medi-Cal enrollees who rely on long-term services and supports (LTSS).

In the May Revision, the Administration proposes the following changes to its Coordinated Care Initiative:

- **Implementation date**. In response to stakeholder feedback that more time is needed to prepare for enrollment, the May Revision proposes to move the implementation date from January 1, 2013 to **March 1, 2013**. Enrollment will be phased in throughout the rest of 2013.
- **Demonstration Counties**. The number of counties proposed for demonstration implementation in 2013 has been reduced from ten to eight. The Administration has suspended work on launching the demonstration in Contra Costa and Sacramento counties for 2013, but intends to include those counties in the second year expansion.
- **Mandatory Medi-Cal Managed Care Enrollment**. The May Revision limits dual eligible mandatory enrollment in Medi-Cal managed care in 2013 to only the eight counties where the duals demonstration is implemented. Previously, the Coordinated Care Initiative proposed mandatory Medi-Cal managed care for wrap-around Medi-Cal services in all managed care counties in 2013. (This change was made in February, but the fiscal estimates have been updated in the May Revision to reflect this change.)
- **Long-Term Supports and Services.** The May Revision indicates the Administration's intention to eventually transition In-Home Supportive Services collective bargaining from the local government level to the state. This issue will be discussed at the Subcommittee#3 hearing on May 22, 2012.

Table: May Revise Coordinated Care Savings (dollars in millions)

	Total Funds	**General Fund**
Medicare Shared Savings	-$12.3	-$12.3
Long-Term Supports and Services	223.2	111.6
Defer Managed Care Payment	-1,271.1	-635.5
Delay Check-write	-150.4	-75.2
Total	**-$1,210.6**	**-$611.5**

It should be noted that detailed estimates on the May Revision savings are not available. However, the Administration indicates that the revised Medicare Shared Savings reflects a delay in the implementation date and a lower participation of Medicare enrollees (the January budget assumed 90 percent participation and the May Revision assumes 60 percent participation).

Please also note that the Coordinated Care Initiative was discussed at the following Senate hearings:

- Senate Budget and Fiscal Review Committee hearing on February 23, 2012. The materials for that hearing can be found at: http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/FullC/2232012SBFRHearingAgendaMediCal%20ManagedCareIHSSIntegration.pdf

- Senate Budget Subcommittee #3 hearing on April 26, 2012. The materials for that hearing can be found at: http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/SUB3/4262012Sub3DHCS.pdf

Additionally, there is a detailed discussion of the Administration's January proposal in the Senate Budget and Fiscal Review Committee's Overview of the 2012-13 Budget Bill, starting on page 3-1: http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/overview/OverviewOfThe2012_13BudgetBillSB957.pdf

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue with stakeholders, federal CMS, and the Legislature.

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

1. Please provide an overview of the May Revision changes to the CCI.

2. Please provide an update on DHCS' discussions with CMS regarding this demonstration proposal, including any feedback from CMS on the federal/state sharing ratio of Medicare savings.

3. Please highlight some of the key discussion points and issues that have been raised during the stakeholder meetings.

4. During the past budget committee and subcommittee hearings on the CCI, the Legislature has expressed a strong interest (if this proposal is approved) in developing a process to monitor and learn from implementation of the demonstration project to inform the potential future transition of additional counties. The May Revision does not include such a process or plan. Please comment why this is not included and if the Administration thinks this an important mechanism to ensure that the implementation of the demonstration is successful.

5. Community-Based Adult Services Program (DOF Issue 125 and 107)

Budget Issue. In the May Revision, the DHCS requests an increase of $71.7 million General Fund due to a revised estimate of the number of former Adult Day Health Care (ADHC) enrollees eligible for the Community-Based Adult Services (CBAS) program. The January budget proposal estimated that 50 percent of ADHC enrollees would be eligible for CBAS. The May Revision projects that 80 percent of ADHC enrollees would be eligible for CBAS.

Additionally, in the May Revision, the DHCS requests five limited-term positions to implement and operate the Community-Based Adult Services (CBAS) program. DHCS proposes to redirect existing limited term Adult Day Health Care (ADHC) positions (five limited-term and one permanent positions) to perform this workload. However, the limited-term positions expire on December 31, 2012. Consequently, the term of these newly proposed five limited-term positions would begin January 1, 2013 and expire August 31, 2014. The term of these positions corresponds to the time period of the Settlement Agreement. Additionally, the 1115 Waiver requires these services to be available until August 2014. Funding for the positions is noted in the table below.

Table: Proposed Funding for CBAS Positions

Year	General Fund	Federal Funds	Total Funds
2012-13	$162,000	$196,000	$358,000
2013-14	$280,000	$321,000	$601,000

The role of DHCS staff will be to oversee the transition of ADHC to CBAS and to provide contract oversight and monitoring of the managed care plans as CBAS becomes a managed care benefit on July 1, 2012. Essential activities conducted by DHCS staff would include:

- Instituting program improvement and performance expectations with CBAS providers.
- Ensuring appropriate utilization of CBAS center services.
- Overseeing and monitoring health plan contracts as they relate to CBAS services.
- Working with health plans to provide enhanced case management to CBAS participants.
- Supporting performance measurement, enrollment, and state hearing coordination to ensure health plan members receive medically necessary covered services.

Background. AB 97 (Statutes of 2011) eliminated ADHC as an optional Medi-Cal benefit to provide for an estimated $170 million in General Fund savings in 2011-12. The 2011 budget provided $85 million (General Fund) to provide for a temporary transition program for existing ADHC enrollees to other Medi-Cal appropriate services. As part of this transition, the Legislature provided for the development of policy legislation to create a federal Waiver program, but the Governor vetoed this budget bill language.

Settlement Agreement. Consequently, through the summer and fall of 2011, the Administration developed a transition plan for existing ADHC beneficiaries. However, as part of the settlement of a lawsuit that challenged the elimination of the ADHC benefit, an agreement was reached between the state and the plaintiffs to phase out the ADHC program and replace with a new program called the Community-Based Adult Services (CBAS) that will

provide necessary medical and social services to those with the greatest need. CBAS will be provided as a Medi-Cal managed care benefit no sooner than July 1, 2012.

CBAS Eligibility. At the time of the settlement, DHCS had estimated that roughly half of the "settlement class" (approximately 40,000 individuals who received ADHC services on or since July 1, 2011 through February 29, 2011) would qualify for CBAS; however, it is now estimated that approximately 80 percent of the class would be eligible.

Eligibility to participate in CBAS would be determined by state medical professionals on the basis of medical need, and the benefits provided would be coordinated with managed care plans. The CBAS program was originally expected to be implemented on March 1, 2012, but was not implemented until April 1, 2012, because of delays in getting federal CMS approval.

Contempt Motion. At the end of March 2012, Disability Rights California (DRC) filed a contempt motion stating that DHCS had not been following the terms of the settlement agreement. Since then, DRC and DHCS have come to agreement on the following:

- Both sides agree that DHCS will not be required to conduct further presumptive eligibility reviews.
- Both sides agree that a denial of presumptive eligibility is not appealable at a fair hearing.
- Both sides agree that the 37,000 people with disabilities and seniors who are part of the settlement class and were determined ineligible for the new CBAS program prior to April 1, 2012, who were not eligible to receive CBAS-pending, but who prevail at their respective fair hearings, will be deemed eligible CBAS retroactive to the date of CBAS implementation, April 1, 2012.
- The DHCS will coordinate with DRC and the California Department of Social Services State Hearings Division to offer optional telephonic hearings for the settlement class.

The other issue discussed in the contempt motion is the quality assurance process for the more than 315 eligibility determinations from 13 ADHC centers. DRC withdrew this contempt motion because it found that individuals who were first deemed eligible for CBAS through a state-run assessment and then subsequently deemed ineligible can still exercise their rights through fairness hearings.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the funding adjust to reflect the anticipated CBAS caseload and to approve the request for positions to implement and operate CBAS. This proposal is consistent with the terms of the Settlement Agree.

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

1. Please provide a brief overview of these proposals.

6. Expand Medi-Cal Managed Care to Rural Counties

Budget Issue. Beginning in June 2013, the Administration proposes to expand Medi-Cal managed care into the 28 rural counties (listed below) that are now Fee-For-Service (FFS). This proposal would result in General Fund savings of $2.7 million in 2012-13 and $8.8 million in 2013-14.

Table: Medi-Cal Fee-For-Service Counties

County	Number of Medi-Cal Eligibles
Alpine	204
Amador	4,095
Butte	47,834
Calaveras	6,106
Colusa	4,271
Del Norte	7,706
El Dorado	17,216
Glenn	6,610
Humboldt	25,208
Imperial	54,563
Inyo	3,213
Lassen	4,544
Lake	16,556
Mariposa	2,599

County	Number of Medi-Cal Eligibles
Modoc	1,866
Mono	1,143
Nevada	10,452
Placer	28,269
Plumas	2,971
San Benito	9,334
Shasta	38,039
Sierra	458
Siskiyou	9,759
Sutter	21,724
Tehama	16,049
Trinity	2,628
Tuolumne	7,511
Yuba	18,857
Total	**369,785**

Subcommittee Staff Comment and Recommendation. On March 30, 2012, DHCS released a Request for Interest (RFI) in providing Medi-Cal managed care services in the 28 FFS counties. The DHCS indicates that it received many responses to the RFI and is evaluating these proposals.

It is recommended to reject the Administration's proposed trailer bill language on this proposal and instead, adopt placeholder trailer bill language to expand Medi-Cal managed care to rural counties beginning June 2013 and require DHCS to engage with stakeholders on a discussion of what metrics might be used to ensure that the appropriate controls and oversight available with a locally sponsored plan would be specified under this expansion.

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

1. Please provide an overview of this proposal.

2. What are the next steps and how does DHCS plan to reach out to interested stakeholders and consumer advocates?

7. Default Managed Care Plan Assignment

Budget Issue. The Administration intends to change how it selects a default managed care plan when a Medi-Cal enrollee does not make a health plan selection. The Administration proposes to consider health plan cost in addition to quality of care and safety net population factors as part of the default algorithm. Specifically, the default algorithm would be adjusted to increase defaults to low cost plans by 5 percent.

Savings would be recognized based on the shift of beneficiaries that would have been defaulted to the higher cost plans under the normal default ratios to lower cost plans. General Fund savings for 2012-13 are projected to be $2.4 million and $5.8 million for 2013-14.

This default algorithm would be implemented for Geographic Managed Care (GMC) and Two-Plan counties with the exception of Kings and Madera counties. Managed care is new in these counties and, consequently, plans in these counties are currently paid the same capitation rate since health plan quality data is not yet available. It is anticipated that beginning on January 1, 2013, plans in these two counties would use the proposed default algorithm (as health plan quality data would be available).

As shown in the table below, a majority of these savings are the result of the change to the default algorithm for the Family aid category.

Table: Default Algorithm Savings Per Aid Category

	Total		**SPDs**		**Family**	
2012-13	Total Funds	General Fund	Total Funds	General Fund	Total Funds	General Fund
Health Plan Default Assignment Method	-$5,256,000	-$2,628,000	-$188,000	-$94,000	-$5,068,000	-$2,534,000
Defer Managed Care Payment	$438,000	$219,000	$16,000	$8,000	$422,000	$211,000
Total amount	-$4,818,000	-$2,409,000	-$172,000	-$86,000	-$4,646,000	-$2,323,000
Total %		100.00%		3.57%		96.43%

Background. When a Medi-Cal enrollee does not select a Medi-Cal managed care plan, a default health plan is assigned. Currently, the default algorithm defaults beneficiaries into a plan based health plan quality (6/8 of the weighting, using six HEDIS measures) and safety net population factors (2/8 of the weighting). This algorithm is based on Family and Seniors and

Persons with Disabilities (SPD) aid categories. DHCS has regulatory authority to determine how assignments of default beneficiaries are to be made.

In 2011, 40 percent of new Medi-Cal managed care enrollees were defaulted into a health plan. See table below for more specific information.

Table: New Medi-Cal Managed Care Enrollee Health Plan Assignment for 2011

Plan Type	New Enrollment	Choice		Defaults					
				Linked to Prior Plan		Auto Assigned Using Algorithm		Combined Defaults	
	Totals	Totals	% Total Enroll	Totals	% Total Enroll	Totals	% Total Enroll	Totals	% Total Enroll
GMC	230,801	143,974	62%	26,440	11%	60,387	26%	86,827	38%
Two-Plan	1,336,706	796,620	60%	189,135	14%	350,951	26%	540,086	40%
Combined	1,567,507	940,594	60%	215,575	14%	411,338	26%	626,913	40%

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue regarding the Administration's proposals to expand Medi-Cal managed care.

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

1. Please provide an overview of this proposal.

8. ACA Primary Care Provider Payments

Budget Issue. In the May Revision, the DHCS proposes trailer bill language to increase certain physician primary care service rates to no less than 100 percent of the Medicare rate for specific services beginning January 1, 2013 to December 31, 2014, as required by federal health care reform. Since the state must restore these rates to the level of payment in effect on July 1, 2009, $38.7 million General Fund is needed to restore this payment rate level.

Background. The Affordable Care Act (ACA) requires Medi-Cal to increase certain physician primary care service rates to no less than 100 percent of the Medicare rate for specific services beginning January 1, 2013 to December 31, 2014. For services furnished during this time period, the federal CMS provides for 100 percent federal funding for the differential between Medi-Cal baseline rates (the level of payment in effect on July 1, 2009) and Medicare rates. Regular federal matching applies for any payment amounts above the minimum requirement or for any increases necessary to achieve the July 2009 rate.

After December 31, 2014, CMS will no longer provide 100 percent federal funding for the difference between the level of payment in effect on July 1, 2009 and 100 percent of the Medicare rate. The level of federal funding for the incremental difference in payments will revert to the regular funding level of 50 percent federal funds and 50 percent General Fund if the State decides to maintain the increased payments. Maintaining the higher levels of payments after December 31, 2014, will require additional General Fund dollars. Since the State is currently not in a position to commit increased General Fund necessary to maintain the incremental increase in payments to 100 percent of Medicare for the primary care services and services related to immunization administration for vaccines and toxoids, the incremental increase in payments will sunset on December 31, 2014.

Subcommittee Staff Comment and Recommendation—Approve. This proposal is consistent with federal law and provides incentives to strengthen the primary care workforce in preparation for health care reform. It is recommended for approval.

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

1. Please provide an overview of this proposal.

9. Use of First 5 California Funding for Medi-Cal (DOF Issue 129)

Budget Issue. The budget proposes to use $40 million in Proposition 10 Funds to fund Medi-Cal services for children (aged five and under) to offset General Fund support in the program for 2012-13.

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.

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.

Subcommittee Staff Comment—Hold Open. 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. Please provide a brief summary of this proposal.

2. What is the status of discussions with First 5 on this proposal?

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Monday, May 21 (Room 3191)

VOTE ONLY CALENDAR

A. 4260 Department of Health Care Services (DHCS)

1. Medi-Cal Estimate Update
   - Action – Approve Administration's proposal.
   - Vote – 3-0

2. Medi-Cal Provider Payment Reductions
   - Action – Approve Administration's proposal.
   - Vote – 3-0

3. Family Health Estimate – CHDP, CCS, GHPP
   - Action – Approve Administration's proposal.
   - Vote – 3-0

4. CMAC Staff Transition
   - Action – Approve Administration's proposal.
   - Vote – 2-1 (Senator Emmerson voting no.)

5. Privacy and Security of Medi-Cal Information
   - Action – Approve Administration's proposal.
   - Vote – 3-0

6. Positions for HIPAA
   - Action – Approve Administration's proposal.
   - Vote – 3-0

7. Every Women Counts Technical Adjustment
   - Action – Approve Administration's proposal.
   - Vote – 3-0

8. Eliminate the Advisory Committee on Genetically Handicapped Persons
   - Action – Modify Administration's proposal and approve staff recommendation.
   - Vote – 3-0

9. Radiology Rate Reduction
   - Action – Approve staff recommendation.
   - Vote – 3-0

10. FQHC/RHC Audit Staffing
    - Action – Approve staff recommendation.
    - Vote – 3-0

11. Medi-Cal Electronic Health Records – State Match
    - Action – Approve staff recommendation.
    - Vote – 3-0

12. Eliminate Sunset for LEA Medi-Cal Billing Option Program
    - Action – Reject Administration's proposal.
    - Vote – 2-1 (Senator Emmerson voting no.)

B. 4265 Department of Public Health (DPH)

1. Licensing and Certification Program Estimate Update
   - Action – Approve Administration's proposal.
   - Vote – 3-0

2. Proposition 99 – Research Account Adjustment
   - Action – Approve Administration's proposal.
   - Vote – 3-0

3. Expand California's Newborn Screening Program
   - Action – Approve Administration's proposal.
   - Vote – 3-0

4. Women, Infant, and Children (WIC) Program
   - Action – Approve Administration's proposal.
   - Vote – 3-0

C. 4280 Managed Risk Medical Insurance Board (MRMIB)

1. County Health Initiative Matching Fund Caseload Update
   - Action – Approve Administration's proposal.
   - Vote – 3-0

2. AIM Caseload and Funding Update
   - Action – Approve Administration's proposal.
   - Vote – 3-0

3. Major Risk Medical Insurance Program
   - Action – Approve Administration's proposal.
   - Vote – 3-0

ISSUES FOR DISCUSSION

A. 4265 Department of Public Health

1. AIDS Drug Assistance Program (ADAP) Estimate Update (DOF Issues 561 and 651)

- Action – Approve staff recommendation.
- Vote – 2-1 (Senator Emmerson voting no.)

2. Transition of Ryan White/ADAP Clients to LIHP

- Action – Approve staff recommendation.
- Vote – 3-0

3. Public Health Laboratory Training Program (DOF Issue 602)

- Action – Approve staff recommendation.
- Vote – 3-0

4. Close Southern California Laboratory

- Action – Approve Administration's proposal.
- Vote – 3-0

5. Biomonitoring Fund Shifts

- Action – Approve Administration's proposal.
- Vote – 2-1 (Senator Emmerson voting no.)

B. 4280 Managed Risk Medical Insurance Board

1. Healthy Families Program Caseload Update (DOF Issue 102, 103, 104, 111, 112)

- Action – Approve staff recommendation.
- Vote – 3-0

2. Transition of Healthy Families Children to Medi-Cal – MRMIB and DHCS

- Action – Approve staff recommendation.
- Vote – 2-1 (Senator Emmerson voting no.)

3. Transfer of MRMIB Programs to the Department of Health Care Services

- Action – Reject Administration's proposal.
- Vote – 3-0

C. 4150 Department of Managed Health Care

1. DMHC's Role in Coordinated Care Initiative (DOF Issue 103)

- Held open.

2. Medi-Cal Dental Managed Care Program (DOF Issue 102)

- Action – Approve 2 positions for oversight of existing Medi-Cal dental managed care plans.
- Vote – 3-0
- Action – Approve 1 position for oversight of Medi-Cal dental managed care plans as Healthy Families Program children (in families with income under 133 percent of the federal poverty level) transition to Medi-Cal.
- Vote – 2-1 (Senator Emmerson voting no.)

D. 0530 California Health and Human Services Agency and 4260 Department of Health Care Services

1. CalHEERS Integration with the State's Public Assistance Systems

- Held open.

E. 4260 Department of Health Care Services

1. Eliminate Gross Premium Tax Sunset Date for Medi-Cal Managed Care Plans

- Action – Approve staff recommendation.
- Vote – 2-1 (Senator Emmerson voting no.)

2. Non-Emergency ER and Prescription Drug Copay (DOF Issue 121)

- Held open.

3. County Medi-Cal Eligibility Processing

- Action – Approve staff recommendation.
- Vote – 3-0

4. **Coordinated Care Initiative (DOF Issue 124)**
    - Held open.

5. **Community-Based Adult Services Program (DOF Issue 125 and 107)**
    - Action – Approve Administration's proposal.
    - Vote – 2-1 (Senator Emmerson voting no.)

6. **Expand Medi-Cal Managed Care to Rural Counties**
    - Action – Approve staff recommendation.
    - Vote – 2-0 (Senator Emmerson abstaining.)

7. **Default Managed Care Plan Assignment**
    - Held open.

8. **ACA Primary Care Provider Payments,**
    - Action – Approve Administration's proposal.
    - Vote – 2-1 (Senator Emmerson voting no.)

9. **Use of First 5 California Funding for Medi-Cal (DOF Issue 129)**
    - Held open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 22, 2012

1:30 PM

Room 4203
(John L. Burton Hearing Room)

Staff: Jennifer Troia, Brady Van Engelen (DCSS)
& Catherine Freeman (CSD)

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 noted in the Agenda unless otherwise directed by the Chair.

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Vote-Only Agenda

Discussion Agenda

VOTE-ONLY AGENDA

4170 Department of Aging (CDA)

Staffing Changes Related to Adult Day Health Care (ADHC) & Community Based Adult Services (CBAS) Programs

Budget Issue: The 2011-12 budget included statutory and budgetary changes to eliminate the Medi-Cal ADHC program. After the subsequent settlement of a related lawsuit, *Darling et al v. Douglas*, this elimination occurred on February 29, 2012; but as part of the settlement, the ADHC program was then replaced with a new program called Community-Based Adult Services (CBAS) on March 1, 2012. The new program is intended to provide necessary medical and social services to individuals with intensive health care needs.

CDA proposes a net reduction of $787,000 ($473,000 GF) resulting from the elimination of the ADHC program and implementation of the new CBAS program. CDA, via an interagency agreement with the Department of Health Care Services, previously certified ADHCs for participation in the Medi-Cal program. Under the proposed structure of the new CBAS program, the Department would retain this role. These requests would remove base funding and authority for 23 positions associated with the ADHC program from the CDA budget and create 16 positions and corresponding funding associated with CBAS. Other issues related to the transition from the ADHC to CBAS program are being heard under the Department of Health Care Services' budget.

Staff Recommendation: Approve the proposed staffing and resources.

4300 Department of Developmental Services (DDS)

Estimate Changes & Technical Adjustments

Budget Issue: DDS proposes, as is customary during the May Revision, to update its estimates based on more recent data than was available at the time of the Governor's January budget release.

Caseload Estimates: The Governor's January and May estimates of the developmental services caseload looking ahead to January 1, 2013 include:

Program	January Estimate	May Revision
Regional Centers/Community	256,059	255,972
Developmental Centers	1,533	1,544

Other Technical Changes: The May Revision also reflects the Administration's requests to make technical changes described below.

For Developmental Centers:

- **Workload Adjustments (Issues 201, 202, 203, and 206)—**It is requested that Schedule (1) of Item 4300-003-0001 be increased by $1,197,000, reimbursements be increased by $620,000, Item 4300-003-0890 be decreased by $20,000, and Schedule (1)(a) of Item 4300-004-0001 be decreased by $138,000, and Schedule (1)(b) be increased by $138,000 to reflect adjustments in Level-of-Care and Non-Level-of-Care Staffing, operating expenses and equipment, and a fund shift in the Foster Grandparent Program.

- **Lanterman Developmental Center Closure Update (Issue 204)—**It is requested that Schedule (1) of Item 4300-003-0001 be decreased by $1,091,000 and reimbursements be decreased by $494,000 to reflect changes in staff support costs associated with leave buyout, unemployment insurance, and resident transition activities.

- **Federal Certification of Porterville Developmental Center (Issue 200)—**It is requested that reimbursements be decreased by $13.0 million to reflect the federal Centers for Medicare and Medicaid Services' (CMS) denial of certification to expand Medi-Cal eligibility to a portion of the population in the Secure Treatment Program.

- **$200.0 Million General Fund Trigger Reduction Adjustment (Issue 209)—**It is requested that Schedule (1) of Item 4300-003-0001 be decreased by $9.1 million and reimbursements be increased by $1.3 million to reflect a reallocation of the $200.0 million General Fund trigger reductions proposed in the Governor's Budget from regional center Purchase of Services to developmental centers.

For Regional Centers:

- **Quality Assurance Fees** (Issues 301 and 302)—It is requested that Schedule (1) of Item 4300-101-0001 be increased by $76,000, Schedule (2) be increased by $411,000, and reimbursements be increased by $139,000 to reflect updated day treatment and transportation costs for Intermediate Care Facility/Developmentally Disabled (ICF/DD) residents.

- **Money Follows the Person Grant Fund Shift (Issue 316)—**It is requested that reimbursements be decreased by $2,134,000 to reflect new federal restrictions on the amount that Money Follows the Person grant expenditures can be reimbursed for administrative costs.

- **Targeted Case Management Administration Fund Shift (Issue 317)—**It is requested that reimbursements be decreased by $328,000 to reflect a decrease in federal financial participation due to reduced eligible expenditures.

- **$200.0 Million General Fund Trigger Reduction Adjustment (Issue 322)—**It is requested that Schedule (1) of Item 4300-101-0001 be decreased by $7.0 million, Schedule (2) of Item 4300-101-0001 be decreased by $3.4 million and reimbursements be decreased by $20.8 million to reflect the reallocation of a portion of the $200.0 million

General Fund trigger from regional center Purchase of Services budget to the developmental center budget.

- **Race-to-the-Top Grant for the Early Intervention Program (Issue 321)—**It is requested that Schedule (3) of Item 4300-101-0001 and reimbursements be increased by $286,000 to reflect the DDS share of federal Race-to-the-Top grant funds for the Early Intervention Program.

- **Extend Liquidation Period for Prior Year Appropriations (Issue 001 and 002) —**It is requested that Budget Bill language be approved for a one-year extension of the liquidation period for funds appropriated in the 2009 and 2010 Budget Acts in order to achieve approved General Fund savings targets (See Attachment 1). The DDS is in the process of retroactively rebilling the federal government for day treatment and transportation services provided to Medi-Cal beneficiaries residing in licensed ICF/DDs.

Subcommittee Recommendation: Adopt the above described technical adjustments, with any changes to conform as appropriate to other actions that have been or will be taken.

Proposed Funding Change for Early Start Services

Budget Issue: In 2009-10, Governor Schwarzenegger vetoed $50 million GF from the budget for developmental services provided to children from birth to age five who have, or are at risk for, developmental delays or disabilities. The California Children and Families Commission (created by Proposition 10 in 1998 and commonly known as the First 5 Commission) then provided $50 million to prevent the loss of services that would otherwise have resulted. The Commission provided these funds again in the 2010-11 and 2011-12 budget years. The Governor's January budget did not assume continuation of these First 5 funds in 2012-13. The May Revision does, however, assume $40 million in First 5 funding for Early Start services in 2012-13.

Additional background on Early Start services and on Proposition 10 was included in the Subcommittee's agenda for March 26.

Staff Recommendation: Approve the May Revision proposal to anticipate $40 million in First 5 funding for Early Start services.

4700 Department of Community Services & Development

Lead Hazard Control Program

Budget Issue: The May Revision requests a one-time Federal Trust Fund augmentation in the amount of $1.9 million for the U.S. Department of Housing and Urban Development Lead Hazard Control Program. The augmentation will allow the department to evaluate and remediate lead-based paint hazards in pre-1978 low-income privately-owned homes.

Staff Recommendation: Approve the proposed augmentation. The LAO concurs in this recommendation.

5160 Department of Rehabilitation

Proposed Elimination of the Orientation Center for the Blind Trust Fund Committee

Budget Issue: The May Revision proposes eliminating the Orientation Center for the Blind Trust Fund Committee (Committee). There are no GF costs or savings associated with the proposal.

Background: The Committee was established in 1997 to consult with the Department concerning the use of funds in the Orientation Center for the Blind Trust Fund (Fund). The Fund's revenues include gifts and donations that are used to supplement the services and programs provided by the Orientation Center to their students. The Committee is made up of three members, all of whom must be graduates from the Orientation Center. They serve on a voluntary basis and are not compensated for their service.

The Administration indicates that the Committee is unnecessary as the Blind Advisory Committee (BAC) (which was created in statute in 2003) has a broader scope and could absorb the Committee's functions. The BAC provides consultation to the Department on strategies to increase competitive employment, enlarge economic opportunities, enhance independence and self-sufficiency, and otherwise improve services for persons who are blind and visually impaired.

Stakeholder Comments: The California Council of the Blind opposes the proposed elimination of the Committee and indicates its opinion that the BAC does not have the same expertise or capacity as the Committee.

Staff Comment & Recommendation: Given the concerns raised and the lack of a fiscal impact related to the proposal, staff recommends rejecting the proposed elimination at this time.

5180 Department of Social Services (DSS)

Estimate Changes & 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.

Caseload Estimates: January and May estimates of the average monthly caseloads (rounded figures) associated with some DSS programs in 2012-13 include:

Program	January Budget (November forecast)	May Revision
CalFresh (food stamps)[1]	1,607,000 families	1,629,000 families
Supplemental Security Income/State Supplementary Payment (SSI/SSP)	1,305,000 cases	1,296,000 cases
CalWORKs	597,000 cases	570,000 cases
In-Home Supportive Services (IHSS)	459,600 recipients	452,400 recipients

To reflect corresponding changes in the programs' caseload and workload budgets, DSS requests the following technical changes to budget bill items, totaling a net decrease of $131,246,000 (decreases of $181,322,000 General Fund, $807,000 Child Support Collections Recovery Fund, and $74,892,000 reimbursements, partially offset by an increase of $125,775,000 Federal Trust Fund):

Program	Item	Change from Governor's Budget
CalWORKs / Kin-GAP	5180-101-0001 5180-101-0890 5180-601-0995	-$320,934,000 $853,272,000 -$2,745,000
Supplemental Security Income/State Supplementary Payment (SSI/SSP)	5180-111-0001	-$28,332,000
In-Home Supportive Services (IHSS)	5180-111-0001 5180-611-0995	$25,275,000 -$67,645,000
Other Assistance Payments	5180-101-0001 5180-101-0890	$106,719,000 -$802,289,000
County Administration and Automation Projects	5180-141-0001 5180-141-0890 5180-641-0995	$37,271,000 $67,253,000 $6,220,000
Community Care Licensing	5180-151-0001 5180-151-0890	$105,000 $46,000
Realigned Programs		
Adoption Assistance Program	5180-101-0890	-$6,204,000

[1] This reflects the non-assistance caseload.

Program	Item	Change from Governor's Budget
Foster Care	5180-101-0001 5180-101-0890 5180-101-8004 5180-141-0001 5180-141-0890	$4,000 $9,325,000 -$807,000 -$6,000 $2,126,000
Child Welfare Services (CWS)	5180-151-0001 5180-151-0890 5180-651-0995	-$1,424,000 -$218,000 -$11,227,000
Title IV-E Waiver	5180-153-0890	$2,464,000
Adult Protective Services	5180-651-0995	$505,000

Revised Estimates Related to Previously Adopted Solutions: The May Revision also reflects the Administration's revised estimates of savings related to the following previously adopted policies:

Program	Policy	Change from January
IHSS	Sales Tax on Supportive Services (Issue 202)	Erosion of $95.4 million GF savings due to assumption of no federal approval (though the federal government has not officially approved or disapproved of the implementing state plan amendment)
IHSS	Requirement for Certification of Need by Health Care Provider (Issue 203)	Erosion of $117.3 million GF savings due to revised estimating methodology based on initial implementation period
IHSS	Proposed Domestic & Related Services Reduction (Issue 205)	Erosion of $38.5 million GF savings given revised implementation date (from July 1 to October 1, 2012)

Title IV-E Waiver Carryover (Issue 302): In addition, the May Revision reflects a technical adjustment to carry over $6.6 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 currently participants in the waiver project.

Staff Recommendation: Adopt the above described caseload and other estimate adjustments—with the exception of the assumption related to the sales tax on

supportive services, which staff recommends holding open. This action is subject to any changes to conform as appropriate to other actions that have been or will be taken.

Coordinated Care Initiative – Requested Positions

Budget Issue: DSS requests $460,000 ($230,000 GF) to permanently fund three staff positions across two departmental divisions and to fund annually for three years $100,000 ($50,000 GF) of contract costs. The requested resources are intended to support the Department's work related to the Governor's proposed Coordinated Care Initiative. More specifically, the Adult Programs Division of DSS would gain a research analyst and a staff services manager specialist, while the fiscal systems and accounting branch would gain an accounting administrator. The requested contract resources would support consulting regarding the development of a universal assessment tool for various long term supports and services, as proposed under the Initiative.

The Coordinated Care Initiative has been the subject of several previous full Budget and Subcommittee #3 hearings (including hearings on February 23, April 26, and May 21, with agendas for all three available online at http://sbud.senate.ca.gov/hearingagendas).

Staff Recommendation: Hold this issue open, as any action should ultimately be taken along with larger decisions regarding the Coordinated Care Initiative.

Other Conforming Issues: Child Care-Related Proposals, Transfers of Specified Alcohol & Drug Programs & Budget Bill Language Related to Health Care Reform

Budget Issue: The May Revision proposes adjustments to the DSS budget that correspond to child care, alcohol & drug programs, and health care reform-related proposals that will be heard during other Subcommittee or full Committee hearings.

With respect to child care, the May Revision proposes: 1) budget bill language to authorize a transfer of funds for staffing and operational costs associated with the proposed transfer of program oversight from the Department of Education to DSS (Issues 010, 110), and 2) savings of $55.7 million GF due to a proposed reduction in the Regional Market Reimbursement rate for payments to child care providers (Issue 107).

With respect to alcohol & drug programs, the May Revision includes a technical adjustment to budget authority and new budget bill language (Issues 301, 302) to reflect the proposed transfer of specified programs to DSS.

With respect to health care reform, the May Revision proposes budget bill language to allow the Director of Finance to augment the DSS budget by up to $18 million GF to address system changes necessary to implement the requirements of the federal Affordable Care Act (Issue 401).

Staff Recommendation: Hold these items open, as they will ultimately conform to other actions.

LEADER Replacement System (LRS)

Budget Issue: LEADER is one of three existing consortia systems that comprise the Statewide Automated Welfare System (SAWS). 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. The LEADER system serves Los Angeles (LA) County. The Governor's January budget for 2012-13 included $12.9 million GF (and corresponding federal funds) for LRS. Based on updated estimates of the budget year costs incurred to move forward with development of LRS, the May Revision increases this amount to $28.2 million GF.

In 2011, OSI estimated a total cost of $370.2 million over four years ($196.1 million GF/TANF, $147.3 million federal funds and $26.8 million county funds) for development and implementation of LRS. Other than costs added to the project resulting from the 2011-12 budget's direction for the Administration to migrate existing data from the C-IV consortia to the new LRS, these overall costs are not anticipated to have changed since that time. For additional information about LRS and the migration, as well as prior actions taken with respect to these issues, please see the Subcommittee agenda for May 10, 2012.

Staff Recommendation: Approve the revised estimate for 2012-13 LRS development costs.

Case Management, Information, and Payrolling System (CMIPS) II

Budget Issue: In a January budget change proposal, OSI requested $97,968 for one limited-term Senior Information Systems Analyst to replace an expiring position to support development of the Case Management Information Payrolling (CMIPS) II automation system. Additionally, DSS requested $929,000 ($464,000 GF) for a one-year extension of eight existing limited-term positions. OSI and the Department indicated that the requested positions are necessary to ensure continuity of knowledge and meet a heavy programmatic workload during the final phases of the system's development. The Administration also sought authority to delay some project costs from the 2011-12 to the 2012-13 fiscal year. The May Revision proposes an additional shift of vendor payment costs from 2011-12 to 2012-13 (Issue 113).

Background on CMIPS II & Rationale for Position Requests: CMIPS is the automated, statewide system that handles payroll functions for all IHSS providers. The current vendor (formerly Electronic Data Systems, now Hewlett Packard) has operated the 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 completion was due in part to the vendor's technical difficulties in getting data to convert accurately from the old to the new system. The vendor has since submitted a new plan for compliance with data conversion requirements and a revised schedule.

Staff Recommendation: Approve the staffing requests for DSS and OSI, as well as the shift of costs between fiscal years.

IHSS Public Authority Funding Methodology

Budget Issue: The 2011-12 budget included trailer bill language directing the Department, in consultation with stakeholders, to develop a new rate-setting methodology for public authority (PA) administrative costs, beginning with the 2012-13 fiscal year. The effort to develop these changes has taken longer than anticipated, and the California Association of Public Authorities has proposed extending the timeframe specified in statute to instead begin with the 2013-14 fiscal year.

Background: Under state law, a county board of supervisors may elect to establish a Public Authority (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. 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.

PA rates are county-specific and are computed by multiplying case-months by the average hours per case and 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.

Staff Recommendation: Adopt trailer bill language extending the timeframe specified in statute for use of a newly developed ratesetting methodology for PA funding--to begin with the 2013-14 fiscal year, rather than 2012-13.

Sharing of Criminal Offender Record Information with the Department by the Public Authorities

Budget Issue: The California Association of Public Authorities proposes technical clean-up language to allow public authorities to share Criminal Offender Record

Information (CORIs) with the Department when a provider seeks an exception to criminal background exclusion policies adopted as part of the 2010-11 budget. The proposed language would amend WIC 12305.87 to change subsection (e)(2) and add public authorities to existing language requiring counties to submit CORIs to DSS for general exception applicants. CAPA states that per DSS, as of the end of December 2011, there were 41 general exception applications pending which could not be processed without the Department receiving the CORIs from the Public Authority.

Staff Comment & Recommendation: Adopt the proposed revision to WIC 12305.87, which is a technical change to the policies adopted in the 2010-11 budget.

DISCUSSION AGENDA

4300 Department of Developmental Services (DDS)

Proposals to Achieve $200 million Trigger Reduction

Budget Issue: The May Revision proposes policy changes and corresponding trailer bill language to implement a reduction of $200 million annually that was triggered in December 2011 by lower than anticipated state revenues (pursuant to AB 121, Chapter 41, Statutes of 2011). The Department indicates that the proposals are guided by three priorities: 1) preserving the entitlement to developmental services established by the Lanterman Act, 2) minimizing the impacts on consumers of DDS services, and 3) spreading the impacts across the developmental services system. To inform its development of these proposals, the Department conducted six workgroup meetings throughout the state with stakeholders and invited written input as well. The proposals include policies to:

A. Maximize Federal Funds

The Department proposes to capture additional federal financial participation through: 1) more aggressive enrollment in the state's Home and Community-Based Services (HCBS) Waiver (for $61.0 million GF savings in 2012-13), and 2) amending the state's plan for its Community First Choice Option (for $1.9 million GF savings in 2012-13). No trailer bill language is proposed related to these proposals.

The HCBS Waiver underlying this proposal, which is authorized under Section 1915(c) of the federal Social Security Act, allows the state to provide long-term care services in home and community-based, rather than institutional, settings. Services funded under the Waiver for individuals who are otherwise eligible for an institutional level of care can include case management, personal care, homemaker services, respite care, and others. Enrollment in the Waiver is a matter of choice for DDS consumers who qualify. The state's most recent 1915(c) Waiver was approved by the federal government for five years, effective March 29, 2012.

As of the end of April, there were approximately 96,400 Waiver participants. The recently approved Waiver anticipates that a maximum of 100,000 individuals will be enrolled, with an annual increase of 5,000 participants each March. The Administration proposes to conduct an aggressive campaign to encourage Regional Centers, families, and providers to increase enrollment to reach this cap of 100,000 in March 2013.

The Community First Choice Option (CFCO) is a state plan option available under Section 1915 (k) of the Social Security Act that provides an additional six percent in federal matching payments for certain eligible personal care services. California's CFCO plan, which is currently focused on services provided through the state's In-Home Supportive Services program, is under consideration by the federal government.

The Administration's proposal is to amend the state's plan one year after the issuance of federal regulations to include some services provided through the Regional Centers, potentially including components of Supported Living Services.

B. Implement Previously Enacted Legislation (SB 946)

Statutes that take effect July 1, 2012 (enacted by SB 946, Chapter 650, Statutes of 2011) will require health insurers to provide coverage for specified behavioral health treatment for individuals who are diagnosed to have pervasive developmental disorders or autism. Because of the requirement that Regional Centers use generic resources available to consumers before purchasing services, the Department estimates that this change will result in $69.4 million GF savings in 2012-13. In addition, the Department indicates that the Department of Managed Health Care recently announced that the CalPERS and Healthy Families insurance plans will be required to cover behavioral health treatment (as a result of requirements for mental health services to be provided on parity with other health services) as well. As a result, the Department assumes an additional $10.4 million GF savings in the developmental services system, for a total savings of $79.8 million GF.

C. Redesign Services for Individuals with Challenging Needs

In the largest proposed policy changes under the Governor's May Revision related to developmental services, the Department proposes to significantly amend the statutory criteria for admissions to Developmental Centers (DCs) and to make changes to existing uses of locked mental health facilities and out-of-state placements. The Department assumes that these changes, taken together, will result in $20 million GF savings in 2012-13.

Proposed Changes to DC Admissions Criteria

Under current law, the primary statutory processes for judicial commitments to DCs are: 1) Section 6500 *et seq.* of the Welfare & Institutions Code, providing for judicial commitment of a person determined to be both "mentally retarded" and a danger to himself, herself, or others; and, 2) Section 1370.1 of the Penal Code, to restore competency of individuals with developmental disabilities who are determined to be incompetent to stand trial on criminal charges. In addition, based on caselaw [*In re Hop* (1981) 29 Cal.3d 82 case, a California Supreme Court decision that found the state's statutory scheme for involuntary admissions of people with developmental disabilities to DCs unconstitutional on due process grounds], and absent a statutory commitment scheme, courts have been providing judicial review for admission of persons with developmental disabilities who do not meet the criteria of Section 6500—either because they are not "mentally retarded" or are not a danger to themselves or others—under procedures and criteria that vary from county to county. (Current law also allows for an automatic right to return on a provisional placement for a period of one year for individuals who move out of a DC.)

The newly proposed criteria would instead allow new admissions to DCs only under a limited set of circumstances, including when: 1) individuals are committed by the criminal or juvenile justice systems to restore competency, 2) individuals involved in the criminal or juvenile justice system are a danger to themselves or others and their competency cannot be restored, and 3) individuals are in "acute crisis" and require short-term stabilization. (The one-year right of return for provisional placements after individuals move out of a DC would also continue.)

Under the proposed trailer bill language to effectuate these changes, acute crisis would mean that there is imminent risk for harm and the consumer's needs cannot be met in the community. Fairview DC would be the only DC authorized to accept these admissions, which would need to occur pursuant to a court order. As soon as possible within 30 days of an acute crisis admission, a comprehensive assessment would be conducted by the Regional Center in coordination with the DC, and an Individual Program Plan (IPP) meeting would then be convened. Stays of longer than 90 days would require an extension by the Department. After six months, a consumer's stay could only be extended if ordered by a court because the consumer continued to be in acute crisis and other specified criteria were met.

Other Changes

The Department also proposes:

- To establish a Statewide Specialized Resource Service that tracks the availability of specialty services, coordinates those services with Regional Centers, and identifies supports that can be made available in the community.

- To require Regional Centers to complete comprehensive assessments of specified consumers residing in DCs on July 1, 2012, who have not had such an assessment in the prior two years, and to provide those assessments to the consumers' IPP teams.

- To require Regional Centers to conduct a comprehensive assessment, convene an IPP meeting, and request assistance from the Statewide Specialized Resource Service prior to submitting a request for out-of-state services. Those services would then be authorized for only six months, unless a new assessment determines the continued need for the out-of-state services, in which case they could be extended for no more than an additional six months. Regional Centers would also be required to submit transition plans for consumers residing out-of-state for whom they are purchasing services as of June 30, 2012.

- To limit, as specified, Regional Centers' ability to rely on residential services provided in facilities with capacities of 16 or more beds and mental health facilities that are not eligible for Medicaid reimbursement.

- To prohibit admissions to DCs when the Department determines that it cannot safely serve a consumer without placing other residents' safety at risk.

D. Redesign Supported Living Assessments

Supported Living Services (SLS) assist DDS consumers to live in their own homes that they own, lease, or rent. The consumer pays for living expenses out of Social Security income, work earnings, or other personal resources, and the Regional Center pays the SLS vendor to provide supportive services.

Statutory language added as a part of the 2011-12 budget requires an independent assessment of the needs of consumers who receive SLS that exceed 125 percent of the annual statewide median costs of those services. The assessment is to be completed by an entity other than the SLS vendor providing the services to the consumer. Several stakeholders have expressed concerns that these independent needs assessments are unnecessary and/or cumbersome.

DDS proposes to rescind these existing requirements (and avoid the costs of meeting them) and to instead replace them with a new assessment process that applies more broadly. More specifically, the Department proposes an increase of $4.2 million GF in savings from requiring the IPP teams of consumers receiving SLS services to complete a standardized assessment questionnaire.

E. Reduce Regional Center & Provider Rates by 1.25 Percent

Regional Centers and community-based developmental service providers have operated, with some limited exceptions, under a payment reduction since February 2009, when a three percent reduction first took effect. That initial reduction was increased to 4.25 percent on July 1, 2010, and is currently scheduled to sunset on June 30, 2012. These payment reductions have been a subject of great concern for many stakeholders. The Governor's January budget for 2012-13 did not assume an extension of the existing payment reduction. The May Revision does, however, assume $30.7 million GF savings from continuing 1.25 of the existing 4.25 percent reduction. The Department proposes to make this new reduction permanent.

F. Achieve Additional Cost Savings and Efficiencies

The Department also proposes savings from:

- Downsizing Community Care Facilities to allow them to meet requirements for federal financial participation ($2.0 million GF)

- A declining need for "gap" funds when a Community Care Facility transfers ownership and is temporarily ineligible for federal funding until it can be recertified under its new ownership ($0.3 million GF)

- The use of technology to allow for participation in services or events remotely, including remote access to court proceedings for DC residents ($0.4 million GF), expanded use of virtual training ($0.5 million GF), and service delivery using existing and available technology ($1.1 million GF).

Staff Recommendation: Hold these issues open.

Questions for the Administration:

1) With respect to the Home & Community Based Services Waiver enrollment, what are the Department's plans for outreach and activities to support the proposed increase in participation? How will the Department determine if a Regional Center is maximizing utilization of the Waiver?

2) With respect to the CalPERS and Healthy Families health insurance programs, is there a GF cost elsewhere in the state's budget that parallels the $10.4 million in savings assumed by DDS?

3) Please describe the proposed changes regarding admissions criteria for Developmental Centers, the use of out-of-state facilities, and the use of mental health facilities that are not eligible for federal financial participation. What are the policy reasons for these changes?

Also, what safeguards are in place to ensure that individuals' needs will be met in the community if the new, more limited criteria for DC admissions are not met? And what, if any, efforts will be made to develop local or regional community-based crisis placements and services so that admission to a DC does not become the only option for people experiencing crises?

4) Please describe the anticipated impact of the 1.25 percent payment reduction on Regional Centers, providers, and the overall developmental services system.

5) What process would be used to determine which services might be provided more efficiently through "existing and available technology"? What technology is envisioned to be used? And what safeguards would be in place to ensure the effectiveness of any changes?

Proposals for New Trigger Impacts

Budget Issue: The May Revision proposes to trigger, as of January 1, 2013, a reduction of $50 million GF to 2012-13 developmental services expenditures if the Governor's revenue-related ballot initiative does not pass in November. The Administration indicates that the reduction, if triggered, is proposed to become $100 million GF when annualized and is proposed to be permanent. The policy changes that would lead to this reduction are not specified and the Administration has not yet released its proposed trailer bill language that would effectuate the change. The trigger proposal related to the November initiative also proposes to newly count General Fund resources dedicated to the Early Start program as educational expenditures under Proposition 98.

Staff Comment & Recommendation: Staff recommends holding these proposals open, as they will conform to actions taken in other hearings. If the reduction proposal is ultimately adopted, staff would recommend that the final trailer bill language include provisions similar to those below that were included in 2011-12 trigger reduction language:

> "A variety of strategies, including, but not limited to, savings attributable to caseload adjustments, changes in expenditure trends, unexpended contract funds, or other administrative savings or restructuring can be applied to this reduction with the intent of keeping reductions as far away as feasible from consumer's direct needs, services, and supports, including health, safety, and quality of life.
>
> The department may utilize input from workgroups comprised of consumers and family members, consumer-focused advocacy groups, service provider representatives, regional center representatives, developmental center representatives, other stakeholders, and staff of the Legislature, to develop General Fund savings proposals as necessary."

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

In-Home Supportive Services (IHSS)

New Proposal for Seven Percent Across-the-Board Reduction in Recipients' Hours of Service

Budget Issue: With a 2011-12 budget of $5.0 billion ($1.4 billion GF), the IHSS program provides personal care services to approximately 440,000 qualified low-income individuals who are blind, aged (over 65), or who have disabilities. IHSS services include tasks like feeding, bathing, bowel and bladder care, meal preparation and clean-up, laundry, and paramedical care. These services frequently help program recipients to avoid or delay more expensive and less desirable institutional care settings.

The May Revision newly proposes $99.2 million GF savings[2] (and an associated larger federal fund loss) from a seven percent across-the-board reduction in authorized IHSS hours, effective August 1, 2012. This proposal would continue and deepen an existing 3.6 percent reduction that would otherwise sunset July 1, 2012. The proposal does not include any exceptions. Similar to the policy underlying the existing 3.6 percent reduction, the affected recipients would be allowed to direct the manner in which the reduction applies to their previously approved services.

Interaction with 20 Percent Reduction: Existing law enacted as part of the 2011-12 budget triggered a 20 percent across-the-board reduction, with exceptions, to authorized IHSS hours. That reduction has thus far, however, been enjoined by the courts from taking effect. The exceptions allowed for under the 20 percent reduction include, but are not limited to, exceptions for individuals who apply for a partial or full restoration of hours on the basis that they would otherwise be at serious risk of out-of-home placement.

Anticipated Impacts: The Department estimates that 454,000 IHSS recipients would be impacted by the proposed reduction in authorized hours of services. The average loss of hours per recipient is anticipated to be approximately 6 hours per month.

Staff Recommendation: Hold this issue open.

[2] The savings attached to this proposal are sometimes reflected as $99.2 million GF and sometimes reflected as $114.8 million GF. The difference is dependent on interactions with assumptions related to other budget proposals.

CalWORKs

Changes to CalWORKs Reduction & Redesign Proposals

Budget Issue: The January budget proposed $946.2 million GF savings from significant reductions in benefits and services available under the California Work Opportunities and Responsibilities to Kids (CalWORKs) welfare-to-work program. The Governor also proposed restructuring the program to include two new subprograms--CalWORKs Basic and CalWORKs Plus--as well as a new Child Maintenance Program outside of CalWORKs, as below:

- **CalWORKs Basic** would continue much of the current program, but with a 24-month (rather than the existing 48-month) time limit and narrower definitions of what counted as work participation.

- Only adults working sufficient hours in unsubsidized employment were proposed to be eligible for 24 additional months (48 total) in **CalWORKs Plus**.

- The **Child Maintenance** program was proposed to include families currently served in the CalWORKs child-only caseload, as well as 109,000 families in which the adult would lose eligibility. Child maintenance grants would not be time-limited for minors, but maximum grants would be reduced 27 percent.

In January, the Administration also proposed to permanently eliminate intensive case management services targeted for pregnant and parenting teens through the CalLearn program (continuing only the bonuses paid for progress in school) and make other reductions and restrictions within CalWORKs. In addition to other impacts from these reductions in services, grants, and time limits, the January proposals would have resulted in 63,000 families with 125,000 children losing all eligibility for CalWORKs. Additional details on January's proposals are outlined in hearing agendas from March 1 and March 15, available online at: http://sbud.senate.ca.gov/hearingagendas.

The **May Revision** continues largely the same kind of overarching proposals, but with changes that result in an adjusted net savings of $879.9 million GF, including delayed effective dates and the revisions described below.

Changes from Time Limits & Work Participation Rules Proposed in January:

- A return to relying on current state law for a broader definition of allowable work participation activities (including, e.g., adult basic education and a longer period of time for higher education or treatment for substance abuse) for the first 24-months that an adult is eligible for CalWORKs Basic.

- The extension of CalWORKs Basic for a second 24-months, but only for aided adults who meet a stricter definition of allowable work activities under federal law.

Changes from Exemption Policies Proposed in January:

- Short-term exemptions for parents of young children (i.e., a child aged 12 to 24 months or two children under the age of six) that have been in place since 2009 would be extended to October 1, 2012 (rather than expiring on July 1, 2012), with all individuals who would otherwise have been exempted being phased back into work participation requirements by October 1, 2013. During this 12-month period, the affected adults maintain their welfare-to-work exemption-status until their counties re-engage them in welfare-to-work services (although their time in exemption status after October 1, 2012 would newly count against their lifetime 48-month time limit).

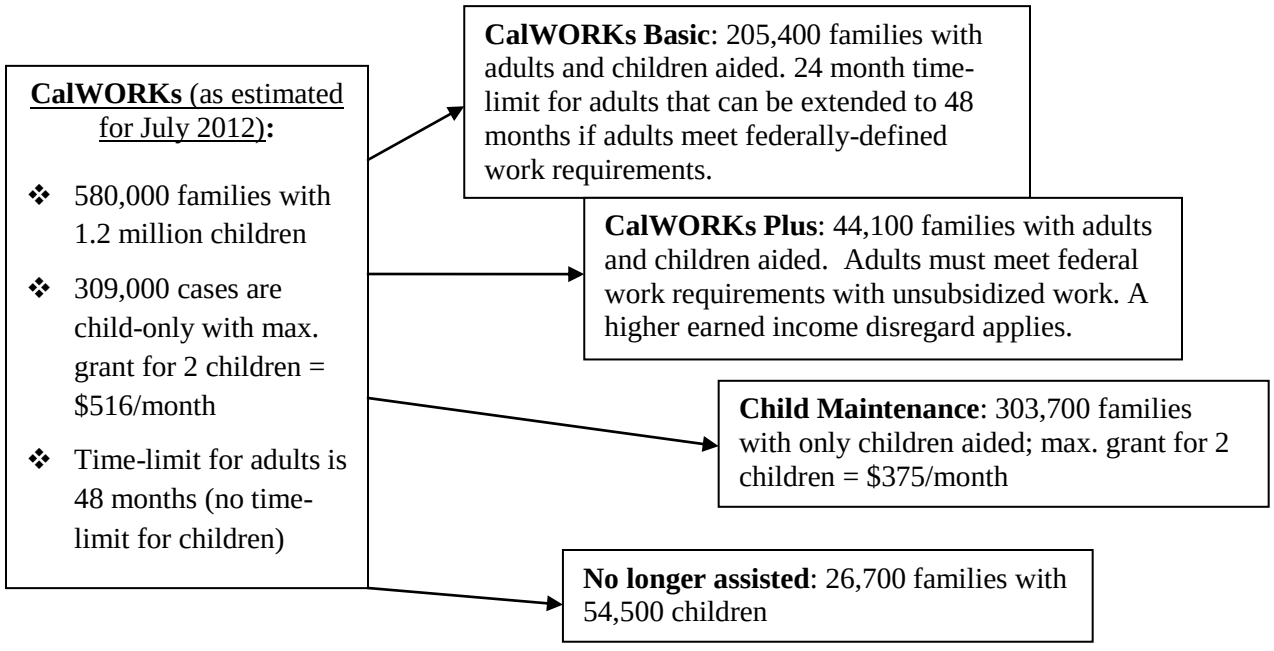
- Prior months in exemption and sanction status would no longer retroactively count against the new time limits (although, as proposed in January, these months would count going forward).

Changes in Assumptions Regarding Recipients' Behaviors in Response:

- New assumptions that approximately 15,600 families that would otherwise be in the Child Maintenance program would move to the CalWORKs Basic (4,300) or CalWORKs Plus (11,300) programs. This change is in part based on an assumption that a 27 percent Child Maintenance grant cut would increase these families' incentives for meeting work requirements and obtaining unsubsidized work. That assumption is also predicated on the availability of work and other allowable activities in which these families would then be able to participate.

Impacts of the Amended Proposal: The chart below summarizes the anticipated impacts of the May Revision proposal.

As Estimated for April 1, 2014



Staff Comment: As noted in response to the January proposals, the impacts of these reductions would come at a time when Californians, especially in low-income families, are facing high unemployment and rising poverty. And while some concerns previously raised regarding the Governor's January proposal are mitigated by May revisions, many significant concerns remain, including that:

- **The proposed restructuring of CalWORKs is far-reaching and technically complex.** As a result, it may present overwhelming implementation challenges on the ground at the same time that families and caseworkers are navigating the impacts of prior (and any potentially impending) reductions in benefits and services. Moreover, as the LAO indicated in its January report, the proposed reductions could be adopted and associated savings achieved without changing the structure of CalWORKs.

- **Relative to measurements of poverty and to the level of support the state has historically provided to needy families with children, the proposed reductions would result in a dramatic shrinkage of benefits and services.** For a family of three with no other income, the proposed maximum Child Maintenance grant of $375 per month ($4,500 annually) would result in an income equivalent to 24 percent of the federal poverty line (which is currently $1,591 per month or $19,090 annually for a family of three).[3] At $638 per month for a family of three in a high-cost county, maximum CalWORKs grants (the grant level available for families without any other income and in which an adult is aided) are the same in actual dollars today as they were in 1987. After adjusting for inflation, the California Budget Project calculates that the purchasing power of these grants is already less than half of what it was in 1989-90. Said another way, if the slightly higher 1989-90 maximum grant of $694 had been adjusted for inflation every year, it would be $1,368 in 2012-13.

Staff Recommendation: Hold these issues open.

Questions for the Administration:

1) Please summarize the key changes to the proposal in the May Revision.

2) On what did the Department base its new assumptions regarding behavioral changes? Is there any specific research or prior policy precedent that supports the proposed conclusions?

[3] The Administration combines this income with maximum CalFresh (food stamp) benefits to instead conclude that families would have income equivalent to 64 percent of the poverty level. However, the inclusion of those non-cash benefits is not generally accepted as a stand-alone adjustment for calculating poverty levels. While several researchers have suggested that in-kind benefits like nutritional assistance should offset calculations of families' costs of living, they also generally recognize other needed adjustments, potentially including an adjustment for varying costs of housing (which may cut the other direction to reduce many Californians' effective incomes relative to the federal measure).

Child Welfare Services/Case Management System (CWS/CMS)

Budget Issue: The May Revision proposes $79.1 million ($38.9 million GF) for maintenance and operations of the Child Welfare Services/Case Management System (CWS/CMS), which is the statewide automation system that supports the state's child welfare services programs. The Administration has indicated that the May Revision also proposes to suspend development of a replacement system for an indefinite period of time, although $2.5 million ($1.2 million GF) is still proposed for efforts related to that new system project. The Administration indicates that those funds would be used to secure state and federal approvals with a state Feasibility Study Report and federal Advance Planning Document and conduct other evaluation and planning activities.

Background on CWS/CMS: CWS/CMS was fully implemented and transitioned to its operational phase in 1998. DSS has overall responsibility for the system, including providing project and program direction to the Office of Systems Integration (OSI). OSI provides information technology expertise and is responsible for implementation and day-to-day operations of the system. The current contract for CWS/CMS runs through November 2016, with potential extensions of up to 3 years.

Replacement of the System: The CWS/Web project to replace CWS/CMS was previously initiated to update outdated technology, improve efficiency, and comply with federal child welfare requirements. For the 2011-12 fiscal year, however, the budget included a delay of its development to achieve cost savings and allow time to reassess the best path forward. Along with this change, the budget included trailer bill language in Assembly Bill (AB) 106 (Chapter 32, Statutes 2011) requiring the Administration to study and report on the degree to which the CWS/CMS system: 1) complies with current law, 2) supports current CWS practice, and 3) links to other needed information. The report was also required to include recommendations about the best approach(es) and next steps for addressing any critical missing functionalities in CWS/CMS, which could include building functionality into the current system, restarting the CWS/Web procurement, or developing a new procurement. The Administration developed a CWS Automation Study Team (CAST) in response to these requirements. The CAST included representatives from DSS, OSI, and the County Welfare Directors Association. The team also consulted with legislative staff.

The Administration submitted the required report in April 2012. After comparing options, the report concluded that it was "neither feasible nor cost-effective to maintain and enhance the old technology of the existing system" and recommended its replacement. More specifically, it indicated that the current system is not compliant with federal and state laws, regulations, and policies and requires costly and time-consuming workarounds. After considering a number of alternatives, the report recommended that the state embark on a "buy/build" option whereby it would purchase an existing application (e.g., one in use in another state) and then customize it.

The estimated General Fund costs for: 1) continuing the existing system (without upgrades), 2) upgrading the existing system, and 3) using the recommended buy/build option, include *approximately*:

Existing CWS/CMS *(Dollars in 000's)*

	Year 1	Year 2	Year 3	Year 4	Year 5	Total After Year 12
Existing System M&O	$40	$41	$44	$45	$45	**$530**

Upgrading CWS/CMS

One-Time Costs	6	6	15	17	31	
Ongoing Costs	-	-	-	-	-	
Existing System M&O	41	41	42	42	42	
Total	47	47	56	59	73	**607**

Buy/Build of New System

One-Time Costs	7	7	47	15	10	
Ongoing Costs	-	-	-	22	22	
Existing System M&O	41	41	42	30	-	
Total	48	48	88	66	31	**449**

Staff Comment & Recommendation: Given the CAST team's conclusion that proceeding to replace CWS/CMS via a buy/build project is the most feasible and cost-effective means of moving forward to support the state's child welfare services' automation needs, staff recommends that the Subcommittee approve the funding included in the budget for the existing system's replacement. Further, staff recommends that the Subcommittee reject characterization of this action as attendant to an indefinite suspension of the development of a CWS/CMS replacement system. The purpose of the funding should instead be characterized as beginning procurement efforts for a buy/build replacement system.

Questions for the Administration & LAO:

1) What are the potential penalties the state could be subject to in the coming years if the system is not changed or replaced to comply with federal requirements?

2) Given the limited amount of funding included in the 2012-13 budget for CWS/CMS replacement, what activities can the state accomplish in order to move forward on a procurement of the buy/build option? How will that affect the timeline for completing the development of a buy/build replacement system?

Unallocated Reduction to Statewide Automated Welfare System (SAWS)

Budget Issue: Three SAWS consortia systems statewide automate 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. The 2011-12 budget included a one-time, unallocated reduction of $5 million GF (with corresponding reductions in federal and county funds) to the consortia systems. This reduction was achieved through mainly one-time savings, including: 1) a reduction in consultant services for statewide project management, 2) a reduction in close-out costs related to the ISAWS Migration, 3) a change in the hardware and software maintenance schedule for C-IV, 4) a reduction in costs for a vendor help desk and support staff based on changes in Welfare Client Data System-CalWIN business processes, and 5) a delay of the LEADER Replacement System's start date. These particular reductions were determined as a result of collaboration between DSS, OSI, the LAO, and the County Welfare Directors' Association. The Governor's January and May budget proposals would continue this unallocated reduction and make it permanent. The Administration indicates that a collaborative process for assigning the reduction across the SAWS system would continue.

Staff Comment & Recommendation: Adopt the proposed unallocated reduction to the SAWS system for 2012-13, but reject the proposal to make the reduction permanent.

Questions for the Administration:

1) What were the impacts of the reduction made in 2011-12?

2) How would the proposed reduction be allocated for 2012-13?

5175 Department of Child Support Services DCSS

Department Overview

The mission of the California Child Support Program is to enhance the well-being of children and the self-sufficiency of families by providing professional services to locate parents, establish paternity, and establish and enforce orders for financial and medical support. The Child Support Program is committed to ensuring that California's children are given every opportunity to obtain financial and medical support from their parents in a fair and consistent manner throughout the state. The Child Support Program is committed to providing the highest quality services and collection activities in the most efficient and effective manner.

The Department of Child Support Services is the single state agency designated to administer the federal Title IV-D state plan. The Department is responsible for providing statewide leadership to ensure that all functions necessary to establish, collect, and distribute child support in California, including securing child and spousal support, medical support and determining paternity, are effectively and efficiently implemented. Eligibility for California's funding under the Temporary Assistance to Needy Families (TANF) Block Grant is contingent upon continuously providing these federally required child support services. Furthermore, the Child Support Program operates using clearly delineated federal performance measures, with minimum standards prescribing acceptable performance levels necessary for receipt of federal incentive funding. The objective of the Child Support Program is to provide an effective system for encouraging and, when necessary, enforcing parental responsibilities by establishing paternity for children, establishing court orders for financial and medical support, and enforcing those orders.

Child Support Administration: The Child Support Administration program is funded from federal and state funds. The Child Support Administration expenditures are comprised of local staff salaries, local staff benefits, and operating expenses and equipment. The federal government funds 66 percent and the state funds 34 percent of the Child Support Program costs. In addition, the Child Support Program earns federal incentive funds based on the state's performance in five federal performance measures.

Child Support Automation: Federal law mandates that each state create a single statewide child support automation system that meets federal certification. There are two components of the statewide system. The first is the Child Support Enforcement (CSE) system and the second is the State Disbursement Unit (SDU). The CSE component 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. In addition, it funds the local electronic data processing maintenance and operation costs. The SDU provides services to collect child support payments from non-custodial parents and to disburse these payments to custodial parties.

Enrollment Caseload Population Estimate

Governor's Budget Request: The Governor's May Revise includes a request to reduce the amount of Federal Funds received by $363,000 and offset the reduction with a $363,000 General Fund increase.

Background: As noted in the May 10 Senate Budget and Fiscal Review Subcommittee No. 3 hearing, there are federal incentives tied to a list of performance measures. While the state improved on their prior year performance measures, other states outperformed the state in some categories, leading to a decrease in federal contributions provided to

the Department of Child Support Services. This request would offset the loss in federal funds that were originally projected to be captured in the Governor's January budget.

2011 Federal Performance Measures

Statewide Paternity Establishment Percentage (PEP) for California measured 107.0 percent for Federal Fiscal Year (FFY) 2011. California's performance increased in this measure by 4.4 percentage points from FFY 2010 to FFY 2011, a 4.3 percent change. Since FFY 2000, Statewide PEP has been above 100 percent. The national average for FFY 2010 was 94.7 percent.

IV-D Paternity Establishment Percentage for California measured 92.2 percent for IV-D PEP in FFY 2011. California's performance increased in this measure by 3.6 percentage points from FFY 2010 to FFY 2011, a 4.1 percent change. The national average for FFY 2010 was 94.1 percent.

Cases with Support Orders Established for California measured 85.8 percent for FFY 2011. California's performance increased in this measure by 3.3 percentage points from FFY 2010 to FFY 2011, a 4.0 percent change. The national average for FFY 2010 was 80.1 percent.

Collections on Current Support for California measured 58.6 percent for FFY 2011. California's performance increased in this measure by 2.6 percentage points from FFY 2010 to FFY 2011, 4.6 percent change. The national average for FFY 2010 was 62.0 percent.

Cases with Collections on Arrears for California measured 61.6 percent for FFY 2011. California's performance increased in this measure by 1.3 percentage points from FFY 2010 to FFY 2011, a 2.2 percent change. The national average for FFY 2010 was 62.1 percent.

Cost Effectiveness for California measured $2.29 for FFY 2011. California's performance declined in this measure by $0.09 from FFY 2010 to FFY 2011, a 3.8 percent change. The national average for FFY 2010 is $4.86.

Staff Recommendation: Adopt May Revise request.

Child Support Automation

Governor's Budget Request: The Governor's May Revise includes a request to decrease the General Fund contribution to the Child Support Automation System by $1 million dollars and reduce the Federal Trust Fund contribution by $1.94 million dollars. In total, this would amount to a $2.94 million reduction in the California Child Support Automation System project maintenance and operations budget.

Background: Beginning in 2008, the California Child Support Automation System was fully implemented. Total cost of the application was approximately $1.5 billion dollars and took nearly eight years to implement. Shortly thereafter, the application received its federal certification as the statewide automation system. The Department of Child Support Services is responsible for maintaining the functionality of the automation system and also responsible of ensuring the LCSAs have access to the system.

Staff Comment: The Department of Child Support Services has noted that the $1.0 million General Fund reduction for the California Child Support Automation System (CCSAS) Maintenance and Operation will be distributed to the CCSAS Maintenance and Operations budget by postponing software purchases and by utilizing savings related to the California Technology Agency's Office of Technology Services rate changes for DCSS's Child Support Enforcement System hosting services.

Staff Recommendation: Approve May Revise request.

Reversion of Remaining California Child Support Automation System Funds

Governor's Budget Request: The Governor's May Revise includes a request to revert prior year appropriations in the amount of $5.49 million that were dedicated to the Child Support Automation System and have gone unencumbered.

Staff Comment: The 2010 Budget Act included a reappropriation of $14.9 million ($5.5 million General Fund). The funds were intended to be utilized for the transition from vendor to in-house services for a component of the California Child Support Automation Service. The funds have remained unencumbered in the current fiscal year and are not expected to be needed due to the recent completion of the state disbursement unit. The reversion is proposed to address a portion of the budget shortfall.

Staff Recommendation: Approve May Revise request.

Reduced Funding for Local Child Support Agencies

Governor's Budget Request: The Administration has requested that the 2012-13 support for Local Child Support Agencies be reduced by $14.7 million ($5.0 million General Fund). Additionally, the Administration has submitted trailer bill language that would reduce state hearing requirements for Local Child Support Agencies.

Background: In addition to the decrease in funding support provided to the Department, the Administration has proposed, via trailer bill language, to no longer require that LCSA's prepare cases for state hearings and would instead continue their required complaint resolution process and to refer cases to the state administrative review.

Per Code of Federal Regulations Title 45, Section 303.5, the Department of Child Support Services (DCSS) is to provide an administrative process by which case participants may request a review of their child support case. Although a formal hearing process is not required by federal government, such a process is codified in California Family Code Sections 17800-17804. The Administration contends that due to ongoing budget constraints and the proposed reduction to LCSA funding of $5 million General Fund that the statute be amended to remove the state requirement for a formal hearing process.

Staff Comment: As per California Family Code, the Legislature has previously determined that a formal complaint resolution process was to be utilized. Staff believes that eliminating the hearing requirement process would represent a significant policy change that would need to be discussed with key stakeholders in a policy related, not fiscal venue.

Staff Recommendation: Reject proposed trailer bill language and make a one-time, unallocated reduction to Local Child Support Agencies by $14.7 million ($5.0 million General Fund).

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 22 & 24, 2012

Human Services Issue Outcomes

Staff: Jennifer Troia, Brady Van Engelen (DCSS)
& Catherine Freeman (CSD)

May 22

4170 Department of Aging (CDA)

Staffing Changes Related to Adult Day Health Care (ADHC) & Community Based Adult Services (CBAS) Programs

Approved (3-0) the proposed staffing and resources.

4300 Department of Developmental Services (DDS)

Estimate Changes & Technical Adjustments

Adopted (3-0) the following technical changes, with any changes to conform as appropriate to other actions that have been or will be taken:

For Developmental Centers:

- **Workload Adjustments (Issues 201, 202, 203, and 206)—**It is requested that Schedule (1) of Item 4300-003-0001 be increased by $1,197,000, reimbursements be increased by $620,000, Item 4300-003-0890 be decreased by $20,000, and Schedule (1)(a) of Item 4300-004-0001 be decreased by $138,000, and Schedule (1)(b) be increased by $138,000 to reflect adjustments in Level-of-Care and Non-Level-of-Care Staffing, operating expenses and equipment, and a fund shift in the Foster Grandparent Program.

- **Lanterman Developmental Center Closure Update (Issue 204)—**It is requested that Schedule (1) of Item 4300-003-0001 be decreased by $1,091,000 and reimbursements be decreased by $494,000 to reflect changes in staff support costs associated with leave buyout, unemployment insurance, and resident transition activities.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 24, 2012

Upon Adjournment of Senate Appropriations Committee

Room 112

Agenda I: Human Services

Staff: Jennifer Troia

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 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 *)

VOTE-ONLY AGENDA

5180 Department of Social Services (DSS)

CalFresh Administration Costs and County Match Waiver

Budget Issue: CalFresh is California's name for the national Supplemental Nutrition Assistance Program (SNAP, formerly known as "food stamps"). Californians are expected to receive a total of $7.2 billion (all federal funds) in CalFresh benefits in 2011-12, rising to $8.4 billion in 2012-13. The Governor's January budget included $1.6 billion ($540.0 million GF) for CalFresh administration costs, which are shared 50/50 federal/non-federal funds (with non-federal funds shared 35/15 by the state/counties).

The January budget also proposed a reduction of $71.9 million GF to CalFresh administration funding in 2012-13. The Administration indicated at the time that the adjustment was based on counties' expenditure patterns for the past few years. The May Revision updates that proposal, resulting instead in a reduction of $45.3 million GF (and corresponding other funds). The Administration indicates that the change is based on more recent data resulting from a survey of counties. There are two components to the proposed reduction to the base funding for FY 2012-13 that each comprise around half of its total value: 1) a proposal to permanently reduce funding by the amount that counties were able to spend in 2010-11 (excluding additional expenditures the counties accessed under an existing county "match-waiver" that is scheduled to sunset on June 30, 2012), and 2) a proposal to permanently reduce funding by the amount that the Administration estimates counties will be able to spend when compared to the total budgeted for 2011-12. Both are described further below.

Match-Waiver: Under the match-waiver in place for 2010-11 and 2011-12, counties can draw down a portion of the General Fund and federal fund allocations for CalFresh administration without fully matching those funds under the standard sharing ratios. The amount of General Fund resources available to the counties as a direct result of the match-waiver in 2010-11 is estimated at $22 million. When the match-waiver was enacted, the Legislature anticipated that counties would be able to raise their expenditures back up to the full amount required under the standard sharing ratios after a few years of relief during the toughest economic times of the recession (which were also resulting in dramatic caseload increases in CalFresh). The Administration's proposal instead assumes the match waiver will not continue and that based on expenditure patterns the counties will permanently expend the lower amount of matching funds – effectively lowering the total administration funding available to the program by $22 million GF and corresponding federal funds on a permanent basis. By contrast, the County Welfare Directors Association (CWDA) indicates that counties still plan to meet the original intent of bringing their expenditures back up to the full matching requirements. CWDA does, however, propose a two-year extension of the match-waiver before counties would be prepared to again reach this level of contribution.

Reduction Related to Recent Expenditures: The Administration estimates that counties will not spend $23 million GF (of the $583 million total GF budgeted) and proposes to lower the 2012-13 budgeted allocation by that amount. CWDA and other stakeholders oppose this change in budgeting methodology and point out that especially in the current budget climate, counties are being cautious about not overspending their allocations and this four percent of the total allocation is within the natural margin of error given that caution.

Proposed Reversion of Funds from 2010-11 and 2011-12: As an alternative to $23 million of the $45.3 million GF reduction assumed in the Governor's May Revision, CWDA proposes budget language to revert any unexpended General Fund resources from 2010-11 and 2011-12 earlier in the process than would normally occur.

Staff Recommendation: Reject the Administration's proposed reduction of $45.3 million GF and adopt a one-year extension of the county match-waiver for the 2012-13 budget year. Further, direct staff to work with the Administration, LAO, and CWDA to develop language that will achieve the early reversion of unexpended resources from prior years and any additional reduction necessary to reach a total of $23 million GF.

Questions for the Administration:

1) Please summarize the proposed reductions included in the May Revision and the existing county match-waiver.

Child Welfare Services/Case Management System (CWS/CMS)

Budget Issue: During its May 22 hearing, the Subcommittee took action to approve the funding included in the Governor's budget for the replacement of the existing CWS/CMS. Further, the Subcommittee rejected characterization of this action as attendant to an indefinite suspension of the development of a CWS/CMS replacement system. The purpose of the funding was instead identified to be for beginning procurement planning efforts for a buy/build replacement system.

Staff Recommendation: To provide additional detail to the Subcommittee's recent action, staff recommends additionally **adopting the trailer bill language below**, subject to refinements in the trailer bill process:

> Funding included in the 2012-13 budget related to replacement of the Child Welfare Services/Case Management System shall be used for the next steps necessary to move forward with the recommendation of the Child Welfare Automation Study Team (CAST) to proceed toward procuring a new system, consistent with a buy/build strategy as described in the CAST report submitted to the Legislature. These next steps shall include, but not be limited to, completing,

in consultation with the counties and the County Welfare Directors Association, a Feasibility Study Report and Federal Advance Planning Document, as well as conducting other planning activities. OSI and the Department shall report the results of these activities, in addition to the key milestones and anticipated timelines for any resulting procurement process, to the Legislature by March 1, 2013 for review during budget hearings in 2013.

4300 Department of Developmental Services (DDS)

Requested Staffing for the Lanterman Developmental Center

Budget Issue: As part of the 2010-11 budget, the Legislature and Governor approved a plan to begin the process of safely transitioning the residents of the Lanterman Developmental Center (Lanterman) to other appropriate living arrangements [as determined by their Individual Program Plans (IPP)] and then closing the facility to resident occupancy. This transition and closure process and the overall budget for Lanterman were discussed at the Subcommittee's March 26 hearing.

During that hearing, the Subcommittee held open the Governor's proposal for approximately $2.9 million ($1.6 million GF) to allow for the retention of 28 authorized positions and five temporary help positions that would otherwise be eliminated under budgeting formulas which factor the facility's resident population into the number of authorized positions. DDS indicated that this enhanced staffing is needed because of additional workload caused by the closure process and in order to prevent the remaining residents from needing to move in order to reside in units or buildings where remaining staff are assigned. The retained position authority would include 10 nursing positions, nine administration transition staff to coordinate among Regional Centers, community providers, and Lanterman employees, eight staff to provide other supports identified as necessary for residents, and one staff member to coordinate the State Staff in the Community program. The retained temporary help positions would include five occupational, physical, or speech therapy positions at a cost of $746,200 ($408,444 GF). These positions are funded under the Department's temporary help blanket authority (and do not include specific position authority).

Staff Recommendation: Approve the requested retention of specified staff for Lanterman.

Proposals to Achieve $200 million GF Reduction

Budget Issue: The May Revision includes policy changes and corresponding trailer bill language to implement the proposed continuation of a reduction of $200 million annually that was triggered in December 2011 by lower than anticipated state revenues

(pursuant to AB 121, Chapter 41, Statutes of 2011, which included a $100 million reduction for a six-month period of the 2011-12 budget year). The Subcommittee agenda for May 22 included additional details regarding these proposals and extensive public testimony regarding their content.

Staff Recommendation: **Adopt the Administration's proposals and trailer bill language** in the following categories, **subject to** refinements in the trailer bill process and the changes and additions mentioned below:

A. Maximizing Federal Funds

B. Implementation of SB 946

C. Redesigning Services for Individuals with Challenging Needs

With the following changes and additions:

1) Limiting short-term acute crisis placements in developmental centers to six months, with the possibility of one six-month extension.

2) Authorizing the use of licensed delayed egress homes to also have secured perimeter fences, contingent on eligibility for federal funding and subject to program standards and a cap on the number of beds statewide in homes with secured perimeter fences, established by emergency regulations to be promulgated by the Department.

3) Prohibiting, effective July 1, 2012, Regional Centers from purchasing new residential services from Institutions for Mental Disease (IMD) for which federal financial participation is not available except in emergencies when alternative services eligible for federal funds are not available. In the case of emergency placements, requires a comprehensive assessment to be completed within 30 days of admission and an Individual Program Plan (IPP) meeting to be convened to plan for the transition of these consumers to the community within 6 months. Also requires comprehensive assessments of consumers currently placed in an IMD and the establishment of a transition plan and timelines for returning the consumer to the community.

4) Ensuring that the comprehensive assessments and reports for consumers residing in developmental centers on July 1, 2012 shall include input from the regional center, the consumer, and the consumer's family, legal guardian, or conservator, when appropriate, and identify the types of community based services and supports available to the consumer.

5) Requiring the Department to annually provide specified information to the policy and fiscal committees of the Legislature on the efforts to serve consumers with challenging needs, including but not limited to:

a) Data regarding developmental center admissions, including but not limited to those that occur in response to acute crises;

b) Outcome data related to the assessment process for consumers living in developmental centers on July 1, 2012;

c) Progress on the development of needed statewide specialty services and supports, including regional community crisis options;

d) Progress in reducing reliance on facilities ineligibile for federal funding and those located outside of the state; and

e) If applicable, any recommendations regarding additional rate exceptions or modifications beyond those allowed for under existing law that the Department identifies as necessary to ensure the success of these policies.

D. Redesigning Supported Living Assessments

With the specification that that regional centers be included, as stakeholders, in development of the assessment tool.

E. Regional Center & Provider Rate Reduction of 1.25 Percent

With a change to extend the 1.25 percent rate reduction for the 2012-13 budget year only.

F. Additional Cost Savings and Efficiencies As Described in the Previous Agenda

With the additional of trailer bill language to clearly establish that the use of technology in place of consumers' in-person court appearances or any direct services for consumers would only occur with the informed agreement of the consumer.

Oversight Related to Access to Developmental Services

Budget Issue: The Senate Select Committee on Autism and Related Disorders recently held a hearing entitled "Ensuring Fair & Equal Access to Regional Center Services for Autism Spectrum Disorders (ASD)." The background materials for the hearing reviewed data on racial and ethnic disparities in mental health services and healthcare and also summarized the findings and implications of a recent four-part series published in the Los Angeles Times, including the following findings:

- For 3-6 year old children with ASD, California's developmental services system spends an average of $11,723 per child on white children, compared with $11,063 for Asian children, $7,364 on Latino children, and $6,593 on African American children.

- Anecdotal indications that underserved communities (primarily based on race/ethnicity and income levels) face formidable challenges and barriers in accessing appropriate services.

Several prior studies conducted since the early 1990s have also examined regional centers' expenditures of purchase-of-services (POS) dollars as a function of a number of variables, including client ethnicity. While the results have been varied and open to interpretation, the studies have overall shown that per capita expenditures are higher for white clients than for other racial and ethnic groups.

Background on Organization of Developmental Services System: The Lanterman Developmental Disabilities Services Act (Lanterman Act) establishes 21 nonprofit regional centers that contract with DDS to provide case management services, conduct assessments, and develop and implement an individual program plan (IPP) for each person determined to be eligible for regional center services under the Lanterman Act. To achieve the stated objectives of a developmental services consumer's IPP, the regional center is required to secure needed services and supports, either from an agency that receives public funds to serve all members of the general public or by purchasing the service or support from a provider using funds allocated to the regional center's POS budget. The Department, through appropriate and regular monitoring activities, is responsible for ensuring that regional centers meet their statutory, regulatory, and contractual obligations, and provide services and supports in compliance with state law.

Staff Recommendation: In order to allow for better statewide and local oversight of access and equity issues within the developmental services system, **adopt placeholder trailer bill language** to require the annual compilation of existing purchase of service utilization and expenditure data by regional center with respect to race and ethnicity, age of consumer, and disability. The age of consumer shall be broken down by birth to two, three to twenty-one, and twenty-two and older. Disability detail shall include the five categories defined in statute. The data reported shall also include the number and percentage of individuals broken down by race and ethnicity, age and disability for those who have been determined to be eligible for regional center services but are not receiving any services using purchase of service funds. The data shall be reported in a consistent manner and the first annual reporting of the data shall be posted publicly no later than December 31, 2012. Within 3 months of the data becoming available and annually thereafter, each Regional Center shall meet with stakeholders regarding the data.

DISCUSSION AGENDA

5180 Department of Social Services (DSS)

Overview of May Revision Proposals Related to Realignment of Human Services Programs

Budget Issue: The 2011 Budget included a major realignment of public safety programs, including the Child Welfare Services (CWS) and Foster Care programs listed in the chart below, as well as Adult Protective Services (APS), and a number of other health and corrections-related programs, from the state to local governments.

Program	Description	Realignment Funds (Formerly GF) In 2011-12 Budget
Child Welfare Services	Services to ensure the safety of children, including emergency response to allegations of abuse or neglect	$670 million
Foster Care	Administration of and monthly assistance payments for out-of-home care and supervision	$433 million
Adoption Assistance Program (AAP)	Monthly assistance payments to families who have adopted children who meet specified criteria for special needs	$387 million
Adoptions Programs	Adoption-related services, oversight, and record-keeping	$64 million[1]
Child Abuse Prevention	Efforts to prevent abuse and neglect and increase public awareness	$13 million

The 2011 Realignment is funded through two sources: 1) a state special fund sales tax of 1.0625 percent, and 2) a dedicated portion of Vehicle License Fees (VLF). Although the revenue stream for 2011 Realignment is ongoing, the initial program allocations were for the 2011-12 fiscal year only.

[1] These costs do not include $6 million associated with Agency Adoptions.

The Governor is proposing **constitutional protection for revenues** dedicated to the 2011 public safety realignment package and **a permanent funding structure** for base and growth funding. Among the Local Revenue Fund accounts created under the funding structure would be a Support Services Account. The Support Services Account would further contain two Subaccounts, including one for Protective Services (Child Welfare Services and Foster Care and Adult Protective Services).

The Governor proposes to allocate **program growth** on roughly a proportional basis first among the Accounts and then among the Subaccounts. Within each Subaccount, federally required programs would receive priority funding if warranted by caseload and costs. Further, CWS would be a priority for growth once base programs are established, which, over time, is anticipated to result in $200 million in additional funds.

The Governor also proposes some **flexibility** for the counties to move money among Subaccounts, including the transfer of up to 10 percent between Subaccounts within the Support Services Account. Transfers would be valid for only one year and would not increase the base of any program.

The May Revision estimates the sales tax to be $5.2 billion and the VLF to be $439.4 million in 2011-12; and the sales tax and VLF values are projected to increase to $5.4 billion and $455.1 million, respectively, in 2012-13.

Changes to Program Allocations Since January: The base for each of the programs included in 2011 Realignment is intended to become a "rolling base," meaning that the previous year's allocation level plus growth will equal the new base for the following year. However, the year in which the base is defined varies by program. For CWS, Foster Care, and APS programs, the base is established by 2011-12 fiscal year funding. The May Revision increases the 2012-13 allocation level for these programs by $5.5 million as compared to the Governor's January budget. This change is based on the availability of more recent caseload estimates and information related to 2011-12 funding.

The May Revision also proposes to increase the base for CWS and Foster Care by $53.9 million GF over the course of three years (the 2012-13 through 2014-15 fiscal years). These funds are intended to reflect the costs for counties to expand eligibility for foster care benefits up to age 21, as authorized by Chapter 559, Statutes of 2010 (AB 12). Funding for the implementation of this recently enacted legislation was inadvertently left out of the initial 2011 estimates related to the realignment of CWS and Foster Care.

Staff Comment: This is an informational item, and no action is required. The larger fiscal superstructure for the 2011 realignment will be heard and voted on during other Committee hearings.

Question for the Administration & LAO:

1) Please summarize the pending realignment-related proposals that would establish the fiscal and programmatic foundations for realignment of CWS, Foster Care and APS in 2012-13 and beyond.

Child Welfare Services and Foster Care (CWS) Realignment: Programmatic Trailer Bill Language

Budget Issue: For the first year of the 2011 realignment, no changes were made to state law governing CWS and adoptions programs. Leading up to the May Revision of the 2012-13 budget, however, the Administration has proposed programmatic trailer bill language related to the following major themes, which, along with other issues raised by stakeholders, are discussed below:

A. Proposed Flexibilities for Counties

B. Accountability & Oversight

C. Congregate Care Reforms & Needs Assessment

D. Technical Changes

A. Proposed Flexibilities for Counties: The Administration's trailer bill language includes proposals for additional county flexibilities with respect to programs that were previously funded by state-only resources. In general, the proposed language makes these programs optional for counties to provide and eliminates requirements for counties to prepare and submit specified plans to the state (unless the information is required for federal reporting purposes). The 2010-11 General Fund allocations for some of these programs are identified below:

Program	General Fund
Transitional Housing Placement Program-Plus (THP-Plus)	$35,417,000
Kinship Support Services Program	$3,520,000
Specialized Training for Adoptive Parents	$531,000
Substance Abuse/HIV Infant Program	$1,844,000

The largest of these programs, **THP-Plus**, is a housing and supportive services program for emancipated foster youth from age 18 up to their 24th birthday. Young adults are currently eligible to participate for up to 24 months if there is a space in a program that accepts them. According to DSS, 53 of the state's 58 counties have THP-Plus programs.

The proposed trailer bill language would require counties that no longer intend to use the funding that was previously designated for these programs to report the rationale for their decision in their annual System Improvement Plan Updates.

The recently released trailer bill language also eliminates the requirement for the Department to approve **Specialized Care Increments** paid by counties in addition to the basic foster family home rate for the costs of meeting the additional daily care needs of a child who has a health and/or behavior problem. Those rates would still, however, be reported by the counties to the Department. Similarly, counties would no longer be required to submit notifications regarding their payments of **clothing allowances** to the Department. The trailer bill language would also eliminate references to state funding of a $100 supplemental clothing allowance and instead require that base amount to be paid for with realignment funding.

Under recently enacted legislation that extends eligibility for foster care to 18 to 20 year-old non-minor dependents (AB 12, Chapter 559, Statutes of 2010), a new foster care placement type called **THP-Plus-Foster Care** was also created for non-minor dependents. Although the trailer bill language originally released by the Administration included amendments to statutes governing this program that were combined with newly proposed county flexibility language, the Administration has since clarified that it did not intend to alter the nature of THP-Plus-Foster Care as a foster care placement type for non-minor dependents. DSS has been working with stakeholders on revisions to the proposed language that would make this placement type, like other foster care placement types, subject to statewide licensure by the Department.

Finally, the trailer bill language originally released by the Administration also appeared to eliminate a requirement that counties use an administrative procedure currently mandated in statute that ensures young people will be able to apply for **Supplemental Security Income (SSI)** in advance of emancipating from foster care. However, this language was combined with technical changes intended to alter references to state and county funds given the change to instead have counties utilize realignment funding, and the Department has since indicated that it does not intend to alter the administrative procedure.

B. Accountability & Oversight: The federal Administration for Children and Families (ACF) conducts Child & Family Services Reviews (CFSRs) of states' child welfare systems, which include assessments of compliance with outcome measures related to the safety, permanency, and well-being experienced by children and families who come into contact with CWS, as well as systemic factors. If the state fails to improve after implementing corrective actions, the federal government can also issue penalties. Prior to realignment, the state was at risk for the full costs of any federally imposed penalties for failure to meet CFSR requirements.

The trailer bill language proposes to give counties 100 percent responsibility for any disallowances or other financial consequences established by the federal government as a result of non-compliance with applicable laws. For **penalties** related to outcomes measured by the CFSR, the trailer bill language proposes to allow the Director of the Department to assess no more than 50 percent of the resulting cost against the county or counties whose performance contributed to the penalty issuance. Under specified circumstances, the Director may also waive the county's payment of the penalty and/or

allow a county to reinvest the funds at issue. Correspondingly, counties would have the opportunity to participate in any appeals or federal administrative remedies associated with disallowances or penalties.

Under state law created by the Child Welfare System Improvement and Accountability Act (**AB 636**, Chapter 678, Statutes of 2001), there is also a statewide accountability system that became effective in 2004. It includes 14 performance indicators related to safety, permanency, and well-being. All 58 counties receive quarterly reports on their outcomes, conduct self-assessments, and develop System Improvement Plans. Counties that are not in compliance receive technical assistance from teams of state and peer-county administrators. If DSS determines that a county is "substantially failing" to comply, the department can notify the local welfare director and Board of Supervisors and allow time for corrective action. If that fails to resolve the issues, the DSS director can seek injunctive relief or take administrative actions.

The recently proposed trailer bill language also includes amendments to accountability provisions that the Department indicates are intended to strengthen its authority to establish performance targets and monitor counties' performance.

C. Congregate Care Reforms & Needs Assessment: The recently proposed trailer bill language includes provisions that would establish workgroups tasked with: 1) reviewing the current rate-setting system and services across the continuum of out of home care, and 2) developing an improved means of determining children's needs and identifying whether placement in group care is appropriate.

D. Technical changes: The Administration's trailer bill language also includes amendments to conform to 2011 realignment legislation (AB x1 16), which eliminated the requirement for county child welfare agencies to be licensed before they could provide adoption services. Finally, the language proposes to amend numerous statutory references to state and county sharing ratios from before the 2011 realignment. The Department has also deleted references to what it has identified as obsolete committees or fiscal systems.

Other Issues Raised by Stakeholders: In addition to input related to the provisions of the proposed trailer bill described above, stakeholders have also raised questions or concerns about:

- the need for transparency and fiscal reporting that will allow for tracking of any changes in the CWS and foster care systems that may result from realignment;

- a desire for the Department to consult with counties prior to submitting federal waivers or state plan amendments; and

- the continued implementation of the Health Care Program for Children in Foster Care (commonly known as the "foster care nurses program").

Staff Recommendation: Hold these issues open.

Questions for the Administration:

1) Please briefly summarize the key components of the programmatic trailer bill language.

2) What changes does the Administration anticipate putting forward with respect to that trailer bill language? When will any proposed changes be submitted?

3) Given the specificity of many federal requirements, how much financial and programmatic flexibility do the state and counties have in delivering child welfare services?

4) What fiscal reporting mechanisms may be appropriate to consider in light of realignment?

CWS Realignment: DSS Children's Program Staffing

Budget Issue: The Department requests, in a May Revision proposal, to reduce its budget by a net 42.0 positions in response to the realignment of the Agency Adoptions program to the counties. Currently, eleven counties have expressed interest in transitioning the program to the county, resulting in a reduction of a total of 53.5 positions in the Department's Child and Family Services Division. However, the Department proposes to retain and repurpose 11.5 of those positions to meet other requirements related to its role as the single state agency responsible for implementing the state's Child Welfare Services and foster care programs. The Department indicates that the positions are needed because of recent court orders and to ensure implementation and compliance with recently enacted state and federal legislation.

Staff Comment & Recommendation: Hold this item open.

Questions for Administration:

1) Please describe the need for each of positions requested to be retained.

2) What would the consequences be if some or all of the positions proposed to be retained are not approved?

- **Federal Certification of Porterville Developmental Center (Issue 200)—**It is requested that reimbursements be decreased by $13.0 million to reflect the federal Centers for Medicare and Medicaid Services' (CMS) denial of certification to expand Medi-Cal eligibility to a portion of the population in the Secure Treatment Program.

- **$200.0 Million General Fund Trigger Reduction Adjustment (Issue 209)—**It is requested that Schedule (1) of Item 4300-003-0001 be decreased by $9.1 million and reimbursements be increased by $1.3 million to reflect a reallocation of the $200.0 million General Fund trigger reductions proposed in the Governor's Budget from regional center Purchase of Services to developmental centers.

For Regional Centers:

- **Quality Assurance Fees** (Issues 301 and 302)—It is requested that Schedule (1) of Item 4300-101-0001 be increased by $76,000, Schedule (2) be increased by $411,000, and reimbursements be increased by $139,000 to reflect updated day treatment and transportation costs for Intermediate Care Facility/Developmentally Disabled (ICF/DD) residents.

- **Money Follows the Person Grant Fund Shift (Issue 316)—**It is requested that reimbursements be decreased by $2,134,000 to reflect new federal restrictions on the amount that Money Follows the Person grant expenditures can be reimbursed for administrative costs.

- **Targeted Case Management Administration Fund Shift (Issue 317)—**It is requested that reimbursements be decreased by $328,000 to reflect a decrease in federal financial participation due to reduced eligible expenditures.

- **$200.0 Million General Fund Trigger Reduction Adjustment (Issue 322)—**It is requested that Schedule (1) of Item 4300-101-0001 be decreased by $7.0 million, Schedule (2) of Item 4300-101-0001 be decreased by $3.4 million and reimbursements be decreased by $20.8 million to reflect the reallocation of a portion of the $200.0 million General Fund trigger from regional center Purchase of Services budget to the developmental center budget.

- **Race-to-the-Top Grant for the Early Intervention Program (Issue 321)—**It is requested that Schedule (3) of Item 4300-101-0001 and reimbursements be increased by $286,000 to reflect the DDS share of federal Race-to-the-Top grant funds for the Early Intervention Program.

- **Extend Liquidation Period for Prior Year Appropriations (Issue 001 and 002) —**It is requested that Budget Bill language be approved for a one-year extension of the liquidation period for funds appropriated in the 2009 and 2010 Budget Acts in order to achieve approved General Fund savings targets (See Attachment 1). The DDS is in the process of retroactively rebilling the federal government for day treatment and transportation services provided to Medi-Cal beneficiaries residing in licensed ICF/DDs.

Proposed Funding Change for Early Start Services

Approved (3-0) the May Revision proposal to anticipate $40 million in First 5 funding for Early Start services.

Proposals to Achieve $200 million Trigger Reduction

See May 24 outcomes below.

Proposals for New Trigger Impacts

Held issue open with note that if the reduction proposal is ultimately adopted, staff would recommend that the final trailer bill language include provisions similar to those below that were included in 2011-12 trigger reduction language:

> "A variety of strategies, including, but not limited to, savings attributable to caseload adjustments, changes in expenditure trends, unexpended contract funds, or other administrative savings or restructuring can be applied to this reduction with the intent of keeping reductions as far away as feasible from consumer's direct needs, services, and supports, including health, safety, and quality of life.
>
> The department may utilize input from workgroups comprised of consumers and family members, consumer-focused advocacy groups, service provider representatives, regional center representatives, developmental center representatives, other stakeholders, and staff of the Legislature, to develop General Fund savings proposals as necessary."

4700 Department of Community Services & Development

Lead Hazard Control Program

Approved (3-0) the proposed augmentation. The LAO concurs in this recommendation.

5160 Department of Rehabilitation

Proposed Elimination of the Orientation Center for the Blind Trust Fund Committee

Rejected (2-1, Emmerson no) the proposed elimination at this time.

5180 Department of Social Services (DSS)

Estimate Changes & Technical Adjustments

Adopted (3-0) the following technical changes to budget bill items, totaling a net decrease of $131,246,000 (decreases of $181,322,000 General Fund, $807,000 Child Support Collections Recovery Fund, and $74,892,000 reimbursements, partially offset by an increase of $125,775,000 Federal Trust Fund):

Program	Item	Change from Governor's Budget
CalWORKs / Kin-GAP	5180-101-0001 5180-101-0890 5180-601-0995	-$320,934,000 $853,272,000 -$2,745,000
Supplemental Security Income/State Supplementary Payment (SSI/SSP)	5180-111-0001	-$28,332,000
In-Home Supportive Services (IHSS)	5180-111-0001 5180-611-0995	$25,275,000 -$67,645,000
Other Assistance Payments	5180-101-0001 5180-101-0890	$106,719,000 -$802,289,000
County Administration and Automation Projects	5180-141-0001 5180-141-0890 5180-641-0995	$37,271,000 $67,253,000 $6,220,000
Community Care Licensing	5180-151-0001 5180-151-0890	$105,000 $46,000
Realigned Programs		
Adoption Assistance Program	5180-101-0890	-$6,204,000
Foster Care	5180-101-0001 5180-101-0890 5180-101-8004 5180-141-0001 5180-141-0890	$4,000 $9,325,000 -$807,000 -$6,000 $2,126,000
Child Welfare Services (CWS)	5180-151-0001 5180-151-0890 5180-651-0995	-$1,424,000 -$218,000 -$11,227,000
Title IV-E Waiver	5180-153-0890	$2,464,000
Adult Protective Services	5180-651-0995	$505,000

Revised Estimates Related to Previously Adopted Solutions:

Program	Policy	Change from January

IHSS	Requirement for Certification of Need by Health Care Provider (Issue 203)	Erosion of $117.3 million GF savings due to revised estimating methodology based on initial implementation period
IHSS	Proposed Domestic & Related Services Reduction (Issue 205)	Erosion of $38.5 million GF savings given revised implementation date (from July 1 to October 1, 2012)

Title IV-E Waiver Carryover (Issue 302)

The above actions are subject to any changes to conform as appropriate to other actions that have been or will be taken.

Also, the assumption related to erosions of savings tied to the sales tax on supportive services (Issue 202) was held open.

Other Conforming Issues: Child Care-Related Proposals, Transfers of Specified Alcohol & Drug Programs & Budget Bill Language Related to Health Care Reform

The May Revision proposes adjustments to the DSS budget that correspond to child care, alcohol & drug programs, and health care reform-related proposals that will be heard during other Subcommittee or full Committee hearings (Issues 010, 107, 110, 301, 302, 401). These items were held open.

In-Home Supportive Services (IHSS)

IHSS Public Authority Funding Methodology

Adopted (2-1, Emmerson no) trailer bill language extending the timeframe specified in statute for use of a newly developed ratesetting methodology for PA funding--to begin with the 2013-14 fiscal year, rather than 2012-13.

Sharing of Criminal Offender Record Information with the Department by the Public Authorities

Adopted (3-0) the proposed revision to WIC 12305.87, which is a technical change to the policies adopted in the 2010-11 budget.

Coordinated Care Initiative – Requested Positions

Held open.

New Proposal for Seven Percent Across-the-Board Reduction in Recipients' Hours of Service

Held open.

CalWORKs

Changes to CalWORKs Reduction & Redesign Proposals

Held open.

Automation Issues

LEADER Replacement System (LRS)

Approved (2-1) the revised estimate for 2012-13 LRS development costs.

Case Management, Information, and Payrolling System (CMIPS) II

Approved (3-0) the staffing requests for DSS and OSI, as well as the shift of costs between fiscal years.

Child Welfare Services/Case Management System (CWS/CMS)

See outcomes for 5.24 below.

Unallocated Reduction to Statewide Automated Welfare System (SAWS)

Adopted the proposed unallocated reduction to the SAWS system for 2012-13, but rejected the proposal to make the reduction permanent.

5175 Department of Child Support Services DCSS

Enrollment Caseload Population Estimate

Adopted (2-1) May Revise request.

Child Support Automation

Approved (3-0) May Revise request.

Reversion of Remaining California Child Support Automation System Funds

Approved (3-0) May Revise request.

Reduced Funding for Local Child Support Agencies

Rejected (3-0) proposed trailer bill language and made a one-time, unallocated reduction to Local Child Support Agencies by $14.7 million ($5.0 million General Fund).

May 24

4300 Department of Developmental Services (DDS)

Requested Staffing for the Lanterman Developmental Center

Approved (2-1, Emmerson no) the requested retention of specified staff for Lanterman.

Proposals to Achieve $200 million GF Reduction

Adopted (3-0, except as otherwise noted under Section B below) **the Administration's proposals and trailer bill language** in the following categories, **subject to** refinements in the trailer bill process and the changes and additions mentioned below:

A. Maximizing Federal Funds

B. Implementation of SB 946

1) $69.4 million GF savings related to SB 946 (3-0)
2) $10.4 million GF savings related to Healthy Families & CalPERS (2-1,Emmerson no)

C. Redesigning Services for Individuals with Challenging Needs

With the following changes and additions:

1) Limiting short-term acute crisis placements in developmental centers to six months, with the possibility of one six-month extension.

2) Authorizing the use of licensed delayed egress homes to also have secured perimeter fences, contingent on eligibility for federal funding and subject to program standards and a cap on the number of beds statewide in homes with secured perimeter fences, established by emergency regulations to be promulgated by the Department.

3) Prohibiting, effective July 1, 2012, Regional Centers from purchasing new residential services from Institutions for Mental Disease (IMD) for which federal financial participation is not available except in emergencies when alternative services eligible for federal funds are not available. In the case of emergency placements, requires a comprehensive assessment to be completed within 30 days of admission and an Individual Program Plan (IPP) meeting to be convened to plan for the transition of these consumers to the community within 6 months. Also requires comprehensive assessments of consumers currently placed in an IMD and the establishment of a transition plan and timelines for returning the consumer to the community.

4) Ensuring that the comprehensive assessments and reports for consumers residing in developmental centers on July 1, 2012 shall include input from the regional center, the consumer, and the consumer's family, legal guardian, or conservator, when appropriate, and identify the types of community based services and supports available to the consumer.

5) Requiring the Department to annually provide specified information to the policy and fiscal committees of the Legislature on the efforts to serve consumers with challenging needs, including but not limited to:

a) Data regarding developmental center admissions, including but not limited to those that occur in response to acute crises;

b) Outcome data related to the assessment process for consumers living in developmental centers on July 1, 2012;

c) Progress on the development of needed statewide specialty services and supports, including regional community crisis options;

d) Progress in reducing reliance on facilities ineligibile for federal funding and those located outside of the state; and

e) If applicable, any recommendations regarding additional rate exceptions or modifications beyond those allowed for under existing law that the Department identifies as necessary to ensure the success of these policies.

D. Redesigning Supported Living Assessments

With the specification that that regional centers be included, as stakeholders, in development of the assessment tool.

E. Regional Center & Provider Rate Reduction of 1.25 Percent

With a change to extend the 1.25 percent rate reduction for the 2012-13 budget year only.

F. Additional Cost Savings and Efficiencies As Described in the Previous Agenda

With the additional of trailer bill language to clearly establish that the use of technology in place of consumers' in-person court appearances or any direct services for consumers would only occur with the informed agreement of the consumer.

Oversight Related to Access to Developmental Services

Adopted (3-0) **placeholder trailer bill language** to require the annual compilation of existing purchase of service utilization and expenditure data by regional center with respect to race and ethnicity, age of consumer, and disability. The age of consumer shall be broken down by birth to two, three to twenty-one, and twenty-two and older. Disability detail shall include the five categories defined in statute. The data reported shall also include the number and percentage of individuals broken down by race and ethnicity, age and disability for those who have been determined to be eligible for regional center services but are not receiving any services using purchase of service funds. The data shall be reported in a consistent manner and the first annual reporting of the data shall be posted publicly no later than December 31, 2012. Within 3 months of the data becoming available and annually thereafter, each Regional Center shall meet with stakeholders regarding the data.

5180 Department of Social Services (DSS)

CalFresh Administration Costs and County Match Waiver

Adopted:

- a one-time reduction of $45 million GF (3-0), and
- A one-year extension of the match-waiver (2-1, Emmerson no)

With as much of the reduction achieved through reversions of funding unexpended in prior years as possible. To the extent that the reduction is achieved through a reduction in 2012-13 funding, required the Department to consult with counties regarding how to allocate the

reduction and to report back to the Legislature during budget hearings regarding the resulting impacts on the program.

Additionally adopted budget bill or trailer bill language, as determined necessary by Subcommittee staff, to effectuate these actions.

Child Welfare Services/Case Management System (CWS/CMS)

Voted (2-1, Emmerson no) to approve budgeted amount of funding and adopted the trailer bill language below, subject to refinements in the trailer bill process:

> Funding included in the 2012-13 budget related to replacement of the Child Welfare Services/Case Management System shall be used for the next steps necessary to move forward with the recommendation of the Child Welfare Automation Study Team (CAST) to proceed toward procuring a new system, consistent with a buy/build strategy as described in the CAST report submitted to the Legislature. These next steps shall include, but not be limited to, completing, in consultation with the counties and the County Welfare Directors Association, a Feasibility Study Report and Federal Advance Planning Document, as well as conducting other planning activities. OSI and the Department shall report the results of these activities, in addition to the key milestones and anticipated timelines for any resulting procurement process, to the Legislature by March 1, 2013 for review during budget hearings in 2013.

Child Welfare Services and Foster Care (CWS) Realignment: Programmatic Trailer Bill Language

Held open.

CWS Realignment: DSS Children's Program Staffing

Held open.

Replacement Recommendation
Department of Social Services
Issue 1: CalFresh Administration Costs & County Match-Waiver

Staff Recommendation: Adopt a one-time reduction of $45 million GF and a one-year extension of the match-waiver, with as much of the reduction achieved through reversions of funding unexpended in prior years as possible. To the extent that the reduction is achieved through a reduction in 2012-13 funding, require the Department to consult with counties regarding how to allocate the reduction and to report back to the Legislature during budget hearings regarding the resulting impacts on the program.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 22 & 24, 2012

Human Services Issue Outcomes

Staff: Jennifer Troia, Brady Van Engelen (DCSS)
& Catherine Freeman (CSD)

May 22

4170 Department of Aging (CDA)

Staffing Changes Related to Adult Day Health Care (ADHC) & Community Based Adult Services (CBAS) Programs

Approved (3-0) the proposed staffing and resources.

4300 Department of Developmental Services (DDS)

Estimate Changes & Technical Adjustments

Adopted (3-0) the following technical changes, with any changes to conform as appropriate to other actions that have been or will be taken:

For Developmental Centers:

- **Workload Adjustments (Issues 201, 202, 203, and 206)—**It is requested that Schedule (1) of Item 4300-003-0001 be increased by $1,197,000, reimbursements be increased by $620,000, Item 4300-003-0890 be decreased by $20,000, and Schedule (1)(a) of Item 4300-004-0001 be decreased by $138,000, and Schedule (1)(b) be increased by $138,000 to reflect adjustments in Level-of-Care and Non-Level-of-Care Staffing, operating expenses and equipment, and a fund shift in the Foster Grandparent Program.

- **Lanterman Developmental Center Closure Update (Issue 204)—**It is requested that Schedule (1) of Item 4300-003-0001 be decreased by $1,091,000 and reimbursements be decreased by $494,000 to reflect changes in staff support costs associated with leave buyout, unemployment insurance, and resident transition activities.

- **Federal Certification of Porterville Developmental Center (Issue 200)—**It is requested that reimbursements be decreased by $13.0 million to reflect the federal Centers for Medicare and Medicaid Services' (CMS) denial of certification to expand Medi-Cal eligibility to a portion of the population in the Secure Treatment Program.

- **$200.0 Million General Fund Trigger Reduction Adjustment (Issue 209)—**It is requested that Schedule (1) of Item 4300-003-0001 be decreased by $9.1 million and reimbursements be increased by $1.3 million to reflect a reallocation of the $200.0 million General Fund trigger reductions proposed in the Governor's Budget from regional center Purchase of Services to developmental centers.

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- **Quality Assurance Fees** (Issues 301 and 302)—It is requested that Schedule (1) of Item 4300-101-0001 be increased by $76,000, Schedule (2) be increased by $411,000, and reimbursements be increased by $139,000 to reflect updated day treatment and transportation costs for Intermediate Care Facility/Developmentally Disabled (ICF/DD) residents.

- **Money Follows the Person Grant Fund Shift (Issue 316)—**It is requested that reimbursements be decreased by $2,134,000 to reflect new federal restrictions on the amount that Money Follows the Person grant expenditures can be reimbursed for administrative costs.

- **Targeted Case Management Administration Fund Shift (Issue 317)—**It is requested that reimbursements be decreased by $328,000 to reflect a decrease in federal financial participation due to reduced eligible expenditures.

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Proposed Funding Change for Early Start Services

Approved (3-0) the May Revision proposal to anticipate $40 million in First 5 funding for Early Start services.

Proposals to Achieve $200 million Trigger Reduction

See May 24 outcomes below.

Proposals for New Trigger Impacts

Held issue open with note that if the reduction proposal is ultimately adopted, staff would recommend that the final trailer bill language include provisions similar to those below that were included in 2011-12 trigger reduction language:

> "A variety of strategies, including, but not limited to, savings attributable to caseload adjustments, changes in expenditure trends, unexpended contract funds, or other administrative savings or restructuring can be applied to this reduction with the intent of keeping reductions as far away as feasible from consumer's direct needs, services, and supports, including health, safety, and quality of life.
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> The department may utilize input from workgroups comprised of consumers and family members, consumer-focused advocacy groups, service provider representatives, regional center representatives, developmental center representatives, other stakeholders, and staff of the Legislature, to develop General Fund savings proposals as necessary."

4700 Department of Community Services & Development

Lead Hazard Control Program

Approved (3-0) the proposed augmentation. The LAO concurs in this recommendation.

5160 Department of Rehabilitation

Proposed Elimination of the Orientation Center for the Blind Trust Fund Committee

Rejected (2-1, Emmerson no) the proposed elimination at this time.

5180 Department of Social Services (DSS)

Estimate Changes & Technical Adjustments

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Adult Protective Services	5180-651-0995	$505,000

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Program	Policy	Change from January

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Title IV-E Waiver Carryover (Issue 302)

The above actions are subject to any changes to conform as appropriate to other actions that have been or will be taken.

Also, the assumption related to erosions of savings tied to the sales tax on supportive services (Issue 202) was held open.

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In-Home Supportive Services (IHSS)

IHSS Public Authority Funding Methodology

Adopted (2-1, Emmerson no) trailer bill language extending the timeframe specified in statute for use of a newly developed ratesetting methodology for PA funding--to begin with the 2013-14 fiscal year, rather than 2012-13.

Sharing of Criminal Offender Record Information with the Department by the Public Authorities

Adopted (3-0) the proposed revision to WIC 12305.87, which is a technical change to the policies adopted in the 2010-11 budget.

Coordinated Care Initiative – Requested Positions

Held open.

New Proposal for Seven Percent Across-the-Board Reduction in Recipients' Hours of Service

Held open.

CalWORKs

Changes to CalWORKs Reduction & Redesign Proposals

Held open.

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LEADER Replacement System (LRS)

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Child Welfare Services/Case Management System (CWS/CMS)

See outcomes for 5.24 below.

Unallocated Reduction to Statewide Automated Welfare System (SAWS)

Adopted the proposed unallocated reduction to the SAWS system for 2012-13, but rejected the proposal to make the reduction permanent.

5175 Department of Child Support Services DCSS

Enrollment Caseload Population Estimate

Adopted (2-1) May Revise request.

Child Support Automation

Approved (3-0) May Revise request.

Reversion of Remaining California Child Support Automation System Funds

Approved (3-0) May Revise request.

Reduced Funding for Local Child Support Agencies

Rejected (3-0) proposed trailer bill language and made a one-time, unallocated reduction to Local Child Support Agencies by $14.7 million ($5.0 million General Fund).

May 24

4300 Department of Developmental Services (DDS)

Requested Staffing for the Lanterman Developmental Center

Approved (2-1, Emmerson no) the requested retention of specified staff for Lanterman.

Proposals to Achieve $200 million GF Reduction

Adopted (3-0, except as otherwise noted under Section B below) **the Administration's proposals and trailer bill language** in the following categories, **subject to** refinements in the trailer bill process and the changes and additions mentioned below:

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B. Implementation of SB 946

1) $69.4 million GF savings related to SB 946 (3-0)
2) $10.4 million GF savings related to Healthy Families & CalPERS (2-1,Emmerson no)

C. Redesigning Services for Individuals with Challenging Needs

With the following changes and additions:

1) Limiting short-term acute crisis placements in developmental centers to six months, with the possibility of one six-month extension.

2) Authorizing the use of licensed delayed egress homes to also have secured perimeter fences, contingent on eligibility for federal funding and subject to program standards and a cap on the number of beds statewide in homes with secured perimeter fences, established by emergency regulations to be promulgated by the Department.

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5) Requiring the Department to annually provide specified information to the policy and fiscal committees of the Legislature on the efforts to serve consumers with challenging needs, including but not limited to:

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b) Outcome data related to the assessment process for consumers living in developmental centers on July 1, 2012;

c) Progress on the development of needed statewide specialty services and supports, including regional community crisis options;

d) Progress in reducing reliance on facilities ineligibile for federal funding and those located outside of the state; and

e) If applicable, any recommendations regarding additional rate exceptions or modifications beyond those allowed for under existing law that the Department identifies as necessary to ensure the success of these policies.

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With the specification that that regional centers be included, as stakeholders, in development of the assessment tool.

E. Regional Center & Provider Rate Reduction of 1.25 Percent

With a change to extend the 1.25 percent rate reduction for the 2012-13 budget year only.

F. Additional Cost Savings and Efficiencies As Described in the Previous Agenda

With the additional of trailer bill language to clearly establish that the use of technology in place of consumers' in-person court appearances or any direct services for consumers would only occur with the informed agreement of the consumer.

Oversight Related to Access to Developmental Services

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5180 Department of Social Services (DSS)

CalFresh Administration Costs and County Match Waiver

Adopted:

- a one-time reduction of $45 million GF (3-0), and
- A one-year extension of the match-waiver (2-1, Emmerson no)

With as much of the reduction achieved through reversions of funding unexpended in prior years as possible. To the extent that the reduction is achieved through a reduction in 2012-13 funding, required the Department to consult with counties regarding how to allocate the

reduction and to report back to the Legislature during budget hearings regarding the resulting impacts on the program.

Additionally adopted budget bill or trailer bill language, as determined necessary by Subcommittee staff, to effectuate these actions.

Child Welfare Services/Case Management System (CWS/CMS)

Voted (2-1, Emmerson no) to approve budgeted amount of funding and adopted the trailer bill language below, subject to refinements in the trailer bill process:

> Funding included in the 2012-13 budget related to replacement of the Child Welfare Services/Case Management System shall be used for the next steps necessary to move forward with the recommendation of the Child Welfare Automation Study Team (CAST) to proceed toward procuring a new system, consistent with a buy/build strategy as described in the CAST report submitted to the Legislature. These next steps shall include, but not be limited to, completing, in consultation with the counties and the County Welfare Directors Association, a Feasibility Study Report and Federal Advance Planning Document, as well as conducting other planning activities. OSI and the Department shall report the results of these activities, in addition to the key milestones and anticipated timelines for any resulting procurement process, to the Legislature by March 1, 2013 for review during budget hearings in 2013.

Child Welfare Services and Foster Care (CWS) Realignment: Programmatic Trailer Bill Language

Held open.

CWS Realignment: DSS Children's Program Staffing

Held open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 24, 2012

Upon Adjournment of Appropriations Committee

Room 112

Agenda – Part 2

(Michelle Baass)

PLEASE NOTE:

Only those 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 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 916-651-1505. Requests should be made one week in advance whenever possible. Thank you.

VOTE ONLY CALENDAR

A. 4440 Department of Mental Health

1. Community Treatment Facilities

Budget Issue. The Administration proposes to eliminate $750,000 General Fund that is paid as a supplemental rate to Community Treatment Facilities (CTFs). The Administration argues that since this is not a statewide program, counties can use local funds to fund these CTFs at their discretion. (There are no federal funds for CTFs.)

There are two active CTFs in California:

- Starview Children and Family Services in Los Angeles County (40 beds)
- Vista Del Mar Child and Family Services in Los Angeles County (21 beds)

The San Francisco Community Alternatives Program in San Francisco County is in the process of closing and is performing assessments on all of its clients in order to refer each one to other programs and services in the area.

The $750,000 General Fund supplemental rate was based on three CTFs being operational in the state.

This issue was discussed at the April 12, 2012 Subcommittee #3 hearing.

Subcommittee Staff Recommendation—Approve. It is recommended to approve this proposal. Given the state's fiscal situation and since there are only two facilities in the state, counties can use realignment funds to fund placement at these facilities.

2. Reappropriation Metropolitan New Main Kitchen Project

Governor's Request. A Spring Finance Letter proposes reappropriation authority to complete the New Main Kitchen project at Metropolitan State Hospital.

Background. The New Main Kitchen Project started in 2004 and is complete, with one exception - a required fire water line is needed to be built to satisfy State Fire Marshall requirements. The water system's velocity and pressure required to pass the State Fire Marshal requirements to bring the Central Kitchen online were not met. The fire water line is currently being built; however, it has had the following challenges:

1. Unforeseen site conditions in the fire water line trench with existing utilities and soil conditions requiring new fill material meeting project requirements;
2. A contractor that is unfamiliar with state projects; and,
3. Issues in obtaining the required approvals on deferred submittals from the appropriate state entities.

These issues are being resolved and the project will be completed by the end of the year; however, there will be a lapse in project authority. This reappropriation provides an extension of existing authority so that the fire water line can be completed and any claims can be paid using the remaining funds available for this project.

Staff Comment and Recommendation—Approve. It is recommended to approve this item.

B. 0977 California Health Facilities Financing Authority

1. Funding for Competitive Grant Program for New Methods of Health Care Delivery

Issue. The California Health Facilities Financing Authority (CHFFA) Fund has over $6.5 million available in its reserve that could be used to fund a competitive grant program for one or more projects to demonstrate new or enhanced methods of delivery health care services to improve access and health outcomes for vulnerable populations or communities, or both that are effective at enhancing health outcomes and improving access to quality health care and preventive services. Those funds not awarded as a competitive grant would revert back to the fund balance on January 1, 2020.

Background. CHFFA was established in 1979 to be the state's vehicle for providing financial assistance to public and nonprofit health care providers through loans funded by the issuance of tax-exempt bonds. CHFFA also administers the Healthcare Expansion Loan Program II (HELP II), which provides direct loans to small and rural health facilities, and several grant programs that have provided funding for community clinics and 13 of the state's children's hospitals.

By borrowing through CHFFA, health facilities can likely obtain lower interest rates than they would through conventional bonds. Generally, nonprofit, licensed health facilities in California, including adult day health centers, community clinics, skilled nursing facilities, developmentally disabled centers, hospitals, and drug and alcohol rehabilitation centers are eligible for CHFFA financing.

Fees paid by CHFFA borrowers are deposited into the CHFFA Fund. These fees are competitively set and take into account the fees charged by competing lenders.

Subcommittee Staff Comment and Recommendation. It is recommended to create a competitive grant program using up to $6.5 million from the CHFFA Fund reserve. Given the reductions in services and funding for California's underserved and vulnerable populations in the past few years, this available fund balance provides an opportunity to fund innovative and cost-effective ways of delivering high quality care to vulnerable populations.

C. 4260 Department of Health Care Services

1. Eliminate Sunset Date for Specialty Provider Contracting

Budget Issue. AB 1183 (Statutes of 2008) amended Welfare and Institutions Code 14105.3 and allowed DHCS to enter into contracts with providers who distribute and provide care for specialty drugs and services. This provision allows DHCS to restrict payment of specialty drugs and services to a limited number of providers. The legislation included an annual reporting requirement following the first two years and a sunset provision of July 1, 2013.

Subcommittee Staff Comment and Recommendation—Reject. It is recommended to reject this proposed trailer bill language as there are no budget implications and there is time for the department to do policy legislation on this topic.

2. Adjustments to Gross Premium Tax (DOF Issue 134)

Budget Issue. The May Revision proposes a technical adjustment to the amount of Gross Premium Tax revenue available for the Medi-Cal program. The May Revision estimates a decrease of $26.6 million will be available.

Subcommittee Staff Comment and Recommendation—Approve. This is technical adjustment based on updated estimates.

3. Technical Changes to Implement AB 396 – Medi-Cal Juvenile State Inmate Program

Budget Issue. In the May Revision, the Administration proposes technical clean-up trailer bill language that is necessary to make changes to the provision of AB 396 (Mitchell, Statues of 2011).

Background. Prior to AB 396, county juvenile detainees were not eligible for Medi-Cal because they were juvenile inmates who, pursuant to Welfare and Institutions Code Section 14011.10, must be suspended and may not receive Medi-Cal benefits during the pendency of their suspension. As such, the counties were responsible to provide and pay for the medical services received by the county juvenile detainees whether the services were provided on or off the detention facilities.

AB 396 changed this by requiring that Medi-Cal eligibility not be denied to a county juvenile inmate who is an inpatient in a medical institution because of their status as an inmate of a public institution. AB 396 authorizes DHCS to develop a process for the counties to receive any available federal financial participation for acute inpatient hospital services and inpatient

psychiatric services provided to Medi-Cal eligible juvenile inmates admitted as inpatients into a medical institution off the grounds of the detention facilities.

Subcommittee Staff Comment and Recommendation—Reject. It is recommended to reject the Administration's technical clean-up language regarding AB 396.

ISSUES FOR DISCUSSION

Public testimony will be taken for each of the items listed in this section.

A. 4440 Department of Mental Health, Community Mental Health

Background on Community Mental Health

California has a decentralized public mental health system with most direct services provided through the county mental health system. In 2011-12, major changes to the state's oversight and responsibility for these programs were initiated. (These changes are described in detail below.) Prior to 2011-12, the Department of Mental Health (DMH) was the lead state agency responsible for administering state and federal statutes pertaining to mental health treatment programs.

County Mental Health Plans. Counties (i.e., County Mental Health Plans) have the primary funding and programmatic responsibility for the majority of local mental health programs.

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

Specialty Mental Health Services Managed Care. California provides "specialty" mental health services under a comprehensive Waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. These specialty mental health services are "carved out" of the Medi-Cal Program administered by the Department of Health Care Services (DHCS), which provides physical health care.

County Mental Health Plans are the responsible entity that ensures that specialty mental health services are provided. Medi-Cal enrollees *must* obtain their specialty mental health services through the County.

Medi-Cal enrollees may also receive certain limited mental health services, such as pharmacy benefits, through the Fee-For-Service system.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. EPSDT is a federally mandated program that requires the state to provide Medi-Cal beneficiaries under age 21 with any physical and mental health services that are deemed medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, including services not otherwise included in the state's Medicaid plan. Counties are responsible for a 10 percent share of cost for the growth in EPSDT.

2011 Realignment and Mental Health Services. The 2011-12 budget realigned many public safety and health and human services and intended for the future realignment of Medi-Cal Specialty Mental Health and EPSDT in 2012-13. These programs were not realigned in 2011-12 because AB 100 (Statutes of 2011, budget trailer bill legislation) amended the Mental Health Services Act (MHSA) to allocate, on a one-time basis, $861 million in MHSA funds to counties to support EPSDT and Medi-Cal Specialty Mental Health managed care, and mental health services provided to special education students

Historically, County Mental Health Plans were funded with 1991 Realignment funds, General Fund, and federal funds and EPSDT was funded by the General Fund and federal funds with the counties paying a 10-percent share of cost above a specified baseline.

Administrative Transfer from DMH to Department of Health Care Services. AB 102 (Statutes of 2011) continued the process to restructure the state's mental health system. AB 102 transfers from DMH to the Department of Health Care Services (DHCS), effective July 1, 2012, the state administrative functions for the operation of Medi-Cal Specialty Mental Health Managed Care, the EPSDT Program, and applicable functions related to federal Medicaid requirements.

It required DHCS, in collaboration with DMH and the California Health and Human Services Agency (Agency), to create a state administrative and programmatic transition plan, in consultation with stakeholders that included specified components to guide the transfer of Medi-Cal Specialty Mental Health managed care and the EPSDT Program to DHCS.

AB 102's legislative intent is that the transfer occur in an efficient and effective manner, with no unintended interruptions in service delivery to clients and families, and that the transfer accomplish improved access to culturally appropriate community-based mental health services; effectively integrate the financing of services to more effectively provide services; improve state accountabilities and outcomes; and provide focused, high-level leadership for behavioral health services within the state administrative structure.

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

AB 100 also made changes to MHSA administration, including reducing the percentage amount available from MHSA revenues for state administration from 5 percent to 3.5 percent, requiring monthly distributions from the MHSA Fund, having the "state" (instead of DMH) administer the MHSA Fund, and having the Mental Health Services Oversight and

Accountability Committee provide technical assistance to counties. AB 100 was point-in-time legislation that was developed with the intention of coming back to define a process to restructure the state's mental health system.

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

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

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

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

1. Realignment - Medi-Cal Specialty Mental Health and EPSDT

Budget Issue. The May Revision includes trailer bill language on the 2011 Realignment Superstructure and updated estimates for Medi-Cal Specialty Mental Health and EPSDT. Additionally, in April, the Administration released trailer bill language to implement the realignment of Medi-Cal Specialty Mental Health services and EPSDT.

Realignment Superstructure. In the May Revision, the Administration is proposing trailer bill language to create a permanent structure for 2011 Realignment. The funding structure is designed to provide local entities with a known, reliable, and stable funding source for these programs. Within each Subaccount, counties would have the flexibility to meet their highest priorities, and will be able to use their funds to draw down the maximum amount of federal funding for these programs. In those programs in which there are federal requirements, such as eligibility and statewideness, counties would be responsible for meeting those requirements.

The realignment superstructure would establish the following two accounts in the County Local Revenue Fund: (1) Support Services Account and (2) Law Enforcement Services Account.

The **Support Services Account** will contain two Subaccounts:
- **Protective Services Subaccount** will contain funding for Foster Care; Child Welfare Services; Adoptions; Adoptions Assistance Program; Child Abuse Prevention, Intervention, and Treatment; and Adult Protective Services.
- **Behavioral Health Subaccount** will contain funding for Drug Medi-Cal; Drug Courts; Perinatal Drug Services; Non-Drug Medi-Cal Services; Mental Health Managed Care (Medi-Cal Specialty Mental Health); and Early and Periodic Screening, Diagnosis, and Treatment.

The **Law Enforcement Services Account** will contain five subaccounts:
- Trial Court Security Subaccount.
- Law Enforcement Services Subaccount.
- Community Corrections Subaccount.
- District Attorney/Public Defender Subaccount.
- Juvenile Justice Subaccount, containing both the Youthful Offender Block Grant and Juvenile Reentry Fund.

In addition, local realignment funding for the 1991 Mental Health Responsibilities would be allocated to the Mental Health Account (separate from the two subaccounts listed above).

Growth. The Governor proposes to allocate program growth on roughly a proportional basis first among the Accounts and then among the Subaccounts. Within each Subaccount, federally required programs would receive priority funding if warranted by caseload and costs.

The following components (related to mental health) are addressed in the realignment superstructure:

- ***County Share of EPSDT.*** The proposed trailer bill language continues counties' existing 10 percent match on EPSDT growth and clarifies that the match shall come from a funding source other than the Local Revenue Fund.

- ***Reallocation.*** In addition, the proposed language includes reallocation provisions similar to those in the 1991 realignment between the Protective Services Subaccount and the Behavioral Health Subaccount (the reallocation may not exceed 10 percent of the amount deposited in the subaccount with the lowest balance) and clarifies the reallocation is for one fiscal year and not a permanent funding source. This reallocation must be heard at a regularly scheduled County Board of Supervisors hearing and the documentation of this reallocation must be submitted to the State Controller (who would be required to provide this information to the Legislature upon request).

Program Base Funding. The base for each of the programs included in 2011 Realignment will ultimately become a "rolling base," meaning the previous year's allocation level plus growth will equal the new base for the following year.

The table below identifies the proposed "2011 Realignment" funding for mental health services.

Table: 2011 Realignment Funding – Local Revenue Fund (LRF) (dollars in millions)

	2011-12		**2012-13**	
	2011 Budget Act	Proposed	January Estimate	May Revision Estimate
Medi-Cal Specialty Mental Health	-	-	$188.8	$196.7
EPSDT	-	-	$544.0	$584.2
1991 Mental Health Responsibilities	$1,083.6	$1,083.6	$1,164.4	$1,120.6

Medi-Cal Specialty Mental Health. The May Revision proposes $398 million ($196.7 million Local Revenue Fund and $201 million federal funds) for Medi-Cal Specialty Mental Health.

The $7.9 million increase in Local Revenue Fund from the January budget estimate, noted in the table above, for Medi-Cal Specialty Mental Health (i.e., the mental health managed care program) reflects an increase in psychiatric inpatient services and includes an increase for Solano County that pertains to a previous pilot project.

EPSDT Estimate. The May Revision proposes $1.568 billion for EPSDT ($584.2 Local Revenue Fund, $882.9 million federal funds, and $99.7 million county funds). The May Revision includes the following adjustments to the Local Revenue Fund for EPSDT:

1. **Claims.** An increase of about $7.3 million LRF ($14.5 million total funds) based on an increase of approved claims for the forecast period.
2. **Healthy Families Program Transition to Medi-Cal.** Full year costs for the transition of Healthy Families Program children to Medi-Cal. The January estimate included $6.1 million LRF ($17.6 million total funds) for partial year implementation and the May Revision includes $17.3 million LRF ($49.3 million total funds).
3. ***Katie A.* Settlement.** Full year costs for the implementation of the *Katie A.* settlement. The January estimate included $5.3 million LRF ($10.6 million total funds) for partial year implementation and the May Revision includes $26.7 million LRF ($53.5 million total funds).

Realignment of Medi-Cal Specialty Mental Health and EPSDT. In April, the Administration released trailer bill language to implement the realignment of Medi-Cal Specialty Mental Health services and EPSDT. With this language, fiscal responsibility for Medi-Cal Specialty Mental Health and EPSDT would shift to the counties. However, given that these programs receive federal Medicaid funds, the Department of Health Care Services would maintain a role in the oversight of these programs.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold these items (i.e., the realignment superstructure trailer bill language, the mental health realignment trailer bill language, and the estimates for EPSDT and Medi-Cal Specialty Mental Health) open as discussions continue regarding realignment.

Realignment Superstructure. Concerns have been raised regarding the requirement that counties continue to provide the 10 percent match to any new growth in the cost of EPSDT and require that counties funding for this come from a source other than funds in each county's Local Revenue Fund allocation.

Program Baseline Funding. At the April 12, 2012 Subcommittee hearing on this topic, concerns were expressed that the level of funding for EPSDT was not sufficient and that the Administration did not account for full-year implementation of the Healthy Families Program Transition to Medi-Cal and the *Katie A.* lawsuit. The Administration has addressed these concerns.

Realignment of Medi-Cal Specialty Mental Health and EPSDT. Concerns have been raised that there are inconsistencies regarding state rule-making authority between the trailer bill language proposals to implement the 2011 Realignment for mental health services, alcohol and drug programs, and social services programs.

Additionally, counties highlight that the trailer bill language for mental health services realignment does not require the Department of Health Care Services to consult with counties prior to submitting federal waivers or state plan amendments. Under Realignment 2011, counties are responsible for 100 percent of the share of cost for federal programs and as such find that they should be at the table when policy and/or fiscal changes to these programs are proposed.

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

1. Please provide an brief overview of the realignment superstructure and the proposal to realign EPSDT and Medi-Cal Specialty Mental Health.
2. Please provide an overview of the May Revision EPSDT and Medi-Cal Specialty Mental Health estimates and how they compare to the January budget.

2. Transfer of State Administration of Medi-Cal Specialty Mental Health

Budget Issue. The Administration proposes trailer bill language to proceed with statutory changes necessary to transfer the administrative functions for Medi-Cal Specialty Mental Health managed care plan services and EPSDT from DMH to DHCS.

Background. AB 102 (Statutes of 2011) transferred the administration of the Medi-Cal Specialty Mental Health Services Program from DMH to DHCS, effective July 1, 2012. The intent of the transfer is to:

- Improve access to culturally appropriate community-based mental health services, including a focus on client recovery, social rehabilitation services, and peer support;
- Effectively integrate the financing of services, including the receipt of federal funds, to more effectively provide services;
- Improve state accountabilities and outcomes;
- Provide focused, high-level leadership for behavioral health services within the state administrative structure.

Effective September 1, 2011, 118.5 DMH Medi-Cal positions were transferred to DHCS.

AB 102 required DHCS, in collaboration with DMH and the California Health and Human Services Agency (Agency), to create a state administrative and programmatic transition plan, in consultation with stakeholders that included specified components to guide the transfer of Medi-Cal Specialty Mental Health managed care and the EPSDT Program to DHCS.

DHCS was required to provide the transition plan to all fiscal committees and applicable policy committees of the Legislature by October 1, 2011. AB 102 required the state administrative transfer to conform to the state administrative transition plan provided to the Legislature. Finally, AB 102 also authorized the transition plan to also be updated by the Governor and provided to the Legislature upon its completion, but no later than May 15, 2012.

DHCS submitted the required transition plan, and two updates to that plan. Issues raised by stakeholders in the October 1, 2011 transition plan included the following:

- That DHCS improve business practices (examples include maximizing the claiming of federal funds; improving the claims reimbursement system, streamlining the cost reporting and settlement processes; eliminating redundancies in the provider certification process; facilitating same day billing for mental and physical health care services; integrating audits; integrating information technology systems; and, reducing processing times);
- That DHCS assure access and improve services (examples include adopting community-based best practices, such as peer support and maximizing the use of social rehabilitation services; increasing the use of telepsychiatry; focusing on prevention and early intervention; ensuring state staff are knowledgeable about mental health services; assuring children's mental health policy expertise; assuring providers can continue to

serve clients during and after the transfer; continuing progress in assuring cultural competence of services; addressing racial, ethnic, and cultural disparities in access to care and outcomes; reducing discrimination and stigma experienced by clients; eliminating disparity in access to services; integrating services; facilitating coordination with non-Medi-Cal mental health services; incentivizing the use of community settings; and assuring accountability in the mental health system and, of its providers and administrators);

- That DHCS ensure stakeholder participation (examples include providing regularly scheduled venues for regular stakeholder engagement; consulting with stakeholders on program changes, efficiencies, regulations, State Plan Amendments, and waiver amendments; engaging stakeholders in ongoing quality improvement, including county representation in assessment of legal issues and court decisions that require county implementation; facilitating stakeholder participation by funding travel to meetings; and, clearly identifying individuals that serve as state contacts for programs and services).

Subcommittee Staff and Recommendation—Hold Open. It is recommended to hold this item open as it is related to the Realignment issue above.

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

1. Please provide an overview of this proposal and the planning process that occurred in the summer and fall of last year.

3. Transfer of Non Medi-Cal Community Mental Health Programs

Budget Issue. The Governor's budget proposes to eliminate the Department of Mental Health (DMH), establish the Department of State Hospitals to provide long-term care and services to individuals with mental illness at state hospitals, and redirect funding and positions for all remaining mental health services to other departments.

The reorganization of behavioral health began in 2011-12, as discussed above. The Administration intends that this proposal completes these efforts by transferring the remaining mental health programs to various state departments that perform related or similar functions. The Administration believes the consolidation of mental health, substance use disorder, and physical health at DHCS will provide for a continuum of care for consumers in preparation for health care reform in 2014.

Department of Health Care Services. The majority of existing community mental health programs and functions are proposed to be transferred to a new Division of Mental Health and Substance Use Disorders Services within DHCS. In addition to the transfer of these programs, the Administration proposes to create a new Deputy Director, Mental Health and Substance Use Disorder Services, who would lead this new division. The new Deputy Director would be a Governor's Appointee and would require Senate confirmation. The following functions would be transferred to DHCS:

- **Oversight of Certain MHSA Components.** DHCS would be responsible for the collection of data relating to certain Mental Health Service Act (MHSA) programs (Full Service Partnerships). In addition, DHCS would be responsible for MHSA state-level issue resolution which is a process by which consumers and stakeholders have a mechanism to resolve issues related to MHSA. And finally, DHCS would be responsible for MHSA Statewide Prevention and Early Intervention Projects (Suicide Prevention, Student Mental Health Initiative, and Stigma and Discrimination Reduction Programs).

- **Certification of Mental Health Programs at Facilities.** DHCS would assume responsibilities for the certification of mental health treatment programs at Skilled Nursing Facilities with Special Treatment Programs, Community Residential Treatment Systems (also known as Social Rehabilitation Programs), and Community Treatment Facilities.

- **Oversight of Federal Grants.** In addition, DHCS would be responsible for the oversight and administration of federal mental health funds including the Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant and the Projects for Assistance in Transition from Homelessness (PATH). The SAMHSA block grant can be used to establish or expand an organized community-based system of care for providing non-Medi-Cal mental health services to children with serious emotional disturbances and adults with serious mental illness. The state administers this block grant and allocates the funds each year to 58 local county mental health agencies. The county mental health departments and contracted providers deliver a broad array of treatment and support

services that include over 150 individual programs supported by the block grant. PATH funds community-based outreach, mental health and substance abuse services, case management, and limited housing services for people experiencing serious mental illness who are experiencing homelessness or are at risk of becoming homeless.

- **Oversight of Contracts and Other Mental Health Programs.** Finally, DHCS would be responsible for the oversight of certain administrative and training contracts related to the above-mentioned programs and the coordination of efforts related to veteran's mental health and co-occurring disorders.

Department of Public Health (DPH) - Office of Multicultural Services and Disaster Services. As discussed later in the agenda, the Administration proposes to transfer the Office of Multicultural Services (OMS) to DPH's new Office of Health Equity. Additionally, the $60 million in MHSA funds for the California Reducing Disparities Project (CRDP) would be transferred to DPH (with $15 million being appropriated each year for four years as a state administrative item). This appropriation to DPH is discussed later in the agenda under the Department of Public Health.

The CRDP is a project under the Prevention and Early Intervention component of the Mental Health Services Act. The initiative is focused on five populations: African Americans; Asian/Pacific Islanders; Latinos; Lesbian, Gay, Bi-sexual, Transgender, Questioning; and Native Americans. The project will develop population-specific reports that will form the basis of a statewide comprehensive strategic plan to identify new approaches to reduce disparities.

This proposal also transfers DMH's Disaster Services Unit to DPH. The Disaster Services Unit is responsible for the statewide coordination of disaster mental health responses to major disasters in support of local mental health agencies. This includes the development and maintenance of the mental health section of the State Emergency Plan and training and technical assistance to local mental health agencies on planning, preparedness, and mitigation for a disaster.

The DPH is the designated lead state agency for public health emergency preparedness and response.

Department of Social Services (DSS) – Licensing of MHRCs and PHFs. The Administration proposes to transfer DMH's facility licensing and quality improvement efforts to the Department of Social Services (DSS). DMH currently licenses mental health rehabilitation centers (MHRCs) and psychiatric health facilities (PHFs). The Administration finds that these facilities are similar to other residential facilities that are licensed by DSS.

Mental Health Rehabilitation Centers (MHRCs). MHRCs provide community-based intensive support and rehabilitation services designed to assist persons, 18 years or older, with mental disorders who would have been placed in a state hospital or another mental health facility to develop the skills to become self-sufficient and capable of increasing levels of independent functioning. There are currently 20 MHRCs with a total of 1,363 beds.

The Legislature's intent with creating MHRCs was to create innovative programs that were alternatives to hospital care.

Psychiatric Health Facilities (PHFs). PHFs offer acute inpatient psychiatric treatment to individuals with major mental disorders in a nonhospital setting. PHFs mainly provide acute psychiatric treatment services to individuals subject to involuntary commitment under the Lanterman-Petris-Short Act. There are 25 PHFs in California with 432 beds. These facilities are locked facilities. PHFs employ a multidisciplinary model (consistent with its enabling legislation) which called for an innovative approach to acute psychiatric care.

PHFs were conceptualized and designed to be an alternative to acute psychiatric hospitals which are traditionally based on a medical model.

Approval of Involuntary Hold Facilities. Additionally, the Administration proposes to transfer DMH's roles and responsibilities related to Lanterman-Petris-Short Act involuntary holds (pursuant to Welfare and Institutions Code Section 5150) to DSS. These responsibilities include the approval of facilities designated by counties for 72-hour treatment.

Department of Education – Early Mental Health Initiative. The proposal transfers the Early Mental Health Initiative (EMHI) program to the Department of Education. The EMHI is a school-based program funded with Proposition 98 funds. The Senate Budget Subcommittee #1 will discussed this proposed transfer at its April 26 hearing.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to adopt placeholder trailer bill language to reorganize the non-Medi-Cal community mental health programs to reflect agreement with agreement with the Administration on licensing and certification, technical changes regarding the elimination of DMH, and transfering programs to DHCS and DPH.

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

1. Please provide a summary of this proposal.

2. How has the Administration reached out to stakeholders to solicit feedback on this reorganization?

4. Proposition 63 – Mental Health Services Act

Budget Issue. In addition to the reorganization of non-Medi-Cal community mental health, the Administration's proposed trailer bill language makes changes to the Mental Health Services Act (MHSA), including:

- Changes approval of the MHSA innovation programs from the Mental Health Services Oversight and Accountability Commission (MHS OAC) to the county board of supervisors.
- Removes MHS OAC's authority to issue guidelines for MHSA innovation programs.
- Requires each county mental health program to prepare and submit a three-year plan adopted by its county board of supervisors to MHS OAC.
- Eliminates performance contracts between the state and counties.

Background. AB 100 (Statutes of 2011) made several changes to the Mental Health Services Act (MHSA). These changes include:

- Deleted the requirement that the Department of Mental Health (DMH) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) annually review and approve county plans and updates.
- Deleted the requirement that a county annually update the 3-year plan but still required that there be updates.
- The "state," instead of DMH, would administer the Mental Health Services Fund (MHSF).
- Starting July 1, 2012, the State Controller shall distribute, on a monthly basis, to counties all unexpended and unreserved funds on deposit in the MHSF as of the last day of the prior month.
- Reduced the administrative funds for state departments from 5 percent to 3.5 percent.

AB 100 also contained language specifying that it was the Legislature's intent to ensure continued state oversight and accountability of the MHSA and that in eliminating state approval of county mental health programs, the Legislature expects the state to establish a more effective means of ensuring that county performance complies with the MHSA.

AB 100 Workgroup. Because several changes made by AB 100 needed clarification before they could be implemented, a workgroup was convened in an effort to try to develop consensus recommendations. This workgroup included representatives from DMH; the California Mental Health Planning Council; MHSOAC; the California Mental Health Directors; the National Alliance on Mental Illness; the California Network of Mental Health Clients; the Mental Health Association, California; and United Advocates for Children and Families.

Recommendations from the AB 100 workgroup include, but are not limited to:

- Implement the MHSA state level issue resolution process as a mechanism to assure county level compliance with the MHSA values.
- Charge MHSOAC with MHSA performance outcome evaluation.
- Continue MHSA programs through a performance contract.

Performance Contracts. Performance contracts were developed during the 1991 realignment as a way to ensure county accountability. These contracts provide for county assurance and reports and provide a mechanism to address noncompliance.

Senate Bill 1136 (Steinberg). Senator Steinberg has introduced SB 1136 to address issues regarding the restructuring of the public mental health system at both the local and State levels. Specifically, SB 1136 serves to address the changes occurring in the public mental health system as they pertain to the Mental Health Services Act. Key aspects of SB 1136 are discussed below.

Innovative Programs. SB 1136 clarifies the content of projects by reflecting guidelines adopted by the MHS OAC. The author finds that articulating these requirements in statute provides for transparency and accountability for all involved, including local constituencies, the counties and the State.

Prevention & Early Intervention (PEI) Programs. It provides for the Department of Health Care Services, in coordination with counties, to establish PEI Programs, and requires any revisions to these programs to be consistent with MHS OAC guidelines. These changes would assist in facilitating a stronger partnership at both the State and local levels.

Integrated Three-Year Plans and Updates. SB 1136 modifies the Integrated Plan approval process to ensure community participation, provide for Board of Supervisor approval, and oversight by the MHS OAC. It streamlines the expenditure of funds to ensure dollars are directed to needed services and supports. It requires both the Mental Health Director and County Auditor Controller to certify compliance with key cornerstones of the Act, including stakeholder participation, and non-supplantation requirements.

Mental Health Services Oversight Commission. This bill illuminates the ongoing role of the MHS OAC by:

- Continuing their oversight of the Innovative Programs and PEI projects;
- Requiring counties to provide their Integrated three-year plans and annual updates to the MHS OAC;
- Adding the MHS OAC as a joint partner in the establishment of performance outcomes and in the design of an evaluation plan;
- Continuing their authority to refer critical issues related to performance of a county mental health program to the DHCS; and
- Including the MHS OAC in the DHCS regulatory process by requiring coordination in these endeavors.

Expands Role of the California Mental Health Directors Association (CMHDA). This bill recognizes the integral role of counties in the implementation and success of the Mental Health Services Act and actively engages the CMHDA in key decisions including the establishment of performance measures, design of a comprehensive joint plan, the methodology used for revenue allocations to the counties, and provisions of technical assistance.

Provides for Local Accountability. This bill provides for local accountability through the following key changes:

- Provides authority to Board of Supervisors to approve Integrated three-year plans and annual updates;
- Clarifies that Integrated three-year plans and annual updates are to follow designated local stakeholder processes; and
- Requires certification of compliance with key cornerstones of the Act.

Workforce Development and Five Year Plan. This bill identifies that the next five-year plan is due April 1, 2014 and designates the Office of Statewide Health Planning and Development (OSHPD) to lead this effort. It recognizes the role of the California Mental Health Planning Council in this endeavor and links the county needs assessment to this process.

Deputy Director Position. SB 1136 also requires the Governor or Director of Health Care Services to appoint a Deputy Director of Mental Health and Substance Use Disorder and requires this new position to be subject to Senate Rules confirmation. Funding for this position is in the Governor's proposed Budget for 2012-13.

Section 18 of Proposition 63. The changes proposed in SB 1136 are clarifying procedures and terms within the meaning of Section 18 of Proposition 63. Legislative Counsel has keyed SB 1136 as a majority vote measure to reflect their concurrence.

Mental Health Services Act Background. Approved by voters on November 2, 2004, Proposition 63, the Mental Health Services Act (MHSA), applies a 1 percent tax on personal income in excess of $1 million. About $1 billion in revenues is generated annually. These annual revenues are devoted to reducing the long-term adverse impact of untreated mental illness by expanding mental health services and supports and monitoring progress towards statewide goals of serving children, transition age youth, adults, older adults and families with mental health needs.

The Mental Health Services Act addresses a broad continuum of prevention, early intervention and treatment service needs through systems of care and provides funding for necessary infrastructure.

California's community-based public mental health system is undergoing significant evolution due to transformative changes resulting from the Mental Health Services Act, pending implementation of 2011 Realignment of Medi-Cal Specialty Mental Health Services, and the restructuring of State administration which commenced through the enactment of AB 100, Statutes of 2011 and AB 102, Statutes of 2011.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to reject the Administration's trailer bill language regarding MHSA. The Administration's proposed trailer bill language did not address the issues that need clarification as a result of AB 100 (since AB 100 was point in-time legislation necessary for last year's budget).

Instead it is recommended to adopt SB 1136's language as placeholder trailer bill language for implementing changes to the MHSA. This language has been vetted through a health policy committee and has had the involvement of stakeholders.

Add DHCS Positions for MHSA Activities. In order to maintain the integrity of Proposition 63 as intended by the voters, the State needs to oversee revenues and allocations made to the counties, and to ensure that these funds are expended for the purposes of the Mental Health Services Act.

To provide this oversight, it is recommended to provide the following 13 positions to the DHCS and $250,000 for technical assistance, for total expenditures of $1.650 million (Mental Health Services Act Funds). It should be noted that Subcommittee staff requested and received technical assistance for discerning the necessity of these positions and their classifications.

Outcome and Evaluation Functions (Four positions). The DHCS, Mental Health Services Oversight and Accountability Commission (MHS OAC), as well as the Mental Health Planning Council and the CA Mental Health Directors Association are to work collaboratively in establishing performance outcomes for all MHSA services programs and components.

Core functions that are currently unfunded or underfunded include:

(1) Design evaluation plan elements; evaluation goals; data to be used, collection of data, and timelines for data collection and evaluation partners;
(2) Data analysis;
(3) Reporting of data; and
(4) Working with interested partners.

The positions include: one Health Program Specialist I; two Associate Governmental Program Analysts; and one Research Analyst II.

Performance Contract (Four positions). The DHCS needs to address county perform through the performance contracting process established in Proposition 63. The DMH had not been performing this function in a comprehensive manner. Performance contracting for Proposition 63 coupled with the Medi-Cal Program realignment, will enable the DHCS to more comprehensive monitor and measure the public community mental health system.

The positions include: one Staff Services Manager I; one Associate Governmental Program Analyst; one Health Program Auditor III; and one Office Technician.

Methodology and Track and Review County MHSA Reports (Three positions). Core functions to be addressed here include:

(1) Obtaining and analyzing data for the methodology, including population data, rating factors, CPI data and other aspects;
(2) Coordinating with the State Controller's Office as to the distribution methodology;

(3) Maintain data and records documenting changes in population, service provisions, county expenditures, level of need and other methodology criteria;
(4) Analyzing county MHSA Reports on revenues and expenditures;
(5) Verify county attestations and communicate with counties; and
(6) Disseminating information.

The positions include: two Health Program Auditor IIIs and one Health Program Specialist I.

Regulations. Regulations will continue to be necessary and it is recommended to provide one Senior Staff Counsel and one Legal Analyst for this purpose.

Consultant Funds. It is further recommended to provide $250,000 (MHSA Funds) for the DHCS to utilize for the purpose of providing technical assistance with stakeholder groups during this transition, development of outcome measures and performance metrics, improvement of data sources to strength data validity and reliability and related aspects.

MHSA State Administrative Cap. State administrative expenses related to MHSA would still be under administrative cap of 3.5 percent (as discussed earlier, this cap was reduced from 5 percent to 3.5 percent under AB 100). The MHSA 3.5 percent administrative cap reserve would be $7.8 million, which would be allocated to the counties if unexpended.

Additionally, it should be noted that as will be discussed below, $15 million for the California Reducing Disparities Project is proposed to be budgeted under the state administrative cap for the Department of Public Health; thereby, increasing MHSA local assistance expenditures by $15 million. In total, the counties are getting $22.8 million from within the state's administrative cap.

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

1. Please provide an overview of the Administration's language regarding MHSA.

5. Patients' Rights Office

Budget Issue. Included in the Administration's trailer bill language for the reorganization of non-Medi-Cal community mental health is the proposal to have the Department of Health Care Services be responsible for the contract with a nonprofit entity for independent advocacy services for individuals in licensed health and community care facilities and to have the new Department of State Hospitals be responsible for the contract with a nonprofit entity for independent advocacy services for individuals in state hospitals.

Currently, the Department of Mental Health is the single state entity responsible for contracting out these services for both individuals in licensed health and community care facilities and individuals in state hospitals.

Background. The Patients' Rights Advocates (PRA) in the state hospitals are employees of Disability Rights California. The California Office of Patients' Rights is contracted by the Department of Mental Health to ensure that the treatment and legal rights of people receiving mental health treatment are maintained. Disability Rights California is a nonprofit agency that provides legal and other advocacy assistance to people with disabilities.

Under the contract with California's Department of Mental Health, Disability Rights California operates the California Office of Patients' Rights (C.O.P.R.) to provide support to Patients' Rights Advocates in the counties and employs a Patients' Rights Advocate at each State Hospital to directly advocate for the rights of people with psychiatric disabilities.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to modify the Administration's trailer bill language regarding the Patients' Rights Office to allow the Department of Health Care Services and the Department of State Hospitals the ability to jointly contract with a nonprofit entity. Rather than requiring both state departments to enter into a contract.

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

1. Please provide a summary of trailer bill language regarding the Patients' Rights Office.

6. Elimination of Remaining Department of Mental Health Statutes

Budget Issue. The Administration proposes trailer bill language to eliminate statute referencing the Department of Mental Health (DMH) (i.e., the programs and statute remaining that is not proposed to be moved to another department).

These changes include, but are not limited, the elimination of statute referencing the:

- **Early Intervention Mental Health Program** - DMH does not implement this program and it is not proposed to be moved to another department.

- **Suicide Prevention Programs** – DMH created an Office of Suicide Prevention under an Executive Order and is funded through Mental Health Services Act funds.

- **Administration of State Institutions – Families of Persons with Serious Mental Disorders -** DMH indicates that this program has never been implemented. (It was intended to provide a self-help program for families who have family members in mental facilities at a statewide level.)

- **Primary Intervention Program –** The Early Mental Health Initiative program is proposed to be eliminated in the budget.

Subcommittee Staff Comment and Recommendation – Modify. It is recommended to adopt placeholder trailer bill language to eliminate statues that are no longer valid, such as statute referencing a report completed in 2001 regarding the Department of Youth Authority and the use of psychotropic medication; however, it recommended to not eliminate statute referencing programs created by the Legislature and the intention in which these programs were created.

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

1. Please provide an overview of this proposal.

B. 4140 Office of Statewide Health Planning and Development

1. Mental Health Services Act Workforce Education and Training Fund

Budget Issue. In the May Revision, the Administration is requesting a technical adjustment to the Governor's Budget as it relates to implementing the transfer of the Mental Health Services Act (MHSA) Workforce Education and Training (WET) program from the Department of Mental Health (DMH) to the Office of Statewide Health Planning and Development (OSHPD).

A one-time budget year appropriation of $15.0 million is required to support the WET program appropriated to OSHPD in accordance with AB 100. The following budget bill language is proposed to provide OSHPD with the authority to expend these funds:

Provisional Language for 4140-101-3085

X. The funds appropriated in this item are for the purposes of the Workforce, Education and Training (WET) programs established pursuant to Welfare and Institutions Code Sections 5820, 5821, and 5822. It is the intent of the Legislature that a total of $6,000,000 in WET funds be appropriated for purposes of Welfare and Institutions Code Sections 5820, 5821, and 5822 in a manner subject to the requirements set forth in Welfare and Institutions Code Sections 5820(a), 5820(e), and 5848 (a). It is further the intent of the Legislature that $9,000,000 be appropriated, for implementation of the Regional Partnerships component of the WET programs in equal amounts over a three year period beginning in 2014-15. The funds appropriated in this item are available for expenditure without regard to fiscal year.

Background. The Governor's January budget proposes to eliminate the Department of Mental Health. As part of this reorganization, coordination of the WET program is proposed to move to OSHPD. DMH recently conducted an audit of the Mental Health Services Act (MHSA) WET funds and found that $444.5 million of MHSA revenues were available for the WET program. Of this amount, $15 million has not been appropriated and must be set-aside in the MHSF for WET programs.

Subcommittee Staff Comment and Recommendation—Approve. This proposal is consistent with the MHSA and ensures that unexpended funds for the WET program are available in out years for this purpose.

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

1. Please provide an overview of this proposal.

C. 4265 Department of Public Health

1. Mental Health Services Act – California Reducing Disparities Project (DOF Issues 551 and 552)

Budget Issue. In the May Revision, the Administration requests an augmentation of $15 million from the Mental Health Services Fund (MHSF) per year for four years ($60 million total) for DPH to support the California Reducing Disparities Project (CRDP). These funds are to be augmented though the 3.5 percent state administrative cap of the MHSF and a new appropriation whereby funds may be spent without regard to fiscal year until the balance of funds are fully expended.

Background. The Governor's January budget proposes to eliminate the Department of Mental Health. As part of this reorganization, coordination of the CRDP is proposed to move to DPH. The CRDP is a project under the Prevention and Early Intervention component of the Mental Health Services Act. The initiative is focused on five populations: African Americans; Asian/Pacific Islanders; Latinos; Lesbian, Gay, Bi-sexual, Transgender, Questioning; and Native Americans. The project will develop population-specific reports that will form the basis of a statewide comprehensive strategic plan to identify new approaches to reduce disparities.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the augmentation for CRDP and adopt the revised budget bill language:

Item 4265-001-3085 (DPH state support, Mental Health Services Act Fund)

Provisions:
1. It is the intent of the Legislature that a total of $60,000,000 for the California Reducing Disparities Project which seeks to improve timely access to mental health services for unserved and underserved populations in California by bringing forward community-defined solutions and recommendations developed by diverse workgroups comprised of community representatives shall be available over the course of four years beginning in fiscal year 2012-13. Contracts with entities representing focused populations to develop strategic planning workgroups are presently in effect to identify population-focused, culturally competent recommendations for reducing disparities in mental health services and to improve outcomes by identifying community-defined, strength-based solutions and strategies to eliminate barriers in the mental health service system. Results from these strategic planning workgroups are to be used to effectuate changes in the mental health system to reduce and mitigate multi-ethnic, sexual orientation, and cultural disparities.

Of the amount appropriated in this item, $15,000,000 is to fund the California Reducing Disparities Project beginning in 2012-13, and shall be available without regard to fiscal years.

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

1. Please provide an overview of this proposal.

2. Office of Health Equity

Budget Issue. The Administration proposes to create a new Office of Health Equity (OHE) at the Department of Public Health. This office would take a more comprehensive and integrative approach to address the issues of health disparity and promote healthy communities.

The OHE would be created by consolidating the following entities:

- Office of Multicultural Health (OMH) at DPH
- Office of Women's Health (OWH) at the Department of Health Care Services (DHCS)
- Office of Multicultural Services (OMS) at the Department of Mental Health (DMH)
- Health in All Policies Task Force (HiAP) at DPH
- Healthy Places Team at (HPT) DPH

Concerns were raised by various stakeholders at the April 12, 2012 Subcommittee #3 hearing on this proposal that the proposed trailer bill language was vague and provided no metrics to hold this new office accountable for improving health equities. Additionally, stakeholders were concerned that with the elimination of the existing offices, there would be a loss of focus on women's issues, for example.

Since the April 12, 2012 hearing, Legislative staff and stakeholders have worked together to strengthen the administration's proposal.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to adopt the revised placeholder trailer bill language to create a new Office of Health Equity.

This placeholder trailer bill language describes the duties of the office as:

(1) Conducting policy analysis and developing strategic policies and plans on specific issues affecting vulnerable communities and vulnerable places to increase access to services and supports, quality of care, and positive health and mental health outcomes for the communities described in subdivision (b) and decrease health and mental health disparities and inequities. The policies and plans should also include strategies to address social and environmental inequities and improve health and mental health.

(2) Establishing a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities. The strategies and recommendations developed shall take into account the needs of the communities described in subdivisions (b) of this chapter and other defining characteristics to ensure strategies are developed throughout the state to eliminate health and mental health disparities and inequities. This plan should be developed in collaboration with the Health in All Policies Taskforce. This plan shall establish goals and benchmarks for specific strategies in order to measure and track disparities and the effectiveness of these strategies. This plan shall be updated periodically, but not less than every three years, to keep abreast of data trends, best practices, promising practices, and to more effectively focus and direct necessary resources to mitigate and eliminate disparities and inequities. The Office of Health Equity shall seek input from the public on the plan through an inclusive public stakeholder process.

(3) Working with state agencies and departments to consider health impacts of policies. The Office of Health Equity shall mirror and support the work of the Health in All Policies Taskforce and Strategic Growth Council in working with state agencies and departments to consider health in appropriate and relevant aspects of public policy development. The Office of Health Equity shall work collaboratively with the Health in All Policies Taskforce and Strategic Growth Council to assist state agencies and departments in developing policies, systems, and environmental change strategies that have population health impacts in the following ways:

(i) Develop intervention programs with universal and targeted approaches to address health and mental health inequities and disparities.

(ii) Prioritize building cross-sectoral partnerships within and across departments and agencies to changes policies and practices to advance health equity.

(iii) Provide a forum to identify and address the complexities of health and mental health inequities and disparities and the need for multiple, inter-related, and multi-sectoral strategies.

(iv) Provide technical assistance to state and local agencies and departments on building organizational capacity, staff training, and facilitating communication to implement strategies to reduce health and mental health disparities.

(v) Highlight and share evidence-based, evidence-informed, and community based promising practices on reducing health and mental health disparities and inequities.

(vi) Work with local public health departments, county mental health or behavioral health departments, local social services, and mental health agencies and other local agencies that address key health determinants including but not limited to housing, transportation, planning, education, parks, and economic development. The Office of Health Equity will seek to link local efforts with statewide efforts.

(4) Consulting with community based organizations and local governments agencies to ensure community perspectives and input are included in policies and any strategic plans, recommendations, and implementation activities.

(5) Assisting in coordinating projects funded by the state that pertain to increasing the health and mental health status of the communities described in subdivision (b).

(6) Identifying future service needs, trends, and unnecessary duplication of services, and providing information to impacted departments and state agencies.

(7) Providing consultation and technical assistance to state departments and other state and local agencies charged with providing or purchasing state-funded health and mental health care, in their respective missions to identify, analyze and report disparities and to identify strategies to address health and mental health disparities.

(8) Providing information and assistance to state and local departments in coordinating projects within and across state departments that improve the effectiveness of public health and mental health services to the communities described in subdivision (b) and that address community environments to promote health.

(9) Communicating and disseminating information within the department and with other state departments to assist in developing strategies to improve the health and mental health status of persons in communities described in subdivision (b) and to share strategies that address the social and environmental determinants of health.

(10) Encouraging innovative responses by public and private entities that are attempting to improve the health and mental health status of communities described in subdivision (b).

(11) Seeking additional resources, including in-kind assistance, federal funding, and foundation support.

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

1. Please provide an overview of this proposal.

2. What efforts has the department undertaken since the April hearing to reach out to stakeholders and solicit feedback? What were some key stakeholder concerns and how would you plan to address them?

3. April Letter – Special Fund Efficiency – Drinking Water Certification Program

Budget Issue. Through a Spring Finance Letter, DPH requested to eliminate the Residential Water Treatment Device Certification Program (and a reduction of $382,000 from the Water Device Certification Special Account). Currently, water devices require third party approval in addition to State certification. That approval is provided by an independent testing organization that has been accredited by American National Standards Institute (ANSI) or by the federal government.

California is only one of six states nationally that require water device products to have State certifications. According to DPH, eliminating California certification will have minimal impact on public health, as products will still require third party approval before being offered for sale in California.

Background. When a manufacturer claims that a drinking water treatment device will reduce contaminants or makes other health related performance claims, the device must be certified by DPH. The funding for the program is provided by fees collected from manufacturers for certifying water treatment devices. When a manufacturer desires certification for a new product, DPH assesses a fee of $1,400 to review the test data, determination compliance with California laws and regulations, and issue the certificate, which is good for five years. The manufacturer must then pay an annual renewal fee of $400 to continue to have the device listed in the DPH directory and on the DPH website. After five years, the product must be recertified (new test data submitted) and the fee is $1,400 for the recertification. The fee to revise the certification for a product that has been modified after initial certification is $300. Currently, there are approximately 300 certified devices.

Subcommittee Staff Comment and Recommendation—Reject. On May 10, 2012, this Subcommittee approved this proposal. However, concerns have been raised that removing the state's role in certifying these water devices could impact public health. It is important for the state to approve technologies for specific contamination types and review how the technology is being used in California. Leaving the approval in the hands of a third-party entity, does not ensure that state's public health is the primary focus of the certification. Consequently, it is recommended to reject this proposal.

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

1. Please provide an overview of this proposal.

2. How could the elimination of this program impact public health?

D. 4260 Department of Health Care Services

1. Cash Flow Loan for the County Medical Services Program

Budget Issue. The May Revision proposes trailer bill language that would permit the Director of Finance to approve no more than $100 million General Fund in cash flow loans in fiscal years 2012-13 and 2013-14 for County Medical Services Program (CMSP) Governing Board expenditures associated with a Low Income Health Program (LIHP) operated by the CMSP Governing Board. Any cash flow loans made would be considered short term and would not constitute General Fund expenditures. The loans and their repayment would not affect the General Fund reserve. Interest on this loan would be charged at the Pooled Money Investment Account rate.

The CMSP Governing Board elected to administer a LIHP; however, due to the fiscal challenges its member counties currently face, it requires a loan to bridge the time between when it will be required to pay out its first claims and when federal funds will begin to flow back to the program. This proposal would allow the CMSP Governing Board, upon approval from the Director of Finance, access to a cash flow loan of no more than $100 million over two fiscal years, 2012-13 and 2013-14, in order to ensure the Board's ability to maintain a financially solvent LIHP.

Background. The CMSP provides health care coverage to low-income adults who are ineligible for Medi-Cal in 34 counties, and, effective July 1, 2012, 35 counties. The CMSP Governing Board was established in 1995 and has overall program and fiscal responsibility for the program.

***Low Income Health Program*.** As part of California's Bridge to Reform section 1115 Medicaid Demonstration, counties or a consortium of counties, such as the CMSP Governing Board, are implementing LIHP. The LIHP consists of two programs: Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). MCE will provide coverage for very-low income adults with incomes under 133 percent of the FPL and its federal funding through the waiver is capped. HCCI is coverage for low-to-moderate income adults with incomes between 133 and 200 percent of FPL and federal funding for HCCI is capped.

The state projects that 512,000 adults would be eligible for LIHP, with 385,000 eligible for MCE and 127,000 eligible for HCCI. Both programs are at county option and each county determines its own eligibility rules and sets its own income eligibility standards. For example, Los Angeles county set its MCE eligibility level at 133 percent of FPL, whereas San Francisco county set its MCE eligibility level at 25 percent of FPL.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this placeholder trailer bill language. This would ensure that CMSP is able to administer a LIHP.

It should be noted that Senator Wolk's SB 1517 is similar to the proposed trailer bill language and authorizes a $30 million loan to CMSP to cover its LIHP startup costs.

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

1. Please provide an overview of this proposal.

2. Children Services Program/Medical Therapy Program Financial Test

Budget Issue. The DHCS proposes trailer bill language to apply financial eligibility requirements to qualify for the California Children's Services (CCS) Medical Therapy Program (MTP). These financial eligibility requirements would be:

- A family income ceiling of $40,000 per year adjusted gross income (AGI) OR
- An estimated annual CCS related medical expenses in excess of 20 percent of family AGI

These financial requirements are the same as those used to qualify a child for CCS diagnosis and treatment services.

The proposal would result in annual savings of $21.9 million ($10.9 million General Fund and $11 million county funds) as 4,779 of 24,433 children receiving CCS MTP would not qualify under the proposed financial eligibility requirements.

Background. The CCS MTP provides physical therapy, occupational therapy, and medical therapy conference services to children who meet specific medical criteria. These services are provided in an outpatient clinic setting known as the Medical Therapy Unit (MTU) that is located on a public school site. Currently, 24,433 CCS children are served by 125 school based MTUs operated by county CCS programs. Therapists at these sites are employed by the county.

Of these children, 14,273 have an Individual Education Program (IEP) under the provisions of the federal Individuals with Disabilities Education Act (IDEA). By federal law, schools are required to provide all therapy services included in a child's IEP, including "medical" therapy. However, it is generally understood that medical therapy services provided at an MTU and included in a child's IEP are paid for by CCS (state and county funds) and educational therapy services not provided at the MTU are funded by the schools.

Subcommittee Staff Comment and Recommendation—Reject. It is recommended to reject the Administration's proposal to add a financial eligibility test for CCS/MTP.

Instead it is recommended to use available federal special education funds to cover the costs of providing services to children with IEPs who receive therapy (that is included in the IEP) at an MTU. A conservative estimate of these costs is $24.6 million ($12.2 million General Fund and $12.4 million county funds). This reflects that 5,352 children would now be covered using special education funds with annual cost per child at an MTU of $4,595. This estimate is based on 75 percent (or 10,705) of the 14,273 children with an IEP receiving therapy at an MTU that is included in their IEP and of these children, 50 percent (or 5,352) of therapy is included in the IEP and covered under federal special education law.

Additionally, it is recommended to adopt placeholder trailer bill language to implement this alternative and budget bill language allowing the Department of Finance to adjust this estimate with notification to the Joint Legislative Budget Committee based on additional information

provided by the MTUs. DHCS is currently working with the MTUs to collect additional data, to get a better understanding of the number of children this may impact.

The subcommittee staff recommendation would require schools to pay for all therapies included in a child's IEP, including medical, (as required by federal law) and to provide schools with this additional special education funding to cover the increased cost. Under this scenario, the state would continue to require MTUs to provide medically necessary therapies, but placeholder language would specify that medically necessary therapies included in an IEP would not be the financial responsibility of the CCS, but would be funded by the schools.

Conforming action would be made on the education items.

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

1. Please provide a summary of the Subcommittee staff recommendation.

3. Value Based Purchasing

Budget Issue. The DHCS is proposing trailer bill to establish a process for Value-Based Purchasing in the Medi-Cal fee-for-service (FFS) system. This proposal would save $75 million General Fund in 2012-13 and annually thereafter. Of the $75 million, $26.6 million is attributable to the savings as a result of Medi-Cal no longer paying for services directly related to potentially preventable hospital admissions (for Medi-Cal managed care), as required by the Affordable Care Act (ACA) (effective July 1, 2012).

Under this proposal, DHCS would implement value-based service design to ensure beneficiary access to necessary health care services by adding services or by identifying and reducing services that do not improve health outcomes, may cause harm to patients, or that are overused and should only be provided under limited conditions. Although this process would allow DHCS to change the way in which providers may deliver services, it would not change the benefits covered under the State Plan.

The proposed value-based service design process encompasses the following:

- Evidence review which shall include systematic reviews and individual studies published in peer-reviewed literature or evidence-based treatment guidelines issued by organizations whose primary mission is to conduct objective analyses of the effectiveness of medical or evidence-based clinical practice guidelines.

- Determination of fiscal effect by analyzing proposals for the costs and savings associated with adding, modifying, limiting, or eliminating services.

- Feasibility analyses to consider administrative and process issues related to the addition, modification, limitation, or elimination of services, such as the cost and timeframe for computer system changes, the staffing and expertise needed to craft utilization policies that limit inappropriate use of a service without interfering with appropriate use of that same service, and the ability to use utilization management.

Stakeholder Input. Under this proposal, DHCS would inform and consult with stakeholders, including health professionals, Medi-Cal providers, and consumer advocacy organizations for input prior to implementing changes pursuant to the Value-Based Purchasing process. DHCS would notify stakeholders of proposed changes to targeted services, rate methodologies and payment policies by regularly updating the Medi-Cal website. Stakeholders would have 30 days to provide written input regarding changes proposed through the Value-Based Purchasing process and, upon request, DHCS would provide a public meeting to hear their comments. DHCS would respond to stakeholder comments. Implementation of proposed changes would occur no sooner than 30 days from the date the department notifies stakeholders of the proposed changes or 30 days from the date a public meeting is held.

Outcome Review. DHCS would monitor policy and program changes to ensure that the department obtains the intended results for achieving value regarding clinical quality

outcomes, access, and cost effectiveness. Where ongoing monitoring indicates results are not as expected or negative, DHCS would modify the intervention accordingly.

Federal Approval. DHCS states it would not implement changes pursuant to the Value-Based Purchasing process until it obtains any necessary federal approvals. DHCS would implement changes in the development of rate methodologies and payment policies only if they comply with applicable federal Medicaid requirements and if federal financial participation is available.

Background. Currently, DHCS must use regulations or statute to add, modify, limit, or eliminate reimbursement and services in the Medi-Cal program. For example, DHCS uses the Medi-Cal Manual of Criteria to define services associated with covered benefits, which is embedded in the California Code of Regulations (CCR). According to DHCS, the regulatory process is time-consuming and ineffective, often taking a year or more for completion. During this processing time, the Medi-Cal program continues to pay for services and utilize payment methodologies that may be ineffective and inefficient. According to DHCS, due to the intensive staff effort required to promulgate regulations, the last formal regulatory update to the Manual of Criteria was on December 6, 2007.

Value-Based Purchasing is an approach that is commonly used in the private sector by large, self-insured companies, major public entities responsible for health care purchasing such as CalPERS, and by purchasing coalitions such as the Pacific Business Group on Health. As such, this proposal seeks to align DHCS with other major health care purchasers.

Health care spending continues to increase at a significant rate, but the increased cost is not always accompanied by an increase in the quality of care or value to the consumer. For example, experts estimate that Medicare wastes 20 to 30 percent of its $500 billion in annual expenditures on treatments and procedures that have minimal or no benefit to the patients.

Subcommittee Staff Comment and Recommendation. It is recommended to do the following:

- Reject the Administration's proposed trailer bill language. The proposed Value-Based Purchasing process is outside the current regulatory framework which has established safeguards to ensure stakeholder participation and disclosure of departmental actions.
- Approve the $30 million in General Fund savings as a result of Medi-Cal no longer paying for services directly related to potentially preventable hospital admissions. Changes to statute or regulations are not necessary to implement these savings.

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

1. Please provide an overview of this proposal.

4. Eliminate Sunset Date for Nursing Home Quality Assurance Fee

Budget Issue. The DHCS proposes to eliminate the sunset date for the nursing home quality assurance fee (QAF) program and the rate-setting methodology established under AB 1629 (Statutes of 2004) and; thereby, make this program permanent. The QAF program sunsets on July 31, 2013.

If the QAF program and rate-setting methodology sunset dates are not extended, the department will no longer be authorized to assess and collect the QAF and continue paying facility-specific rates to nursing homes. Maintaining the QAF collection offsets General Fund expenditures and can fund rate increases to the skilled nursing facilities. According to DHCS, if the QAF sunsets, over $400 million in General Fund support could be at risk.

Background. Certain nursing home rates are reimbursed under Medi-Cal using combinations of federal funds, General Fund and revenues collected from Quality Assurance Fees (QAF). Use of QAF has enabled California to provide reimbursement increases to certain nursing homes with *no* added General Fund support.

AB 1629 imposes a QAF on skilled nursing facilities and requires using these funds to leverage a federal match in the Medi-Cal program to provide additional reimbursements to certain nursing facilities that support improvement efforts. The Legislature's goal with AB 1629 and the new reimbursement system was that it would result in improvements in individual access to appropriate long term care services, quality resident care, decent wages and benefits for nursing home workers, a stable workforce, and provider compliance with all applicable state and federal requirements.

Subcommittee Staff Comment and Recommendation. It is recommended to:

- Reject the Administration's trailer bill language to eliminate the sunset date for the nursing home quality assurance fee.
- Adopt placeholder trailer bill language that extends the nursing home quality assurance fee sunset date for two years (until July 31, 2015) and creates a special fund to deposit the QAF revenues.

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

1. Please provide a brief summary of this proposal.

5. Nursing Home Rate Reduction (DOF Issue 130)

Budget Issue. In the May Revision, the Administration proposes various rate reductions to skilled nursing facilities (SNFs) and subacute care units that generate $70.9 million in General Fund savings. These proposals are to:

1. Rescind a rate increase in 2012-13 that is up to the difference between 2.4 percent and the rate increase provided in 2011-12 for a savings of $33 million General Fund.

2. Delay the implementation of the Quality and Accountability Supplemental Payment System (QASP) until April 2014 and the redirect the 1 percent set-aside for QASP to the General Fund. This would result in $23.3 million in General Fund savings.

3. Recognize $13.2 million additional General Fund savings as a result of additional revenue from the quality assurance fee.

Included as part of these savings is keeping the savings from capping the professional liability insurance (PLI) at the 75th percentile in the General Fund instead of transferring it to the Skilled Nursing Quality and Accountability Special Fund ($8.5 million total funds, $4.25 million General Fund).

Background. AB 1629 (Statutes of 2004) changed the methodology for calculating reimbursement rates for freestanding SNFs and subacute units of those freestanding SNFs and allowed DHCS to assess a Quality Assurance Fee (QAF) to provide a revenue stream to fund the higher payments to SNFs under the new reimbursement methodology.

ABX1 19 (Statutes of 2011) mandated the following changes:

- Provided a rate increase of no more than 2.4 percent in 2012-13 rate year (resulting from the difference between the 2.4 percent increase and the actual rate increase from the 2011-12 rate year);
- Terminated the 10 percent reductions, as required by AB 97 (Statutes of 2011), on August 1, 2012, for AB 1629 SNFs;
- Held harmless facilities from rates that are less than their rate that was on file as of May 31, 2011;
- Provided a one-time supplemental payment in the 2012-13 rate year that is equivalent to the 10 percent reduction applied from June 1, 2011, to July 31, 2012, for Medi-Cal fee-for-service SNFs;
- Delayed until rate year 2012-13 the set-aside to the Quality and Accountability Supplemental Payment System (QASP) of 1 percent of the AB 1629 facilities reimbursement rate; and
- Delayed implementation of the QASP for one year.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open and discussions continue on this proposal.

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

1. Please provide an overview of this proposal including its interactions with ABX1 19.

6. Public Hospitals and Low Income Health Programs

Issue. State statute allows Low Income Health Programs (LIHPs) to be reimbursed under a capitated model. It also requires an LIHP to agree to a capitated rate with DHCS during a given demonstration year. That rate may then be implemented retroactively back to the first day of the demonstration year if it is agreed upon during the same demonstration year.

Public hospital systems are prepared to evolve their Low Income Health Programs from fee-for-service to risk-based programs to using capitated rates, but there is concern that federal approval of the proposed rates and subsequent agreement between LIHP and DHCS will not be finalized before June 30, 2012, the end of the current demonstration year. This would mean that these LIHPs would lose the ability to go capitated during the current demonstration year resulting in a loss of significant federal reimbursement.

Background. As part of California's Bridge to Reform section 1115 Medicaid Demonstration, counties are implementing LIHP. The LIHP consists of two programs: Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). MCE will provide coverage for very-low income adults with incomes under 133 percent of the FPL and its federal funding through the waiver is capped. HCCI is coverage for low-to-moderate income adults with incomes between 133 and 200 percent of FPL and federal funding for HCCI is capped.

The state projects that 512,000 adults would be eligible for LIHP, with 385,000 eligible for MCE and 127,000 eligible for HCCI. Both programs are at county option and each county determines its own eligibility rules and sets its own income eligibility standards. For example, Los Angeles county set its MCE eligibility level at 133 percent of FPL, whereas San Francisco county set its MCE eligibility level at 25 percent of FPL.

Subcommittee Staff Comment and Recommendation. It is recommended to adopt technical trailer bill language to preserve the state's option under the existing 1115 Medi-Cal Waiver with the federal government to utilize a capitation rate under the LIHP. It is necessary to take this action before June 30, 2012. The technical trailer bill language is below:

1. Amend Section 15911 (e) as follows:

Section 15911 (e).

Notwithstanding Section 15910.3 and subdivision (d) of this section, if the participating entity cannot reach an agreement with the department as to the appropriate rate to be paid under Section 15910.3, at the option of the participating entity, the LIHP shall be reimbursed on a cost basis in accordance with the methodology applied to Health Care Coverage Initiative programs established under Part 3.5 (commencing with Section 15900), including interim quarterly payments. If the participating entity and the department reach an agreement as to the appropriate rate, the rate shall be applied no earlier than the first day of the LIHP year in which the parties agree to the rate, except that for the LIHP year ending June 30, 2012, the rate may apply as early as July 1, 2011 without regard to the date of the agreement between the participating entity and the department.

2. Add Legislative Intent Language as follows:

The department, in consultation with a number of the Low-Income Health Programs (LIHPs), has proposed LIHP capitation rates for federal approval. However, federal approval of the proposed rates may not be received and implemented through contract amendments before June 30, 2012. This statutory amendment would allow the federally approved capitation rates to apply to the LIHP year (July 1, 2011 through June 30, 2012), even if federal approval and the necessary contract amendments are not finalized until after June 30, 2012. Therefore, it is the Legislature's intent in amending Section 15911(e) to allow the LIHP capitation rates to apply for FY 2011-2012, even if final agreements on the capitation rates are delayed while awaiting federal approval and are not finalized until after June 30, 2012.

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

1. Please provide a summary of this issue and proposed technical trailer bill language.

7. Hospital Quality Assurance Fee Background & Technical Adjustment (DOF Issue 123)

Budget Issue. The May Revision reflects a decrease of $85 million General Fund to reflect the shift of $85 million in hospital quality assurance fee collection from the current year to the budget year. This is a result of not yet receiving federal CMS approval of the fee.

The May Revision estimates that the Hospital Quality Assurance Fee will bring in $2.9 billion in revenue and will be used to draw down $2.3 billion in federal funds in 2012-13. Of this $537 million would be for children's health care coverage.

Background. AB 1383 (Jones, Statues of 2009) authorized the implementation of a quality assurance fee (QAF) on applicable general acute care hospitals during April 2009 through December 2010. The fee was deposited into the Hospital Quality Assurance Revenue Fund (HQARF) created by AB 188 (Jones, Statutes of 2009). This fund is used to provide supplemental payments to private and nondesignated public hospitals (NDPHs), grants to designated public hospitals (DPHs), and increased payments to managed health care and mental health plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

AB 1653 (Jones, Statutes of 2010) and SB 208 (Steinberg, Statutes of 2010) revised the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383. AB 1653 altered the methodology, timing, and frequency of supplemental payments, increased capitation payments, and increased payments to mental health plans. AB 1653 also allowed the State to retain up to $420 million from the portion of the QAF fund set aside for direct grants to DPHs for the State's use while the bill is in effect. In exchange, a portion of federal flexibility funding was allocated to the DPHs and was identical to the amount of the sum retained by the State from the QAF fund. The Department claimed these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and distributed those funds in conformity with the Hospital QAF payment schedule. SB 208 compressed the timeframe for collection of the QAF and distribution of supplemental payments, allowed accumulation of fees in the HQARF in order to make managed care payments, and altered the priority of payments.

SB 90 (Steinberg, Statutes of 2011) extended the QAF program established by AB 1383, for the period of January 2011 through June 2011. The extension provided for supplemental payments to private hospitals, increased payments to managed health care, and mental health plans if enough fees were collected to warrant payments. It also provided funding for health care coverage for children and for staff and related administrative expenses.

SB 335 (Hernandez, Statutes of 2011) creates a new QAF program for the period July 2011 through December 2013. This 30 month program was modeled on the original QAF program and two quarter extension. This program provides for supplemental payments to private hospitals, grants to DPHs and NDPHs, increased payments to managed health care, and mental health plans if enough fees are collected to warrant payments. It also provided funding for health care coverage for children and for staff and related administrative expenses.

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

Statute establishes a per diem fee assessed on every private acute care hospital for every acute, psychiatric, and rehabilitation inpatient day at the following:

- $86.40 per managed care day (other than Medi-Cal)
- $383.20 per Medi-Cal day
- $48.38 per prepaid health plan hospital managed care day
- $214.59 per prepaid health plan hospital Medi-Cal managed care (MCMC) day
- $309.86 per Fee for Service (FFS) day (other than Medi-Cal).

It should be noted that DHCS may alter the specified QAF amount in order to obtain federal CMS approval. As such, the above fee schedule may be altered.

DHCS is working with CMS on approval for this QAF.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this technical adjustment.

1. Please provide a brief overview of the hospital quality assurance fee.

2. What is the status of federal approval of the current hospital quality assurance fee?

8. Hospital Quality Assurance Fee Positions

Budget Issue. In order to extend the Hospital Quality Assurance Fee (QAF) program through 2013, as required by SB 335 (Statutes of 2011), DHCS requests the following:

- To extend 9.5 positions that are set to expire on June 20, 2012 until December 31, 2015 for a cost of $1 million ($471,000 from the Hospital Quality Assurance Revenue Fund and $562,000 in federal funds)
- Contract funds to calculate and validate capitation rates for a cost of $600,000 for 2011-12 and $100,000 for 2012-13 (costs for these contracts would be split equally between the Hospital Quality Assurance Revenue Fund and federal funds)

Department of Health Care Services—9.5 State Staff. For 2012-13, DHCS requests to extend 9.5 positions to administer this program.

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

- Develop and secure federal approval for State Plan amendments, fee models.
- Monitor plans' contracts with hospitals to ensure compliance resulting in pass-through of appropriate funds.
- Reconcile QAF funds included in the capitation rates paid to managed care plans to actual amounts paid to hospitals.
- Respond to legal issues regarding the QAF program.

Subcommittee Staff Comment and Recommendation–Approve. This issue was heard at the March 22, 2012 Subcommittee #3 hearing and was held open to get further updates from DHCS on the status of CMS's approval of the fee. DHCS is still working with CMS on approval of this fee. It is recommended to approve this item to implement SB 335.

Questions. The Subcommittee requests the DHCS to respond to the following questions:

1. Please provide a brief overview of the structure for this Quality Assurance Fee (QAF).

2. Please provide an update regarding progress being made with the federal CMS regarding the approval of this QAF.

9. May Revision – Hospital Solutions Summary and Background

The May Revision includes several hospital payment savings proposals. The Medi-Cal program currently spends about $15 billion ($3.4 billion General Fund) on hospitals. The chart below (provided by DHCS) summarizes these proposals (which are discussed later).

Table: Hospital Solutions Summary of Governor's May Revision Proposal (in millions)

	General Fund			Net Hospital Impact		
	FY12-13	**FY13-14**	**Total**	**FY12-13**	**FY13-14**	**Total**
Non-Designated Public Hospitals (46)						
Eliminate Current In-Patient (IP) Fee-For-Services (FFS) Methodology	$ (76.42)	$(76.42)	$(152.84)	$(152.84)	$(152.84)	$(305.69)
Eliminate Current NDPH Supplemental Pool	(1.90)	(1.90)	(3.80)	(3.80)	(3.80)	(7.60)
Eliminate AB113 Inter-Governmental Transfer Supplemental Payment	3.32	3.32	6.64	(31.68)	(31.68)	(63.36)
Convert to IP FFS CPE	-	-	-	100.00	100.00	200.00
New Safety Net Care Pool (SNCP) Uncompensated Care (FFP only)	-	-	-	30.00	40.00	70.00
New Delivery System Reform Incentive Pool (DSRIP) (Only FFP shown here, funded by IGT)	-	-	-	30.00	60.00	90.00
NDPH Subtotal	$(75.00)	$(75.00)	$(150.00)	$(28.32)	$11.68	$(16.64)
Designated Public Hospitals (21)						
Health Care Coverage Initiative (HCCI) Rollover	$(100.00)	$(9.00)	$(109.00)	$(100.00)	$(9.00)	$(109.00)
Fee-funded Direct Grants	-	(21.50)	(21.50)	-	(21.50)	(21.50)
Fee-funded managed care (through increased children's coverage amount)	-	(20.00)	(20.00)	-	(40.00)	(40.00)
DPH Subtotal	$(100.00)	$(50.50)	$(150.50)	$(100.00)	$(70.50)	$(170.50)
Private Hospitals (~300)						
Increase children's coverage (decreased managed care for private hospitals)	$(150.00)	$(75.00)	$(225.00)	$(300.00)	$(150.00)	$(450.00)
Diagnosis-Related Group (DRG) Savings*	-	$(75.00)	$(75.00)	-	$(150.00)	$(150.00)
Private Subtotal	$(150.00)	$(150.00)	$(300.00)	$(300.00)	$(300.00)	$(600.00)
Total Hospital Solutions	***$ (325.00)***	***$(275.50)***	***$(600.50)***	***$(428.32)***	***$(358.82)***	***$(787.14)***

*Assumes DRG implementation date is July 1 2013.

10. Non-Designated Public Hospitals – Change Reimbursement Methodology (DOF Issue 131)

Budget Issue. The May Revision proposes to change the reimbursement methodology of non-designated public hospitals (NDPH). Currently, NDPHs receive either the California Medical Assistance Commission (CMAC) negotiated per diem rates or cost-based reimbursement for inpatient Medi-Cal fee-for-service (FFS). These reimbursements are paid with 50 percent General Fund and 50 percent federal funds. With the proposed change in methodology, NDPHs would be funded for their inpatient Medi-Cal FFS in the same manner as Designated Public Hospitals in that they would use their certified public expenditures (CPEs) to draw down federal funds. This would result in $75 million General Fund savings (as General Fund would no longer be used to reimburse NDPHs).

In addition, qualified NDPHs receive supplemental reimbursements from the NDPH Supplemental Fund, which is funded with 50 percent General Fund and 50 percent federal funds. This supplemental reimbursement would no longer be available, resulting in a General Fund savings of $1.9 million.

Finally, NDPHs would no longer be eligible for the supplemental payments authorized by AB 113 (Statutes of 2011), which are funded by intergovernmental transfers and federal funds.

Table: May Revision Impact on Non-Designated Public Hospitals (in millions)

	General Fund			Net Hospital Impact		
	FY12-13	**FY13-14**	**Total**	**FY12-13**	**FY13-14**	**Total**
Non-Designated Public Hospitals (46)						
Eliminate Current In-Patient (IP) Fee-For-Services (FFS) Methodology	$ (76.42)	$(76.42)	$(152.84)	$(152.84)	$(152.84)	$(305.69)
Eliminate Current NDPH Supplemental Pool	(1.90)	(1.90)	(3.80)	(3.80)	(3.80)	(7.60)
Eliminate AB113 Inter-Governmental Transfer Supplemental Payment	3.32	3.32	6.64	(31.68)	(31.68)	(63.36)
Convert to IP FFS CPE	-	-	-	100.00	100.00	200.00
New Safety Net Care Pool (SNCP) Uncompensated Care (FFP only)	-	-	-	30.00	40.00	70.00
New Delivery System Reform Incentive Pool (DSRIP) (Only FFP shown here, funded by IGT)	-	-	-	30.00	60.00	90.00
NDPH Subtotal	$(75.00)	$(75.00)	$(150.00)	$(28.32)	$11.68	$(16.64)

Under this proposal, DHCS would seek a waiver amendment to increase Safety Net Care Pool (SNCP) and Delivery System Reform Incentive Pool (DSRIP) funding available to California. The additional funds would be made available to NDPHs to offset their uncompensated care costs and to support their efforts to enhance the quality of care and the health of the patients and families they serve. NDPHs are currently not eligible for these funds.

Because they would no longer be funded with General Fund, NDPHs would be exempt from the Diagnosis-Related Group (DRG) payment methodology for inpatient services that will replace the current inpatient reimbursement methodology effective July 1, 2013.

Background. NDPHs are publicly owned and operated facilities, the majority of which are operated by health care districts. There are approximately 46 NDPHs. Approximately 16 of the NDPHs are designated as Critical Access Hospitals (CAHs) under Medicare. To be designated a CAH, a hospital must be located in a rural area; provide 24-hour emergency services; have an average length of stay for its patients of 96 hours or less; be located more than 35 miles (or more than 15 miles in areas with mountainous terrain) from the nearest hospital; and have no more than 25 beds.

Safety Net Care Pool (SNCP). Under the current Medi-Cal 1115 Waiver, the Safety Net Care Pool Uncompensated Care (SNCP) pool includes $7.1 billion over five years (from October 1, 2010 – October 31, 2015) to be used to reimburse Public Hospitals for uncompensated care costs. Additionally, the state will be able to access up to $400 million (and receive a federal match) annually for the state designated programs.

Delivery System Reform Incentive Pool (DSRIP). The current Medi-Cal 1115 Waiver includes the opportunity for Public Hospitals to receive up to $3.3 billion over five years (from October 1, 2010 – October 31, 2015) through the Delivery System Reform Incentive Pool (DSRIP). This pool is a subset of the Safety Net Care Pool. The DSRIP is intended to support California's Public Hospitals' efforts in enhancing the quality of care and the health of the patients and families they serve. Individual Public Hospital systems will submit proposals for state and federal approval that are focused on improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

Subcommittee Staff Commend and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of all the proposed changes to Non-Designated Public Hospitals.

11. Designated Public Hospitals – Unexpended Public Hospital Waiver Funds (DOF Issue 132)

Budget Issue. The May Revision proposes to allow the state to retain 50 percent of the federal funding attributable to the Health Care Coverage Initiative (HCCI) rollover that would have gone to Designated Public Hospitals (DPHs). There is a total of $218 million in rollover.

With this proposal, Designated Public Hospitals (DPHs) would voluntarily utilize their certified public expenditures (CPE) to claim the additional Safety Net Care Pool Uncompensated Care (SNCP) and allow the state obtain 50 percent of this federal funding. This proposal relies on DPHs spending their CPEs to draw down federal funds, of which the state is proposing to take 50 percent.

In addition, this proposal requires that, to the extent necessary for the State to achieve its designated General Fund savings of $400 million for SNCP, DPHs would allow the State to utilize their excess CPE.

This proposal would result in $100 million in General Fund savings in 2012-13.

Table: May Revision Impact on Designated Public Hospitals (in millions)

	General Fund			Net Hospital Impact		
	FY12-13	FY13-14	Total	FY12-13	FY13-14	Total
Designated Public Hospitals (21)						
Health Care Coverage Initiative (HCCI) Rollover	$(100.00)	$(9.00)	$(109.00)	$(100.00)	$(9.00)	$(109.00)
Fee-funded Direct Grants	-	(21.50)	(21.50)	-	(21.50)	(21.50)
Fee-funded managed care (through increased children's coverage amount)	-	(20.00)	(20.00)	-	(40.00)	(40.00)
DPH Subtotal	$(100.00)	$(50.50)	$(150.50)	$(100.00)	$(70.50)	$(170.50)

Background. The Bridge to Reform (BTR) Medi-Cal 1115 Waiver includes federal funding available to counties for the Health Care Coverage Initiative (HCCI) component of the Low Income Health Program (LIHP) to provide coverage to uninsured individuals between 133 percent and 200 percent of the federal poverty limit.

Under the Bridge to Reform (BTR) Medi-Cal Waiver, $360 million in total funding is available annually, through December 2013, for counties to establish HCCI coverage programs under their Low Income Health Programs (LIHPs), for individuals between 133 percent and 200 percent of the federal poverty limit. Based on the current LIHP contracts, significant HCCI funding will remain unclaimed; therefore, in 2011 DHCS submitted a Waiver amendment to CMS to rollover unclaimed HCCI funding into the SNCP Uncompensated Care component.

Additionally, as discussed in the item above, under the current Medi-Cal 1115 Waiver, the state has access up to $400 million (and receive a federal match) annually for state designated programs. This proposal would allow the state to use Designated Public Hospital's CPEs for claim federal funding for SNCP.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue.

Questions. The Subcommittee has requested DHC to respond to the following question:

1. Please provide an overview of this proposal.

12. Redirect Hospital Fee Revenue (DOF Issue 133)

Budget Issue. The May Revision proposes to make changes to hospital fee revenue allocations for a total of $150 million General Fund savings in 2012-13. These changes include:

- Redirecting $150 million in hospital fee revenue in 2012-13 to the General Fund. This revenue was intended to fund supplemental payments to private hospitals by managed care plans.
- Redirecting $95 million in fee revenue in 2013-14 to the General Fund. Under current law, this funding would be provided to managed care plans ($75 million would have supported supplemental payments to private hospitals and $20 million for supplemental payments to designated public hospitals).
- Eliminating direct grants to designated public hospitals in 2013-14 ($21.5 million) and would instead use the funds for children's health coverage under Medi-Cal.

Table: May Revision Impact on Private and Designated Public Hospitals (in millions)

	General Fund			Net Hospital Impact		
	FY12-13	**FY13-14**	**Total**	**FY12-13**	**FY13-14**	**Total**
Designated Public Hospitals (21)						
Health Care Coverage Initiative (HCCI) Rollover	$(100.00)	$(9.00)	$(109.00)	$(100.00)	$(9.00)	$(109.00)
Fee-funded Direct Grants	-	(21.50)	(21.50)	-	(21.50)	(21.50)
Fee-funded managed care (through increased children's coverage amount)	-	(20.00)	(20.00)	-	(40.00)	(40.00)
DPH Subtotal	$(100.00)	$(50.50)	$(150.50)	$(100.00)	$(70.50)	$(170.50)
Private Hospitals (~300)						
Increase children's coverage (decreased managed care for private hospitals)	$(150.00)	$(75.00)	$(225.00)	$(300.00)	$(150.00)	$(450.00)
Diagnosis-Related Group (DRG) Savings*	-	$(75.00)	$(75.00)	-	$(150.00)	$(150.00)
Private Subtotal	$(150.00)	$(150.00)	$(300.00)	$(300.00)	$(300.00)	$(600.00)

Background. DHCS implemented California's first hospital provider fee and supplemental payment program for the period of April 1, 2009, through December 31, 2010. That program resulted in fee collections of $3 billion, and hospital payments of $5.7 billion. Fee revenue of $560 million was retained by the state to pay for health care coverage for children. The program was initially extended for the additional six month period of January 1 through June 30, 2011. The six month program resulted in fee collection of $1 billion, hospital payments of

$1.9 billion, and $210 million in General Fund offsets to pay for health care coverage for children.

SB 335 (the most recent hospital fee legislation) extended the fee program through December 31, 2013, and is projected to generate approximately $7.1 billion in fees from hospitals during the program period. Approximately $6.1 billion will be used to draw down an equal amount in additional federal funds in order to increase Medi-Cal payments to private hospitals and managed care plans. About $920 million will be retained to offset General Fund costs to pay for health care coverage for children. SB 335 set up various hospital payments, including supplemental fee-for-service payments made directly to private hospitals, increased payments to managed health care plans for the purposes of providing supplemental payments to private and designated public hospitals, direct grants to designated and non-designated public hospitals, and funding for children's health care coverage.

According to DHCS, hospital services represent the largest expenditure within the Medi-Cal program. These changes will enable the State to ensure continued support for children's health care coverage, while still providing for significant supplemental payments to hospitals under the fee program. With the proposed changes, about 81 percent of hospital fee revenue would be used to fund increased payments to hospitals and about 19 percent would be retained for General Fund savings. Fee revenue is projected to be $2.8 billion for 2012-13 and supplemental reimbursement to hospitals would total $4.6 billion with matching federal funds.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this item.

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

1. Please provide an overview of this proposal.

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Agenda - Part 2
Thursday, May 24 (Room 112)

VOTE ONLY CALENDAR

A. 4440 Department of Mental Health

1. Community Treatment Facilities

   - Action – Approve Administration's proposal.
   - Vote – 3-0

2. Reappropriation Metropolitan New Main Kitchen Project
   - Action – Approve Administration's proposal.
   - Vote – 3-0

B. 0977 California Health Facilities Financing Authority

1. Funding for Competitive Grant Program for New Methods of Health Care Delivery
   - Action – Approve staff recommendation.
   - Vote – 2-1 (Senator Emmerson voting no.)

C. 4260 Department of Health Care Services

1. Eliminate Sunset Date for Specialty Provider Contracting
   - Action – Reject Administration's proposal.
   - Vote – 3-0

2. Adjustments to Gross Premium Tax
   - Action – Approve Administration's proposal.
   - Vote – 2-1 (Senator Emmerson voting no.)
3. Technical Changes to Implement AB 396 – Medi-Cal Juvenile State Inmate Program
   - Action – Reject Administration's proposal.
   - Vote – 3-0

ISSUES FOR DISCUSSION

A. 4440 Department of Mental Health, Community Mental Health

1. Realignment - Medi-Cal Specialty Mental Health and EPSDT
   - Held open
2. Transfer of State Administration of Medi-Cal Specialty Mental Health
   - Held open
3. Transfer of Non Medi-Cal Community Mental Health Programs
   - Action – Approve staff recommendation.
   - Vote – 2-0 (Senator Emmerson not voting.)
4. Proposition 63 – Mental Health Services Act
   - Action – Approve staff recommendation.
   - Vote – 2-0 (Senator Emmerson not voting.)
5. Patients' Rights Office
   - Action – Approve staff recommendation.
   - Vote – 2-1 (Senator Emmerson voting no.)
6. Elimination of Remaining Department of Mental Health Statutes
   - Action – Approve staff recommendation.
   - Vote – 3-0

B. 4140 Office of Statewide Health Planning and Development

1. Mental Health Services Act Workforce Education and Training Fund
   - Action – Approve Administration's proposal.
   - Vote – 3-0

C. 4265 Department of Public Health

1. Mental Health Services Act – California Reducing Disparities Project
   - Action – Approve Administration's proposal.
   - Vote – 2-1 (Senator Emmerson voting no.)
2. Office of Health Equity
   - Action – Approve staff recommendation.
   - Vote – 2-1 (Senator Emmerson voting no.)
   - Per Senator Alquist's request received commitment from the department to provide an update on the Licensing and Certification Program's efforts to improve its enforcement of state and federal law regarding health facilities and the activities of the Office of Health Equity in six months.
3. April Letter – Special Fund Efficiency – Drinking Water Certification Program
   - Action – Reject Administration's proposal.
   - Vote – 2-1 (Senator Emmerson voting no.)

D. 4260 Department of Health Care Services

1. Cash Flow Loan for the County Medical Services Program
   - Action – Approve Administration's proposal.
   - Vote – 3-0

2. Children Services Program/Medical Therapy Program Financial Test
   - Action – Approve staff recommendation and the addition of budget bill language to reflect that federal funding be used for related services pursuant to the IDEA.
   - Vote – 2-0 (Senator Emmerson not voting.)

3. Value Based Purchasing
   - Action – Approve staff recommendation.
   - Vote – 3-0

4. Eliminate Sunset Date for Nursing Home Quality Assurance Fee
   - Action – Approve staff recommendation.
   - Vote – 3-0

5. Nursing Home Rate Reduction
   - Held open

6. Public Hospitals and Low Income Health Programs
   - Action – Approve staff recommendation.
   - Vote – 3-0

7. Hospital Quality Assurance Fee Background & Technical Adjustment
   - Action – Approve Administration's proposal.
   - Vote – 3-0

8. Hospital Quality Assurance Fee Positions
   - Action – Approve Administration's proposal.
   - Vote – 3-0

9. May Revision – Hospital Solutions Summary and Background
   - Information item

10. Non-Designated Public Hospitals – Change Reimbursement Methodology
    - Held open

11. Designated Public Hospitals – Unexpended Public Hospital Waiver Funds
    - Held open

12. Redirect Hospital Fee Revenue
    - Held open

A SYSTEM IN TRANSITION: CALIFORNIA'S DEVELOPMENTAL CENTERS

October 23, 2012 Oversight Hearing

Subcommittee #3 of the Senate Committee on Budget & Fiscal Review & Senate Human Services Committee

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Introduction/Opening Remarks

Panel I. Overview of Developmental Centers & Their Utilization in California

A. Utilization of Developmental Centers
B. Developmental Center Funding
C. Oversight of Developmental Centers – Roles and Functions of Key Entities

Panelists:

Terri Delgadillo, Director, Department of Developmental Services
Lishaun Francis, Legislative Analyst's Office

Panel II. Licensing Citations and Patient Care at Sonoma Developmental Center

A. Overview of the Concerns Raised and Potential Federal Funding Implications
B. Responses to Those Concerns at Sonoma & Throughout the Developmental Center System

Panelists:

Kathleen Billingsley, RN, Chief Deputy Director, Policy & Programs, Department of Public Health
Lishaun Francis, Legislative Analyst's Office
Terri Delgadillo, Director, Department of Developmental Services
Santi Rogers, Executive Director, San Andreas Regional Center
Leslie Morrison, Director of the Investigations Unit, Disability Rights California
Kathleen Miller, President, Parent Hospital Association

Public Testimony, Part I

Panel III. Update on the Closure Process at Lanterman Developmental Center

A. Overview of Closure Process to Date & Challenges Encountered
B. Anticipated Timeframes & Key Milestones Ahead

Panelists:

Terri Delgadillo, Director, Department of Developmental Services
Keith Penman, Executive Director, San Gabriel/Pomona Regional Center
Anna Agopian, Co-President, Lanterman Parents Coordinating Council
Catherine Blakemore, Executive Director, Disability Rights California
Jimmy White, Consumer

Panel IV. Implementation of Recent Legislation Regarding Services for Individuals with Complex Needs

A. Overview of Key Changes in Developmental Center Admissions Standards and Community Services
B. Initial Implementation of Key Changes

Panelists:

Terri Delgadillo, Director, Department of Developmental Services
Carlos Flores, Executive Director, San Diego Regional Center
Terry DeBell, President, CASH-PCR
Catherine Blakemore, Executive Director, Disability Rights California

Public Testimony, Part II

Closing Remarks

SENATE
CALIFORNIA LEGISLATURE

STATE CAPITOL
SACRAMENTO, CALIFORNIA
95814

A SYSTEM IN TRANSITION: CALIFORNIA'S DEVELOPMENTAL CENTERS

A JOINT HEARING OF SUBCOMMITTEE #3 OF THE SENATE COMMITTEE ON BUDGET AND FISCAL REVIEW AND THE SENATE HUMAN SERVICES COMMITTEE

Senator Mark DeSaulnier, Chair, Subcommittee #3
Senator Carol Liu, Chair, Human Services Committee
Senator Bill Emmerson, Vice Chair, Subcommittee #3 & Human Services Committee

OCTOBER 23, 2012
STATE CAPITOL, ROOM 4203
10 A.M.

I. EXECUTIVE SUMMARY

California's Department of Developmental Services (DDS) operates four institutional Developmental Centers (DCs) and one smaller state-operated community facility that care for approximately 1,650 adults and children with developmental disabilities. These DCs are part of a larger system of developmental services overseen by DDS, which also includes services and supports for approximately 250,000 people with developmental disabilities who live in their communities. In the current budget year (2012-13), the anticipated costs associated with DCs are approximately $559 million, including $284 million in state General Fund (GF) resources. The budget for the larger developmental

services system, including DCs as well as community-based services, includes $4.7 billion ($2.7 billion GF).

The first DC opened in 1888, and residents with developmental disabilities were typically co-mingled with patients whose primary needs were related to mental illness. At their peak in 1967, the state's DCs housed more than 13,000 people. Since the late 1960s, however, California has been reducing its use of DCs as a placement for individuals with developmental disabilities. In general, this decline in the use of DCs coincides with the development of strategies to allow individuals to live at home or in other community-based living arrangements, e.g., new assessment and individual service planning procedures and appropriate services and supports.

The focus of this hearing is on some of the critical issues facing the state as it continues to decrease reliance on institutional care in DCs. First, the state must continue to ensure the health, safety, and well-being of individuals who reside in DCs. Recent, serious licensing citations related to the Sonoma DC have raised questions about whether this fundamental obligation is being fully met there and about how the protection of clients in DCs can and must be improved. Second, the state must ensure the timely, safe, and effective transition of clients who are exiting DCs in order to reside in their communities. This obligation exists on a statewide basis, and is particularly relevant with respect to the ongoing process of closing the Lanterman DC. Finally, looking forward, the state must implement new statutes enacted as part of the budget process that significantly narrow the basis for admissions into DCs and for making other restrictive placements for individuals with especially complex needs. DDS, regional centers, advocates, and other partners must assess the needs of developmental services consumers with challenging needs, including severe behavioral issues, co-occurring mental health disorders, and other complexities. Working together, stakeholders must also bolster the breadth, availability, and processes for accessing specialized resources to support these consumers.

II. BACKGROUND

A. DEVELOPMENTAL CENTER AND DEVELOPMENTAL SERVICES OVERVIEW

California's four DCs lie on large campuses with various residential units; many of them were built more than a century ago to house individuals who were unable to remain at home. Each DC has a mix of units that are licensed as skilled nursing facilities, general acute care hospitals, or intermediate care facilities. Housing within the units is based on the needs of individual residents. In addition, the state operates a smaller community facility.

The DCs are part of a larger system of care overseen by DDS that also includes services and supports (e.g., day programs, transportation, employment supports) for approximately 250,000 people with developmental disabilities who live in their communities (e.g., with parents or other relatives, in their own houses or apartments, or in group homes). Care outside the developmental centers is coordinated through 21 non-

profit regional centers, which manage individual cases and contract for appropriate services in their local communities. Regional Centers are non-profit organizations that provide diagnosis and assessment of eligibility and help plan, access, coordinate, and monitor consumers' services and supports. Regional Centers also are one of the entities responsible for oversight of the care of individuals residing within developmental centers.

A developmental disability is defined as a severe and chronic disability that is attributable to a mental or physical impairment that begins before age 18 and is expected to continue indefinitely. These disabilities include mental retardation, cerebral palsy, autism, epilepsy, and other similar conditions. Infants and toddlers (age 0 to 36 months) may also be eligible for some developmental services if they are at risk of having developmental disabilities or if they have a developmental delay.

Determination of which services an individual consumer needs is made through the process of developing an Individualized Program Plan (IPP). The IPP is prepared jointly by an interdisciplinary team that includes the consumer, parent/guardian/conservator, persons who have important roles in evaluating or assisting the consumer, and representatives from the regional center and/or DC.

Under the law that existed prior to 2012 statutory changes described later in this document, individuals with developmental disabilities could be placed in DCs through involuntary judicial commitment because of a danger to themselves or others or in order to restore their competency to stand trial on criminal charges, or with judicial review in other circumstances, including voluntary placements.

B. BUDGET FOR DEVELOPMENTAL SERVICES AND CENTERS

The 2012-13 Developmental Services budget includes approximately $4.7 billion [$2.7 billion General Fund (GF)]. Of this total, approximately $550 million ($328 million GF) is dedicated to DC expenditures. The receipt of federal funding for DCs is contingent upon satisfying requirements in eight licensing categories. The two main sources of DC costs are: 1) personnel and 2) operating expenses and equipment. There are approximately 5,150 staff positions allocated to DCs for 2012-13.

The 2011-12 budget also included uncodified trailer bill language that required DDS to reimburse the Office of Statewide Audits and Evaluations within the Department of Finance for a review of the budgeting methodology used to establish annual budget estimates for DCs. The audit, which was completed in April 2012, found that overall the DDS budget methodology for DCs was reasonable and accurately calculated. Specifically, the audit found that the methodology took into account relevant budgetary drivers, including the DC client population, evaluations of client needs, and prior expenditure levels. At the same time, the audit did find that some staffing standards and evaluation systems were outdated and made recommendations for changes. One of those systems is the Client Development Evaluation Report (CDER) program. As a result, DDS began using an updated CDER intended to better reflect the needs of the current population and established a category to better capture the needs of the dually diagnosed.

These changes were incorporated in the May Revision and final 2012-13 budget. Non-level-of-care staffing standards were also updated.

Recent Reductions to the System

Over the three years from 2009-10 to 2011-12, DDS GF spending remained relatively flat, even while the developmental services caseload grew. In general, this cost containment occurred because of: 1) increased use of federal and other funding sources; 2) a reduction in the rate of payments to service providers (ranging from three to 4.25 percent); and 3) administrative changes, cost-control measures, and some service reductions. The anticipated savings from these changes in the years they were enacted (several of which also result in ongoing savings) combined to total over $1 billion GF.

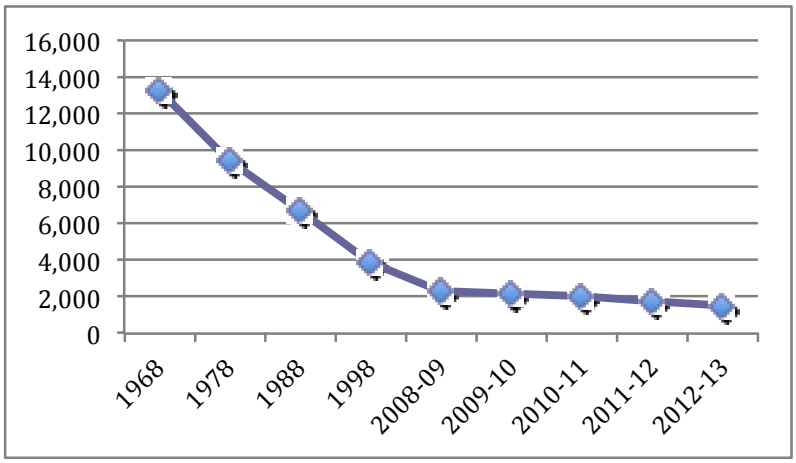
The 2012-13 budget included $240 million GF savings: $40 million from the anticipated receipt of California First 5 (Proposition 10) Commission funding for certain services for children with developmental disabilities and $200 million from a variety of strategies that included increasing federal funds, implementing recent legislation regarding the use of private health insurance for certain services, changes to policies related to the use of DCs (described in greater detail toward the end of this document), and a 1.25 percent reduction to regional center and provider payment rates. The 2012-13 budget also included a "trigger" for an additional $50 million in unspecified reductions to the budget for DDS if the voters do not approve of Proposition 30 in the November election.

C. ADDITIONAL BACKGROUND ON THE USE OF DEVELOPMENTAL CENTERS

The first DC opened originally as the Agnews Insane Asylum in 1888, and residents with developmental disabilities were typically co-mingled with patients whose primary needs were related to mental illness. Over the next 70 years, increased awareness of the unique needs of individuals with developmental disabilities prompted a change in focus, as well as the establishment of other state facilities specifically for people with developmental disabilities. At their peak in 1967, the state's DCs housed more than 13,000 people.

Since the late 1960s, California has been reducing its use of DCs as a placement for individuals with developmental disabilities (as summarized in the table below through point-in-time data from the years reflected). In general, this decline in the use of DCs began as strategies were developed to allow people to keep their family members at home or in other community-based living arrangements, e.g., with new assessment and individual service planning procedures and appropriate services and supports. In the last five years, the population of individuals residing in California's developmental centers has declined about 38 percent, from 2,732 on September 24, 2007, to 1,686 residents at the beginning of the 2012-13 fiscal year.

DEVELOPMENTAL CENTER POPULATION



Placements In Developmental Centers

The shift to community-based care also was given weight by the U.S. Supreme Court, which ruled in *Olmstead vs. LC* (527 U.S. 581, 1999) that a lack of community supports was not legal grounds for denying people with disabilities who could benefit from community placement by a move from an institution to a community setting. Such a denial, they said, was discrimination based on disability under the Americans with Disabilities Act and a violation of individual civil rights. Soon after the ruling, many states began shutting down their institutions and developing additional community-based services.

California's effort to de-institutionalize individuals with developmental disabilities was given another push by a lawsuit settled in 2009, known as *Capitol People First et al v. Department of Developmental Services et al*. Under the settlement agreement, the state provided additional funding to ensure regional center caseworkers would attend planning meetings in the DCs, and agreed to provide consumers with information about community living options. The state additionally agreed to identify best practices and provide training for regional centers to better identify and support individuals who are diagnosed dually with a developmental disability and mental illness. DDS and the regional centers also agreed to develop additional community placement options.

California's current efforts to close the Lanterman Developmental Center in Pomona were preceded by four other closures in the past two decades. In 1995, the state shuttered the Stockton State Hospital. In 1997, the state closed Camarillo State Hospital, which had housed clients with both mental illness and developmental disabilities. In 2009, DDS closed Agnews Developmental Center. Sierra Vista, a state-operated community facility, closed in 2010.

According to DDS, care in DCs has become more focused on serving individuals with severe behavioral issues, autism, co-occurring mental health disorders, and risk factors associated with medical conditions and sensory impairments that require additional

support. Nearly half of the residents living in DCs are aged 52 or older, including 17 percent who are 62 or older.

II. OVERSIGHT ISSUES FOR THIS HEARING

A. Recently Identified Health & Safety Concerns at Sonoma Developmental Center

Sonoma Developmental Center (SDC) is the oldest facility in California established specifically for serving the needs of individuals with developmental disabilities. The facility opened its doors to 148 residents on November 24, 1891. As of October 1, 2012, 522 individuals live on the sprawling campus in Eldridge, just south of the Sonoma County town of Glen Ellen. About 1,530 staff members work at SDC. The facility's 2012-13 budget includes $146 million ($76 million GF).

On July 3, 2012, licensing staff from the California Department of Public Health conducted an annual survey of SDC to assess whether the facility was in compliance with state licensing regulations, as well as to conduct, by proxy, a federal licensing review by the Centers on Medicaid and Medicare Services. Licensing requirements include eight Conditions of Participations that support the delivery of services to residents of an Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID). These licensing requirements include:

- Appropriate oversight by the governing body, or facility management
- Client protections in areas such as freedom from harm, participation in social activities, accounting of personal funds, and others
- Facility staffing adequate to support resident functions
- Active treatment services that are purposeful and appropriate for each individual
- Client behavior and facility practices including appropriate safeguards for behavioral interventions
- Health care services appropriate to serve clients on a 24-hour basis
- Dietetic services appropriate for individual needs of consumers
- A physical environment that is safe and secure

During the July visit, licensing officials found numerous violations, outlined in a 250 page report, which included lapses in six of these eight categories. Among the findings were that SDC's management failed to take actions that identified and resolved problems of a systemic nature, failed to ensure adequate facility staffing, failed to provide active treatment, failed to provide appropriate health care services and several other key categories. According to page 3 of the report:

> "Individuals have been abused, neglected and otherwise mistreated and the facility has not taken steps to protect individuals and prevent reoccurrence. Individuals were subjected to the use of drugs or restraints without justification. Individual freedoms have been denied or restricted without justification."

On four separate occasions during the survey, the team identified conditions that posed immediate jeopardy to the health and safety of patients at the facility. Among the concerns of surveyors were:

- Thirty-five incidents in which residents ate non-edible items such as gloves, buttons, sunglasses, paper and other items. Two clients required emergency surgery to remove items from their abdomens. These consumers have pica, a disability that compels them to eat such items as clay, glass, paper and other non-edibles. In the instances documented in the Sonoma report, consumers ingested items that were documented in their files as items of concern, including the client who ate the sunglasses.
- Eleven clients who bore injuries that resembled burns from a stun gun. Facility law enforcement personnel found a loaded gun and a stun gun of another type in a staff member's car.
- The sexual assault of two residents by a staff member. Although another staff member who witnessed the alleged perpetrator expose himself to a consumer reported this incident, the facility was faulted for failure to ensure thorough and timely investigation of the incident, as well as implementation of corrective action plans for analysis of facility injury data for patterns and trends to prevent others from harm.
- Inadequate supervision of clients resulting in falls, attacks upon other consumers, clients who ran from the facility, and heightened anxiety among some clients.
- Severe and consistent understaffing patterns which resulted in employees being forced to work consecutive shifts, units being frequently short-staffed and staff members being moved into units to care for consumers they did not know. The report documents at least one incident in which a consumer's agitation was linked to frequent changes in care providers.
- The death of one client from acute peritonitis related to a misplaced gastrostomy tube. After the client's death, it was determined that physician's orders did not accurately identify the gastrostomy tubes and prescribe their care, nor did procedures at SDC adequately provide staff with information about manufacturer's specifications or best practices for gastrostomy tube care.

DDS's responses to these findings have included the removal of two top executives at the facility, contracting with an internal monitor for ongoing evaluation of the plans of correction, requiring unannounced checks by facility managers, as well as the DDS director and other executive staff from DDS headquarters in Sacramento, and implementing a number of new policies designed to provide closer supervision and better training for staff. DDS also indicates that it has informed families of the actions taken and initiated the use of a questionnaire to allow family members, visitors, and clients to provide feedback and request a response to concerns throughout the facility.

The corrective action process is ongoing, with DDS and licensing surveyors continuing to review procedures at SDC. If the issues are not resolved to the satisfaction of federal officials, the state could lose approximately $28 million in federal financial participation in the current year (if funding were to stop on November 1st) for care provided in SDC's Intermediate Care Facilities (ICFs). After this year, if the issues are not resolved to the

satisfaction of federal officials, the state could lose approximately $42.5 million annually in federal financial participation for care provided in those facilities.

CRITICAL QUESTIONS TO ADDRESS DURING THE HEARING:

1. For DPH/DDS: Please describe the next steps in the federal licensure review, including identifying which actions are most critical to mitigate licensing concerns and the risk of federal fund losses.

2. For DDS: The licensing report identified significant SDC staffing shortages and the use of overtime as concerns, and recent data indicates continued high vacancy rates compared with other DCs. Can you discuss how the staffing levels reached such a critical level and what steps you are taking to remedy the concerns?

   a. Do other Developmental Centers employ mandatory overtime or have similar staffing levels? If so, are those also being addressed?

   b. SDC also has a significantly higher proportion (39 percent as of September 2012) of unlicensed staff providing direct care than in the other DCs (which have rates of 12 and 17 percent). What accounts for this discrepancy? Do you have a plan in place to reduce it?

3. For All Panelists: What are the most critical steps that the Department, Sonoma Developmental Center leadership, and other involved stakeholders can take to better protect the health and safety of the facilities' residents? Are those steps already being taken and are sufficient communications about them taking place?

4. For All Panelists: How are oversight bodies and involved stakeholders (DDS, Regional Centers, advocates, others) able to ensure that similar care concerns do not exist at the state's other Developmental Centers?

B. The Closure Process for Lanterman Developmental Center

Lanterman Developmental Center (Lanterman) in Pomona consists of 21 client residences, one acute hospital unit, a variety of training and work sites, and recreational facilities, including a camp. The facility's 2012-13 budget includes $96 million ($52 million GF).

Lanterman opened in May 1927 as the Pacific Colony facility, and was later renamed to honor former Assembly Member Frank D. Lanterman for his work in creating a system of community resources, including the regional centers. At its peak, Lanterman housed more than 1,900 individuals. DDS submitted its plan to close Lanterman to the Legislature in January 2010 as part of its budget proposal for 2010-11. The plan was approved in October 2010, and the department instructed regional centers to begin developing additional residential options for consumers who would be moving to the community. At the same time, the department began collaborating with managed care

plans to provide health services for transitioning consumers and embarked on other key transitional activities.

When closure was proposed, there were approximately 400 residents and 1,300 staff at the facility. At that time the majority of the residents were between the ages of 21 and 85 years old. Twenty-three percent lived in the Nursing Facility, while the remaining 77 percent lived in the ICF/IID. As of October 1, 2012, there are 238 residents with 936 staff members who provide a wide range of services at the LDC. The majority of consumers residing at Lanterman (59 percent) have lived there for more than 30 years and 73 percent are between 40 and 65 years old. Overall service delivery needs for 27 percent fall into the Significant Health needs category with 32 percent falling within Protection and Safety. The remaining population has needs within Significant Behavioral Services (23 percent) and Extensive Personal Care needs (19 percent).

According to the department, the transition of each Lanterman resident to other appropriate living arrangements is only occurring after necessary services and supports identified in the IPP process are available elsewhere. The closure process is thus focused on assessing those needs and developing community resources to meet them. The Department and the 12 Regional Centers involved in the closure process use Community Placement Plans as one tool to help them accomplish those goals. DDS has also received recommendations from three advisory groups that include a Resident Transition Advisory Group, Quality Management Advisory Group, and Staff Support Advisory Group. The Department indicates that its staff meets regularly with parents and family members of Lanterman residents, Lanterman employees, and the involved Regional Centers.

The 132 former residents of Lanterman who have transitioned to the community so far have similar lengths of stay at Lanterman, ages, and disabilities as the overall residential population. As of June, more of the individuals who had moved have significant behavioral issues as their primary service need than the overall population of Lanterman residents (42 percent of those who have moved as compared to 19 percent of the overall residential population). Fewer of the individuals who had moved have significant health needs as their primary service need (9 percent as compared with 27 percent). The Department indicates that this is due at least in part to the pace of development of specialized homes (i.e., SB 962 homes) that are equipped to handle these particular health needs.

As part of its transition plan, the Department visits consumers who have moved into community residences at 5 days, 30 days, 90 days, and at 6 and 12 months after the move. Regional centers also visit at regular intervals and provide enhanced case management for the first two years after the move. Special incidents, including hospitalizations and other negative outcomes, are tracked by DDS, and individuals who move from Lanterman into the community are asked to participate in a National Core Indicator (NCI) study. The NCI study uses a nationally validated survey instrument that allows DDS to collect statewide and regional center-specific data on the satisfaction and personal outcomes of consumers and family members.

The Administration has declined to give a target date for closure of the facility as the development of these necessary community resources to ensure a safe and successful transition for each consumer is a continual and complex process. However, in March 2012, Subcommittee #3 of the Senate Committee on Budget and Fiscal Review requested for DDS to provide anticipated timeframes for the remaining transitions and steps in the closure process. Subcommittee #1 of the Assembly Budget Committee made a similar request. The Department's draft response to these requests, which was recently released for stakeholder feedback, is attached as an addendum to this background paper.

CRITICAL QUESTIONS TO ADDRESS DURING THE HEARING:

1. For DDS: Without identifying a specific closure deadline, please summarize the anticipated timeframes for the remaining phases of the closure process.

2. For All Panelists: What have been the significant challenges in making progress toward safely transitioning Lanterman residents to the community to date? How can those challenges be overcome in the near term (e.g., the next three months)? How do you envision progress over one year?

3. For All Panelists: How do you define and measure a successful transition?

C. Early Implementation of Recent Statutory Changes

AB 1472 (Chapter 25, Statutes of 2012), a 2012-13 budget trailer bill that was related to savings anticipated to be achieved within the DDS budget, included a series of statutory changes intended to redesign services for consumers with challenging needs. These changes, which are anticipated to result in $20 million GF savings annually, include significant restrictions on the statutory criteria for admissions to DCs, limitations on the use of locked mental health facilities and out-of-state placements, and provisions to strengthen the capacity of the community to serve individuals with challenging needs (including expanded availability of Adult Residential Facilities for Individuals with Special Health Care Needs and the creation of a statewide Specialized Resource Service).

Restrictions on DC admissions and other specified placements

Efforts to shrink the state's reliance on DCs over the past decade have been hampered by continued admissions to the institutions, largely for consumers with complex forensic or behavioral needs. DDS data from 2011-12 indicated that approximately 100 new admissions to DCs were occurring annually in recent years. While some of these admissions were court-ordered and required by law for individuals who may not be able to understand the criminal charges filed against them, other admissions were believed to be avoidable with appropriate community resources (including some resources which may have needed to be developed). As a result, the 2012-13 budget included language restricting new admissions to DCs, except under specific conditions, including when:

- Individuals are committed for competency training under the state's Incompetent

to Stand Trial statute, which requires the state to attempt to restore individuals to competency to face criminal charges. The unit that provides this training is housed at Porterville Developmental Center.

- Individuals are in need of short-term care based on a judicial determination that they are dangerous to themselves or others due to a crisis. These individuals will be housed at the Fairview Developmental Center in a unit specifically for this purpose. In order to make a crisis placement, a regional resource development program must make a determination that admittance to a DC is necessary due to an acute crisis, as defined, and include a regional center report detailing all considered community-based options (excluding out-of-state placements and specified placements that are ineligible for federal Medicaid funding) and an explanation of why those options cannot meet the consumer's needs.

At the same time, AB 1472 created restrictions on placements in what were considered inappropriate and costly mental health institutions (mental health rehabilitation centers, MHRCs, or institutions for mental disease, IMDs) in order to encourage development in California of services for individuals with developmental disabilities who are experiencing serious mental health issues. The legislation also prohibits regional centers from purchasing out-of-state services without prior DDS authorization, places time limitations on out-of-state placements, and requires regional centers to submit a transition plan by the end of 2012 for all DDS consumers currently residing out of state.

Development of community resources for individuals with complex needs

The recent DDS budget trailer bill requires regional centers to complete comprehensive assessments of consumers residing in developmental centers by December 2015. The assessments will be provided to individual program planning (IPP) teams to help determine the least restrictive environment for each consumer. The legislation requires that this assessment be updated annually as part of the IPP process.

Finally, AB 1472 also included requirements intended to promote the development of additional community resources. Among those was the establishment of a statewide resource service to track specialty programs to serve individuals with more challenging needs, and to coordinate those services with regional centers statewide. The new statutes also require regional centers to prioritize the development of specialty resources, including regional community crisis homes. In addition, AB 1472 authorizes specified licensed community facilities to utilize delayed egress devices and secured perimeters.

CRITICAL QUESTIONS TO ADDRESS DURING THE HEARING:

1. For DDS & Regional Centers: Have there been crisis admissions to Fairview Developmental Center? If so, please provide the number of admissions and a general description of the nature of services needed.

2. For All Panelists: Please describe the types and numbers of resources that have been

developed (or are being planned) in the community as a result of the recent statutory changes for individuals with the challenging needs, including individuals who have both a developmental disability and mental illness.

3. For All Panelists: What progress has been made to begin conducting the assessments newly required for developmental center residents? What have been (and will be) the regional centers' roles, and roles of others, in planning and conducting those assessments?

IV. CONCLUSION

California's four Developmental Centers house some of the state's most uniquely challenged citizens: individuals who may have profound physical needs, social and behavioral challenges, mental illness, and in some cases, all three. The state's Department of Developmental Services has significant responsibility for their care and safety. Other organizations and individuals also play key roles in oversight and care management, including the regional centers, parents and family members, advocates, community-based organizations, outside providers, other caretakers, and consumers themselves.

At a time when California and the nation are continuing to transition from reliance on institutions to the ongoing development and refinement of community resources, it is critical to understand the role each entity plays in the transition and the collective responsibility for each individual's health, safety, and opportunity to thrive. This hearing offers an opportunity to highlight critical concerns related to the care and support of these especially vulnerable Californians, and to identify opportunities to strengthen that care and support.

LAO
70 YEARS OF SERVICE

October 23, 2012

Funding and Oversight of State Developmental Centers

LEGISLATIVE ANALYST'S OFFICE

Presented to:
Senate Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services
Hon. Mark DeSaulnier, Chair

Senate Human Services Committee
Hon. Carol Liu, Chair

LAO
70 YEARS OF SERVICE

Organization of Handout

☑ ***Organization of Handout.*** This handout provides the following:

- Overview of the Department of Developmental Services (DDS) programs.
- Background information on the Developmental Centers (DCs) program.
- Overview of funding for the DCs.
- Overview of the major entities that perform oversight of the DCs.

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Overview of DDS Programs

☑ ***Lanterman Act Is Basis for Providing Services.*** The Lanterman Developmental Disabilities Services Act of 1969 forms the basis of the state's commitment to currently provide about 254,000 developmentally disabled individuals with a variety of services that are overseen by DDS. The DDS provides community-based services as well as institutional care as follows:

- ***Community Services Program.*** About 252,000, or more than 99 percent, of DDS consumers receive services under the Community Services Program. These community-based services are coordinated locally through 21 nonprofit organizations called regional centers, which provide diagnosis, assessment of eligibility, and help consumers coordinate and access the services they need.

- ***Developmental Services Program.*** About 1,600, or less than 1 percent, of DDS consumers live in state-operated facilities known as DCs. The DDS operates four DCs (Fairview in Orange County, Lanterman in Los Angeles County, Porterville in Tulare County, and Sonoma in Sonoma County) and one smaller leased facility (Canyon Springs in Riverside County) that provide 24-hour care and supervision to their residents.

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Background on the DC Program

☑ ***The DCs Provide a Wide Array of Services.*** All of the DCs provide residential and day programs, as well as health care and assistance with activities of daily living, education, and employment.

☑ ***The DC Population Has Steadily Declined in Recent Years.*** Between 2001-02 and 2011-12, the DC population has declined from 3,632 to 1,682—an average annual year-over-year decline of about 7 percent. This is consistent with federal and state policy to provide services to developmentally disabled individuals in the community rather than in an institutional setting. The following significantly contributed to the decline in the DC population over the last decade:

- ***Closure of Agnews DC.*** The closure of Agnews DC (San Jose) was completed in 2009. Most of the Agnews residents were moved to community placements while some were moved to other DCs.
- ***Planned Closure of Lanterman DC.*** The administration announced plans to close Lanterman DC in 2010. Between 2010-11 and 2011-12, the population of Lanterman DC has decreased from 311 to 254.

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Background on the DC Program *(Continued)*

☑ ***The DCs Are Aging Facilities.*** With the exception of Canyon Springs, all of the DCs are more than 50 years old. In 1998, consultants from Vanir Construction Management, Inc. assessed the condition of the five DCs operating at that time and recommended hundreds of millions of dollars in capital outlay improvements, most of which have not yet occurred.

☑ ***Porterville DC Serves a Unique Population.*** The Porterville DC operates the secure treatment program to provide services to consumers who have (1) mild-to-moderate mental retardation, (2) have come into contact with the criminal justice system, (3) have been determined to be a danger to themselves or others and/or incompetent to stand trial, and (4) have been determined by the court to meet the criteria requiring treatment in a secure setting. The Porterville DC also serves developmentally disabled individuals who have not come into contact with the criminal justice system and do not require secure treatment.

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Overview of DC Funding

☑ ***Caseload and Costs Vary Significantly by Facility.*** As shown in the figure below (with 2011-12 data), caseload, staffing, and costs vary significantly among the four DCs and Canyon Springs.

2011-12 DC Costs and Other Data, by Facility

(Dollars in Millions)

	Caseload	Number of Personnel Years	Personnel Cost	Operating Expenses and Equipment Cost	Total Costs
Lanterman	271	1,051	$86.2	$9.5	$95.7
Porterville	499	1,481	118.6	24.4	143.0
Sonoma	555	1,630	139.3	18.0	157.3
Fairview	377	1,263	101.4	13.5	114.9
Canyon Springs	50	122	9.6	3.9	13.5
6th Center[a]	—	25	8.5	44.2	52.7
Totals	**1,752**	**5,572**	**$463.6**	**$113.5**	**$577.1**

[a] 6th Center = funds that are not allocated to a specific developmental center at the beginning of the fiscal year and are generally allocated based on need at a later date.

☑ ***Funding for $550 Million DC Budget in 2012-13 Comes From Two Main Sources.*** Of the total of $550 million budgeted in 2012-13 for the DCs, $534 million, or 97 percent, comes from the following two sources: (1) General Fund ($286 million), and (2) Federal Title XIX Medi-Cal reimbursements ($248 million) that are passed through to DDS via the Department of Health Care Services—the single state agency recognized by the federal government for Medi-Cal to fund services provided to DC residents. Other funding for DCs comes from: (1) other reimbursements ($15.3 million) for such services as the Community Industries Contract and rental income contracts, (2) grants ($504,000 federal funds) for the Federal Foster Grandparent Program, and (3) State Lottery Education Funds ($453,000).

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Overview of DC Funding *(Continued)*

☑ ***There Are Two Main Drivers of DC Costs.*** There are two main drivers of DC costs: personnel and operating expenses and equipment (OE&E). Personnel costs refer to the cost of employees including wages, salary, and benefits. The OE&E refers to general expenses such as the cost of equipment, communication, electricity, and general use of the facility.

- ***Some Costs Are Fixed, Others Are Variable.*** Some costs of operating a DC are fixed, meaning that they do not vary based on the number of residents. For example, costs for grounds maintenance that do not change due to increases or decreases in caseload are fixed costs. However, costs for staff that provide direct care to DC residents do vary based on the number of residents and how acute their needs are for services.

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Overview of Major Entities That Perform DC Oversight

☑ ***Several Entities in State Perform Oversight of DCs.*** Several entities in the state oversee various aspects of DC operations. The major oversight entities and their roles are as follows:

- ***DDS.*** The DDS has a general oversight role with DCs in that it hires all their executive level staff, helps manage their budgets, and creates rules and guidelines for how criminal investigations are to be handled. The DDS set forth a new set of reporting guidelines to handle abuse allegations in 2002 and recently updated them in 2012.

- ***Regional Centers (RCs).*** The state provides community-based services to consumers through 21 nonprofit corporations known as RCs, which are located throughout the state. While RCs do not have a direct oversight role over DCs, each DC consumer is also a RC consumer, so RCs are in effect responsible for monitoring each DC client's care. The RCs are responsible for eligibility determinations and client assessment, the development of an individual program plan for each consumer, and case management.

- ***California Department of Public Health (DPH).*** As a health care facility, DCs are subject to being licensed and certified by DPH. To be licensed means that the entity has permission to operate, and to be certified means it has met certain standards set forth by the state and/or federal government. The DCs are licensed and certified as Skilled Nursing Facilities, Intermediate Care Facilities, and General Acute Care hospitals. In addition to ensuring DCs comply with state laws and regulations, DPH communicates with the federal government to ensure that DCs are meeting the federal requirements to receive Medi-Cal funding.

- ***Disability Rights of California (DRC).*** The DRC—a non-profit organization operating in the state—has traditionally taken the role of advocating on behalf of the developmentally disabled by ensuring their legal rights are protected. However, DRC also has federal authority to audit incidents at

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Overview of Major Entities That Perform DC Oversight *(Continued)*

the DCs and has done so in the past. The DRC has brought class action lawsuits on behalf of the disability community. For example, in 2009 DRC litigated *Capitol People First v. DDS*, a case that required the state's large facilities, such as DCs, to inform consumers of various community living options and to allow those individuals to choose where they want to live in the community.

- ***State Council on Developmental Disabilities (SCDD).*** The SCDD was established by state and federal law as an independent agency whose purpose is to ensure that people with developmental disabilities receive the services they need. The SCDD produces a report called the State Plan, in which they state its intent and goals to improve the access and services for disabled individuals. In its recent State Plan, SCDD set a goal to be more involved in the planning and closure process of DCs and to work with state and federal entities in order to protect the rights of residents in DCs. Additionally, SCDD has an interagency agreement with DDS to deliver client rights and volunteer advocacy services for DC consumers. This allows them to have two staff members based at each DC to ensure consumer rights are protected and to ensure consumers get the services they need.

☑ Federal Government Plays a Role in DC Oversight

- Under the Civil Rights of Institutionalized Persons Act (CRIPA), the U.S. Department of Justice (USDOJ) routinely conducts investigations in institutions that provide services for persons who are disabled or mentally ill. In 2004, USDOJ opened an investigation in Lanterman and subsequently in Agnews and Sonoma DCs. The USDOJ identified constitutional violations at Lanterman and similar violations at Agnews and Sonoma DCs. For example, USDOJ found that Lanterman failed to protect its residents from neglect and physical harm—a problem compounded by Lanterman's inadequate reporting and investigation system.

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Overview of Major Entities That Perform DC Oversight *(Continued)*

☑ **Failure to Meet Federal Licensing Requirement Has Fiscal Implications**

- In 1998-99, several DCs faced sanctions as a result of licensing surveys by the Department of Health Services and the federal Health Care Financing Administration. The surveys cited the DCs for numerous examples of inadequate care and understaffed residential and treatment units. As a result of the surveys, the state was unable to receive the federal match for Medi-Cal for individuals who were newly admitted to the two institutions. The state was instructed to increase staffing in all five of its institutions. In response, the state developed a four-year plan to increase staffing levels to help address federal concerns and to restore lost federal funding. In total, the four-year plan added approximately 1,700 positions at a cost of $107 million ($55 million General Fund).

☑ **Failure to Meet Federal USDOJ Requirements Has Fiscal Implications**

- Although USDOJ has not brought any legal actions against DDS to bring the DCs into compliance with CRIPA, it has done so in respect of other California state institutions. For example, several of the state's mental hospitals recently operated under a CRIPA consent decree for several years. The 2012-13 budget plan includes approximately $65 million related to the state mental hospital workload associated with this judgment. The DDS noted in its program budget estimate released in May of 2012 that it is engaged in settlement negotiations with USDOJ to resolve the investigations.

MILESTONES FOR CLOSURE OF
LANTERMAN DEVELOPMENTAL CENTER
October 18, 2012

The Department of Developmental Services (Department) provides services to individuals with significant developmental disabilities in state-operated Developmental Centers. Over the years, as community resources and capacity have increased, reliance on the developmental centers has declined. In April 2010, the Department submitted its recommendation and plan for the closure of Lanterman Developmental Center (LDC) to the Legislature for consideration. The health and safety of each LDC resident is the Department's highest priority and a core principle of the closure plan. The plan expressly states the Department's commitment to meet the needs of each resident while they reside at LDC and throughout all phases of their transition into an alternative living arrangement. This means that no LDC resident will move until the appropriate services and supports identified in each individual's plan are available. Because of these commitments, the Department's plan does not specify a closure date. As required by statute, however, the Department does provide regular updates to the Legislature regarding closure activities and progress in plan implementation.

In addition to reporting on progress, the Legislature has also requested that the Department provide estimated completion dates for significant milestones related to implementation of the plan. To assist in developing these milestones, the Department requested input from a broad array of stakeholders. Two conference calls to obtain input were held on August 21 and 29, 2012, and written comments were accepted by the Department until September 14, 2012. The Department also held a conference call on September 7, 2012, with LDC families and representatives from the Parents Coordinating Council. Through these efforts the Department received valuable input for development of the draft milestones from many perspectives, including LDC families and employees, regional centers, service providers, advocates, legislative staff and the general public.

The Department is asking stakeholders to review the draft milestones and provide additional feedback by November 5, 2012, which the Department will consider prior to finalization of the milestones.

In the course of the stakeholder process, apart from input on milestones and their completion dates, the Department also received suggestions and requests for other information and data related to the facility closure, including, for example: incident report data, unit consolidations, unique and individualized community services, and utilization of the Staff Options and Resource Center. The Department understands that this information is also critical and will make it available throughout the closure process.

The Department would like to thank those that participated in the calls and/or submitted written comments. The Department recognizes that the needs of individuals and their families may change as the closure progresses, and will continue to work closely with

families, advocates, regional centers, LDC staff and other stakeholders to monitor the progress on a regular basis, collect and analyze data related to the closure, and provide updates.

Milestones for Closure of LDC

Milestone	Estimated Completion Date
A. Residents	
1. Comprehensive Assessments Current comprehensive assessments will be completed for all residents of LDC by June 2013. This milestone represents one of the key activities performed by regional centers to determine the individual services and supports needed for successful transition to a community living arrangement. **Baseline:** As of October 1, 2012, of the 238 individuals who reside at LDC, 139 have a current comprehensive assessment.	June 2013
2. Peer Informational Meetings (a.k.a. Choices Project) The Choices Project, as included in the closure plan, is a voluntary process for residents to work with designated peers to learn about the variety of living options and the services and supports they provide. Residents may participate in Choices meetings to communicate what is important to them about their home and leisure time activities and help determine their future. The information is considered in their transition plans. **Baseline:** As of October 15, 2012, 92 residents have participated in the Choices Project.	May 2013
3. Case Transfers Residents may request to reside in a community that is outside the catchment area of the individual's current regional center. This request may stem from relocation of their family members or a desire to live with existing roommates or friends in the community. Requested or anticipated regional center transfers of consumer case management services will be jointly discussed monthly between regional centers, LDC and the Department. Residents and families may make or withdraw requests for case management transfers as individual preferences and circumstances change. **Baseline:** Currently, approximately 30 families are exploring living options in an alternate regional center.	November 2012 and Ongoing

Milestone	Estimated Completion Date
4. Individual Transition and Health Transition Plans Individual Transition Plans are developed as part of an intensive person-centered Individual Program Plan (IPP) process. In addition, an Individual Health Transition Plan is developed before a resident moves and includes their health history, a current evaluation of their health status, specific information regarding how health needs will be met after transition and specific transition health services. Individual Transition and Health Transition Plans, which are typically completed a few months prior to placement, will be developed for all current residents by March 2014. This milestone represents the completion of a crucial element in facilitating an individual's safe and successful transition into the community. **Baseline:** As of October 1, 2012, 238 individuals currently reside at LDC, of which 55 have plans and 183 still need plans. In addition, 132 former residents had transition plans.	March 2014
B. Community Supports	
1. Residential Facilities The Department annually funds Department-approved regional center Community Placement Plans, which are earmarked for the development of resources in the community for individuals transitioning out of a developmental center. The development of residential facilities to meet the needs of individuals transitioning to the community is expected to be completed by January 2014. This milestone represents the availability of residential services in the community to meet the needs and allow for successful transition of LDC residents. The milestone is divided into three components as presented below.	January 2014
a. All required residential property is either acquired (if owned by housing non-profit agency associated with the regional center) or identified (if owned by a service provider.)	January 2013
b. Regional centers have identified all service providers and completed the required profiles on the entity. The provider profiles have been sent to the LDC Parent Coordinating Council (PCC) and the regional center has included a link on their internet websites to the PCC's website.	May 2013
c. All homes are licensed and ready for occupancy. **Baseline:** 100 residential options to be developed as part of the regional center requested and approved Community Placement Plans. Of the 100 residential options to be developed: • 75 have a site secured, 3 are in escrow and 22 have no site identified. • 27 of the 75 secured sites are licensed.	January 2014

Milestone	Estimated Completion Date
2. Day Programs and Other Community Resources The Department's Community Placement Plan includes funding for the development of programs to meet the individuals' need for activities during the day. Developing day program services generally requires less lead time than residential programs. The development of day programs to address the needs of LDC residents transitioning to the community is expected to be completed by March 2014. The day program component of this milestone is divided into two components as presented below. In addition, other community service needs may be identified in a resident's transition plan. Many of these support services already exist in the community and are available for individuals as they transition from LDC. However, if the regional center identifies an unmet need, they will work with providers to develop the necessary resources to support the individuals residing in the community, including such services as transportation, crisis supports, etc. The development of other community resources to address the needs of LDC residents transitioning to the community is expected to be completed by March 2014.	March 2014
a. The sites of all day programs have been secured (e.g., lease).	December 2013
b. All day programs are to be licensed and available to provide services. **Baseline:** Six programs are currently scheduled for development based on regional center requests for Community Placement Plan funding, of which two are pending licensure.	March 2014
C. Developmental Center	
1. LDC Staffing Level It is essential that sufficient staffing levels be maintained at LDC throughout the closure to ensure residents' health and safety. However, the need for staff that provides direct care will decrease consistent with the decline in the number of residents and changes in the acuity of those individuals remaining at the facility. Non-direct care staffing also decline throughout the closure process, but generally at a slower rate due to their responsibilities to maintain facility systems and supports that are not related to the resident population. This milestone will include a comparison of staffing to resident population at LDC, as compared to the reduction based upon resident health and safety and acuity, since the announcement of the closure. This comparison will not include any staffing that has been identified to support transition and/or closure activities such as warm shutdown. It can be expected that for every 50 residents that leave the LDC population, the staffing at LDC will reduce by approximately 10%.	Ongoing throughout Closure Process

Milestone	Estimated Completion Date
Baseline: At the time of the closure there were 401 residents at LDC, with a staffing of 1280 Personnel Years (PYs). As of October 1, 2012, there were 238 residents at LDC, with a staffing of 894 PYs. This is slightly above the targeted staffing of 880 PYs that was expected for the resident population of 250 on August 1, 2012. A staff reduction plan was announced shortly thereafter.	
2. <u>Outpatient Clinic</u> As an additional measure to bridge the transition of residents from LDC to community living arrangements, the Department's plan includes the establishment and operation of an outpatient clinic to provide medical, dental and behavioral services for former LDC residents to assist in stabilizing the person in their new setting while they are in the process of transferring care to a new healthcare provider. The Department opened an outpatient clinic in August 2011, which provides services throughout closure and assists the successful transition of healthcare services for all former residents. • The facility will be staffed and ready for full implementation of a freestanding outpatient clinic upon the transfer of the last resident. • The clinic will be able to serve both LDC movers and other consumers. **Baseline:** The clinic currently operates under the LDC license and serves only LDC movers.	Summer 2014
3. <u>Community State Staff Program</u> Legislation that supports the closure efforts allows LDC employees to participate in a Community State Staff (CSS) program that provides an opportunity for individuals to support former LDC residents in the community while retaining their state employment status. Through this program, the specialized knowledge, skills and abilities of state staff are shared with co-workers thereby enhancing service continuity. Although the program is voluntary for the employees and the providers, the interest in the CSS program by residents and families supported the development of this milestone. In support of the CSS program, the Department will conduct informational/training sessions regarding the program, complete a survey of LDC staff to determine interest in the program, and ensure an adequate number of Direct Support Professional (DSP) trainings. The milestone is divided into three components as presented below.	Ongoing throughout the closure process
a. The number of informational/training sessions regarding the utilization of State staff in the community that have been provided to service providers, LDC families and LDC staff. **Baseline:** Throughout the closure there have been 11 informational/question and answer sessions on the CSS program – three (3) for LDC staff and eight (8) for regional centers, service providers, family members and union representatives. Three (3) additional comprehensive trainings will be completed in FY 2012/13.	June 2013

Milestone	Estimated Completion Date
b. The Department will survey LDC staff regarding interest in the CSS program to include geographic preferences. **Baseline:** A survey was distributed to LDC staff in February 2012; results indicated an interest in learning about the CSS program. A follow-up survey will be conducted in November 2012.	November 2012
c. The Department will ensure an adequate number of DSP trainings are held throughout the closure process in support of the CSS program. **Baseline:** As of October 1, 2012, no DSP trainings have been offered as there are no provider contracts in place at this time for the CSS program.	March 2014